

NEIGHBORHOOD HEALTH PLAN POLICY

POLICY TITLE: Fraud Reporting and Whistleblower Protections

POLICY #: CMP-099

VERSION #: 1

POLICY OWNER: Senior Director, Regulatory Affairs

COMMITTEE APPROVAL DATE: 12/15/06, 01/16/08, 12/18/09; 01/19/11

APPROVED BY: Standards, Expectations & Compliance Committee

IMPLEMENTATION DATE: 01/01/07

RESPONSIBLE DEPARTMENT: Quality and Compliance

IMPACTED TEAMS: All NHP

IMPACTED PROGRAMS: All programs

MANDATED BY: EOHHS, HHS

NCQA STANDARDS: NA

EOHHS APPROVAL DATE: 12/09

LEGAL APPROVAL DATE: NA

POLICY COMMUNICATION/ACKNOWLEDGEMENT: (Select all that apply)

Audience: NHP All

- E-Mail Notification to Select Group/No Return Receipt Required
 E-Mail Notification to Select Group/Return Receipt Requested

CONFIDENTIALITY:

Internal:

- Please check box if policy should not be accessible to all NHP employees. Policy will be listed but not accessible to all employees in the centralized policy database.

External:

- Please check box if policy should not be shared outside of NHP.

Please note that any external requests for policies that are not a part of public record must be approved by the Senior Director of Regulatory Affairs.

POLICY

Neighborhood Health Plan (NHP) is committed to complying with all applicable federal and state laws concerning the detection and prevention of fraud and abuse. This policy sets forth NHP's policies and procedures for detecting and

preventing fraud and abuse. Additionally, the policy provides detailed information about the Federal Civil False Claims Act, the Federal Program Fraud Civil Remedies Act, the Massachusetts False Claims Act, and the rights of employees to be protected as whistleblowers.

All employees, agents and contractors of NHP are required to and are responsible for reporting health care billing, financial reporting and other compliance concerns, including actual or potential violations of law, regulation, policy, or procedure.

NHP considers it a serious breach of responsibility for any employee, agent or contractor of NHP to knowingly refrain from reporting health care billing, financial reporting and other compliance concerns to an appropriate authority. NHP may take appropriate disciplinary action for failure to report, up to and including termination of employment or contractual relationships.

NHP does not retaliate against any employee, agent or contractor of NHP who has reported, in good faith, a health care billing, financial reporting or other compliance problem, whether that report is made internally, according to established procedures, or externally to oversight agencies, such as the Office of Inspector General, the Office of the Attorney General or the state Medicaid Fraud Unit.

NHP does not retaliate against nor discriminate against any employee, agent or contractor who cooperates in any government or law enforcement authority's investigation or prosecution of suspected fraudulent activities.

NHP does comply with all reporting requirements of the Executive Office of Health and Human Services (EOHHS) and the Health Insurance Connector Authority (Connector) regarding suspected instances of fraud or abuse, including the written reporting of individual cases within ten days to the appropriate authority and the submission of periodic summary reports and certification statement in formats specified by EOHHS or the Connector.

NHP notifies the EOHHS upon contact by the Medicaid Fraud Division, the Bureau of Special Investigations or any other investigative authorities conducting Fraud and Abuse investigations unless specifically directed by the investigative authorities not to do so.

NHP cooperates fully with the Medicaid Fraud Division, the Bureau of Special Investigations or any other investigative authorities conducting Fraud and Abuse investigations, including providing timely exchange of information, prompt and direct access to information, free copies of requested documentation and other available information related to program violations. In addition, NHP makes knowledgeable employees available at no charge to support any investigation, court or administrative proceeding.

NHP notifies EOHHS of all Provider overpayments above \$75,000 or any voluntary Provider disclosure resulting in receipt of overpayment in excess of \$75,000, even if there is no suspicion of fraudulent activity.

PURPOSE

Without the cooperation from employees, agents, and contractors, it is difficult to learn of possible compliance problems and to make necessary corrections through prevention, detection and resolution of instances that do not conform to appropriate health care billing and financial reporting compliance.

This policy, therefore, is established to assist employees, agents and contractors of NHP to understand their responsibility to report potential compliance problems that will allow NHP to make reasonable efforts towards the prevention, detection and correction of any potential fraud, abuse or waste in the Medicaid program.

PROCEDURE

As part of every new employee's orientation, the Human Resource Department provides an overview of the Compliance Program, including a review of the *Code of Ethics*, the *Conflict of Interest* policy, *Fraud Reporting and Whistleblower Protections* policy and NHP's HIPAA privacy policies.

Departmental Directors, Managers and Supervisors are responsible for continuing the employee's orientation to NHP's *Code of Ethics* by discussing the implications of the Code with respect to the individual's specific job responsibilities. This should include providing examples of fraudulent or abusive incidents that could occur or be observed within the specific department and how to report such suspicions.

Annually, all employees, during the performance review process, are required to complete an e-learning module on NHP's *Code of Ethics* and NHP's *Fraud Reporting and Whistleblower Protection* policy.

In accordance with NHP's policy on *Problem Reporting and Non-Retaliation*, every NHP employee has a responsibility to report a suspected compliance problem through one of several channels if they see something that looks suspicious. Departmental Directors, Managers and Supervisors are responsible for reviewing the procedures with all employees at least annually.

Although NHP does not allow any form of retaliation against employees who report instances of noncompliance, employees and others may feel more comfortable reporting the situation without revealing their identity. Therefore, in accordance with NHP's *Compliance Hotline* policy, employees, agents and contractors may report concerns or problems anonymously via the Hotline Services.

NHP provides education regarding the responsibility of its agents and contractors to report healthcare billing, financial reporting and other compliance concerns via NHP's *Provider Manual*.

NHP contracts only with entities who affirm their willingness to abide by applicable federal and state laws regarding the prevention, detection and reporting of health care fraud.

Upon receiving a complaint of fraud or abuse from any source or upon identifying any questionable practices, the Compliance Office conducts a preliminary review to determine whether there are grounds to believe that a provider, member or employee of NHP has engaged in fraud or abuse. This preliminary review is documented in NHP's compliance tracking system (CIRTS).

If the preliminary review determines that fraud or abuse may have occurred and that it may have involved a MassHealth member and/or Medicaid funds, the Senior Director of Regulatory Affairs, in his role as Fraud and Abuse Prevention Coordinator, reports the matter both orally and in writing to the EOHHS within ten (10) calendar days. NHP implements measures to prevent further improper transactions from being processed, provided that such actions do not involve contacting a provider or member suspected of engaging in the fraudulent or abusive activities.

Subsequent actions that might involve contacting a provider or member suspected of engaging in the fraudulent or abusive activities or in the recovery of improper payments or funds misspent due to fraudulent or abusive actions occur after consultation with the EOHHS. NHP implements any actions directed by EOHHS. In addition, NHP requires any involved provider or subcontractor to develop and implement approved corrective action plans. In some cases, in lieu of corrective action plans, NHP may choose to terminate the provider or subcontractor contract.

Any NHP employee who is contacted by the Medicaid Fraud Division, the Bureau of Special Investigations or any other investigative authorities conducting Fraud and Abuse investigations must notify the Compliance Office immediately, unless specifically directed by the investigative authorities not to do so. The Compliance Office in turn notifies the EOHHS, unless specifically directed by the investigative authorities not to do so. This notification is made verbally within 24 hours of notification. Refer to NHP's policy on *Responding to External Fraud and Abuse Investigations*.

Upon notification of a fraud or abuse investigation, the Compliance Office, in consultation with NHP's attorneys, provides leadership and direction to all employees. Unless specifically directed to the contrary by the investigative authority or by the Compliance Office in order to ensure the confidentiality and

integrity of the investigation, NHP employees are prohibited from discussing the nature of the investigation with anyone internal or external to the organization.

Federal and State Statutes Concerning the Detection and Prevention of Fraud and Abuse

The Federal Civil False Claims Act

The Federal False Claims Act (“FCA”) imposes civil liability on any person or entity that submits a false or fraudulent claim for payment to the government. The FCA includes Medicare and Medicaid programs.

Summary of Provisions: The FCA imposes civil liability on any person who knowingly: (1) presents (or causes to be presented) a false or fraudulent claim for reimbursement by a Federal health care program, including Medicare and Medicaid; (2) uses (or causes to be used) a false record or statement material to a false or fraudulent claim; (3) conspires with others to get a false or fraudulent claim paid by the Federal Government; and (4) repays less than what is owed to the Federal Government.

The term “knowingly” is defined to mean that a person, with respect to information: (1) has actual knowledge of information in the claim; (2) acts in deliberate ignorance of the truth or falsity of the information in the claim; or (3) acts in reckless disregard of the truth or falsity of the information in a claim.

In general, the FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud. A broad array of scenarios can constitute FCA violations. Some examples include the following: a contractor falsifies test results or other information regarding the quality or cost of products it sells to the Federal Government; a health care provider bills Medicare and Medicaid for services that were not provided or were unnecessary; or a grant recipient charges the Federal Government for costs not related to the grant. For Medicaid managed care plans, fraud can occur in the areas of contract procurement, e.g., making false statements in responding to procurement bids; marketing, e.g., misleading enrollees, enrollment and disenrollment; e.g., cherry-picking enrollees; underutilization, e.g., delaying or stinting on care; and data collection and submission, e.g., misclassifying enrollees.

Penalties: The FCA imposes civil penalties and is not a criminal statute. Persons (including organizations and entities such as hospitals and managed care organizations) may be fined a civil penalty of not less than \$5,500 nor more than \$11,000 for each claim, plus treble damages, except that double damages may be ordered if the person committing the violation furnished all known information within thirty (30) days. The amount of damages in health care terms includes the amount paid for each false claim that is filed. In addition, a

convicted party may also be excluded from participation in federal and state health care programs.

Qui Tam (Whistleblower) Provisions: Any person may bring an action under this law (called a qui tam relator or whistleblower suit) in federal court. The case is initiated by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The case will remain sealed for at least 60 days and will not be served on the defendant so the government can investigate the complaint. The government may obtain additional time for good cause. The government on its own initiative may also initiate a case under the FCA.

After the 60 day period, or any extensions, has expired, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on his/her own in federal court. If the government proceeds with the case, the qui tam relator bringing the action will receive between 15 and 25 percent of any proceeds, depending upon the contributions of the individual to the success of the case. If the government declines to pursue the case, the successful qui tam relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorney's fees and costs awarded against the defendant.

A case cannot be brought more than six years after the committing of the violation or no more than three years after material facts are known or should have been known, but in no event more than ten years after the date on which the violation was committed.

Non-retaliation and Anti-discrimination: Anyone, including employees, contractors or agents, initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer. The employee, contractor or agent is authorized under the FCA to initiate court proceedings for any job or business related losses resulting from any such discrimination or retaliation.

Reduced Penalties: The FCA includes a provision that reduces the penalties for providers who promptly self-disclose a suspected FCA violation. The Office of Inspector General self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages and submit the findings that involve more serious problems than just simple errors to the agency.

The Federal Program Fraud Civil Remedies Act of 1986

The Federal Program Fraud Civil Remedies Act (the "Act") creates administrative remedies against any person who makes false claims separate from and in addition to the remedies provided by the FCA.

The Act deals with submission of improper “claims” or “written statements” to a federal agency. Specifically, a person violates the Act if they know or have reason to know they are submitting a claim that is:

- False, fictitious or fraudulent; or,
- Includes or is supported by written statements that are false, fictitious or fraudulent; or,
- Includes or is supported by a written statement that omits a material fact, the statement is false, fictitious or fraudulent as a result of the omission, and the person submitting the statement has a duty to include the omitted facts; or
- For payment for property or services not provided as claimed.

A violation of the Act carries a \$5,000 civil penalty for each such wrongfully filed claim. In addition, a penalty of two times the amount of the claim may be assessed, unless the claim has not actually been paid.

A person also violates the Act if they submit a written statement which they know or should know:

- Asserts a material fact which is false, fictitious or fraudulent; or,
- Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

A violation of the prohibition for submitting an improper statement carries a civil penalty of up to \$5,000.

Massachusetts False Claims Act (MFCA)

The MFCA is a state statute that is modeled after the FCA and is directed at prosecuting fraud against the Commonwealth of Massachusetts.

Summary of Provisions: The MFCA prohibits knowingly making a false claim against the Commonwealth. False claims can take the form of overcharging for a product or service; making a false statement to conceal, avoid or decrease a financial obligation to the Commonwealth; using a false record to obtain payment from the Commonwealth; or conspiring to defraud the Commonwealth by allowing the payment of false claims.

Penalties: The MFCA imposes civil penalties and is not a criminal statute. Persons (including organizations such as hospitals) may be fined a civil penalty of not less than \$5,000 nor more than \$10,000 per violation, plus three (3) times the amount of damages, including consequential damages, sustained by the government because of the act of that person. The amount of damages in health care terms includes the amount paid for each false claim that is filed.

Whistleblower Provisions: The MFCA contains provisions that allow for an individual to bring suit in state court. Under the MFCA, the case will remain sealed for at least 120 days and the Commonwealth may obtain additional time for good cause.

After the 120 day period or any extensions has expired, the Commonwealth may pursue the matter in its own name, or decline to proceed. If the Commonwealth declines to proceed, the person bringing the action has the right to conduct the action on his own in state court. If the Commonwealth proceeds with the case, the person bringing the action, called the “relator,” will receive between 15 and 25 percent of any proceeds, depending upon the contributions of the individual to the success of the case. If the Commonwealth declines to pursue the case, the relator, if successful, will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorney’s fees and costs awarded against the defendant.

Non-retaliation and Anti-discrimination: The MFCA prohibits an employer from discharging, demoting, suspending, threatening, harassing, denying promotion to, or in any other manner discriminating against an employee in the terms or conditions of employment for disclosing information in furtherance of a false claims action. An employee is authorized under the MFCA to initiate court proceedings to make him/herself whole for any job related losses resulting from any such discrimination or retaliation, including reinstatement with the same seniority status, two times the amount in back pay, interest on back pay, and reimbursement of litigation costs.

Reduced Penalties: The MFCA includes a provision that reduces the penalties for individuals who, within established time periods, fully cooperate with the Commonwealth’s investigation of alleged violations.

REFERENCES

31 U.S.C. §§ 3729 – 3733 (Federal False Claims Act)
31 U.S.C. §§ 3801 (Federal Program Fraud Civil Remedies Act of 1986)
M.G.L. Ch 12 Sect 5 (Massachusetts False Claims Act)
MassHealth MCO Contract 2.3K
Deficit Reduction Act of 2005

RELATED POLICIES

- Code of Ethics
- Non-Retaliation for Reporting of Compliance Violations
- Compliance Hotline
- Detecting and Responding to Member Fraud and Abuse
- Detecting and Responding to Provider Fraud and Abuse
- Responding to External Fraud and Abuse Investigations