

Contra Costa Health Services

Compliance	Reporting Suspected Fraud, Waste, and Abuse	Policy # 705-C
		Original Date: 01/2007
		Revised:
		Supercedes:

PURPOSE The purpose of this policy is to outline the reporting options available to employees, contract employees, or agents of Contra Costa Health Services (CCHS) should they have reason to believe any individual or entity acting on behalf of Contra Costa Health Services is engaging in an activity that appears to be an inappropriate practice or a violation of the law.

POLICY Contra Costa Health Services is committed to ethical and legal conduct that is compliant with all relevant laws and regulations, and to correcting any wrongdoing wherever it may occur within the organization. Each individual has a responsibility to report any activity by any employee, physician, subcontractor, or vendor that appears to violate applicable laws, rules, regulations, accreditation standards, standards of medical practice, Federal healthcare Conditions of Participation, or the CCHS Compliance Program.

This policy applies to employees, contract employees, and agents of CCHS, and expands on the basic principles of the Health Services Compliance Program as outlined in the Code of Conduct, the Compliance Program Manual, and the policies and procedures developed at any level of the organization which address regulatory compliance and the business activities of the Health Services Department.

REFERENCES Deficit Reduction Act of 2005 (S.1932)
 Title 31, United States Code, Sections 3729-3733, False Claims Act
 California Government Code, Article 9, Sections 12650-12655, False Claims Actions
 Contra Costa Health Services Policy 700-C, ‘*Compliance Program*’

PROCEDURE CCHS is committed to providing quality health care services and medical education training in compliance with all federal and state laws and regulations. Although the health care environment is increasingly complex, making it difficult at times to understand the intent of federal and state laws and regulations, violations of these laws could result in both civil and criminal penalties, as well as exclusion from participation in Federal health care programs. Accordingly, we at CCHS expect all employees to be responsible for appropriate ethical and legal behavior in the work place.

The Compliance Program addresses organizational integrity through implementation of policies and procedures, education and training

programs, monitoring and auditing processes, investigation and reporting systems, disclosure of fraud and abuse, corrective action plans, and referral as appropriate to quality assurance committees. Violations of the law, or failure to comply with CCHS policies and procedures will be addressed in accordance with County employment policies and union contracts.

Internal Reporting of Potential Compliance Concerns

The Compliance Program establishes an internal process for reporting suspected instances of fraud, waste, and abuse. Whenever possible, potential compliance issues should be addressed with your immediate supervisor. When that is not possible, or if the individual feels that another course of action is required, contacting a member of Senior Management or the Compliance Officer directly is also an option. Employees also have the option of reporting compliance concerns to the Contra Costa Health Services 24 Hour Compliance Hotline at 1-800-304-9490. Other reporting options, including E-mail and direct mail reporting are discussed in the CCHS Code of Conduct.

The confidentiality of the identity of any individual who files a report will be maintained unless disclosure of their identity is mandated by law or County policy. There is no retribution or discipline for anyone who reports a concern in good faith. Anyone who deliberately makes a false accusation with the intent of harming or retaliating against a co-worker is subject to discipline.

All potential compliance issues will be investigated promptly and confidentially to the extent possible. The Compliance Officer will coordinate all investigations and initiate corrective action. All CCHS staff are expected to cooperate with investigations.

Where an internal investigation substantiates a reported violation, corrective action is expected. Corrective action includes making prompt restitution of any overpayments, disclosure to the appropriate governmental agency, and instituting disciplinary action where needed.

External Reporting of Potential Compliance Concerns

1. The Federal False Claims Act

Although there is no requirement for employees to first report problems internally, the most effective and efficient way to correct a wrong is through the Contra Costa Health Services Compliance Program.

In the event an individual reports a compliance concern and feels the internal reporting mechanism has failed to take appropriate and necessary action, the Federal False Claims Act gives individuals the option to initiate actions on behalf of the government in lawsuits called *qui tam* actions. The False Claims Act (FCA) allows the government to recover significant damages from persons or entities submitting false or fraudulent claims, and permits the individual initiating the action, called a *qui tam* plaintiff or “whistle-blower”, to receive up to 30 percent of any damages recovered by the government.

Elements of a Violation of the Federal False Claims Act

Under the FCA, a health care provider is liable if it “knowingly” causes a “false claim” to be presented to the government or “knowingly” makes a false statement to obtain payment of a “false claim.” A *claim* is simply a request for payment. A *false claim* is a request for payment that is somehow untrue.

In order for a health care provider to be found liable for false claims, it must be shown that the provider acted “knowingly.” A health care provider will be found to have acted “knowingly” if it acted with either:

- 1) ***Actual Knowledge***. This requires that a health care provider actually knew that the claim it made to the government was false or fraudulent when it submitted the claim.
- 2) ***Deliberate Ignorance*** of the truth or falsity of the claim. This means the health care provider was aware there was a high probability that the claim was in fact false or fraudulent, yet ensured that the organization remained ignorant of the truth.
- 3) ***Reckless Disregard***. This can be shown when a health care provider was aware there was a high probability that the claim was in fact false or fraudulent, but acted with indifference.

A health care provider that merely makes an innocent mistake or acts negligently will not satisfy the “knowingly” standard.

Types of Violations of the Federal False Claims Act

Under the FCA, health care providers and their employees may be liable if they take certain steps to obtain improper payments from the government. The statute delineates seven “acts” that are unlawful:

- 1) ***Submitting False Claims:*** This violation occurs if a health care provider knowingly submits to the government a claim for payment that is somehow untrue.
- 2) ***Making False Records or Statements:*** Under this provision, a health care provider is liable for knowingly making a false statement that results in payment of a false claim.
- 3) ***Conspiracy:*** It is unlawful for a health care provider to conspire to defraud the government by having a false claim paid.
- 4) ***Withholding Money:*** A health care provider violates the FCA if it willfully delivers or causes to be delivered to the government less property or money than agreed.
- 5) ***Certifications:*** A health care provider violates the FCA if it certifies that the government has received property without knowing whether the certification is true.
- 6) ***Improper Purchase:*** It is a violation of the FCA if a health care provider knowingly buys property from an employee of the government who is not authorized to sell the property.
- 7) ***Avoiding Obligations to the Government:*** A health care provider violates the FCA if it knowingly uses a false record or statement to conceal, avoid, or decrease an obligation to pay money or transfer property to the government.

Liability Under the Federal False Claims Act

If a health care provider is found to have violated the FCA, the potential liability could be substantial. The violator will be liable for up to triple the actual damages incurred by the government, and can be assessed civil penalties by the government of at least \$5,000 and up to \$10,000 for each violation of the FCA.

Thus, even if the government was not materially damaged, a health care provider could be liable for millions of dollars in penalties based on the number of individual claims submitted to the government that contain false or fraudulent information. For example, a \$20 fraudulent claim may not materially damage the government. However, under the FCA, a \$20 fraudulent claim submitted 500 times could result in penalties of \$5,000,000 (\$10,000 penalty per violation x 500 claims) even though the government only suffered \$10,000 in actual damages (\$20 error x 500 claims).

Enforcement of the Federal False Claims Act

The FCA may be enforced by the government and also by private individuals who bring actions on behalf of the government. The government, through the United States Attorney's Office or the Department of Justice (DOJ) may file a FCA action. In addition, private persons are empowered by the FCA to initiate civil actions for FCA violations on behalf of the United States government.

These individuals are called *qui tam* plaintiffs (or "whistle-blowers" or "relators"). The lawsuits are called *qui tam* actions because the plaintiff sues for the government as well as himself. Under the FCA, the *qui tam* plaintiff may receive a portion of any amounts recovered in the civil action. The remainder goes to the government.

The *qui tam* provisions were motivated by Congress' concern that limited government resources prevented effective enforcement of the FCA. It was also believed that fraud would be difficult to detect without informants acting as whistle-blowers.

Qui Tam Procedure

The whistle-blower/relator must file his/her lawsuit in a federal district court. The lawsuit will be filed "under seal," meaning the lawsuit is kept confidential while the government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

If the government determines that the lawsuit has merit and decides to join ("intervene"), the prosecution of the lawsuit will be directed by the U.S. Department of Justice. At this point, the government will be the "plaintiff," or party suing the health care provider. If the government decides not to intervene, the whistle-blower can continue with the lawsuit on his/her own.

2. The California False Claims Act

Since the federal FCA does not address the problems of fraud in state and local government programs, the California Legislature adopted a state FCA to protect state governments from the same type of fraud prohibited by the federal FCA. The California FCA was modeled after the federal FCA with a few exceptions.

As described above, the federal FCA delineates seven acts that are unlawful. These same seven acts are unlawful under the California FCA, but the California FCA also contains an additional provision that

subjects health care providers to liability. Under the California statute, providers are also liable if they benefit from an inadvertent submission of a false claim to the state government, but do not disclose the false claim to the state within a reasonable time after discovery.

Liability Under the California False Claims Act

As in the case of the Federal FCA, a person found to have violated the California FCA may be liable for three times the actual damages sustained by the government, as well as penalties. The California FCA assesses penalties for each false claim up to \$10,000, but does not set a mandatory minimum amount.

Enforcement of the California False Claims Act

Both the government, through the Attorney General's Office, and private individuals (*qui tam* plaintiffs) may initiate actions under the California FCA. In addition, the prosecuting authority for a particular subdivision that was the recipient of the false claim may bring an action (i.e. a city attorney could bring action against a violator who submitted a false claim to that city's government).

Employee Protections

Under the FCA, an employer cannot make any rule or policy that prevents an employee from disclosing information to a government or law enforcement agency in furtherance of an FCA action. An employer also cannot discriminate against an employee (by discharging, demoting, suspending, or threatening the employee) for lawful acts performed in furtherance of an FCA action.

The California FCA can protect employees even though the employee's actions may appear tenuously linked to a potential FCA action. An employer who is found to have unlawfully retaliated against an employee in this manner may be subject to various sanctions, and the employee may be awarded reinstatement, double his or her back pay plus interest, compensation for special damages, and possibly punitive damages.

CCHS Strategy to Protect Against False Claims Actions

In order to avoid or reduce its FCA liability, Contra Costa Health Services has adopted a voluntary Compliance Program and maintains a corporate culture of compliance with all applicable legal requirements.

As part of its Compliance Program, CCHS has established systems that enable it to learn of potential problems before a *qui tam* plaintiff

blows the whistle. This includes establishing internal disclosure policies, creating a 24-hour Compliance Hotline for reporting suspected compliance violations, instituting self-monitoring programs, conducting internal audits and investigations, and utilizing an exit interview program to solicit information from departing employees regarding potential misconduct and suspected violations of the CCHS Compliance Program or the organization’s policies and procedures.

The CCHS Code of Conduct and the Compliance Program Manual establish the framework for the CCHS Compliance Program. These documents outline the principles and guidelines that employees should follow to enable CCHS to conduct its activities in an ethical and legal manner. Together these documents comprise CCHS Policy 700-C, entitled ‘*Compliance Program*’.

The Code of Conduct and the Compliance Program Manual are available on the CCHS intranet. To view these documents and other information on the Contra Costa Health Services Compliance Program, go to the Intranet, click on ‘Sites’, and then click ‘Compliance’. You can also obtain information on the Compliance Program by contacting your supervisor or the Compliance Office.

RESPONSIBLE Compliance Officer
Division Directors

Departmental Review	Signature	Date
Health Services Director		
Compliance Officer		

Contra Costa Health Services

Compliance	Preventing Fraud, Waste and Abuse: Audits and Risk Assessment	Policy # 706-C
		Original Date: 01/2007
		Revised:
		Supersedes:

PURPOSE One way to demonstrate an effective Compliance Program is to have a strong auditing and monitoring process. Audits and risk assessments are essential to ensure compliance with government and private payer rules and regulations. The purpose of this policy is to summarize the results of internal risk assessments by identifying the processes, systems, and/or procedures implemented by Contra Costa Health Services to detect and prevent fraud, waste, and abuse.

POLICY Contra Costa Health Services (CCHS) is committed to ethical and legal conduct that is compliant with all relevant laws and regulations. This policy documents the protective measures implemented by Contra Costa Health Services to prevent fraud, waste, and abuse, and discusses some of the monitoring processes utilized by CCHS to detect potential problems.

REFERENCES Deficit Reduction Act of 2005 (S.1932)
1998 Office of Inspector General Compliance Program Guidance for Hospitals
2005 Supplemental Compliance Program Guidance for Hospitals

PROCEDURE The Contra Costa Health Services Compliance Program was developed to detect and prevent violations of any law or regulation, whether criminal or non-criminal, for which the organization is, or would be, liable. The basic principals of our Compliance Program are found in the Contra Costa Health Services Code of Conduct and the Compliance Program Manual. Together, these documents provide employees with standards to carry out their daily work activities, establish guidelines for determining prohibited activity and conduct, and provide detailed information to employees for reporting possible compliance violations.

To supplement the standards established by the Code of Conduct and the Compliance Program Manual, CCHS has implemented a variety of protective measures designed to address issues that the Office of Inspector General has determined are most vulnerable to fraud and abuse.

Preventing Fraud, Waste, and Abuse

There are several different types of allegations the government can make when pursuing a case against a provider. Most noteworthy are

cases involving inaccurate or unsupported claims. There are six types of inaccurate billing patterns or “traps” providers can fall into:

- 1) No documentation.
- 2) Insufficient documentation.
- 3) Double or duplicate billing.
- 4) Billing for medically unnecessary services.
- 5) Billing for unbundled services.
- 6) Billing for inaccurate/incorrect providers.

Depending upon the scope of these billing patterns, the OIG may allege fraud against the provider, particularly if investigations reveal an ongoing pattern or reveal knowledge of a problem without taking any corrective action. A pattern of billing for services that were never provided is a solid basis for fraud. This policy summarizes the preventative measures implemented by Contra Costa Health Services to ensure that correct claims are submitted to payers.

1. Policies and Procedures

Contra Costa Health Services has developed a number of Policies and Procedures to provide employees with guidance on how to carry out their daily work activities in a way that is consistent with applicable federal and state laws and regulations.

In addition to Health Services Department Policies, each Division has established specific policies to provide guidance to employees working in high-risk areas so that they may conduct their day-to-day activities in a compliant manner. These policies are available to the affected employees, and most are available for review on the CCHS I-Site intranet.

Specific guidance is also available to address the following issues identified by the Office of Inspector General as areas that are vulnerable to fraud and abuse:

- Screening Individuals for Federal Sanctions

Procedures are in place to ensure no payment is made for items or services provided by an individual excluded from participation in a Federal Health Care Program.

- Medicare 72-Hour Rule

Procedures have been developed to ensure Medicare is not billed for outpatient services occurring within 72 hours of an inpatient admission.

- Medicare Post Acute Care DRG Transfers

CCHS has implemented procedures to properly identify transfer situations when they occur so that the correct patient status code is assigned during the abstracting process to ensure proper reimbursement is claimed from the Medicare fiscal intermediary. CMS established this policy to prevent hospitals from discharging patients early to maximize profits.

- One-Day Stays

Utilization Review evaluates all inpatient Medicare one-day stays to determine whether the patient actually received observation services and therefore should have been registered and billed as an outpatient.

- Physicians at Teaching Hospitals (PATH) Guidance

Family Practice Residency Billing Guidance was developed to ensure compliance with the Physicians at Teaching Hospitals guidelines. Although the Medicare and Medi-Cal programs allow Family Practice residency billing with proper teaching physician oversight, Contra Costa Health Services has established stricter guidelines and has elected not to bill any payer for any services associated with the residency program until the resident has received his or her license number and has obtained a Medicare UPIN and a Medi-Cal provider number.

- Criteria for Determining Facility Charges

Under the Outpatient Prospective Payment System (OPPS), the Centers for Medicare and Medicaid Services (CMS) will assume that a facility is in compliance with the reporting requirements as they relate to the facility code reported on the bill as long as the services furnished are documented and medically necessary, and the facility is following its own system which reasonably relates the intensity of facility resources to the different levels of CPT codes for patient care. CCHS has established a system for

mapping the services provided to every patient seen in the Clinics, Emergency Department, or Psychiatric Emergency Department to the different levels of effort represented by the CPT codes that define these respective visits.

- Medicare Secondary Payer (MSP)

A policy has been developed to ensure the Registration staff screens all Medicare patients to determine if Medicare is the secondary payer to any other health coverage or program.

- Advance Beneficiary Notice

A procedure has been developed to assure that Medicare patients are properly instructed regarding their liability should Medicare deny payment due to lack of medical necessity.

- Laboratory Compliance

Lab policies have been developed to address numerous high-risk areas including:

- Standing Orders and Reflux Testing,
- Unbundling, Panel Billing and Automated Multi-Channel tests,
- Outside lab referrals, and
- Customized Panel Billing.

Guidance is also available to address issues identified by internal reviews and investigations as being potentially vulnerable to fraud and abuse. Policies have been developed to address:

- Psychiatric Emergency Medicare Billing
- Inpatient Psych Medicare Secondary Payer Billing
- Inpatient Psych Commercial Secondary Payer Billing

2. Electronic Edits on Billing Data

Contra Costa Health Services utilizes the Keane billing system to process and generate claims data. Keane contains a number of billing edits that are utilized to review the aggregate claims data. Claims data from Keane is passed through additional billing edits in DSG (Data Systems Group) prior to generating a final bill. The table below summarizes some of the edits used to review data in order to minimize the risk of false claims.

Edit	Function of Edit
Code Accuracy	Ensure all codes are valid to the extent they are up-to-date and have the correct number of digits.
Bundling	CPT codes are run through the National Correct Coding Initiative unbundling edits to ensure services are not over-billed due to unbundled codes.
Duplicate Codes	Eliminates duplicate codes, unless the procedure is performed more than once and the procedure can be billed more than once.
Medical Necessity	CPT and ICD-9-CM data are run through the medical necessity edits of the Fiscal Intermediary (United Government Services) and the CMS National Coverage Determinations.
Gender Accuracy	Sex-specific codes agree with the sex field in the patient's record (e.g. a gynecology procedure or diagnosis must be on a female record).
Volume Controls	Establish norms for CPT and ICD-9-CM codes, based on federal, state, or local data.
Administrative	Edit for completion of all administrative fields, such as provider number, dates of service, patient status, condition codes, etc.

3. Chargemaster Review Software

To manage the integrity of our chargemaster, CCHS utilizes Craneware Active Chargemaster, an automated tool that facilitates accurate coding and reimbursement.

4. Audits and Aggregate Data Analysis

Abstracting reviews and internal audits are utilized to determine whether claims are supported by appropriate documentation in the patient's medical record. In addition, Medicare billing information compiled by Lumetra, the local Medicare Quality Improvement Organization, is reviewed to determine whether CCHS Medicare billing data exceeds national or regional norms. These types of reviews are crucial for identifying and preventing potential billing errors, including CPT and DRG upcoding.

5. Mechanisms to Detect Fraud, Waste, and Abuse

CCHS has also implemented a number of monitoring techniques to detect potential fraud and abuse. These include:

- 1) Implementation of the CCHS 24-Hour Compliance Hotline for employees to report potential compliance violations.
- 2) Review of existing Policies and Procedures, CMS directives, OIG Fraud Alerts, and other guidance.
- 3) Professional meetings, seminars, and publications.
- 4) Prepayment audits.
- 5) Notifications from the Medicare Fiscal Intermediary (United Government Services) or the Medicare Carrier (National Heritage Insurance Company).
- 6) Exit interviews conducted with departing employees.
- 7) Interviews with personnel to determine whether policies and procedures either do not exist, or have not been updated in years.

RESPONSIBLE Compliance Officer
 Division Directors

Departmental Review	Signature	Date
Health Services Director		
Compliance Officer		

DEFICIT REDUCTION ACT COMPLIANCE

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

I. POLICIES AND PROCEDURES TO PROTECT AGAINST FRAUD

Contra Costa Health Plan has policies and procedures to protect against fraud, waste, and abuse, in compliance with federal Medicaid regulations, 42 C.F.R. § 438.608, for Medicaid managed care organizations. Specifically, the requirement is for CCHP to have a compliance plan to guard against fraud and abuse which includes written policies, procedures, and standards of conduct.

Contra Costa Health Plan is a division of Contra Costa Health Services. As such, CCHP's requirements for reporting suspected fraud, waste and abuse are contained in Policy# 705-C. CCHP also has Policy 706-C, Preventing Fraud, Waste and Abuse: Audits and Risk Assessment.

Both these policies combined with the Health Services Compliance Program and Code of Conduct cover false claims, compliance reporting, fraud detection, and whistleblower protections. These policies are available on the Contra Costa County Health Services Intranet site, available and accessible to all CCHP employees for review.

II. INFORMATION ON FEDERAL AND STATE LAWS REGARDING FALSE CLAIMS

A. The Federal False Claims Act, 31 U.S.C. § 3279-3733

The False Claims Act ("FCA") is a set of Federal statutes that cover fraud involving any Federally-funded contract or program, including Medicare and Medicaid. The FCA establishes liability for any person who knowingly:

- Presents or causes to be presented, a false claim for reimbursement by a Federal health care program, including Medicare or Medicaid;
- Makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- Repays less than what is owed to the Government;
- Makes, uses, or causes to be made or used, a false record or statement material to reducing or avoiding repayment to the Government; and/or
- Conspires to defraud the Federal Government through one of the actions listed above.

The term “knowingly” is defined to mean that a person, with respect to information:

- Has actual knowledge of information in the claim
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

Claims

The FCA is not limited to false health care claims but also includes any false statements or records that are material to the claim. In addition, the government has prosecuted health plans that fail to comply with applicable Medicaid statutes and regulations that are a condition or a requirement of payment.

For Medicaid managed care plans, fraud can occur in the areas of contract procurement (e.g., falsifications), marketing (e.g., misleading recipients), enrollment and disenrollment (e.g., cherry-picking enrollees), underutilization (delaying, discouraging, or stinting on care), and data collection and submission (e.g., misclassifying enrollees).

Liability

A health plan that violates the FCA can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted. In addition to this civil penalty, a health plan can be required to pay three times the amount of damages sustained by the U.S. Government. If a health plan is convicted of a False Claims Act violation, the Department of Health and Human Services, Office of Inspector General may seek to exclude the health plan from participation in Federal and State health care programs, such as Medicare and Medicaid.

B. Qui Tam Whistleblower Provisions, 31 U.S.C. § 3730(h)

To encourage individuals to come forward and report misconduct involving false claims, the Federal Claims Act includes a “qui tam” or whistleblower provision. This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government. Such persons are referred to as “relators.”

Qui Tam Procedure

The whistleblower/relator must file his or her lawsuit on behalf of the Government in Federal district court. The lawsuit will be filed “under seal,” meaning that the lawsuit is kept confidential while the Government reviews and investigates the allegations contained in the lawsuit and decides how to proceed. If the Government determines that the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the government decides not to intervene, the whistleblower can continue with the lawsuit on his or her own.

Award to Qui Tam Whistleblowers

If the lawsuit is successful, and provided certain legal requirements are met, the qui tam relator or whistleblower may receive an award ranging from 15 to 30 percent of the amount recovered. The whistleblower may also be entitled to reasonable expenses including attorneys’ fees and costs for bringing the lawsuit.

Whistleblower Rights

The FCA prohibits employers from retaliating against employees, contractors or agents who file or participate in the prosecution of a whistleblower suit. Employees, contractors or agents who are discharged, demoted, suspended, threatened, harassed, or in any way discriminated against in the terms and conditions of employment by their employer for “blowing the whistle” are entitled to recover all relief necessary to make the employee, contractor or agent whole. Damages available to the employee, contractor or agent who proves retaliation include: reinstatement with the same seniority status, two times back pay, interest on the back pay, compensation for special damages (i.e., emotional distress), and litigation costs and attorneys fees.

C. California False Claims Laws

Since the federal FCA does not address the problems of fraud in state and local government programs, the California Legislature adopted a state FCA to protect state governments from the same type of fraud prohibited by the federal FCA. The California FCA was modeled after the federal FCA with a few exceptions.

As described above, the federal FCA delineates seven acts that are unlawful. These same seven acts are unlawful under the California FCA, but the California FCA also contains an additional provision that subjects health care providers to liability. *Under the California statute, providers are also liable if they benefit from an inadvertent submission of a false claim to the state government, but do not disclose the false claim to the state within a reasonable time after discovery.*

Liability Under the California False Claims Act

As in the case of the Federal FCA, a person found to have violated the California FCA may be liable for three times the actual damages sustained by the government, as well as penalties. The California FCA assesses penalties for each false claim up to \$10,000, but *does not set a mandatory minimum amount*.

Employee Protections

Under the FCA, an employer cannot make any rule or policy that prevents an employee from disclosing information to a government or law enforcement agency in furtherance of an FCA action. An employer also cannot discriminate against an employee (by discharging, demoting, suspending, or threatening the employee) for lawful acts performed in furtherance of an FCA action.

The California FCA can protect employees even though the employee's actions may appear tenuously linked to a potential FCA action. An employer who is found to have unlawfully retaliated against an employee in this manner may be subject to various sanctions, and the employee may be awarded reinstatement, double his or her back pay plus interest, compensation for special damages, and possibly punitive damages.

D. Program Fraud Civil Remedies Act, 31 U.S.C. § 3801-3812.

The Program Fraud Civil Remedies Act ("Act") is a federal statute which provides additional penalties separate from the Federal False Claims Act for improper claims and improper statements.

Improper Claims

A person violates the Act if they know or have reason to know they are submitting a claim that is:

- False, fictitious or fraudulent; or,
- Includes or is supported by written statements that are false, fictitious, or fraudulent; or,
- Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a results of the omission; and the person submitting the statement has a duty to include the omitted facts; or
- For payment for property or services not provided as claimed.

A violation of this provision of the Act carries a penalty of \$5,500 for each such improper claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid.

Improper Statements

A person violates the Act if they submit a written statement which they know or should know:

- Asserts a material fact which is false, fictitious, or fraudulent; or,
- Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

A violation of the provision for submitting an improper statement carries a civil penalty of up to \$5,500.

DEFICIT REDUCTION ACT COMPLIANCE

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

I. Policies and Procedures to Protect Against Fraud (Please circle the correct answer)

A. What do federal laws require CCHP to have in order to protect against fraud, waste, and abuse in our Medicaid (Medi-Cal) management care plan?

1. *Compliance plan to guard against fraud and abuse which includes written policies, procedures, and standards of conduct*
2. *Full-time Security Guard*
3. *Contract with Sheriff*
4. *None of the above*

B. Which policies contain the CCHP's requirements for reporting suspected fraud, waste and abuse?

1. *Policy #2004-8258*
2. *Policy #705-C and Policy #706-C*
3. *Policy Fraud Waste Abuse*
4. *All of the above*

II. Information on Federal and State Laws Regarding False Claims

A. The Federal False Claims Act, 31 U.S.C. § 3279 (True or False)

a. The False Claims Act ("FCA")?

T___ F___ FCA is a federal statute that covers fraud involving any federally funded contract or program, including Medicare and Medicaid.

Employee education about false claims (continued)

Information on Federal and State Laws Regarding False Claims

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b. How do you violate the FCA?

T___F___ *The FCA is violated when any person knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment*

c. What happens when a health plan violates the FCA?

T___F___ *A health plan that violates the FCA can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted. In addition, a health plan can be required to pay three times the amount of damages sustained by the U.S. Government.*

B. Program Fraud Civil Remedies Act, 31 U.S.C. § 3801

a. What is the Program Fraud Civil Remedies Act?

1. *Group of volunteers acting together*
2. *The Program Fraud Civil Remedies Act is a federal statute which provides additional penalties separate from the Federal False Claims Act for improper claims and improper statements*
3. *A Play*
4. *All of the above*

b. What is the penalty if there is a violation of this claim?

1. *Slap on the wrist*
2. *Lifetime imprisonment*
3. *The penalty is \$5,000 for each improper claim*
4. *None of the above*

Employee education about false claims (continued)

Information on Federal and State Laws Regarding False Claims

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C. California False Claims Laws (True or False)

a. Why did the California Legislature adopt a state FCA?

T___F___ *To protect state governments from the same type of fraud prohibited by the federal FCA. The California FCA was modeled after the federal FCA with a few exceptions.*

b. What is the liability under the California False Claims Act?

T___F___ *A person found to have violated the California FCA may be liable for three times the actual damages sustained by the government, as well as penalties. The California FCA assesses penalties for each false claim up to \$10,000, but does not set a mandatory minimum amount.*

D. Qui Tam Whistleblower Provisions, 31 U.S.C. § 3730(h)

a. What is the “qui tam” or whistleblower provision?

1. *A latin musical*
2. *This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government. These persons are called “relators”.*
3. *All of the above.*
4. *None of the above.*

b. If the government determines that the lawsuit has merit and decides to intervene, who will direct the prosecution of the lawsuit?

1. *The prosecution of the lawsuit will be directed by the U.S. Department of Justice.*
2. *President of the United States*
3. *1 and 2.*
4. *None of the above*

Employee education about false claims (continued)

Information on Federal and State Laws Regarding False Claims

Page 4

c. Besides *qui tam* plaintiffs, who may initiate actions under the California FCA?

1. *i. The government, through the Attorney General's Office; or
ii. The prosecuting authority for a particular subdivision that was the recipient of the false claim.*
2. *The local police department.*
3. *All of the above.*
4. *None of the above.*

Test taken by:

Name

Date

Department

DEFICIT REDUCTION ACT COMPLIANCE

<ANSWERS>

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

I. Policies and Procedures to Protect Against Fraud (Please circle the correct answer.)

A. What do federal laws require CCHP to have in order to protect against fraud, waste, and abuse in our Medicaid (Medi-Cal) management care plan?

- X 1. *Compliance plan to guard against fraud and abuse which includes written policies, procedures, and standards of conduct*
- 2. *Full-time Security Guard*
- 3. *Contract with Sheriff*
- 4. *None of the above*

B. Which policies contain the CCHP's requirements for reporting suspected fraud, waste and abuse?

- 1. *Policy #2004-8258*
- X 2. *Policy #705-C and Policy #706-C*
- 3. *Policy Fraud Waste Abuse*
- 4. *All of the above*

II. Information on Federal and State Laws Regarding False Claims

A. The Federal False Claims Act, 31 U.S.C. § 3279 (True or False)

a. The False Claims Act ("FCA")?

T X F..... *FCA is a federal statute that covers fraud involving any federally funded contract or program, including Medicare and Medicaid.*

Employee education about false claims (continued)

Information on Federal and State Laws Regarding False Claims

Page 2

b. How do you violate the FCA?

T X F _____ *The FCA is violated when any person knowingly;*

- Presents or causes to be presented, a false claim for reimbursement by a Federal health care program, including Medicare or Medicaid;
- Makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- Repays less than what is owed to the Government;
- Makes, uses, or causes to be made or used, a false record or statement material to reducing or avoiding repayment to the Government; and/or
- Conspires to defraud the Federal Government through one of the actions listed above.

c. What happens when a health plan violates the FCA?

T X F _____ *A health plan that violates the FCA can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted. In addition, a health plan can be required to pay three times the amount of damages sustained by the U.S. Government.*

B. Program Fraud Civil Remedies Act, 31 U.S.C. § 3801

a. What is the Program Fraud Civil Remedies Act?

1. *Group of volunteers acting together*

X 2. *The Program Fraud Civil Remedies Act is a federal statute which provides additional penalties separate from the Federal False Claims Act for improper claims and improper statements*

3. *A Play*

4. *All of the above*

b. What is the penalty if there is a violation of this claim?

1. *Slap on the wrist*

2. *Lifetime imprisonment*

X 3. *The penalty is \$5,000 for each improper claim*

4. *None of the above*

Employee education about false claims (continued)

Information on Federal and State Laws Regarding False Claims

Page 3

C. California False Claims Laws (True or False)

a. Why did the California Legislature adopt a state FCA?

T X F *To protect state governments from the same type of fraud prohibited by the federal FCA. The California FCA was modeled after the federal FCA with a few exceptions.*

b. What is the liability under the California False Claims Act?

T X F *A person found to have violated the California FCA may be liable for three times the actual damages sustained by the government, as well as penalties. The California FCA assesses penalties for each false claim up to \$10,000, but does not set a mandatory minimum amount.*

D. Qui Tam Whistleblower Provisions, 31 U.S.C. § 3730(h)

a. What is the “qui tam” or whistleblower provision?

1. *A latin musical*
- X 2. *This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government. These persons are called “relators”.*
3. *All of the above.*
4. *None of the above.*

- b. If the government determines that the lawsuit has merit and decides to intervene, who will direct the prosecution of the lawsuit?
- X 1. *The prosecution of the lawsuit will be directed by the U.S. Department of Justice.*
2. *President of the United States*
3. *1 and 2.*
4. *None of the above*

Employee education about false claims (continued)

Information on Federal and State Laws Regarding False Claims

Page 4

c. Besides *qui tam* plaintiffs, who may initiate actions under the California FCA?

- X 1. i. *The government, through the Attorney General's Office; or*
ii. *The prosecuting authority for a particular subdivision that was the recipient of the false claim.*
2. *The local police department.*
3. *All of the above.*
4. *None of the above.*

Test taken by:

Name

Date

Department

Inventory Disparities FAQs

What are inventory disparities?

Inventory disparities are discrepancies between a pharmacy's inventory and the number of units ordered, dispensed, or billed.

How are inventory disparities discovered?

An inventory disparity – either a shortage or overage – may be discovered when a review of invoices and claims indicates that drug quantities on the shelves are lower or higher than what is expected. These disparities are often discovered by an audit or investigation.

How does DPOA find disparities?

The Division of Plan Oversight and Accountability (DPOA), within the Center for Program Integrity (CPI), detects and prevents fraud, waste, and abuse in the Medicare Advantage (Part C) and prescription drug benefit (Part D) programs, including identifying disparities in pharmacy inventories, through analysis of claims data and partnerships with sponsoring organizations and their downstream entities.

Drug Inventory Shortage Reveals Significant Medicare Part D Losses

Issue: Something Wasn't Adding Up

Six pharmacies located in NY, MI, IL, CA, and FL, previously identified as potentially fraudulent, were the target of an investigation into 40 drugs for which Part D claims were submitted over the past year. Teamwork between Pharmacy Benefit Managers (PBM), a Part D sponsoring organization, Health and Human Services/Office of Inspector General (HHS/OIG) investigators, and the Medicare Drug Integrity Contractor (MEDIC) led to an invoice and billing audit focused on the purchase and distribution of 40 high-dollar medications. As part of the audit, the PBMs identified the drug manufacturers and distributors for each suspect pharmacy and obtained purchase invoice information. The PBMs also sent verification letters to physicians and beneficiaries to confirm prescription orders.

Discovery: Claims Volume Did Not Equal Invoicing

A comparison of the volume of medications purchased versus the claims volume by the pharmacies revealed potential drug shortages and overpayments. Based on the invoices and claims history data reviewed, the group determined the drug shortages and exposure for the six pharmacies to be approximately \$2,733,985.

This case exemplifies the value of information-sharing and collaboration. Although a pharmacy's claims under one plan may not seem suspicious, comparing claims and billing information across several purchasers may uncover fraudulent activities.

To report potential or suspected Medicare Part C or D fraud, call 1-877-7SAFERX.

What could indicate inventory disparities?

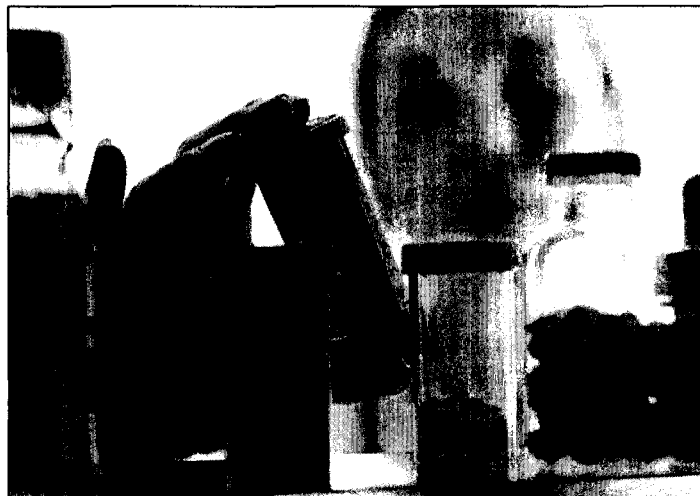
- A comparison of wholesaler invoices with claims indicating the pharmacy is ordering higher than necessary quantities of medications. This disparity may also indicate the pharmacy is supplying a pill mill or selling those overstocked drugs illegally.
- An audit of claims written against wholesale orders revealing insufficient quantities of medications have been ordered. This disparity may also indicate schemes such as "drug shorting" (billing for 60 pills but only dispensing 30 pills), or submitting claims for drugs not dispensed.
- High number of claims not being reversed resulting in inventory overages. When a patient does not pick up a prescription, the pharmacy should back the claim out of the system. However, if drugs are simply reshelfed, then double billing and overages may occur.

A Wholesaler Perspective

- Close collaboration with wholesalers is a valuable way to monitor and detect fraud, waste and abuse by giving insight into what pharmacies are purchasing.
- **A typical neighborhood pharmacy will purchase 80% non-controlled pharmaceuticals. More than 20% controlled substances could raise some red flags to take a closer look.**
- Comparing the types and quantities of drugs purchased by pharmacies from multiple wholesalers could also uncover schemes for pill mills and drug trafficking where pharmacies are over-ordering from multiple sources.

Part C and Part D Working Groups

In an ongoing effort to detect, prevent, and correct fraud, waste and abuse, CMS and the MEDIC have established Part C and Part D Working Groups for information sharing of potential fraud schemes. The next meeting, which is held quarterly, is set for June 15th – 16th via teleconference only. Contact Stephen Campbell at 410-786-5895 or stephen.campbell@cms.hhs.gov for additional information about these Working Groups.



ISSUE BRIEFS

The Division of Plan Oversight and Accountability (DPOA) is launching a fraud, waste and abuse (FWA) educational effort for Part C and Part D and will be sharing monthly Issue Briefs. Issue Briefs are an information sharing series highlighting themes and topics of interest on Medicare Parts C and D FWA issues.

About Issue Briefs

The Issue Briefs will provide an overview focusing on one FWA issue, including frequently asked questions, stakeholder perspectives, case study examples, current legislation, and FWA indicators. This first issue Brief covers the topic Inventory Disparities, a potential indicator of pharmacy FWA, which was a theme introduced at a recent Part D Information Sharing Workgroup Meeting, and discussed collaboratively amongst participants.

MEDICARE REGULATIONS FOR FWA

42 C.F.R. §422.503(b)(4)(vi)

A compliance plan that consists of the following:

(A) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.

(B) The designation of a compliance officer and compliance committee that are accountable to senior management.

(C) Effective training and education between the compliance officer and organization employees.

(D) Effective lines of communication between the compliance officer and the organization's employees.

(E) Enforcement of standards through well-publicized disciplinary guidelines.

(F) Procedures for internal monitoring and auditing.

(G) Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to the organization's MA contract.

(1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.

(2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section.

(H) For MA-PDs, A comprehensive fraud and abuse plan to detect and prevent fraud, waste, and abuse as specified at Sec. 423.504(b)(4)(vi)(H) of this chapter.

42 C.F.R. § 423.504 (b)(4)(vi)

(vi) A compliance plan that consists of the following--

(A) Written policies, procedures, and standards of conduct articulating the organization's commitment to comply with all applicable Federal and State standards.

(B) The designation of a compliance officer and compliance committee accountable to senior management.

(C) Effective training and education between the compliance officer and organization employees, contractors, agents, and directors.

(D) Effective lines of communication between the compliance officer and the organization's employees, contractors, agents, directors, and members of the compliance committee.

(E) Enforcement of standards through well-publicized disciplinary guidelines.

(F) Procedures for effective internal monitoring and auditing.

(G) Procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives relating to the organization's contract as a Part D plan sponsor.

(1) If the Part D sponsor discovers evidence of misconduct related to payment or delivery of prescription drug items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct;

(2) The Part D sponsor must conduct appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) in response to the potential violation referenced above.

(H) A comprehensive fraud and abuse plan to detect, correct, and prevent fraud, waste, and abuse. This fraud and abuse plan should include procedures to voluntarily self-report potential fraud or misconduct related to the Part D program to the appropriate government authority.