Subject Preventing, Detecting and Reporting Fraud, Waste and Abuse	**Attachments** ☒ Yes ☐ No
Key words False Claims Act, Deficit Reduction Act, Whistleblower Protections, MEDIC, Medicare, Medicaid	**Number**
Category Ethics, Rights Responsibilities (ER)	**Effective Date** **01/01/2007**
Manual Office of Integrity and Compliance	**Last Review Date** **September 2016**
Issued By Office of Integrity and Compliance	**Next Review Date** **September 2017**
Applicable All employees, and first tier, downstream and related entities of HealthPartners/GHI	**Origination Date** **December 8, 2006**
	Retired Date
Review Responsibility Office of Integrity and Compliance	**Contact** Office of Integrity and Compliance

I. **PURPOSE** HealthPartners and its First Tier, Downstream, and Related Entities (FDRs) are committed to preventing, detecting and correcting fraud, waste and abuse in health care. An important part of those efforts includes our commitment to working with federal and state authorities to combat health care fraud. The purpose of this policy is to:

- **A.** Describe the Federal False Claims Act, State False Claims Acts, and other laws designed to combat health care fraud
- **B.** Describe the organization's commitment to reporting to, and cooperating with, federal and state authorities in an effort to combat health care fraud
- **C.** Inform our employees, contractors and agents of their obligations to report suspected health care fraud in good faith
- **D.** Inform our employees, contractors and agents of their rights to be protected as good faith reporters of suspected health care fraud

II. POLICY

A. Laws Designed to Combat Health Care Fraud

HealthPartners and its FDRs are committed to upholding the applicable laws pertaining to detecting and preventing fraud, waste and abuse in health care. The federal government and most States have established various laws designed to combat fraud, waste and abuse in health care.

1. Federal False Claims Act (the FCA). The FCA was established to counteract fraudulent billings submitted to government payors of health care. In summary, the FCA prohibits:

   - Knowingly presenting, or causing to be presented to the government a false claim for payment;
   - Knowingly making, using, or causing to be made or used, a false record or statement to get

a false claim paid or approved by the government;

- Conspiring to defraud the government by getting a false claim allowed or paid; and
- Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the government.

Liability for committing fraud against the government could result in criminal punishment or civil fines of $5,000 to $10,000 per false claim. The FCA also contains *qui tam*, or whistleblower, provisions. *Qui tam* is a unique mechanism in the law that allows citizens with evidence of fraud against government contracts and programs to sue, on behalf of the government, in order to recover the stolen funds. In compensation for the risk and effort of filing a *qui tam* case, the citizen whistleblower or "relator" may be awarded between 15 and 30 percent of the funds recovered.

The Government may pursue a false claims matter in an administrative proceeding, rather than court action, under the Program Fraud Civil Remedies Act (the "PFCR Act"). The PFCR Act permits Federal agencies to use administrative procedures to impose penalties and assessments on persons who submit false, fictitious, or fraudulent claims to the government. If an administrative remedy is pursued, the *qui tam* plaintiff initiating the action has the same rights as they would have if the action had proceeded under the FCA.

2. State False Claims Statute. Many states have False Claims and Whistleblower Protection statutes that are similar to the Federal FCA. The states' False Claims statutes vary in specific language, but in general, they address the following elements, as found in the Minnesota False Claims statute:

   (1) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

   (2) knowingly makes or uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

   (3) knowingly conspires to commit a violation of clause (1), (2), (4), (5), (6), or (7);

   (4) having possession, custody, or control of property or money used, or to be used, by the state or a political subdivision and knowingly delivers or causes to be delivered less than all of that money or property;

   (5) is authorized to make or deliver a document certifying receipt for money or property used, or to be used, by the state or a political subdivision and intending to defraud the state or a political subdivision, makes or delivers the receipt without completely knowing that the information on the receipt is true;

   (6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a political subdivision who lawfully may not sell or pledge the property; or

   (7) knowingly makes or uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a political subdivision, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a political subdivision

Contact the Law Department or the Office of Integrity and Compliance for information about laws related to Fraud, Waste, and Abuse and False Claims Acts in any state in which HealthPartners operates (see attachment for listing of states).

5. Deficit Reduction Act of 2005 (DRA). The DRA was established to slow the pace of spending

growth in both Medicare and Medicaid while maintaining commitment to the beneficiaries of these programs. In summary, the DRA provides for the creation of a Federal Medicaid Integrity Program to oversee the states and the programs for combating fraud, waste and abuse.

6. Other Federal Laws. Other federal laws and programs contain important provisions designed to combat health care fraud. These laws include, but are not limited to:
   - ✓ The Social Security Act, including Medicare Parts A, B and D,
   - ✓ The Antikickback Statute, the Stark Law and prohibitions on inducements to beneficiaries,
   - ✓ The Health Insurance Portability and Accountability Act (HIPAA), and
   - ✓ The Federal Food, Drug and Cosmetic Act.

HealthPartners is committed to complying with the applicable requirements of these laws and associated regulations, contractual obligations and sub-regulatory guidance.

B. Reporting to, and Cooperating with, Federal and State Authorities

HealthPartners, through its Integrity and Compliance Program, is committed to identifying and reviewing suspected violations of law, regulation, contractual obligations and other requirements that may result in overpayment, underpayment or instances of fraud, waste and abuse. When reviews identify overpayments to the organization from the government or other inaccuracies, they will be reported and repayments or adjustments will be made following applicable guidelines.

HealthPartners will cooperate with and respond to appropriate data requests, audits and other government inquiries, for example from the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General of the US Department of Health and Human Services (OIG), Minnesota's Department of Human Services (DHS), their designees and law enforcement. In addition, HealthPartners will refer suspected fraud, waste or abuse to Federal or State agencies or their designees (such as a MEDIC designated under Medicare Part C & D) for further investigation.

C. Obligations to Report Suspected Health Care Fraud

It is the responsibility of every employee, FDR and agent to report to HealthPartners any suspected health care fraud, waste or abuse. Reports should be directed to an individual's supervisor or to the Office of Integrity and Compliance. To make a report to the Office of Integrity and Compliance you may either:

- Contact the Chief Compliance Officer or other members of the Office of Integrity and Compliance directly,
- Call the Integrity and Compliance Hotline – 1-866-444-3493, or
- Call the Special Investigation Unit (SIU) Hotline – 952-883-5099

The Office of Integrity and Compliance provides you the option to remain anonymous when making a report.

All reports received by the Office of Integrity and Compliance will be reviewed and investigated in accordance with Office of Integrity and Compliance procedures, which include protections for individuals who report their concerns anonymously or confidentially. Supervisors who receive reports of suspected fraud, waste or abuse must review the report and, if appropriate, initiate an investigation. Supervisors who receive such reports should contact the Office of Integrity and Compliance for assistance with investigations.

Employees also have the right to report suspected fraud, waste or abuse directly to the government. Reporting information can be found at http://www.oig.hhs.gov/fraud/report-fraud/index.asp. However, HealthPartners strongly encourages employees to first bring their concerns to the attention of the organization so that we can fulfill our commitments to combating fraud, waste and abuse.

D. Rights to Be Protected as a Good Faith Reporter of Suspected Fraud, Waste or Abuse

HealthPartners strictly forbids retaliation against anyone who, in good faith, reports suspected fraud, waste or abuse, to the organization or to the government, in accordance with reporter protections under federal and state laws. Employees, and first tier, downstream and related entities will not suffer any penalty or retribution for reporting, in good faith, any known or suspected concern. HealthPartners will take appropriate disciplinary action against anyone that penalizes, ostracizes or harasses someone who has reported concerns in good faith. However, this non-retaliation policy does not allow people to avoid discipline if they are engaged in improper behavior, including, without limitation, making reports that the reporter knows to be false or to be in reckless disregard of the truth. Anyone who has been involved in impermissible activity will be subject to discipline.

Under federal law, any person who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in his or her employment, because of actions as a whistleblower, is entitled to all relief necessary to make the employee whole. This includes reinstatement with the same seniority status that the person would have had but for the discrimination, two times the amount of back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

III. PROCEDURE(S)

MEDIC Reporting: HealthPartners will report fraud, waste, and abuse, as appropriate, to the MEDIC following guidance on the MEDIC website at http://www.healthintegrity.org/contact-us/nbi-medic-contacts. Referrals will be made by phone (1-877-772-3379) or fax (410-819-8698). All documentation of referrals are maintained by the appropriate department(s). Referrals to the MEDIC are reported to the Government Programs Compliance Committee.

SIRS Reporting: HealthPartners will report fraud, waste, and abuse, as appropriate, to the MN SIRS Unit by sending information through secured email. HealthPartners receives referrals from MN SIRS Unit by secure email on the SIRS Referral to MCO form. All documentation of referrals are maintained by the appropriate department(s).

Other Reporting: HealthPartners will report fraud, waste, and abuse, as appropriate, to other applicable Federal or State agencies following the protocols of the applicable agencies. All documentation of referrals are maintained by the appropriate department(s).

IV. DEFINITIONS

First Tier Entity: any party that enters into a written arrangement acceptable to CMS with a Medicare Advantage Organization (MAO) or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA or Part D programs.
Downstream Entity: any party that enters into a written arrangement, acceptable to CMS with persons or entities involved in the MA or Part D benefits, below the level of the arrangement between and a MAO or applicant or a Part D plan sponsor or applicant and a FDR entity. These written arrangements continue down to the level of ultimate provider of both health and administrative services.
Related Entity: any party that is related to the Sponsor by common ownership or control and: performs some of the Sponsor's management functions under contract or delegation; furnishes services to Medicare enrollees under an oral or written agreement; or leases real property or sells materials to the Sponsor at a cost of more than $2,500 during a contract period.

V. COMPLIANCE

All employees, and first tier, downstream, and related entities must comply with this policy, including, without limitation, provisions related to the good faith reporting of suspected health care fraud, waste and abuse, and provisions related to the prohibition against retaliation against individuals who have reported such suspicions in good faith. Failure to comply with this policy may result in disciplinary

action, up to and including termination.

VI. ATTACHMENTS

States in which HealthPartners Operates

VII. OTHER RESOURCES

Internal Resources:

- ✓ Code of Conduct
- ✓ Code of Conduct Training
- ✓ Office of Integrity and Compliance Procedures for Reviewing and Investigating Reported Compliance Concerns
- ✓ Special Investigations Unit Procedures for Investigating Suspected Fraud, Waste or Abuse
- ✓ Oversight of First Tier, Downstream, and Related Entities' (FDRs') Compliance-Related Activities

Other Resources:
Federal False Claims Act: http://www.oig.hhs.gov/authorities/docs/06/waisgate.pdf
Minnesota False Claims Against the State Statute: Minnesota Statutes Chapter 15C
Minnesota Whistleblower Protection Law: Minnesota Statutes Section 181.932
Deficit Reduction Act: https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/index.html
Social Security Act - P.L. 74-271 (49 Stat. 620), XVIII
Antikickback - 42 U.S.C. 1320a-7b
Stark - 42 U.S.C. 1395nn
Prohibition on Inducements to Beneficiaries - Social Security Act 1128A(a)5, 42 USC §1320a-7a(a)(5)
FDAC Act - 21 U.S.C. 301
Medicare Part C and D Regulations – 42 CFR §422, §423, and other CMS sub-regulatory guidance
Fraud Enforcement and Recovery Act of 2009
Stop Medicare Fraud: http://www.stopmedicarefraud.gov
Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119, 747-775)

VIII. APPROVAL(S)

Originally approved by Enterprise Integrity Steering Committee (EISC) on December 8, 2006.
Last update approved by EISC on September 22, 2016.