TITLE: PREVENTING AND REPORTING FRAUD, ABUSE AND WRONGDOING

PURPOSE: To provide Harris Health System's commitment to compliance and to reinforce processes for detecting, preventing, and reporting fraud, abuse, and wrongdoing.

POLICY STATEMENT:

Harris Health System (Harris Health) will comply with 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, detect, and report fraud, abuse, and wrongdoing.

POLICY ELABORATION:

I. DEFINITIONS:

A. **ABUSE:** Incidents or practices that are inconsistent with generally accepted medical, business, or fiscal practices. Abuse may be unintentional.

B. **CONFLICT OF INTEREST:** Any situation in which a Workforce member has direct or indirect interests, including financial and personal interests, or business transactions or professional activities, that may compromise or appear to compromise: (1) the Workforce member's business judgment; (2) the delivery of patient care; (3) the Workforce member's ability to do his or her job.

C. **FEDERAL HEALTH CARE PROGRAM:** 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 program(s);
5. Black Lung Program;

6. TRICARE/Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)/Department of Defense health care programs;
7. Veterans Administration programs; and
8. Certain state healthcare programs.

D. **FRAUD:** Any act characterized by deceit, concealment, or violation of trust; an intentional, knowing, or reckless misstatement of fact that is believed, acted upon, and results in 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.

E. **GOOD FAITH:** Any action taken with honest intent a free from coercion or intimidation that does not take unfair advantage of another person. Actions of Good Faith are aligned with standards of decency and honesty or lawfulness of purpose.

F. **RETALIATION:** Any adverse action taken against a workforce member because the workforce member has reported fraud, abuse or wrongdoing; or has cooperated with an investigation.

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

H. **WORKFORCE:** Harris Health Board of Trustees, employees, medical staff, trainees, contractors, volunteers, and vendors.

I. **WRONGDOING:** Any action that fails to conform to Harris Health's Code of Conduct; applicable federal and state laws, rules and regulations; and Harris Health policies and procedures.

II. BACKGROUND:

A. Harris Health has a Corporate Compliance Program (Compliance Program) to 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 making false statements to 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.

C. Section 6032 of the Deficit Reduction Act of 2005 (DRA) requires that any entity receiving or making annual Medicaid payments exceeding five million dollars ($5,000,000) 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.

III. FEDERAL FALSE CLAIMS ACT:

A. 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.

B. The FCA imposes liability on 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.

C. "Knowingly" in the context of the FCA means a person, with respect to information:

1. Has actual knowledge of the information;
2. Acts in deliberate ignorance of whether the claim or statement is true or false; or
3. Acts in reckless disregard for whether the claim or statement is true or false.

D. Liability under the FCA does not require proof of a specific intent to defraud.

E. If an individual is liable for any of the above actions the federal government may impose a civil penalty of not less than $10,957.00 and not more than $21,916.00, **as** adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, ***plus* 3 times the amount of damages,** which the government sustains.

F. The FCA also allows private parties to 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.

G. 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.

IV. TEXAS MEDICAID FRAUD PREVENTION ACT (FPA)

A. The Texas Medicaid Fraud Prevention Act (FPA) is substantially similar to the FCA, except that unlike the FCA, which applies to all federal claims for payment or reimbursement, the FPA only applies to claims for Medicaid.

B. The FPA imposes liability on anyone who:

1. Knowingly makes or causes to be made a false statement or misrepresentation of material fact to permit the person to receive a benefit or payment under the

Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;

2. Knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;
3. Knowingly applies for and receives a benefit or payment on behalf of another person under the Medicaid program and converts any part of the benefit or payment to a use other than for the benefit of the person on whose behalf it was received;
4. Knowingly makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning:

    a. The conditions or operation of a facility in order that the facility may qualify for certification or recertification required by the Medicaid program, including certification or recertification as:
        i. A hospital;
        ii. A nursing facility or skilled nursing facility;
        iii. A hospice;
        iv. An assisted living facility; or
        v. A home health agency.

    b. Information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program;

5. Except as authorized under the Medicaid program, knowingly pays, charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or product or the continued provision of a service or product if the cost of the service or product is paid for, in whole or in part, under the Medicaid program;
6. Knowingly presents or causes to be presented a claim for payment under the Medicaid program for a product provided or a service rendered by a person who:

    a. Is not licensed to provide the product or render the service, if a license is required; or
    b. Is not licensed in the manner claimed;

7. Knowingly presents or causes to be made a claim under the Medicaid program for:

    a. A service or product that has not been approved or acquiesced in by a treating physician or health care practitioner;
    b. A service or product that is substantially inadequate or inappropriate when compared to generally recognized standards within the particular discipline or within the health care industry; or
    c. A product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate;

8. Makes a claim under the Medicaid program and knowingly fails to indicate the type of license and the identification number of the licensed health care provider who actually provided the service;
9. Knowingly obstructs an investigation by the attorney general of an alleged unlawful act under this section;
10. Knowingly makes, uses, or causes the making or use of a false record or statement material to an obligation to pay or transmit money or property to this state under the Medicaid program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to this state under the Medicaid program;
11. Knowingly engages in conduct that constitutes a violation under the Medical Assistance Program (Tex. Health and Safety Code Ann. §32.001); or
12. Conspires to commit a violation of numbers 1 – 11 above.

C. "Knowingly," in the context of the FPA, means a person:

1. Has knowledge of the information;
2. Acts with conscious indifference to the truth or falsity of the information;
3. Acts in reckless disregard of the truth or falsity of the information.

D. Liability under the FPA does not require proof of a specific intent to commit an unlawful act.

E. Damages and penalties for violating the FPA may include:

1. The amount of any payment or the value of any monetary or in-kind benefit provided under the Medicaid program, directly or indirectly, as a

result of the violation of the FPA, including interest on the amount of the payment or the value of the benefit at the prejudgment interest rate in effect on the day the payment or benefit was received or paid, for the period from the date the benefit was received or paid to the date that the state recovers the amount of the payment or value of the benefit.

Note: a civil penalty of two times the amount of the payment or the value of the benefit set forth above may also be imposed.

2. A civil penalty of:

   a. Not less than $5,500.00 *or* the minimum amount imposed by the FCA if that amount exceeds $5,500.00 and not more than $15,000.00 or the maximum amount imposed by the FCA if that amount exceeds $15,000 for each violation of the FPA committed by the person that results in injury to:

      i. An elderly person;
      ii. A person with a disability; or
      iii. A person younger than eighteen (18) years of age; *or*

   b. Not less than $5,500.00 or the minimum amount imposed by the FCA, if that amount exceeds $5,500.00 and not more than $11,000 or the maximum amount imposed by the FCA, if that amount exceeds $11,000 for each violation that does not result in an injury to the above-named groups of people; *and*

3. Two times the amount of payment or value described in section E(1) above.

F. Like the FCA, the FPA has a provision that permits *qui tam* relators to bring an action on behalf of the State and receive a portion of the recovery if the case is successful. However, the private individual's share could be reduced or eliminated altogether, 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.

V. FRAUD ENFORCEMENT AND RECOVERY ACT (FERA):

The Fraud Enforcement and Recovery Act (FERA) was enacted in 2009 and expanded the FCA by:

A. Extending liability under the FCA to indirect recipients of federal funds and to the retention of overpayments even where there is no false claim;

B. Appropriating additional federal funding for anti-fraud enforcement;

C. Including whistleblower protections; and

D. Increasing the statute of limitations under the federal FCA so that the government can look back as far as ten (10) years.

VI. PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA):

A. 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 and:

1. Established 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;[1]
2. Increased criminal penalties for health care Fraud offenses involving more than one million dollars ($1,000,000) in losses;[2]
3. Enhanced oversight of providers and suppliers participating in or enrolling in Medicare, Medicaid and CHIP through mandatory licensure checks;[3]
4. Provided for the sharing of data among federal agencies to help identify criminals and prevent Fraud; [4]

[1] 42 USC 1320a-7k section 1128J
[2] Section 10606 of Public Law 111-148
[3] Section 6401 of Public Law 111-148

[4] https://www.leclairryan.com/files/Uploads/Documents/ACA%20Anti-Fraud%20Provisions%20slide%20deck%2008%2021%2013%20final.pdf

5. Required 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[5]
6. Expanded Recovery Audit Contractors (RACs) to Medicaid, Medicare Advantage, and Part D (the Medicare Drug Benefit Plan).[6]

B. 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 or 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 the claims.
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.
   Misrepresenting procedures or diagnoses in order to obtain payment for non-covered services.

VII. RESPONSIBILITIES AND PREVENTION:

A. All Workforce members must conduct themselves in an ethical and legal manner as defined in the Harris Health's Code of Conduct (Code).

B. Workforce members have an affirmative duty to report potential or suspected incidents of Fraud, Abuse, and other Wrongdoing.

C. Corporate Compliance Officer (CCO), in consultation with the Harris County Attorney's Office (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.

[5] Section 6401
[6] Section 6411

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 the Code as a foundation document for its Compliance Program that applies to everyone doing business with Harris Health. The Code is made available on the Internet and Intranet. All Workforce members must abide by the Code.

2. **Affirmative Duty to Report**

Harris Health Workforce members have an affirmative duty to report issues, concerns, and perceived violations of law, the Code, or compliance policies. All Workforce members are responsible for reporting potential or suspected incidents of Fraud, Abuse, or other Wrongdoing. Workforce members, contractors, and agents are encouraged to discuss questions or concerns with their direct supervisor, contact a member of the Harris Health management team, call the CCO directly, or call the Compliance Hotline. Workforce members may also contact the County Attorney's Office or Human Resources. The affirmative duty to report suspected violations of law, the Code, or compliance policies is addressed further in the Code.

3. **Harris Health Compliance Hotline**

Harris Health has established a confidential telephone hotline for reporting Fraud, Abuse, or Wrongdoing. The Compliance Hotline is a toll-free telephone number and is available to all Workforce members twenty-four (24) hours a day, seven days a week, by calling **1-800-500-0333**. Workforce members are encouraged to use the Compliance Hotline to report potential or suspected compliance concerns. Callers to the Compliance Hotline may remain anonymous or may request their information be kept confidential. In addition, a post office box is available for reporting concerns to the Office of Corporate Compliance at: P.O. Box 300033, Houston, Texas 77054. For further information, please see Harris Health Policy and Procedures 3.36, *Compliance Hotline.*

4. Non-Retaliation Policy

Harris Health will ensure its Workforce members who report compliance issues and concerns and perceived violations of law, the Code, or compliance policies in Good Faith are protected from Retaliation. No disciplinary action or Retaliation will be taken against anyone for reporting an issue, problem, concern, or actual or suspected violation of law, the Code, or other compliance policies to management, Human Resources, the Compliance Office, the County Attorney's Office, Harris Health's accrediting organization (DNV), a federal or state regulatory body, or the Compliance Hotline, or for acting as a Whistleblower pursuant to the FCA, the FPA, or other applicable law as described above. Any form of Retaliation against anyone reporting Fraud, Abuse, or Wrongdoing in Good Faith or cooperating with an investigation regarding a potential compliance issue is strictly prohibited and will result in disciplinary action up to and including termination. For further information, please see Harris Health Policy and Procedures 3.58, *Non-Retaliation for Reporting Fraud, Abuse, and Wrongdoing.*

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, Abuse, or Wrongdoing is suspected, the CCO, in conjunction with the appropriate supervisor or manager, will consult with the County Attorney's Office prior to directly confronting an individual related to an alleged Fraud, Abuse, or violation of other applicable law. If the Initial Inquiry indicates that there is sufficient evidence of possible Fraud, Abuse, or noncompliance, an investigation will be conducted in accordance with Harris Health policies and procedures. Upon completion of an investigation, corrective action measures will be implemented to prevent similar problems from occurring in the future. For further information, please see Harris Health Policy and Procedures, 3.34 *Corporate Compliance Department Coordination with Human Resources* and Harris Health Policy and Procedures 3.37, *Corporate Compliance Department and Legal Counsel Protocol and Procedures.*

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, 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 Compliance Program. For further information, please see Harris Health Policy and Procedures 3.33 *Compliance Education and Training.*

8. **Cooperation with Investigations**

All Workforce members **must** cooperate with the Office of Corporate Compliance and federal and state agencies that conduct investigations of Fraud, Abuse, or Wrongdoing.

REFERENCES/BIBLIOGRAPHY:

False Claims Act

31 U.S.C. §3729

31 U.S.C. §3730

https://www.federalregister.gov/documents/2017/02/03/2017-01306/civil-monetary-penalties-inflation-adjustment-for-2017

Texas Medicaid Fraud Prevention Act

Tex. Health & Safety Code Ann. §§36.001, *et seq.*

Fraud Enforcement and Recovery Act

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

Patient Protection and Affordable Care Act

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

Policies and Procedures

Harris Health System Code of Conduct

Harris Health System Policy and Procedures 3.36, Compliance Hotline

Harris Health System Policy and Procedures 3.37 Corporate Compliance Department and Legal Counsel Protocols

Harris Health System Policy and Procedures 3.34 Corporate Compliance Department Coordination with Human Resources

Harris Health System Policy and Procedures 3.58 Non-Retaliation for Reporting Fraud, Abuse, or Wrongdoing

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Office of Corporate Compliance

REVIEW/REVISION HISTORY:

Effective Date	Version# (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (If Board of Managers Approved, include Board Motion#)
		Reviewed 11/12/2007	Vice President of Corporate Compliance
		Approved 11/20/2007	Harris Health Policy Review Committee
12/6/2007	1.0		Harris Health Board Of Managers (No. 07.12-584)
	2.0	Revised 12/21/2009	Sr. Vice President of Corporate Compliance
		Approved 02/02/2010	Harris Health Policy Review Committee
	3.0	Revised/Approved 04/09/2013	Operations Policy Committee
		Approved 05/30/2013	Board Of Managers (Board Motion Number (13.05-73)
	4.0	Revised/Approved 04/08/2014	Operations Policy Committee
		Approved 04/24/2014	Harris Health Board of Managers (No. 14.04-46)
	5.0	Approved 07/14/2015	Operations Policy Committee
	6.0	8/19/2019 Expedited Executive Approval via Rapid Cycle	CEO
		Required Post-Approval Rapid Cycle Review Complete 03/10/2020	Structure and Organizational Standards Committee