

# The prevention of fraud, waste and abuse in health insurance programs



## Our Mission

Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care, which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

## Our Values

### Service of the Poor

Generosity of spirit, especially for the persons most in need

### Reverence

Respect and compassion for the dignity and diversity of life

### Integrity

Inspiring trust through personal leadership

### Wisdom

Integrating excellence and stewardship

### Creativity

Courageous innovation

### Dedication

Affirming the hope and joy of our ministry

## Our Vision

We envision a strong, vibrant Catholic health ministry in the United States which will lead to the transformation of healthcare. We will ensure service that is committed to health and well-being for our communities and that responds to the needs of individuals throughout the life cycle. We will expand the role of laity, in both leadership and sponsorship, to ensure a Catholic health ministry of the future.

## Preface

Via Christi strives to deliver quality care and service to those we serve. This includes beneficiaries of federal health insurance programs: Medicare, Medicaid and TRICARE, which covers the U.S. military community.

Our concern for quality extends beyond the care and treatment of those we serve. We also make every effort to ensure that all claims submitted for services and goods are complete and accurate. As stated in our *Standards of Conduct – A Mission based on values and ethics*, we are committed to ethical behavior, including compliance with all state and federal laws and regulations.

This booklet has been developed by the Via Christi Corporate Responsibility Office to provide you with critical information about the prevention of fraud, waste and abuse in federal and state health insurance programs. It explains the laws that forbid the submission of false or fraudulent claims. The booklet explains how to report any concerns to the Corporate Responsibility Office, and includes a reminder that Via Christi welcomes such information and does not tolerate retaliation or retribution for such reporting. You also have rights and responsibilities when reporting concerns under the federal False Claims Act whistleblower provisions.

Please take the time to read this booklet and to ask questions you may have about the content. Keep this booklet as a reference, along with the other information you have received concerning Via Christi. We want you to be informed and involved as we focus on developing and maintaining a culture of integrity and service.



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## Introduction

An integral part of our Mission is caring for the poor, the disabled, the elderly and the vulnerable people in our communities. Via Christi participates in federal health insurance programs, including Medicare, Medicaid and TRICARE, to better serve the public.

This booklet provides essential information about key laws that forbid fraud, waste and abuse by providers that participate in federal health insurance programs.

### **Fraud is defined as:**

... the intentional deception or misrepresentation made by a person who knows that the deception could result in an unauthorized benefit.

### **Abuse is defined as:**

... activities that are not consistent with sound business, fiscal, or medical practices and result in unnecessary costs.

Healthcare fraud and abuse are national problems that affect every one of us directly or indirectly. It is estimated that billions of dollars are lost to fraud and abuse every year. These losses result in higher healthcare delivery costs and increased costs for health insurance coverage.

Two important fraud prevention laws are the federal False Claims Act (FCA) and the Kansas Medicaid Fraud Control Act. Both laws have serious penalties for making or bringing about false or fraudulent claims for payment to the federal health insurance programs.

We have the opportunity to model honesty, ethics and integrity for others employed by Via Christi ministry locations or conducting business with us. Since healthcare regulations are so complex, Via Christi has a Corporate Responsibility program to ensure full compliance with Medicare, Medicaid and TRICARE requirements regarding fraud, waste and abuse. If you have questions or concerns about compliance with antifraud requirements, contact the Via Christi Corporate Responsibility Department.

## Federal Deficit Reduction Act

The Deficit Reduction Act of 2005 introduced specific requirements for employers receiving more than \$5 million per year in Medicaid payments. These healthcare providers must share information with their employees about the federal FCA, any applicable state False Claims Act, the rights of employees to be protected as whistleblowers and the employer's policies and procedures for finding and preventing fraud, waste and abuse. This booklet is provided to you to fulfill these requirements, as well as give you valuable information regarding Via Christi's commitment to a culture of integrity and ethical behavior.

## Federal health insurance programs

Medicare, Medicaid and TRICARE beneficiaries make up a large percentage of persons who seek care at Via Christi ministry locations. The Medicare and Medicaid programs continue to grow and become more complex. The laws governing these programs are complicated, demanding our attention to ensure that we follow the requirements for submitting complete and accurate claims.

The Centers for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services, has reported that more than 1 billion claims are processed each year, paid to more than 1 million healthcare providers. Both the Medicare and Medicaid programs are under increasing pressure due to the healthcare and long-term care needs of retiring baby boomers. Due to rapid growth and new demands, the federal government is taking added measures under the FCA to ensure that every dollar spent actually goes to providing treatment and care and that any dollars paid for false or fraudulent claims are recovered by the government.

In order to understand the FCA, there should be a basic understanding of the primary federal health insurance programs: Medicare, Medicaid and TRICARE.

## Medicare overview

Since 1965, Medicare has provided health insurance for people age 65 and older, for some people with long term disabilities and for patients with end-stage renal (kidney) disease. Medicare is a federally funded program, created by Title XVIII of the Social Security Act. The Medicare program has four parts, as described below:

### Part A

Medicare Part A covers inpatient care and services from providers such as hospitals, skilled nursing facilities, home healthcare, hospices and similar institutions. These providers are paid under the Prospective Payment System (PPS), which means the payments are predetermined based upon an individual's diagnosis and clinical needs. Medicare does not pay for all care and services that may be provided. Some non-covered services are excluded by law and others are excluded by medical criteria.

The government itself does not manage claims or pay the providers. Rather, it contracts with companies called Medicare Administrative Contractors (MACs) to pay providers for services.

### Part B

Medicare Part B covers hospital outpatient care and services from healthcare providers such as physicians, nurse practitioners, certain other "physician extenders," ambulance services, clinical and diagnostic laboratory tests and durable medical equipment. Payments for Part B services to hospital outpatients are paid under the Ambulatory Payment Classification (APC) System. Other Part B payments are based on Medicare fee schedules developed by CMS. Beneficiaries must pay premiums as enrollees of Medicare Part B. Beneficiaries also must pay applicable deductibles or coinsurance amounts to the provider. The federal government also contracts with MACs to manage and pay providers for Part B services.

## fact

The creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) is an effort to fight fraud. This group is led jointly by the Deputy Attorney General and the Deputy Secretary of Health and Human Services (HHS). The team is made up of top level law enforcement agents, prosecutors and staff from the Department of Justice and HHS and their operating divisions. HEAT is an effort dedicated to the prevention of fraud and the enforcement of anti-fraud laws throughout the United States.

(Source: Health Care Fraud and Abuse Control Program, Annual Report for FY 2009)

### Part C

Medicare Part C, known as “Medicare Advantage,” was first established in 1997 to give Medicare beneficiaries the option of joining a managed care program. CMS pays a lump sum to the managed care organization, which in turn is responsible for managing the costs of care. In addition to the traditional services available through Parts A and B, Part C coverage can also include wellness and preventative programs. Beneficiaries may enroll in a managed care organization approved by Medicare, such as a Health Management Organization (HMO) or a Preferred Provider Organization (PPO), and they typically pay a premium to the organization.

### Part D

Medicare Part D is a prescription drug benefit first offered on January 1, 2006. It was one of the many changes made to the Medicare program through the Medicare Modernization Act of 2003 (MMA). It covers outpatient prescription drugs, prescribed biological products, insulin (including medical supplies associated with injections of insulin) and vaccines.

CMS contracts with private Prescription Drug Plans (PDPs) for the administration of this benefit. The standard benefit includes a deductible, coinsurance and monthly payments.

## statistics

In 2015, more than 55 million Americans were enrolled in the Medicare program. That number is expected to grow to 80 million by 2030, when the baby boom generation is fully enrolled.

Kansas is the home of 487,086 Medicare beneficiaries and, at last count in 2016, 408,000 Medicaid enrollees. Approximately 261,000 Kansans remain uninsured.

Source: Kaiser Family Foundation analysis of the CMS State/County Market Penetration file, March 2016

## Medicaid overview

Medicaid was created in 1965 to make sure that healthcare coverage and services are available for low-income and uninsured people. Medicaid is administered by the states, but is jointly funded by federal and state governments. The federal government pays for approximately 57 percent of the program in Kansas. Each state establishes its Medicaid program benefits and eligibility depending upon the needs of its population.

The state government decides how its Medicaid program is administered. KanCare, managed by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS), administers the Medicaid program in Kansas. CMS has oversight of Medicaid at the federal level.

The Deficit Reduction Act of 2005 gave money and technical support to CMS for the creation of a Medicaid Integrity Program. This program has the goal of identifying, recovering and preventing Medicaid payments that are fraudulent, abusive or wasteful.

CMS was required under this law to create a five year plan for fighting Medicaid fraud. CMS must do the following:

- Audit Medicaid claims
- Identify overpayments related to those claims
- Review actions of those seeking payment from Medicaid
- Educate providers and others about payment integrity
- Educate beneficiaries about quality of care

There are many actions that CMS may take when it finds fraudulent or abusive activities:

- Impose a fine
- Impose a civil money penalty, which is a set monetary penalty for fraud, abuse or other activities that violate government regulations
- Refer any suspected criminal conduct to the Department of Health and Human Services, Office of the Inspector General (OIG) or the United States Department of Justice for further investigation and prosecution
- Exclude providers from participating in Medicaid and Medicare

The state of Kansas passed a Medicaid Fraud Control Act that makes it illegal for a person or entity to submit false and fraudulent claims to the Kansas Medicaid program. Violation of this law is a crime punishable by imprisonment and full refund to the state plus payment of interest and all reasonable expenses. Kansas also has established an Office of Inspector General (OIG) within the KDHE. Additional information can be found at [kdheks.gov](http://kdheks.gov). The mission of the Kansas OIG includes identification and prevention of fraud, waste, abuse and illegal acts in the Kansas Medicaid program, the MediKan program and the Children's Health Insurance Program.

## TRICARE overview

TRICARE is the healthcare program that serves active members of the armed forces, National Guard Reserve members, retirees, family members, survivors and certain former spouses. TRICARE joins together the healthcare resources of the uniformed services with networks of civilian healthcare professionals. It has several options available for its beneficiaries.

## Program administration and oversight

CMS manages Medicare and Medicaid, providing direction and policy guidance to healthcare providers and suppliers. Additional information about CMS is available on its website at [cms.gov](https://www.cms.gov).

Within the Department of Health and Human Services, the OIG has oversight of the Medicare program. OIG is responsible for investigating reports of suspected fraud or abuse. If fraud or abuse is found during an investigation, the OIG may impose penalties. These can include monetary fines and excluding an organization from participation in Medicare.

When OIG finds fraud, it may send such cases to the United States Department of Justice and other federal agencies for further civil or criminal action. To learn more about the responsibilities of the OIG visit its website at [oig.hhs.gov](https://www.oig.hhs.gov).

## fact

Since 2009, the Department of Justice has recovered \$17.1 billion for the federal government in cases involving healthcare fraud.

(Source: [justice.gov](https://www.justice.gov), March 2016)

## real story

A hospital in West Virginia paid the federal government \$690,000 to settle allegations made in a qui tam complaint that it billed for supplies and services not rendered, unbundled services, submitted duplicate claims, billed for supplies and services rendered without a physician's order, billed for supplies and services without regard to medical necessity and billed for services rendered by unqualified providers.



## Federal False Claims Act (31 U.S.C. § 3729-3733)

The federal False Claims Act (FCA) has an interesting history and is often called the “Lincoln Law.” It was enacted during the Civil War because there were many unscrupulous suppliers trying to sell lame horses, spoiled food, broken rifles and boxes of sawdust to the Union government.

The FCA establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the United States government for payment or approval. This includes false or fraudulent claims for payment involving Medicare, Medicaid and TRICARE as described previously.

The FCA forbids:

- Knowingly filing a false or fraudulent claim for payment or approval
- Knowingly making or using a false record or statement to get the government to pay or approve a claim
- Knowingly making or using a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money to the government
- Conspiring to defraud a government program

The FCA defines the words “knowing” and “knowingly” to mean any of the following:

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

The government assumes that healthcare providers know the rules when filing a claim.

In May 2009, President Obama signed the Fraud Enforcement and Recovery Act of 2009 which modifies and clarifies certain provisions of the FCA. These updates include the following:

- If a recipient has knowledge of an overpayment by the government and fails to refund the money, this action is considered a false claim.
- The federal government is allowed to share more information with whistleblowers and state agencies involved as plaintiffs in an FCA lawsuit.
- If a person makes a false claim or false statement regarding a claim to any contractor, subcontractor or entity that is paid by the government, that person is liable in the same way as if the false claim or statement had been made directly to the government.
- Claims also include requests for payments from subcontractors.

## fact

The national Health Care Fraud and Abuse Control Program has returned more than \$31 billion to the Medicare Trust Fund since the program began in 1997.

(Source: Health Care Fraud and Abuse Control Program, Annual Report for FY 2016)

## Definition of a claim

According to the FCA, a claim is any request or demand for money that is submitted to the United States government or its contractors. A healthcare claim is a bill for healthcare services or equipment that a provider or supplier turns in to receive payment from your insurance company, including federal insurance programs.

Healthcare providers submit claims to government programs using required forms and formats. There are different forms for electronic claims, paper claims and cost reports. Regardless of the form used, healthcare providers and suppliers must be very careful that claims accurately reflect the procedures and services provided to a patient.

Procedure or diagnostic codes are used to describe every type of service that may be provided, and it is critically important that these codes are correctly entered on all claims for payment. Coding errors, such as not appropriately representing the service provided or upgrading to a higher level of service than actually provided, can lead to allegations of fraud and abuse whether the errors are intentional or not.

## Liability and penalties

It is important to know that the FCA does not require the government to prove a specific intent to defraud under this law in order to prove liability. Healthcare providers and suppliers (both individuals and organizations) who violate the FCA may have to pay civil money penalties ranging from \$10,781 to \$21,563 for each false claim submitted. In addition, providers and suppliers can be required to pay fines for damages up to three times the amount of money owed to the government.

Providers who violate the FCA can also be excluded from participation in federal healthcare programs. This law plays an important role in reducing false and fraudulent Medicare and Medicaid claims.

## Examples of healthcare fraud

Following are some general examples of healthcare fraud. These are based on actual settlements reached between providers and the OIG.

- Billing for goods or services that beneficiaries did not receive
- Billing for services that are not medically necessary
- Billing separately for services that should be a single service (unbundling)
- Falsifying treatment plans or medical records to increase payment
- Failing to report and refund overpayments or credit balances
- Billing twice for the same service
- Illegally giving healthcare providers and referral sources, such as physicians, rewards in exchange for referrals for goods or services
- Billing for services provided by interns, residents and fellows in a teaching setting

If you would like to see additional examples, check the websites for the OIG at [oig.hhs.gov](https://oig.hhs.gov) or the Department of Justice at [usdoj.gov](https://usdoj.gov).

## fact

The Federal Bureau of Investigation (FBI) has a white-collar crime program that puts a priority on healthcare fraud investigations. FBI-led investigations resulted in 637 criminal healthcare fraud convictions and 892 indictments during fiscal year 2016.

(Source: Health Care Fraud and Abuse Control Program, Annual Report for FY 2016)

## Kansas Medicaid Fraud Control Act

As part of the federal Deficit Reduction Act of 2005, the State of Kansas has enacted the Kansas Medicaid Fraud Control Act, K.S.A. 21-3844, as a way to support the federal effort for reducing and eliminating false and fraudulent claims. This law prohibits knowingly making a false claim, statement or representations to Medicaid with intent to defraud.

The Kansas law broadly defines a false claim to include the following:

- Any false or fraudulent claim made to Medicaid
- False information for use in determining payments or amount of payments
- Fraudulent entries in records used to support claims to Medicaid
- Negligent or intentional failures to keep required records and creating any fraudulent documents for submittal to support a claim for payment from Medicaid

There are serious penalties for violations of the Kansas Fraud Control Act. These include criminal and civil money penalties and exclusion from participation in federal programs. These penalties may be in addition to FCA penalties.

The Kansas Medicaid Fraud Control Act creates a Medical Fraud Control Unit (MFCU) within the Office of the Attorney General. The MFCU has the authority to investigate and prosecute fraud cases. The MFCU is also responsible for reviewing complaints alleging abuse and neglect of patients in facilities receiving payments from Medicaid. The MFCU receives 75 percent of its funding from the federal government and 25 percent from the state.

## real story

In Florida, eight Miami-area residents were charged with conspiracy to commit healthcare fraud and other crimes. This was in connection with an alleged \$22 million Medicare fraud scheme operating out of Miami businesses claiming to specialize in home healthcare services. The defendants recruited Medicare beneficiaries and paid them kickbacks and bribes to use their Medicare billing numbers to file claims with Medicare for home healthcare services that were not provided and not medically necessary. The defendants also falsified medical tests and patient records to make it appear that the services were needed. Each of the eight persons has pleaded guilty and the owner and manager received lengthy prison sentences.

## Whistleblower or qui tam provisions of the federal False Claims Act

The FCA includes a whistleblower, or qui tam, provision. This is to encourage a person to come forward and report if one has knowledge about an alleged false or fraudulent claim to the government. Such people are called relators, and they may file a lawsuit on behalf of the United States government.

The words are a Latin abbreviation for “[he] who sues on behalf of the King as well as for himself.” Qui tam actions were first used in England during the 13th century to help enforce the King’s laws. They also were used in the Colonial United States, because the new federal government had almost no law enforcement officers to make sure that laws were not broken.

According to the Department of Justice, the federal government received more than \$4.7 billion from settlements and judgments for fraud during the twelve month period ending on Sept. 30, 2016. Healthcare accounted for a large part of that amount. Of the total amount, \$2.9 billion was collected through lawsuits started by whistleblowers. There are specific guidelines regarding the filing of whistleblower suits. No retaliation is permitted against whistleblowers for filing a qui tam lawsuit.

### Elements of a qui tam proceeding

The relator files a lawsuit on behalf of the government in a federal district court. The lawsuit remains “under seal,” meaning that the action is confidential while the government reviews and investigates the charges and decides how to proceed.

If the government decides that the lawsuit has merit, it may take it up, or intervene. This means that the United States Department of Justice will pursue the case. If the government intervenes and money is recovered, the relator may receive an award ranging from 15 to 30 percent of the amount recovered. If the case is successful, the relator also may be granted reasonable expenses including attorney’s fees and costs incurred for bringing the action to court. The relator also may be entitled to additional relief, including reinstatement of employment, back pay, compensation arising from retaliatory conduct against the relator for filing a qui tam lawsuit, or for committing other lawful acts. These may include providing testimony, investigating a false or fraudulent claim and other assistance during a false claims action. Even if the government decides not to intervene, the relator may continue the case alone.

This overview of the whistleblower or qui tam provision of the FCA does not provide full information about the technical and legal requirements in specific cases. Legal counsel should be retained for detailed advice.

The Corporate Responsibility Program is designed to provide open lines of communication and to foster a reporting process to alert management of possible compliance issues, including false claims. This process is described in the Reporting Concerns section of this booklet and should be followed by all associates as part of their commitment to corporate responsibility and compliant practices. Please review the information about the Corporate Responsibility Program below.

## Statement of policy

Via Christi Policy CR-11, Prevention of Fraud, Waste and Abuse in State Medicaid Program, affirms our commitment to avoid and discourage fraud, waste and abuse in interactions with the Kansas Medicaid program and the federal government. The policy is posted on the Source in the Policy Manual for Via Christi, or you may request a copy from the Corporate Responsibility Office. It applies to all subsidiaries, affiliates, contractors, associates and vendors.

## Via Christi Corporate Responsibility Program

Healthcare organizations must satisfy many legal and regulatory requirements to make sure that safe and quality care is provided and that our claims for payment are correct. The Corporate Responsibility Program is established and endorsed by our board of trustees and executive leadership to help us comply with these requirements.

The Corporate Responsibility Program provides the following antifraud protections:

- Program oversight by the finance committee of the board of trustees
- A Via Christi Corporate Responsibility Officer at senior management level, as well as Responsibility Officers in our various ministry locations
- Standards of Conduct requiring ethical practices and integrity in claims submission
- Compliance committees that assist with administration of the program
- Policies and procedures governing the billing and reimbursement for services provided to patients
- Holding associates accountable to report all compliance concerns known to them
- Education of executives, management and staff regarding identification, reporting and prevention of fraud and fraudulent claims, as well as correction, auditing and monitoring activities related to claims for payment to federal health insurance programs
- A confidential, toll-free Values Line answered 24 hours a day, seven days a week to make sure that fraud or fraudulent claims may be reported at any time to 800.794.9027 or [ascensionhealthvaluesline.org](http://ascensionhealthvaluesline.org)
- A “no retaliation” policy regarding reports to the organization of fraud, abuse or waste

## fact

During fiscal year 2016, the United States Attorneys' offices opened 975 new criminal healthcare fraud investigations involving 802 potential defendants.

(Source: Health Care Fraud and Abuse Control Program, Annual Report for FY 2016)

## Reporting concerns

Via Christi has several methods available for reporting concerns about fraud, waste or abuse related to federal health insurance programs. These avenues may be used to report any type of compliance concern or question. Via Christi does not retaliate against individuals for the reporting of any compliance issues.

Problems cannot be fixed if we do not know about them. You have a duty to ask questions and report in good faith concerns related to your workplace. There are several ways in which you can ask a question or share a concern:

- Discuss any potential issue with your immediate supervisor or that person's supervisor. If your concern involves a specific area, you can contact the supervisor of that area. For example, if you have a quality or safety concern, you can contact the supervisor responsible for the quality or safety programs at your ministry location.
- Contact the Responsibility Officer for your respective ministry location.
- Contact the Via Christi Corporate Responsibility Officer:

Sara Powers  
8200 E. Thorn  
Wichita, KS 67226  
Phone: 316.858.4978

- Call the Values Line, 800.794.9027 or report at [ascensionhealthvaluesline.org](http://ascensionhealthvaluesline.org). When you call, your report will be confidential. A third party will talk to you about your concerns. You will receive a report number. We will investigate your concerns and provide a prompt response through the Values Line service. If you leave an anonymous message, please report enough facts to allow us to investigate your concern. Use the Values Line to report concerns regarding:
  1. Regulatory or legal matters or requirements
  2. Billing, charging, coding or other reimbursement issues
  3. Conflicts of interest and business ethics issues
  4. Concerns regarding contracts or business arrangements
  5. Any other ethics, regulatory, legal or compliance concerns

Via Christi does not permit retaliation or punishment for reporting concerns.





Via Christi offers a continuum of care from the birth of a child to enhancing the lives of older adults. This program or service is part of Via Christi Health, Inc.

Via Christi Health is an Equal Opportunity Employer (EOE) and Affirmative Action Employer. We support diversity in the workplace.

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[viachristi.org](http://viachristi.org)