

**TITLE: PREVENTING FRAUD, ABUSE AND WRONGDOING**

**PURPOSE:** To summarize Harris Health System's commitment to compliance and to reinforce policies and procedures for detecting and preventing fraud, abuse, and wrongdoing, including how to report concerns.

**POLICY STATEMENT:**

Harris Health System (Harris Health) is committed to complying with all applicable laws and regulations, including, but not limited to the Deficit Reduction Act of 2005, the Federal False Claims Act, the Fraud Enforcement and Recovery Act, the Patient Protection and Affordable Care Act, and the Texas Medicaid Fraud Prevention Act. Harris Health supports the efforts of federal and state authorities in identifying incidents of fraud, abuse, and wrongdoing and has implemented procedures to prevent and detect fraud, abuse, and wrongdoing.

This policy provides:

1. An overview of applicable federal and state laws used by the government to enforce compliance with federal and state health care program requirements; and
2. A discussion of the responsibilities and methods available to all members of the Harris Health Workforce in preventing fraud, abuse or wrongdoing.

**POLICY ELABORATION:**

**I. DEFINITIONS:**

- A. **ABUSE:** Incidents or practices that are not fraudulent, but are inconsistent with generally accepted medical, business, or fiscal practices. Abuse may be unintentional.
- B. **FEDERAL HEALTH CARE PROGRAMS:** Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States government. Some of the federal health care programs include, but are not limited to:
  1. Medicare;
  2. Medicaid;
  3. Public Health Services;
  4. Railroad Retirement Board;

5. Black Lung Program;
6. TRICARE/Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)/Department of Defense health care programs; and
7. Veterans Administration.

C. **FRAUD:** Any act characterized by deceit, concealment, or violation of trust. It is an intentional, knowing, or reckless misstatement of fact that is believed and acted upon by the victim to the victim's harm. Fraud can include, but is not limited to:

1. Violations of Federal or state False Claims Act laws;
2. Theft of time;
3. Diversion of revenue;
4. Charging Harris Health for expenses or capital items without authorization;
5. Misstatement of financial accounts;
6. Theft or misappropriation of Harris Health assets; or
7. Unreported conflicts of interest.

D. **WHISTLEBLOWER PROTECTION:** Those provisions of federal and state law that prohibit retaliatory action for reporting violations of law.

E. **WRONGDOING:** Immoral or unethical behavior. Any action that fails to conform to standards of law or morality.

## II. **BACKGROUND:**

A. Harris Health implemented a Corporate Compliance Program in an effort to establish effective internal controls that promote adherence to applicable federal and state laws and the program requirements of federal, state, and private health plans.

B. The federal government and the State of Texas have enacted criminal, civil, and administrative laws that prohibit the submission of false or fraudulent claims and the making of false statements to the federal and state governments. These laws contain various criminal, civil, and administrative penalties and provide governmental authorities with broad authority to investigate allegations of fraud, abuse, and wrongdoing and to enforce compliance with federal and state health care program requirements. The Federal False Claims Act (FCA) imposes liability on any person

who submits a claim to the federal government that he or she knows (or should know) is false.

- C. The Deficit Reduction Act of 2005 (DRA) Section 6032 requires that any entity receiving or making annual Medicaid payments exceeding five (5) million dollars establish and disseminate to all of its employees (including management) and contractors written policies that set forth the entity's policies and procedures for preventing and detecting fraud, abuse, and wrongdoing in federal health care programs and that describe the federal and state false claims laws.
- D. The FCA provides that anyone who:
1. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
  2. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
  3. Conspires to commit a violation of the FCA;
  4. Has possession, custody, or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property; or
  5. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government; is liable to the federal government for a civil penalty of not less than five thousand dollars (**\$5,000**) and not more than ten thousand dollars (**\$10,000**), as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, **plus 3 times the amount of damages** which the government sustains.

“Knowingly” in the context of the FCA means:

- i. Actually knowing that a claim or statement is false;
- ii. Deliberately ignoring whether the claim or statement is true or false; Recklessly disregarding whether the claim or statement is true or false; or
- iii. Requires no proof of specific intent to defraud.

6. The FCA also provides that private parties may bring an action on behalf of the United States. These private parties, known as “*qui tam* relators,” may share in a percentage of the proceeds from an FCA action or settlement.
  7. The FCA provides protection to *qui tam* relators (“whistleblowers”) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA.
- E. *The Texas Medicaid Fraud Prevention Act* (FPA) is substantially similar to the Federal False Claims Act. The actions that trigger civil and criminal penalties under the Texas FPA generally mirror those of the federal FCA, and include making a false statement or concealing information that affects the right to a Medicaid benefit or payment and conspiring to defraud the state by obtaining an unauthorized payment from the Medicaid program or its fiscal agent. In addition, under the FPA, a person may also be liable if he presents a claim for payment under the Medicaid program for a product or service that was rendered by an unlicensed provider or that has not been approved by the patient’s treating healthcare practitioner.

The damages and penalties for violating the FPA include:

1. Payback to the state with interest;
2. Civil penalties of (a) not less than five thousand dollars (**\$5,000**) or more than fifteen thousand dollars (**\$15,000**) per violation if the unlawful act results in injury to an elderly person, a disabled person, or a person younger than eighteen (18) years of age, or (b) not less than five thousand dollars (**\$5,000**) or more than ten thousand dollars (**\$10,000**) for each violation that does not result in injury to a person as described above, ***plus two (2) times the amount of the payment*** or the value of benefit received.

Like the federal FCA, the FPA has a provision that permits private individuals (“whistleblowers”) to bring an action on behalf of the state and receive a portion of the recovery if the case is successful. The private individual’s share could be reduced or eliminated altogether, however, if the individual planned and initiated the activity upon which the lawsuit was based or if the individual is convicted of criminal conduct arising from his role in the illegal activity. Like the FCA, the FPA includes provisions to prevent employers from retaliating against employees for their involvement in FPA actions.

- F. The Fraud Enforcement and Recovery Act (FERA) was enacted in 2009 and expanded the Federal FCA by:
1. Expanding liability under the federal FCA to indirect recipients of federal funds and for the retention of overpayments, even where there is no false claim;
  2. Appropriating additional federal funding for anti-fraud enforcement;
  3. Containing a *Qui Tam* (Whistleblower) protection for individuals who bring suit under this law; and
  4. Expanding the statute of limitations under the federal FCA so that the government can look back as far as fifteen (15) years.
- G. The Patient Protection and Affordable Care Act (PPACA) was enacted in 2010 and is also related to the federal government's efforts against fraud, abuse, and wrongdoing by:
1. Establishing that the failure to report and return an overpayment within sixty (60) days of identifying its existence can give rise to liability under the FCA;
  2. Increased criminal penalties for health care fraud offenses involving more than one million dollars (\$1,000,000.) in losses;
  3. Enhanced oversight of providers and suppliers participating in or enrolling in Medicare, Medicaid and CHIP through mandatory licensure checks;
  4. Additional three hundred and fifty million dollars (\$350, 000.000) in funding over the next ten (10) years to help fight health care fraud;
  5. Sharing of data among federal agencies to help identify criminals and prevent fraud;
  6. Requiring providers and suppliers establish plans detailing how they will follow the rules and prevent fraud as a condition of enrollment in Medicare, Medicaid or CHIP; and
  7. Expansion of Recovery Audit Contractors (RACs) to Medicaid, Medicare Advantage and Part D (the Medicare Drug Benefit Plan).
- H. Examples of Fraud, Abuse, or wrongdoing include but are not limited to:
1. A provider who submits a claim to Medicare for payment of patient care items or services that he/she knows were not provided.
  2. A hospital that disregards reports by hospital billing personnel that claims for services to Medicare or Medicaid are not supported by medical documentation, and continues to submit them.

3. A provider who submits a claim to Medicare or Medicaid that is coded for services at a higher level than the services actually provided (“upcoding”) or billing for portions of a procedure that have been identified as one single procedure (“unbundling”).
4. Delivering health care services without a proper license.
5. Misrepresenting procedures or diagnoses in order to obtain payment for non-covered services.

### **III. RESPONSIBILITIES AND PREVENTION:**

- A. All Board of Managers members, employees, medical staff members, trainees, contractors, volunteers and vendors (“Workforce”) must conduct themselves in an ethical and legal manner as defined in the Harris Health Code of Conduct.
- B. The Workforce has an affirmative duty to report potential or suspected incidents of fraud and abuse, and other wrongdoing.
- C. The Senior Vice President of Corporate Compliance, i.e., Corporate Compliance Officer (CCO), in consultation with the Harris County Attorney’s Office, has responsibility for receiving and acting upon all information suggesting the existence of possible fraud, abuse, or wrongdoing, and for directing or transferring to appropriate departments all investigations arising from this information.
- D. Harris Health has implemented several policies and procedures supporting its efforts to prevent and detect violations of federal and state health care program requirements and Harris Health’s own policies and procedures, including the following:
  1. *Code of Conduct.* Harris Health has implemented a Code of Conduct as a foundation document for its Corporate Compliance Program that applies to everyone doing business with Harris Health. The Code of Conduct is made available on the Internet and Intranet. The Workforce must abide by the Code.
  2. *Open Door policy and Affirmative Duty to Report.* Harris Health has an Open Door policy that encourages employees, contractors, and agents to report problems, concerns, and perceived violations. The Workforce is responsible for reporting potential or suspected incidents of fraud and abuse or other wrongdoing. Employees, contractors and agents are



encouraged to discuss questions or concerns with their direct supervisor, contact a member of the Harris Health management team, the Harris County Attorney's Office or Human Resources, call the Corporate Compliance Officer directly, or call the Compliance Hotline. The affirmative duty to report suspected violations of law, Code of Conduct, or compliance policies is emphasized in the Code of Conduct.

3. *Harris Health Compliance Hotline.* Harris Health has established a confidential telephone hotline. The Compliance Hotline is toll-free telephone number that is available to everyone twenty-four hours a day by calling **1-800-500-0333**. The Workforce is encouraged to use the Compliance Hotline. Callers to the Hotline may remain anonymous or may seek confidentiality. In addition, a Post Office Box is available for reporting concerns anonymously to the Corporate Compliance Department.
4. *Non-Retaliation Policy.* Harris Health is committed to protecting its Workforce members who report problems and concerns in good faith from retaliation and retribution. It is Harris Health policy that no disciplinary action or retaliation will be taken against anyone for reporting a perceived issue, problem, concern, or violation to management, Human Resources, Corporate Compliance, accrediting organization, regulatory body or the Compliance Hotline "in good faith" or acting as a whistleblower pursuant to the Federal False Claims Act, State False Claims act, or other law. Any form of management retaliation against anyone reporting fraud, abuse, or wrongdoing in good faith or cooperating in an investigation regarding a potential compliance issue is strictly prohibited and will result in disciplinary action, up to and including termination.
5. *Responding to Complaints and Allegations.* Upon receipt of a report or notice of suspected noncompliance with any criminal, civil, or administrative law, the CCO will conduct an "Initial Inquiry" into the alleged noncompliance. If fraud is suspected, a supervisor or manager should gain prior approval from the Harris County Attorney's Office prior to directly confronting an individual related to an alleged fraud or violation of law. If the Initial Inquiry indicates that there is sufficient evidence of possible fraud or noncompliance, an investigation will be conducted in

accordance with Harris Health policy. Upon completion of an investigation, appropriate action shall be taken for corrective action measures to prevent similar problems from occurring in the future. Additional information on the conduct of investigations is included in the “Corporate Compliance Department and Legal Counsel Protocols” and the “Corporate Compliance Department Coordination with Human Resources” policies.

6. *Enforcement and Discipline.* Harris Health will take appropriate and consistent disciplinary and enforcement action (i.e., corrective action plans, employment discipline up to and including termination, or contract termination) against Workforce members whose conduct is not in compliance with Harris Health’s compliance policies, the Code of Conduct, or any federal or state law or regulation.
7. *Training and Education.* The development and implementation of regular, effective education and training programs for Workforce members is an integral part of the Harris Health Compliance Program. Additional information about the Harris Health compliance and training program is included in the Compliance Education and Training Policy.
8. *Cooperation with Investigations.* It is Harris Health’s policy to cooperate with federal and state agencies that conduct health care fraud and abuse investigations.



**REFERENCES/BIBLIOGRAPHY:**

Harris Health Code of Conduct

Harris Health Compliance Hotline policy

Harris Health Corporate Compliance Department and Legal Counsel Protocols policy

Harris Health Corporate Compliance Department Coordination with Human Resources policy

Harris Health Non-Retaliation for Reporting Fraud, Abuse, or Wrongdoing policy

False Claims Act, 31 U.S.C., Chapter 37, as amended

42 CFR Part 1003, *Civil Money Penalties, Assessments and Exclusions*,

Program Fraud Civil Remedies Act of 1986, 31 USC Chapter 38

45 CFR Part 79, *Program Fraud Civil Remedies*

Texas Human Resources Code, Chapter 36, *Medicaid Fraud Prevention*

1 TAC, Part 15, Chapter 371, *Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity*

Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410).

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010)

The Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, 123 Stat. 167 (2009)

**OFFICE OF PRIMARY RESPONSIBILITY:**

Harris Health Senior Vice President of Corporate Compliance

**REVIEW/REVISION HISTORY:**

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		Approved 11/20/2007	Harris Health Policy Review Committee
12/6/2007	1.0		Harris Health Board Of Managers (No. 07.12-584)
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	3.0	Revised/Approved 04/09/2013	Operations Policy Committee
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