EC.015 – Detecting and Preventing Fraud, Waste & Abuse and Overpayments

SECTION:	ETHICS AND COMPLIANCE	LAST REVISION DATE:	12.20.2022
SUBJECT:	**Detecting and Preventing Fraud, Waste & Abuse and Overpayments**	LAST REVIEW DATE:	12.20.2022
POLICY NUMBER:	EC.015	APPROVED BY:	ERMC – Policies & Procedures Subcommittee

I. PURPOSE

Like all organizations that do business with government programs such as Medicare and Medicaid, MHN[1], its employees and contractors are subject to many laws and regulations intended to prevent fraud, waste, abuse, and overpayments in taxpayer-supported programs. It is MHN's policy to comply with all applicable laws and regulations, including (a) federal and state false claims laws and (b) the education and non-retaliation obligations in laws such as the Deficit Reduction Act of 2005 (DRA).

II. POLICY

MHN has established a comprehensive Compliance Program, and MHN employees and contractors are required to report any suspected cases of fraud, waste, abuse, and overpayments to MHN management, or to use the anonymous reporting opportunities available through the MHN compliance hotline or email address (See EC.007 – Reporting Compliance Issues.) As noted in more detail below, it is also MHN's policy to refrain from retaliating against any individual who in good faith raises compliance concerns.

More detailed information regarding MHN's compliance policies, procedures, and internal controls is available throughout MHN's Ethics and Compliance Policies and Procedures, as well as MHN's ongoing and annual compliance training materials. Additionally, and in compliance with Section 6032 of the Deficit Reduction Act, this Policy and the Employee Manual include information about the following topics:

- The Federal False Claims Act
- The Federal Antikickback Statute
- Penalties for Submitting False Claims and Statements
- Administrative and Criminal Remedies for False Claims and Statements
- Applicable State False Claims Laws
- Whistleblower Provisions Under State and Federal False Claims Laws
- Non-Retaliation Policies

[1] MHN Enterprise Policies are consistent among Medical Home Network and its affiliates, including but not limited to MoreCare and MHN REACH ACO. A reference to MHN in this policy includes MHN and all MHN subsidiaries, unless expressly superseded by a subsidiary-specific policy.

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- Procedures for Responding to Identified Overpayments
- Toll-Free Numbers for Reporting Fraud, Waste, Abuse and Overpayments

III. PROCEDURAL GUIDELINES

A. Laws Relating to Fraud, Waste, Abuse, and Overpayments

1. **The Federal False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733** The False Claims Act is a federal law that, among other things, prohibits the submission of false or fraudulent claims to government programs, including Medicare and Medicaid. (State laws modeled after the Federal FCA are discussed below.) Liability arises under the FCA for any person who knowingly presents (or causes another person to present) a false or fraudulent claim for payment (or a false or fraudulent report in support of a claim for payment) by the federal government. The FCA prohibits other conduct as well, including conspiracies to submit false claims or reports, and retaliation against employees, contractors or agents because of lawful actions taken to stop one or more FCA violations.
   - **a.** The FCA establishes liability for any person who:
     - **i.** Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
     - **ii.** Knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim;
     - **iii.** Conspires to commit a violation of any FCA provision;
     - **iv.** Has possession, custody or control of property or money used or to be used by the government and knowingly delivers, or causes to be delivered, less than the full amount of that money or property;
     - **v.** Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the government, and intending to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
     - **vi.** Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
     - **vii.** Knowingly makes, 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 government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.
     - **viii.** The Patient Protection and Affordable Care Act (PPACA), provides two additional grounds for liability under the False Claims Act: (a)

the improper retention of an identified overpayment (discussed in additional detail below) and (b) the submission of a claim that includes items or services resulting from a violation of the Anti-Kickback Statute.

b. Examples of "claims" that can be a basis of federal or state FCA liability include many different kinds of statements made in support of requests for payment, reimbursement, approval, or authorization (whether made directly to the government or an intermediary who will pass the claim through to the government), such as:

- **i.** Certifications of compliance with contract terms, laws, or regulatory obligations;
- **ii.** Reports regarding performance levels under government contracts or programs;
- **iii.** Requests for payment under government grants, contracts, loans, insurance, or benefits;
- **iv.** Statements identifying an item or service as reimbursable;
- **v.** Claims for services that are "tainted" by an improper kickback relationship;
- **vi.** Requests for approval or authorization to provide property, services or money; and
- **vii.** Statements of income or expense that are used to determine a rate of payment.

c. Every individual who prepares documentation or submits claims on behalf of MHN must know or believe the information contained in claims or reports he or she submits on behalf of MHN is correct. MHN's representatives cannot (either deliberately or carelessly) ignore questionable information contained in claims submitted by MHN for payment by a government program. Understanding whether information is true and correct includes making reasonably sure that all essential facts are accurate, and that no essential fact is omitted.

B. The Federal Anti-Kickback Statute (AKS) -42 U.S.C. § 1320a-7b

The Federal Anti-Kickback Statute is a criminal statute that prohibits individuals or entities from knowingly and willfully offering, paying, soliciting, or receiving "remuneration" (or kickbacks or bribes) to induce referrals of items or services paid by a federally funded program such as Medicare, Medicaid or Tricare. In short, we may not directly or indirectly pay patients or other health care providers to refer patients to us, unless permitted by an applicable safe harbor.

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Possible penalties for violating the AKS include: fines of up to $25,000, up to five years in jail, and exclusion from Medicare and Medicaid care program business.

As a general matter MHN structures all relationships with potential referrals sources or entities/providers that MHN may refer to in compliance with an applicable safe harbor.

ACO operations and activities are structured specifically to comply with the safe harbor for CMS-sponsored model arrangements (42 CFR 1001.952(ii)(1)).

C. Penalties for Submitting False Claims and Statements

Under the FCA, an individual or organization found liable for knowingly or recklessly submitting a false or fraudulent claim can be required to pay up to three times the amount of the government's losses connected with the false claim(s), plus penalties that, as of 2022, are between $12,537 and $25,076 for each false claim or statement. Penalty amounts are periodically adjusted for inflation.

D. Administrative Remedies for False Claims and Statements

In addition to the damages and penalties that can be imposed under the federal False Claims Act, the government has administrative and criminal remedies available for false claims and statements. For example, the government can recoup (or take back) payments made because of false claims or statements. Civil monetary penalties (currently set at not greater than $5,500 for each false claim) and assessments of up to twice the amount paid under the claim can also be imposed. (See the Federal Program Fraud Civil Remedies Act, Title 31, Chapter 38 of the United States Code.) Additionally, individuals and organizations can be excluded or barred from doing business with the government, sometimes permanently.

E. State False Claims Laws

Many states, including Illinois, (and a few municipalities, including the City of Chicago), have civil and criminal false claims laws that are modeled on the Federal False Claims Laws. These laws also have qui tam (whistleblower) enforcement mechanisms and protections.

F. Whistleblower Provisions Under State and Federal False Claims Laws

To encourage individuals to report misconduct relating to potential false claims, the Federal FCA and many state false claims laws include "whistleblower" provisions, also referred to as the "qui tam" provisions. These laws allow (and encourage) individuals with

actual knowledge of false claims violations to file suit on behalf of the government (state and/or federal). Whistleblowers are also referred to as "relators" under these qui tam false claims laws.

1. If the relator's lawsuit is successful, they may be able to receive a share of the amounts recovered in the litigation, usually ranging between fifteen and thirty percent of the recovery. The relator may also be able to recover their reasonable expenses, including their attorneys' fees and costs of bringing the suit. Finally, relators who experience certain types of retaliation because of their whistleblowing activities may be entitled to additional remedies, including back pay, other compensation and reinstatement (if their employment has been terminated) because of lawful acts performed by the individual in an effort to stop one or more false claims act violations.
2. To qualify as a relator, a whistleblower must generally demonstrate that they are the original source of the information reported to the government in the qui tam suit, and that they have direct and independent knowledge of the allegedly false claims. If the allegations are already the subject of a federal or state investigation, the potential whistleblower may be prevented from obtaining a share of any recovery under the action.
3. Additionally, relators must file their suits in the appropriate court (federal district court or state court, depending on the facts of the case), and the complaint must be filed under seal. The seal requirement is intended to keep the allegations confidential and allow the government to conduct its investigation.

G. Responding to Overpayments

PPACA clarifies that improperly retaining a known overpayment can be the basis for liability under the False Claims Act. Additionally, retained overpayments can be grounds for other penalties and exclusion from participation in government programs. PPACA requires a person or organization that has received an overpayment to do the following:

1. Report and return the overpayment to the Secretary of Health and Human Services, the State, the relevant fiscal intermediary or carrier, or contractor, as appropriate;
2. Provide a written explanation of the reason for the overpayment;
3. Report and return the overpayment by the later of (a) the date that is sixty days after the date on which the overpayment was identified, or (b) the date on which any corresponding cost report is due.

H. Toll-Free Number for Reporting Fraud, Waste, Abuse and Overpayments

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If you think MHN or an MHN contractor, employee, or agent is engaged in conduct that violates federal or state healthcare laws please report your concerns using one of the following resources:

MHN COMPLIANCE HOTLINE
Phone: 1.800.401.8004

Website: http://www.lighthouse-services.com/mhnchicago

E-mail: reports@lighthouse-services.com (must include company name with report)

Fax: (215) 689-3885 (must include company name with report)

The MHN Compliance hotline and email address are available 24 hours a day, seven days a week and are maintained by an independent, outside vendor. Callers may choose to remain anonymous, and all calls will be investigated.

Reports can also be made directly to the agencies listed below:

California Department of Health Care Services
800-822-6222
https://www.dhcs.ca.gov/individuals/Pages/stopmedi-calfraud.aspx

Illinois Department of Healthcare and Family Services
217-785-7030
http://www.state.il.us/agency/oig/reportfraud.asp

Indiana Family and Social Services Administration
800-403-0864
https://secure.in.gov/fssa/medicaidpublic-assistance-fraud/

Michigan Department of Health and Human Services
855-643-7283
https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/fraud/report-medicaid-fraud-and-abuse

North Carolina Department of Health and Human Services
919-527-7700
https://medicaid.ncdhhs.gov/meetings-notices/office-compliance-program-integrity-ocpi

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New York State Office of the Medicaid Inspector General
877-873-728
https://omig.ny.gov/

Ohio Department of Medicaid
800-324-868
https://medicaid.ohio.gov/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud

Oklahoma Health Care Authority
855-817-3728
https://oklahoma.gov/ohca/contact-us/report-suspected-fraud.html

U.S. Department of Health & Human Services Office of Inspector General:
1-800-447-8477
HHSTips@oig.hhs.gov
or by mail to the address below.

Office of Inspector General
Department of Health & Human Services
ATTN: HOTLINE
PO Box 23489
Washington, DC 20026

I. MHN's Non-Retaliation Policy

As noted in the MHN Employee Manual and EC.008 – Non-Retaliation, MHN does not retaliate against employees for lawful reporting of potential violations of law or MHN policies. EC.008 applies equally to employees who report potential FCA violations or bring a civil suit for possible FCA violations. MHN does not discriminate against employees in the terms and conditions of their employment because of actions taken or initiated by an employee in support of a false claims action

IV. RELATED POLICIES

- EC.001 - Code of Conduct
- EC.007 - Reporting Compliance Issues
- EC.008 – Non-Retaliation Policy
- EC.009 – Deficit Reduction Act (DRA) Compliance
- EC.010 – Internal Handling of Hotline Calls
- EC.012 – Compliance Investigations
- MHN Employee Manual

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V. FORMS

N/A

VI. REFERENCES & ACCREDITATION AUTHORITIES

Federal Program Fraud Civil Remedies Act, Title 31, Chapter 38 of the United States Code
The Federal False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733
The Patient Protection and Affordable Care Act
The Deficit Reduction Act of 2005

VII. REVIEW STATEMENT

MHN will maintain the status of this activity and conduct audits as appropriate to ensure compliance. This policy will be reviewed at least every two years or in timely response to changes in local or federal regulations. Modifications to the procedure will be made as needed.

VIII. REVIEW HISTORY

Approved
July 24, 2013

Reviewed
September 7, 2015
November 14, 2017
January 27, 2020
December 20, 2022