Corporate Compliance and Ethics

Human Resource Development
Professional Training and Development

Corporate Compliance and Ethics

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Section 1: Introduction

Corporate compliance programs are a well-established means of preventing fraud and abuse in health care organizations. By enhancing your knowledge regarding the definition of ethics, health care fraud, and best practices in identifying high-risk activities, this course prepares you to contribute to an ethical and compliant environment in your agency. A series of exercises will help you to identify and explain the elements of corporate compliance, as well as how to report suspicious activities.

To complete the course and receive continuing education credits, you must achieve an 80% score on the post-test and complete the course evaluation.

Course Objectives

Upon completion of this course you will be able to:

1. Define corporate compliance, including how it benefits organizations.
2. Summarize the fundamentals of ethics and health care fraud.
3. Identify high-risk activities, as well as the seven elements of a Corporate Compliance program.

Section 2: Overview

What Does "Corporate Compliance" Mean?

In 1997, the Office of the Inspector General of the Department of Health and Human Services initiated a program to promote the identification and investigation of health care fraud and abuse. As a result of this government requirement, health care organizations have developed Corporate Compliance Programs.

Corporate Compliance Defined

"Corporate Compliance" is a system of effective internal controls that promote adherence to federal and state law; program requirements of federal, state, and private health plans; and ethical behavior.

The goal of Corporate Compliance Program is to establish a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to law, as well as an organization's ethical and business policies

What is the purpose of Corporate Compliance programs?

To create a system of checks and balances to DETER, DETECT, and PREVENT fraud, abuse, and mistakes.

Benefits of Corporate Compliance Programs

Effective corporate compliance programs benefit organizations by:

- Demonstrating a strong commitment to being an honest and responsible provider with appropriate corporate conduct.
- Identifying and preventing criminal and/or unethical conduct.
- Developing methodology that encourages employees and providers to report potential problems.
- Developing procedures that result in prompt, thorough investigation of alleged misconduct, and providing for corrective actions.
- Minimizing risk

Section 3: Components of Corporate Compliance

Ethics

An effective compliance program promotes an organizational culture that encourages ethical conduct, as well as a commitment to compliance with laws, regulations, and policies. Such a program articulates a broader set of ethical standards, which employees understand and use as practical guidelines for decision-making and conduct.

"ETHICS" refers to well-based standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues.

COMPLIANCE = WHAT IS LEGALLY REQUIRED
ETHICS = WHAT IS RIGHT

In other words, the ethical question to be asked is, *"Should I do this?"* rather than, *"Can I do this?"* Knowing expectations and never compromising integrity regardless of pressures faced results in ethical behavior. Ethical business and clinical decisions promote an organization's value system. Ethical business practices include accurate billing procedures, accurate filing of claims, and reporting abuses of the system.

Compliance Program Components

There are Seven Components to a Corporate Compliance Program.

1. Written Policies and Procedures

   Establish written compliance policies and procedures that are distributed to all employees and providers. These policies and procedure include standards of conduct, investigations, corrective action, and reporting protocol. Evaluation and modification of these policies and procedures is an integral part of any compliance program. Integral Care describes it's corporate compliance expectation in Board Policy 03.11.

2. Compliance Officer and Committee

   Establish responsibility by designating a Compliance Officer (CCO) and a Compliance Committee from high-level personnel.

3. Mandatory Compliance Training

Provide mandatory education through a formal compliance training program for all employees, officers, managers, supervisors, Board members, long-term temporary employees, providers and possibly contractors. Informal ongoing training also must be provided.

4. Anonymous and Effective Lines of Communication

Develop an internal system for reporting suspected non-compliance. This often is accomplished by establishing an Anonymous Corporate Compliance "Ethics Hot-Line" and providing "drop-boxes." An "open-door" policy for employee access to the CCO also is recommended. Including compliance questions in each employee's annual evaluation also may be enhancing communication.

5. Auditing and Monitoring

Develop an extensive internal audit and monitoring system to ensure compliance. The monitoring system should determine whether recommendations and corrective action plans have been implemented.

6. Investigation and Enforcement Process

Investigations should be conducted in a timely and confidential manner for all suspected compliance breaches. Disciplinary policies should include sanctions for actual non-compliance, for failure to detect non-compliance, and for failure to report actual or suspected non-compliance. The organization also must use care to avoid delegating substantial discretionary authority to individuals whom the organization knows-or should have known- have a propensity to engage in illegal activities.

7. Corrective Action Process

Organizations should respond to non-compliant conduct and take steps to prevent further similar conduct. Modifications of the Corporate Compliance system can be made in response to a risk assessment of potential criminal behavior. "Beginning with an employee's first day of work, he or she should know that ethics and honesty are important to the company. {It is} Not enough to have a code of conduct. ...ethics must become part of the company's DNA." Stephen Cutler, former SEC Director of Enforcement

<u>What Is Fraud and Abuse?</u>

Definitions and Examples of Fraud and Abuse:

1. Health care FRAUD is the knowing and willful execution, or attempt to execute a scheme to defraud a health care benefit program to obtain, by means of false or fraudulent representation or promise, any money or other property owned by a health care benefit program.

DID YOU KNOW? DURING FISCAL YEAR (FY) 2007, A TOTAL OF 560 DEFENDANTS WERE CONVICTED FOR HEALTH-CARE-FRAUD-RELATED CRIMES DURING THE YEAR.

2. ABUSE generally encompasses incidents or practices that are inconsistent with sound fiscal, business, or medical practices that may result directly or indirectly in unnecessary program costs, improper payment, or payment for services that fail to meet professional standards of care, or that are medically unnecessary.

DID YOU KNOW? *DURING Federal FY 2013, THE FEDERAL GOVERNMENT WON OR NEGOTIATED APPROXIMATELY $2.6 BILLION IN JUDGMENTS AND SETTLEMENTS IN HEALTH CARE FRAUD CASES AND PROCEEDINGS. SEVEN-HUNDRED AND EIGHTEEN DEFENDENTS WERE CONVICTED. http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf.*

High-Risk Activities

Activities that are at high-risk for violations according to the Federal government include:

- False claims (up-coding or down-coding the billing code to obtain higher payment).
- Fraudulent billing (billing for services not provided or not necessary).
- Taking bribes or kickbacks, or giving excessive discounts (receiving gifts from other interests that could indicate an incentive to do business with them).
- Payment to other parties to induce referrals.
- Providing service without a valid license.
- Submitting a claim with inadequate documentation to support the amount billed.
- False documentation to support and bill for a service never rendered.

Section 4: Investigations

Investigations and Penalties

Health care fraud and abuse is prosecuted under the Federal False Claims Act. This Act prohibits a person or entity from knowingly presenting--or causing to be presented--claims or false records or statements to the Federal government in order to get payment for a false or fraudulent claim. Civil penalties can range from $5,500 to $11,000 per claim *plus* three times the amount of damages sustained by the Federal government. In addition to monetary fines, organizations can be excluded from Medicare and Medicaid programs, and CEOs and Boards can be subject to criminal penalties.

The Deficit Reduction Act and The Medicaid Integrity Program

To offset health care fraud and abuse the Deficit Reduction Act (DRA) was passed and from this, the Medicaid Integrity Program (MIP) was developed. For FY 2015, the Budget invests a total of $428 million in new Health Care Fraud and Abuse Control Program (HCFAC) and Medicaid program integrity funds. As a result, there is more Federal scrutiny of health care providers, more audits and investigations, and more paybacks.

This increased oversight has resulted in many changes. What was a billing error in 1989 may now be considered FRAUD, and investigations can result in fines that can go back to practices 10 years prior. The standard for guilt in an investigation is, "If you knew or should have known," the fraudulent activity was taking place.

Federal Sentencing Guidelines

An effective corporate compliance program that demonstrates and encourages ethical behavior and compliance with legal and regulatory requirements provides a defense or protection for an organization.

In order to receive "credit" for good corporate behavior, the Federal Sentencing Guidelines require that organizational defendants exercise due diligence in the design and implementation of a compliance program intended to detect and deter fraud, waste, and abuse. However, the existence of a corporate compliance program is not protection from investigation or fines.

What is the Federal False Claims Act?

This Act prohibits a person or entity from knowingly presenting-or causing to be presented-claims or false records or statements to the Federal government in order to get payment for a false or fraudulent claim.

Section 5: Reporting

Reporting

Each employee or provider is responsible for reporting any violation or suspected violation of corporate compliance policy. Integral Care provides a corporate compliance "ethicshot line" for verbal reporting, email at compliancehotline@integralcare.org and incident reporting that can be completed and forwarded to the Corporate Compliance Officer.

Activities That Should Be Reported

Examples of fraudulent or other activities that should be reported are:

- Up-coding
- Billing for a service that has not been provided
- Billing for more time than is actually spent on the service
- Accepting bribes or inappropriate gifts
- Any violation of the ethical business code of conduct and Operating Procedure 07.21
- Employee Rights against retaliation

An employee reporting an illegal activity is protected under Federal and State law.
The reporting person, or whistleblower, cannot be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms of conditions of employment by her/his employer because of lawful acts done by the employee.

If any of these should occur, the employee, an action under the Federal False Claims Act, shall be entitled to all relief necessary to make the employee "whole."

Section 6: Summary

Things to Remember

Corporate Compliance is a system of effective internal controls that promote adherence to federal and state law; program requirements of federal, state, and private health plans; and ethical behavior.

The purpose of corporate compliance programs is to prevent and detect fraud, abuse, and waste by creating systems that enable organizations to operate in a compliant manner within Federal and State legal and regulatory environments.

The seven basic elements of a compliance program are: written policies and procedures including standards of conduct; a compliance officer; mandatory education and training; anonymous and effective lines of communication for a reporting system; auditing and monitoring; investigation and enforcement process; and corrective action process.

"ETHICS" refers to well-based standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues.

Health care fraud is the knowing and willful execution--0r attempt to execute-a scheme to defraud a health care benefit program to obtain, by means of false or fraudulent representation or promise, any money or other property owned by a health care benefit program.

Abuse encompasses practices that are inconsistent with sound fiscal, business, or medical practices that may result in unnecessary program costs, improper payment, or payment for services that fail to meet professional standards of care, or that are medically unnecessary.

Fraudulent high-risk activities include up-coding, billing for services not provided, taking bribes or kickbacks, payment to other parties to induce referrals, providing service without a valid license, submitting claim with inadequate documentation, false documentation to support, and bill for a service never rendered.

The existence of a corporate compliance program is not protection from investigation or fines.

Significantly increased resources are now available for Federal investigations.

Federal and State laws protect "whistleblower" employees from retaliation from reporting corporate compliance violations.

Reporting Process

Integral Care offers a variety of ways for any individual to report possible alleged fraud and to leave general questions. They include:

1. Integral Care Compliance Ethics Hotline: By Phone:
   512/445-7776

   To report possible fraud, ask questions or express concerns, call the Ethics Hotline. Please provide enough information (nature of your concern, program/division involved, specific incident, etc.) in order to better serve you.

2. Corporate Compliance Officer:
   Louise F. Lynch,
   email: Louise.Lynch@integralcare.org By Phone: 512/445-7731

3. HIPAA Privacy Officer:
   Becky Reeves, email: Becky.Reeves@integralcare.org
   By Phone: 512/440-4086

4. Health and Human Services/Office of Inspector General (HHS-OIG)
   By phone - 1-800-HHS-TIPS

Deficit Reduction Act Compliance

Learning Objectives

Upon completion of this course you will:

- Describe the ORA and how it impacts your organization's corporate compliance program.
- Identify examples of false claims.
- Describe protections available to "Whistleblowers".

About This Course

This course describes the important provisions of the federal Deficit Reduction Act and the responsibilities of the organization and employees under the law. It provides a comprehensive review of ethical business practices in healthcare, identification of fraud and the importance of an effective compliance program.

The course also covers the False Claims Act and Whistleblower provisions. To complete the course and receive continuing education credits you must achieve an 80% score on the post-test and complete the course evaluation.

Why Do I Need this Training?

We are providing this training to ensure that you, as our employee, are fully aware of the new Deficit Reduction Act (ORA), which took effect January 2007.

The Five Areas I Need to Know About

The ORA requires entities that make or receive at least $5 million in annual Medicaid payments to establish written policies and procedures designed to educate their employees, contractors and agents in 5 areas

1. The Federal False Claims Act.
2. Administrative remedies for false claims and statements.
3. Any state false claims laws.
4. The rights of employees to be protected as whistleblowers.
5. The role of the employer's policy and procedures for detecting and preventing fraud, waste and abuse.

What Does the ORA do?

By 2030 spending for Medicare and Medicaid and Social Security will be almost 60% of the entire federal budget.

*It is **intended to:***

1. Decrease growth of Medicaid spending.
2. Save the American people money.
3. Bring mandatory Medicaid spending under control.
4. The DRA restrains spending for entitlements programs while ensuring care for those who rely on these programs.

What Else Does the ORA do?

The DRA requirement is part of federal law, but states are responsible for developing oversight and enforcement mechanisms. The DRA dramatically shifts the federal enforcement to Medicaid and provides funding for the federal Medicaid fraud enforcement unit.

How Does the ORA Impact Corporate Compliance?

Corporate Compliance

Corporate Compliance is a system of effective internal controls that promote adherence to federal and state law; program requirements of federal, state, and private health plans; and ethical behavior.

Education on DRA is part of your organization's overall Corporate Compliance system. Failure to comply with DRA requirements may result in an entity losing Medicaid funding.

The impact of the ORA on Corporate Compliance

The Best Defense

Fraud and abuse are being prosecuted under the False Claims Act with fines ranging from $5,000.00 to $10,000.00 per episode, plus triple the amount of the false claims.

The Department of Justice has made healthcare fraud a high priority, second only to violent crime. Increased resources have been allotted and efforts are ongoing to detect fraud and abuse within healthcare facilities.

As a result, the best defense for a facility is to develop a compliance program. Such a program will not guarantee immunity from prosecution, but if a commitment to compliance is evident within the facility, it will be taken into account should an investigation take place.

Ethics and Fraud... What's the Difference?

"Ethics" refers to well based standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues.
Ethical business practices include:

1. Accurate billing procedures.
2. Accurate filing of claims.
3. Accurate medical record documentation.
4. Fraud is an intentional deceptive act done for unfair or unlawful gain.

Examples of fraud include:

1. Billing for services that are not medically necessary.
2. Deliberate overcharging.
3. False codes on healthcare visits or procedures to obtain a higher reimbursement.
4. Claims for reimbursement of services not rendered.
5. Falsification of Medical Records.

Discovery of Fraud

Fraud is an intentional deceptive act done for unfair or unlawful gain. Can you think of examples of healthcare fraud?

1. Deliberate overcharging.
2. Unnecessary home health visits to obtain reimbursement, and
3. Unnecessary procedures done for financial gain.
4. Giving false information for gain is also fraud.

Examples of false information for gain include:

1. Duplicate billing,
2. False codes on healthcare visits or procedures to obtain a higher reimbursement,
3. Claims for reimbursement of home health visits that were not made, and false reports.

What If I Make an Honest Mistake?

Fraud does not include acts that are honest mistakes. Mistakes can occur in billing and there can be reimbursement discrepancies but neither is fraud. However, Federal law does not require **proof** of a specific intent to defraud the United States government.

What If I Suspect Fraud?

All employees have a duty to report cases of fraud. It is also important that you alert your organization to cases that could look like fraud. After being alerted, the organization can solve the problems, and avoid legal accusations of fraud.

To be able to report fraud, you should know that:

Your organization has a policy and procedure for reporting suspected fraud.
You may need to contact a specific person, and/or dial a hotline number.
You cannot be penalized by your organization for reporting suspected fraud.

How Can I Prevent Fraud?

Mistakes such as simple billing errors and reimbursement discrepancies occur and, although not fraud, must be investigated to prevent future errors and to ensure that fraud is not intended. Prevent all errors that could possibly appear as fraud or raise the suspicion of fraud.

If your job involves billing, charging, or coding:

1. Learn the policies and procedures, and then follow them.
2. Document your work accurately.
3. Seek training if you do not understand how to do tasks.
4. Take advantage of training opportunities.
5. Be thorough and ask for help if needed.
6. Treat all customers and clients courteously.
7. Always give customers and clients accurate information.
8. Cooperate in internal audits.

What is the False Claims Act?

The False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program (including Medicare and Medicaid). The FCA does NOT cover tax fraud. The FCA is commonly known as the "Lincoln Law" because it was first enacted to counter fraudulent activities involving military procurement during the Civil war.

Under the False Claims Act those who knowingly make a false claim are liable for civil penalty of not less than $5,000.00 and not more than $10,000, plus 3 times the amount of the damages which the government sustains because of the act of that person.

Activities That Are Covered

The False Claims Act covers the following activities:

1. Knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment.
2. Knowingly using (or causing to be used) a false record or statement to get a claim paid by the federal government.
3. Conspiring with others to get a false or fraudulent claim paid by federal government.
4. Knowingly using (or causing to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government.

What Does "Knowing" and "Knowingly" Mean?

The terms knowing and knowingly mean that a person, with respect to information has actual knowledge of the information, Acts in deliberate ignorance of the truth, or acts in reckless disregard of the truth.

Whistleblower Protection and Employee Responsibility

The False Claims Act contains Qui Tam and whistleblower provisions. **Qui Tam** is a unique mechanism in the law that allows citizens with evidence of fraud against government contractors and programs to sue, on behalf of the government, in order to recover the stolen funds.

The Whistleblower Protection Act can provide confidentiality and protection from retaliation to employees, or former employees who report allegations of fraud and abuse. The act prohibits retaliation by employers on employees "who blow the whistle" by exposing fraud and abuse.

You, as an employee, may not be discharged, demoted, suspended, threatened, harassed or discriminated against by your employer. You are entitled to relief including reinstatement, double back pay, and compensation for any special damages including litigation costs and reasonable attorneys' fees.

What Is My Responsibility as an Employee?

As an employee it is important that you:

- Know and follow your organization's policies and procedures relating to false claims.
- Know and follow your organization's policies and procedures for detecting fraud, abuse and waste. Be aware of your rights to be protected as a whistleblower.

What Is the Medicaid Integrity Program?

The DRA resulted in the creation of the Medicaid Integrity Program (MIP) which dramatically increases resources available to combat Medicaid provider fraud, waste and abuse, and to devise an effective national strategy to do so.

The MIP has at least $75 million each year for combating fraud and abuse and the program is administered through the Medicaid Integrity Group (MIG).

The three primary tasks the MIG is charged with:

1. Develop the national Medicaid claims database.
2. Provide support and assistance to States by developing the Medicaid Integrity Institute.
3. Implement the national Medicaid provider audit program.

What Is the Role of the MIP?

The MIP has at least $75 million each year for combating fraud and abuse and the program is administered through the Medicaid Integrity Group (MIG). The three primary tasks the MIG is charged with:

1. Implement the national Medicaid provider audit program.
2. Provide support and assistance to States by developing the Medicaid Integrity Institute.
3. Develop the national Medicaid claims database.

Let's Review

Ethics refers to well based standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues.

Which is one of the tasks of the Medicaid Integrity Program? Implement the national provider audit program.

Failure to comply with ORA requirements may result in an entity losing Medicaid funding.

Federal law does not require proof of a specific intent to defraud the United States government

If a commitment to compliance is evident within the facility, it will be taken into account should an investigation take place.

The ORA requirement is part of federal law, but states are responsible for developing oversight and enforcement mechanisms.