Policy 0808.00 Prevention of False Claims, and Abuse in Government Funded Health Programs

All District staff will take steps to prohibit any waste, abuse, and fraudulent practices, including but not limited to waste, fraud, or abuse of Medicaid funding. Federal and state laws prohibit waste, abuse, and fraud of Medicaid funds that this District receives for services provided. These laws include the 2005 Deficit Reduction Act and False Claims Act and its subsequent amendments.

Prohibited Practices

Waste, abuse, and fraud related to government claims or payments are prohibited.

Such actions include, but are not limited to, the following:

- Billing for services that were never provided,
- False cost reports whereby inappropriate expenses not related to service provision are intentionally included in cost reports,
- Illegal kickbacks, in which a provider may conspire with another provider to share part of the monetary reimbursement that the providers receive in exchange for services/referrals. Such kickbacks could include cash, vacation trips, automobiles or other items of value.
- Submission of a claim with knowledge that the claim is incorrect
- Submission a fraudulent claim
- Knowingly making a false statement or representation of material fact in any document required to be maintained or submitted to Medicaid
- Submission of a claim for an item or service known to be medically unnecessary
- Failing to provide, upon written request by the Idaho Department of Health and Welfare immediate access to documentation required to be maintained
- Repeatedly or substantially failing to comply with the rules and regulations governing medical assistance payments or other public assistance program payments.
- Knowingly violating any material term or condition of its provider agreement.
- Using a medical provider who fails to meet the qualifications specifically required by rule or by any applicable licensing board.

- Fraudulent Practice The definition of fraudulent practices according to Idaho Code is a person who knowingly makes or causes to be made false statements or misrepresentations of material facts or knowingly fails to disclose material facts in application for payment of services or merchandise rendered or purportedly rendered by a provider participating in the Medicaid program. Filing false claims may result in civil penalties or even criminal punishment under state or federal law.

Under the Federal False Claims Act (FCA), each instance of an item or a service billed to Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback payment may render it false or fraudulent, creating liability under the civil FCA.

Under the Federal False Claims Act, fraudulent acts include but are not limited to:

- Fraudulent claim for payment or approval
- False record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government
- Conspiring against the government by obtaining fraudulent claims payment
- Possession, control or custody of items with the intent to defraud the government
- Certifying receipt of property to be used by the government while intending to defraud
- Buying/receiving items from a government member not authorized to sell the item
- False record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government

The civil FCA defines knowing: to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information.

Reporting and Whistleblowing

- The FCA allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or ex-business partners or employees, District staff, students, parents, or competitors. Any employee who suspects Medicaid fraud, or other waste, abuse or fraud must immediately report that allegation to the Director of Special Services and or the Chief Financial Officer. If the employee suspects either of these persons of waste, abuse, or fraud, the report should be made to the Chief Human Resources Officer, or designee.

The District shall take the following steps following a report of fraud, waste, or abuse:

- An internal investigative review shall be initiated immediately.
- Appropriate corrective actions shall be taken as a result of the review findings.
- If warranted, the District shall self-report to the Idaho Department of Health and Welfare via the Idaho Medicaid Program Integrity Unit.
- If warranted, appropriate disciplinary actions shall be implemented as a result of the internal investigative review.
- All documentation related to the investigative review shall be maintained in Human Resources confidential records.

Reporting Protection

- The False Claims Act contains language protecting "whistleblower employees" who report suspected Medicaid waste, abuse and fraud from retaliation by their employer. Employees that are discharged, demoted, suspended, threatened, harassed or in any way discriminated against in the terms and conditions of employment by the employer for "blowing the whistle" are entitled to recover all relief necessary to make the employee whole, such as reinstatement or backpay.
- A whistle blower may be eligible to recover a portion of the government’s recovery from the fraudulent practice. The False Claims Act allows a private person to file a lawsuit on behalf of the United States government against a person or business that has committed the fraud.
- Any employee who feels they are being retaliated against for reporting Medicaid waste, abuse or fraud should immediately report this concern to the Chief Human Resources Officer, or designee. The District shall implement appropriate protective actions for the employee. An internal investigative review shall be initiated immediately with appropriate corrective actions taken as a result of the investigative findings. If warranted, appropriate disciplinary actions shall be implemented as a result of the internal investigative review. All documentation related to the investigative review shall be maintained in Human Resources as confidential records.

Internal Prevention

The District has key mechanisms and procedures in place to detect and prevent waste, abuse, fraud, and improper documentation, including, but not limited to:

- Annual external audits of all Governmental and Proprietary Funds of the District are completed by an outside Certified Public Accounting Firm.

- Ongoing training and consultation are provided to District employees to facilitate the integrity of the entire Medicaid Claiming Process.
- Service documentation notes are reviewed each month prior to billing for services (internally by District staff) ensuring documentation completion prior to billing for services. Corrective actions are implemented as needed to improve the quality of documentation.
- District billing staff complete random reviews of service documentation notes and files related to the Medicaid services rendered and for which reimbursement has been sought.
- Background checks are completed upon hire for all potential District employees. In addition, staff in Special Services search the Exclusions database on the OIG website to identify any individuals who may be excluded from involvement in government funded health programs such as Medicaid.
- The District upholds its Enrollment Status as a Medicaid Provider with the Idaho Department of Health and Welfare and will continue to honor the guidelines and constructs of this relationship.

Legal References: U.S. Code Title 31, Sections 3729-3733,U.S. Code Title 31, Sections 3801-3812,U.S. Code Title 18, Section 287,Idaho Code § 56-209h