HALIFAX
HEALTH

Policy Title: COM-S-LL-922 Deficit Reduction Act of 2005		
Department: Corporate Compliance		TJC Chapter(s): LD
Title of Policy Owner: Deputy Chief Compliance Officer		Approved by: Vice President and Chief Compliance Officer
Effective Date: 1/1/07	Reviewed Date: 11/14; 12/14; 1/16; 3/16; 7/17	Revised Date: 11/14; 12/14; 1/16; 3/16; 7/17

I. PURPOSE:

This policy describes our compliance with certain requirements set forth in the Deficit Reduction Act of 2005 with regard to federal and state false claims laws.

II. SCOPE:

This policy is applicable to all Halifax Health Team Members, departments, and affiliates.

III. DEFINITIONS:

A *Halifax Health Team Member* is any employee of Halifax Health and its affiliates.

A *contractor or agent* includes supply vendors, vendors who perform billing and coding functions, and vendors who furnish or otherwise authorize the furnishing of Medicaid health care items or services or are involved in monitoring of health care provided by Halifax Health and its affiliates. Vendors who provide security, janitorial, dietary, maintenance, volunteer services, and other services that are not related to providing care to Medicaid patients or billing/ coding functions are NOT *contractors or agents*.

An *affiliate* of Halifax Health is an entity owned or controlled by Halifax Health.

IV. POLICY:

Halifax Health has processes in place for detecting and preventing fraud, waste and abuse related to the Medicaid program. Halifax Health maintains a concerns hotline to which anonymous reports can be made. Halifax Health Team Members will not retaliate against any individual who reports a concern to external governmental agencies. Halifax Health disseminates information about the following to Team Members, Contractors and Agents:

- The False Claims Act, established under sections 3729 – 3733 of title 31 USC;
- Administrative remedies for false claims and statements established under chapter 38 of title 31 USC; and,
- State laws pertaining to civil or criminal penalties for false claims and statement and whistleblower protections under such laws.

Federal False Claims Act

The federal False Claims Act ("FCA") provides for fines ranging from $5,500 to $11,000 for knowingly presenting a false or fraudulent claim to a federal government agency or program. In addition, a party may be required to pay three times the amount of damages to the government.

For purposes of the FCA, "claim" includes "any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States

Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded." In health care, claim includes any of the paper or electronic billing forms submitted to a government health care program for items or services provided to a program beneficiary.

"Knowingly" has been defined as a person, with respect to information on the claim:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

Federal law provides protections for individuals who report possible false claims.

Florida False Claims Act

Under the Florida False Claims Act (§§ 68.081 – 68.092, Florida Statutes), any person who presents a false claim to a state agency can be held liable for a civil penalty up to $10,000 per claim and three (3) times the amount of the overpayment paid or incurred by the state Medicaid agency. If the false claim is disclosed promptly and the person cooperates with the agency, the penalty that might otherwise be assessed may be reduced.

"Claim" includes any request or demand, under a contract or otherwise, for money, property, or services, which is made to any employee, officer, or agent of an agency, or to any contractor, grantee, or other recipient if the agency provides any portion of the money or property requested or demanded, or if the agency will reimburse the contractor, grantee, or other recipient for any portion of the money or property requested or demanded.

Similar to the federal False Claims Act, State law provides protections for individuals who report possible false claims.

Medicaid Integrity Program

The Agency for Healthcare Administration (AHCA), as the Medicaid agency for the state, oversees the activities of Florida Medicaid recipients, providers and their representatives. The program established to provide this oversight is called the Medicaid Integrity Program. The purpose of the Program is to ensure that fraudulent and abusive behavior and neglect of Medicaid recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions.

For purposes of the Medicaid Integrity program:

"Abuse" means provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse can also mean a recipient practice that results in unnecessary cost to the Medicaid program.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, AHCA is the final arbiter of medical necessity. Determinations of

medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

"Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that were provided, are of appropriate quality, covered by the Medicaid program and documented appropriately in the records.

V. PROCEDURE:

A. Halifax Health's processes for detecting and preventing fraud, waste and abuse include:

1. Investigating reports of concerns from Team Members and others;
2. Performing background checks and screening of new Team Members;
3. Performing internal and external reviews of risk areas; and
4. Reporting the resolution of concerns reported through the Compliance hotline to the Compliance Committee and the Board of Commissioners.

B. How to report concerns – Halifax Health's anonymous hotline:

1. Call (844) 251-1880, or
2. Go to: www.halifaxhealth.ethicspoint.com
3. Reports may be made anonymously or reporters may choose to leave contact information;
4. Concerns are investigated and reviewed by Halifax Health's Compliance Committee and Board of Commissioners.

C. Whistleblower Protection:

1. State and Federal laws provide protections for individuals who report concerns to external agencies, such as the Florida Agency for Health Care Administration ("AHCA") (the agency in charge of administering the Medicaid program in Florida). Halifax Health Team Members will not retaliate against persons who report concerns to AHCA or other external government agencies.

D. Distribution of information to Team Members, Contractors and Agents:

1. Team Members, Contractors and Agents (other than supply vendors) receive information about Halifax Health's controls, the concerns hotline and general information on fraud, waste and abuse as part of the Code of Conduct and as part of the General Compliance Training required at policy *COM-S-CP-40 Compliance Training and Education*.
2. Contractors and Agents who are supply vendors receive information about Halifax Health's controls, the concerns hotline and general information on fraud, waste and abuse as part of the vendor registration process through the materials management department using a software called Vendor Mate and as a notification on each purchase order form.

VI. KEYWORDS:

Fraud; Waste; Abuse; Deficit Reduction Act; DRA

VII. REFERENCES:

Halifax Health policy *COM-S-CP-40 Compliance Training and Education*

Halifax Health Code of Conduct https://www.halifaxhealth.org/about-us/code-conduct-quality-content

United States Code Title 31, § 3279, Federal False Claims Act https://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37-subchapIII-sec3729.pdf

§§ 68.081 – 68.092, Florida Statutes, Florida False Claims Act http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0000-0099/0068/Sections/0068.081.html

VIII. REVISION HISTORY:

Date	Revision/Review	By
2/6/2007	Policy established	G.Rousis
6/24/2010	Review; minor edits; published to Pulse.	G.Rousis
7/11/17	Complete re-write of policy	C. Kowatch