

 <p>Colorado Health Partnerships, LLC Pikes Peak ♦ SyCare ♦ West Slope Casa ♦ ValueOptions</p>	Section: II	Number: CHP 101
	Keywords:	Category: A
Review Date:	Page 1 of 3	Original Date of Issue: April 11, 2007
Functional Area: <i>Compliance</i>	Date(s) Revised:	
Operating Unit: All	Subject: Deficit Reduction Act	
Approval Signatures:		
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I. PURPOSE

To provide guidelines for Colorado Health Partnerships, LLC (dba Colorado Health Networks) to ensure compliance with the Deficit Reduction Act of 2005.

II. POLICY

It is the policy of Colorado Health Partnerships (CHP) to comply with federal and state laws and regulations related to the Deficit Reduction Act, False Claims Act, and Criminal Penalties for Acts Involving Federal Health Care Programs Act, and with any government initiatives to reduce healthcare fraud, waste, and abuse.

III. DEFINITIONS

Claim: any request or demand for money that is submitted to the federal government or its contractors.

Contractor or agent: includes any contractor, subcontractor, or agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

IV. PROCEDURES

- A. It is the responsibility of ValueOptions and each Community Mental Health Center (CMHC) to ensure the requirements of the Deficit Reduction Act are met as these entities receive more than \$5 million in annual Medicaid payments. CHP's Compliance Committee will be responsible for providing oversight to ensure all entities comply with the Deficit Reduction Act Requirements through a review of activities, reports and, as necessary, audits.
- B. CHP has the following requirements for compliance with the Deficit Reduction Act:
 1. Implementation of written policies regarding the Deficit Reduction Act and the False Claims Act. Policies are to be applicable to employees, contractors and agents.
 2. Employee, contractor, and agent education regarding:

- a) The Deficit Reduction Act;
 - b) The Federal False Claims Act;
 - c) Administrative remedies for false claims and statements;
 - d) State laws pertaining to false claims and statements and related civil and criminal penalties;
 - e) Whistleblower protection and employee rights under state laws;
 - f) The role of laws including detecting and preventing fraud, waste, and abuse in Federal health care programs;
 - g) The company's policies and procedures for detecting and preventing fraud, waste and abuse including identifying, reporting and investigating potential false claims.
3. Identification and investigation of potential false claims.
 4. Identification and investigation of alleged fraud, waste, or abuse violations.
 5. For those members who are dually insured, ensure that claims are paid by other insurance companies prior to payment by Medicaid as Medicaid is the payor of last resort.
 6. Payment of claims occurs for individuals who are citizens or nationals of the United States or a qualified alien who meets all other Medicaid program eligibility criteria.
 7. Compliance with co-payment limit regulations.
- C. CHP will, upon the state's request, provide eligibility and claims payment data with respect to individuals who are eligible to receive Medicaid.
 - D. CHP will accept an individual's or other entity's assignment of rights to payment from parties to the state.
 - E. CHP will respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than 3 years after the date the item or service was provided.
 - F. CHP requires that all employees be trained on the Code of Conduct and Investigating Fraud and Abuse within 30 days of hire and annually thereafter.
 - G. CHP will ensure that all potential violations of the Deficit Reduction Act will be investigated and actions will be taken to resolve the identified problem.
 - H. Under the FEDERAL FALSE CLAIMS ACT (31 U.S.C. §§3729-3733). Anyone knowingly and willfully submitting or causing a person or entity to submit a false claim for government funds is liable for damages up to three times the amount of the government's damages plus mandatory penalties of \$5,500 to \$11,000 per each false claim.
 - I. CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS (42 U.S.C. SEC 1128B, 1320a-7b) states that criminal penalties will result in conviction of a felony and a fine or not more that \$25,0000 and/or imprisonment for not more that 5 years for whomever:
 1. Knowingly and willfully makes or causes to be made any false statement in applications or any benefit or payment under a Federal health care program;
 2. Knowingly and willfully makes or causes to be made any false statements for use in determining rights to such benefit or payment;
 3. Has knowledge of the occurrence of any event affecting the initial or continued right to a benefit or payment which is fraudulent;
 4. Has knowledge of the occurrence of any event affecting the initial or continued right to any benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment which is fraudulent;
 5. Knowingly and willfully converts the benefit or payment to a use other than the intended; Presents or causes to be presented a claims for a physician's service for which payment may be made under a Federal health care program and knows that the person furnishing the services is not licensed as a physician;
 6. For a fee, knowingly and willfully counsels or assists an individual to dispose of assets in order to be eligible for medical assistance under the state plan;
 7. Knowingly and willfully charges or any service provided to a patient under a Federal health care program in excess of established rates.

- J. THE FALSE CLAIMS ACT WHISTLEBLOWERS EMPLOYEE PROTECTION ACT (31 U.S.C. sec 3730(h)) prohibits a company from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee because of lawful acts done by the employee on behalf of the employer or because the employee testifies or assists in an investigation of the employer.
- K. ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS AND STATEMENTS (31 U.S.C. Chapter 8. §3801): Under this act, any person who makes, presents, or submits a claim that is false or fraudulent is subject to a civil penalty of not more than \$5,000 for each claim and also an assessment of not more than twice the amount of the claim.
- L. No adverse action or retribution of any kind will be taken against an employee because he or she reports a suspected violation of the Deficit Reduction Act or the False Claims Act or other irregularity by another person or entity.
- M. Employees not in compliance with the Deficit Reduction Act and the False Claims Act and the company's related policies, may receive disciplinary action up to and including termination.
- N. The Centers for Medicare and Medicare Services (CMS) web page for state fraud statutes can be accessed <http://www.cms.hhs.gov/apps/mfs/weblist.apa>.

V. REFERENCES

- A. "Criminal Penalties for Acts Involving Federal Health Care Programs", Compilation of Social Security Laws, 42 U.S.C. SEC 1128B, 1320a-7b.
- B. "The Law: An Overview – False Claims Act Whistleblower Employee Protections", WhistleblowerLaws.com
- C. "Deficit Reduction Act: Implications for Compliance Teams", MediRegs
- D. Wilson, Joy Johnson, Health Policy Director, "Deficit Reduction Act of 2005: A Summary of Medicaid/Medicare Health Provisions", National Conference of State Legislators, February 3, 2006.
- E. "Administrative Remedies for False Claims and Statements", U.S. Code, Title 31, Chapter 38, §3801 -3806.
- F. "Public Law 109-171", The Federal Register, February 8, 2006