MAINEGENERAL HEALTH

FUNCTIONAL AREA: Human Resources

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TOPIC: Fraud and Abuse Compliance Workforce Information & Education

AUTHORIZATION:

Chief Human Resources Officer

CEO/President MaineGeneral Health & MaineGeneral Medical Center

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I. PURPOSE: The purpose of this policy is to ensure that the MaineGeneral Health ("MGH") workforce, including management, employees, agents and contractors are provided information about state and federal fraud and abuse laws, and about MGH's Compliance Program policies and procedures intended to prevent and detect healthcare waste, fraud and abuse, in accordance with the requirements of the federal *Deficit Reduction Act of 2005*.[1]

II. POLICY:

Statement of Policy

It is the policy of MaineGeneral Health to ensure that its employees and business practices conform to the highest standards of ethical conduct and comply with applicable laws and regulations aimed to prevent and detect healthcare fraud and abuse.

To that end, this policy provides the following detailed information regarding federal and state False Claims Acts, MGH's policies and procedures, and MGH's Compliance Program for the detection and prevention of healthcare waste, fraud and abuse. All MGH employees, members of management, contractors, and agents, including members of the MGH medical and allied health professional staff, should be familiar with this information.

A. **MGH's Policies and Procedures and Compliance Program for Preventing and Detecting Healthcare Waste, Fraud and Abuse**

1. MGH's Compliance Program for the Prevention, Detection, and Reporting of Healthcare Fraud and Abuse: In addition to this policy, MGH has established a Compliance Program and appointed a Chief Compliance Officer to ensure compliance with state and federal laws, including the fraud and abuse laws described below, and to prevent and detect healthcare waste, fraud and abuse.

[1] *See* § 6032(a)(3) of the *Deficit Reduction Act of 2005,* Pub. Law 109-171, codified at Title 42 U.S.C. § 1396a(a)(68).

2. MGH's Policies and Procedures for Preventing, Detecting, and Reporting Fraud and Abuse: MGH has adopted MGH HR-22 as part of its efforts to promote ethical business practices and to prevent and detect healthcare waste, fraud and abuse, and to ensure that its employees and business practices comply with state and federal fraud and abuse laws. For more specific information concerning MGH's Compliance Program and its policies and procedures for preventing, detecting and reporting healthcare fraud and abuse, see:

   a. MaineGeneral Health Compliance Program and Plan

   b. MaineGeneral Rehabilitation and Nursing Care Compliance Plan

   c. Maine Dartmouth Family Residency Compliance Plan

   d. MaineGeneral Community Care Compliance Plan

   e. MaineGeneral Health Code of Ethical Conduct

   f. MGH HR-18, Employee Discipline and Grievance Policy

   g. MGH LD-01, Compliance Helpline Policy

   h. MGH LD-23, Conflict of Interest

   i. MGH LD-27, Standards of Conduct for Billing Federal Health Programs

   j. MGH RI-01, Organizational Ethics

   k. MGH RI-02, Confidentiality of Information

3. Reporting Suspected Waste, Fraud and Abuse: Employees, agents and contractors who believe that a pattern of reportable billing errors or fraudulent billing of a federal or state healthcare program may have occurred should immediately contact the Chief Compliance Officer or call the MGH Compliance Helpline at 207-621-9350. The Ethics and Compliance Department will investigate the alleged billing error or impropriety. All reports are treated as confidential and calls to the Compliance Helpline may be anonymous. Employees who report in good faith suspected waste, billing errors or fraudulent conduct shall not be discriminated or retaliated against or suffer any form of disciplinary or other adverse employment action for making such reports (see MHG LD-01, Compliance Helpline Policy).

B. ***The Federal* False Claims Act**

1. Conduct Prohibited by the Federal *False Claims Act*: The federal *False Claims Act*[2] was enacted to prevent waste, fraud and abuse of federally funded governmental

[2] Title 31 U.S.C. §§3729-3733 *et seq.*

programs, including federal healthcare reimbursement programs such as Medicare and Medicaid. The *False Claims Act* prohibits, among other things, any person from knowingly submitting, causing to be submitted, or conspiring to be submitted, or from making a false record or statement in connection with the submission of, a false or fraudulent claim for payment to the United States government. It is the policy of MGH that an employee, contractor, or agent of MGH who knowingly and intentionally submits a false claim will be reported to the necessary authorities. Part of the *False Claims Act's* purpose is to create an environment where employees and others feel safe reporting concerns about fraud. MGH fully supports that goal. Any person who lawfully attempts to stop any *False Claims Act violations, or reports information about false claims that are submitted by others, may not be retaliated against, demoted, suspended, threatened or harassed by MGH for such actions.*

The *False Claims* Act also protects individuals who assist in an investigation, provide testimony or participate in the government's handling of a false claim.

2. Retention of Overpayments

Anyone who knowingly retains, conceals, or knowingly and "improperly" avoids, or decreases an obligation to pay or transmit money or property to the Government is subject to False Claims Act Liability. The routine reimbursement reconciliation processes built into government programs are not considered improper retention of an overpayment. MGH LD-27 Policy of Standards of Conduct for Billing Federal Health Programs outlines that substantiated overpayments will be returned accurately and timely. Any errors identified in claim submission will be corrected in a timely manner. The Federal payers shall be promptly reimbursed for any material overpayment and (where possible) the beneficiary shall be reimbursed for any copayment or deductible incorrectly paid in a reasonably prompt manner after the CCO has verified the existence of an error.

3. Administrative Remedies Available for False Claims and Statements under Federal Law: Persons who violate the federal *False Claims Act* may be found liable for three times the government's actual damages, plus civil penalties of between $11,181 - $22,363 per false claim (these monetary amounts are revised periodically). Moreover, additional remedies are available to the government for false claims and statements under a separate federal *Civil Monetary Penalties Law*,[3] including (i) civil fines of up to $10,000 (and higher under certain circumstances) for each item or service falsely or fraudulently billed, (ii) up to three times the amount of each item or service falsely or fraudulently claimed or three times the government's actual damages, and (iii) exclusion from participation in federal healthcare programs.

4. *Qui Tam* Provisions of the *False Claims Act*: The federal *False Claims Act* also contains *qui tam* provisions. *Qui tam* is a unique mechanism in the law that allows

[3] Title 42 U.S.C. §1320a-7a.

a private citizen with evidence that a fraud has been committed against a federal governmental program to bring a civil action on behalf of the government to recover funds that were misappropriated. In compensation for the risk and effort of filing a *qui tam* action, a citizen whistleblower or "relator" may be awarded a percentage of any funds recovered as a result of the action.

5. Whistleblower Protections Afforded under the Federal *False Claims Act*: The federal *False Claims Act* also contains protections for whistleblowers by (i) prohibiting employers from discharging, demoting, suspending, threatening, harassing or taking any other adverse employment action against an employee for initiating, participating, or cooperating in a *qui tam* action brought under the Federal *False Claims Act*, and (ii) providing to employees who are retaliated against for their involvement in a *qui tam* action a separate cause of action for reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay necessary to make the employee whole, interest on back pay owed, and compensation for special damages resulting from the unlawful discrimination such as litigation costs and attorneys' fees.

C. State Laws Affording Civil and Criminal Penalties for False Claims and Statements

In addition to the federal laws noted above, Maine has enacted several state laws and regulations designed to prevent and detect healthcare waste, fraud and abuse within the state and federally funded Medicaid (MaineCare) healthcare program.

1. Definition of Healthcare Fraud and Abuse under Maine Law: MaineCare Rules[4] define healthcare fraud and abuse as follows:

   Fraud includes intentional deception or misrepresentation, oral or written, which an individual knows to be false, or does not believe to be true, made with knowledge that deception or misrepresentation could result in some unauthorized benefits. The requisite intent is present if the misrepresentation was made knowingly or with a reckless disregard for the truth. Examples of conduct that could constitute fraud include, but are not limited to, the following:

   a. Billing for services, supplies, or equipment that were not rendered to, or used for, MaineCare members;

   b. Billing for supplies or equipment that are clearly unsuitable for the member's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;

   c. Flagrant and persistent over-utilization of medical or paramedical services with little or no regard for results, the member's ailments, condition, medical needs, or the provider's orders;

[4] MaineCare Benefits Manual, 10-144 C.M.R. Chapter 101, Chapter I, Section 1.20-1.

d. Claiming of costs for non-covered or non-chargeable services, supplies or equipment disguised as covered items;

e. Material misrepresentations of dates and descriptions of services rendered, or of the identity of the member or the individual who rendered the services;

f. Duplicate billing which appears to be deliberate. This includes, but is not limited to: billing MaineCare twice for the same service or billing both MaineCare, a third party insurer, and/or the member/family/ representative for the same services, billing for the same service under different codes or different policies, billing separately for a service that is included in a per diem or other bundled rate, or billing for the same service under different provider numbers;

g. Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge MaineCare with various devices (commissions, fee splitting) used to siphon off or conceal profits;

h. Charging to MaineCare, by subterfuge, costs not incurred or which were attributable to non-program activities, other enterprises, or personal expenses of principals;

i. Deliberately providing, or receiving medical services on the MaineCare account of another individual;

j. Deliberately billing members rather than MaineCare for covered services;

k. Concealing business activities that would prevent compliance with the provisions of the Provider/Supplier Agreement;

l. Falsifying provider records in order to meet or continue to meet the conditions of participation; and

m. Soliciting, offering, or receiving a kickback, bribe, or rebate.

2. Maine's *False Claims Civil Liability Statute*: Under Maine's *Civil Liability of Persons Making False Claims* statute,[5] any person or entity who, among other things, makes or causes a false or fraudulent claim for payment or approval to be submitted to the Maine Department of Health and Human Services knowing such claim to be false, fictitious or fraudulent, or who makes any false written statement or submits any false document in connection with such a claim, may be subject to civil suit by the State of Maine and required to pay (i) restitution for excess benefits or payments made, (ii) interest on restitution amounts awarded, (iii) civil penalties of up to three [3] times the amount of the excess benefits or payments, but not less than $2,000 for each false claim or false document submitted in support of such false claim, (iv) the State's litigation costs, (v) the State's investigation costs, and (vi) and the State's attorney's fees.

[5] Title 22 M.R.S.A. §15.

3. Other Maine Laws Affording Criminal Penalties for False Claims and Statements: Other Maine laws may be used by the State to impose criminal penalties upon persons who submit false or fraudulent claims and statements for payment to the MaineCare program,[6] including laws that prohibit unsworn falsification,[7] theft by deception,[8] and criminal conspiracy.[9]

4. Whistleblower Protections Afforded under Maine Law: It is the policy of MGH to ensure that employees reporting suspected waste, reportable billing claims errors, or fraudulent or abusive conduct in good faith are protected from any form of discrimination, retaliation, discipline, or adverse employment action. In addition, Maine's *Human Rights Act* contains whistleblower protection provisions[10] that prohibit any person:

   a. From discriminating against a person because that person has opposed any act or practice that is unlawful under the *Maine Human Rights Act* or because that person has made a charge, testified, assisted or participated in any manner in an investigation, proceeding or hearing under the *Maine Human Rights Act*; and

   b. From coercing, intimidating, threatening or interfering with any individual in the exercise or enjoyment of the rights granted or protected by the *Maine Human Rights Act*, or because that individual has exercised or enjoyed, or has aided or encouraged another individual in the exercise or enjoyment of, those rights.

D. **Employee Education about Fraud and Abuse**

MGH will ensure that its members of management, employees, agents, and contractors are provided the educational information about state and federal fraud and abuse laws contained in this policy as follows:

1. An electronic copy of the Compliance Program policy, is made available to all employees, via the MaineGeneral Health's homepage.

2. MGH contractors and agents who provide or authorize items or services, coding or billing functions or monitoring healthcare services by Medicaid must be made aware of this policy.

3. MGH employees will be introduced to the Compliance Program and fraud and abuse issues at orientation. Online fraud and abuse education will be part of annual mandatory training. Additional training and education on compliance issues, including fraud and abuse concerns, will be provided periodically.

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[6] *See MaineCare Benefits Manual*, 10-144 C.M.R. Chapter 101, Chapter I, Section 1.20-2(A)(1)-(3). Provider claims for payment submitted to MaineCare are also subject to other federal laws pertaining to criminal fraud. For a list of such laws, *see MaineCare Benefits Manual*, 10-144 C.M.R. Chapter 101, Chapter I, Section 1.20-2(B)-(C).
[7] Title 17-A M.R.S.A. § 453.
[8] Title 17-A M.R.S.A. § 354.
[9] Title 17-A M.R.S.A. § 151.
[10] Title 5 M.R.S.A. § 4653.

III. RESPONSIBILITY: All MaineGeneral workforce.

IV. PROCEDURE: Refer to Section II of the policy above.

V. POLICY ACCESSIBILITY:

- Original approved MaineGeneral Health Policies are maintained in Administration at the ACH.
- Entities of MaineGeneral Health maintain and file policies specific to their areas in a designated Administrative area of their own
- Copies of MGH policies are filed in the Health Sciences Library of the Thayer Center for Health, Waterville
- Employees can access policies via the MaineGeneral Connect site.

VI. POLICY APPLIES TO:

_ MaineGeneral Medical Center
_ MaineGeneral Rehabilitation & Long Term Care
_ MaineGeneral Retirement Community
_ MaineGeneral Community Care
X All

VII. CITATIONS/BEST PRACTICE REFERENCES: None

VIII. POLICY ATTACHMENTS: None