

To: All Vendors, Agents and Contractors
From: Corporate Compliance & Ethics Department
Re: Deficit Reduction Act of 2005

Dear Vendor/Agent/Contractor:

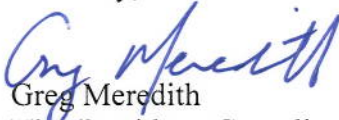
Under the Deficit Reduction Act of 2005 (DRA), Hutchinson Regional Healthcare System (HRHS) is required to provide certain information to all employees (including management, agents and contractors) regarding the following:

- (1) the Federal and State False Claims Act,
- (2) whistleblower protections for employees and others under these laws who provide information regarding any suspected violations of the laws, and
- (3) the policies and procedures for detecting and preventing fraud, waste and abuse.

We have enclosed a copy of the Notice Pursuant to the DRA (Notice), the DRA Policy and our fraud, waste and abuse policy. Please review these enclosures and distribute this letter and our enclosures to all of your employees and agents who provide services to, or on behalf of, HRHS.

If you have any questions or concerns regarding the Notice, reporting of fraud, waste and abuse, the Policy, or any compliance issue, please contact the Compliance Department at 620.665.2203. You may also call the Compliance Hotline to leave an anonymous message at 855.998.9907 (English) or 800.216.1288 (Spanish). Thank you for your time and attention.

Sincerely,



Greg Meredith
Vice President, Compliance and Ethics

Hutchinson Regional Healthcare System
Notice
Pursuant to Deficit Reduction Act of 2005

Hutchinson Regional Healthcare System (HRHS) is made up of Hutchinson Regional Medical Center, Inc., Hutchinson Health Care Services, Inc. d/b/a Health-E-Quip, Hospice of Reno County, Inc. d/b/a Hospice and Home Care of Reno County, and Horizons Mental Health Center, Inc.

HRHS strives to comply with all laws and regulations prohibiting the submission of false claims to State or Federal governments. HRHS requires its employees (including management), contractors, and agents (collectively, "workforce members") to comply with applicable Federal and State laws. Contractors and agents include those who (a) furnish or authorize the furnishing of healthcare items or services on our behalf, (b) perform billing or coding functions on our behalf, or (c) are involved in monitoring the healthcare we provide.

HRHS's Corporate Compliance Program mandates compliance with Federal and State laws. These laws include (for example): (a) the False Claims Act, 31 U.S.C. §§ 3729-3733, (b) the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812, (c) the Anti-Kickback Statute, 42 U.S.C. 1320a-7b(b), (d) Stark Laws, 42 U.S.C. § 1395 et seq. (e) the Kansas False Claims Act, K.S.A. §§ 75-7501-7511; and (f) Kansas Medicaid Fraud Control Act, K.S.A. §§ 21-3844-3856.

HRHS has established the attached policy for compliance with the provisions of Section 6032 of the Deficit Reduction Act. All workforce members should know that they are subject to criminal and civil penalties for failing to comply with Federal and State laws, and to disciplinary action for a failure to comply with our Compliance Program.

HRHS will not take (or permit) retaliatory action against anyone who in good faith reports conduct, which may violate Federal or State laws. Protections given to workforce members who provide assistance to the government during an investigation, or by reporting fraud, waste, or abuse are addressed in the Compliance Program, our Non-Retaliation Policy, SYS:CCE006, the DRA Compliance Policy and the Employee Handbook.

HRHS requires its workforce members to familiarize themselves with our Compliance Program, the DRA Section 6032 Policy, and the Employee Handbook as applicable. These individuals are also required to follow those policies to facilitate compliance with the above laws, principles, and standards.

Workforce members who suspect a failure to comply with the above laws must contact the Compliance Officer in person, by calling 620.665.2203, or emailing compliancereports@hutchregional.com, or without telling us your name, by calling the Compliance Hotline at 855-998-9907 (English) or 800.216.1288 (Spanish).

**2005 DEFICIT REDUCTION ACT (DRA)
SECTION 6032 COMPLIANCE POLICY**

I. PURPOSE:

- a. Hutchinson Regional Healthcare System (“HRHS”) is committed to preventing health care fraud and abuse. We comply with applicable laws. This Policy is to inform and educate HRHS’s employees (including management), contractors and agents (collectively, “workforce members”) about our Compliance Program, and the Federal and State False Claims Acts (“FCA”). This includes the protections provided under the laws for those who report suspected fraud, waste and abuse (as required by Section 6032 of the 2005 Federal Deficient Reduction Act). All workforce members must understand how the Compliance Program and the Federal and State FCAs prevent and help detect fraud, waste and abuse in federal health care programs.

II. POLICY:

- a. Workforce members will comply with the FCA, applicable State and Federal laws and our Corporate Compliance Program. All workforce members have a responsibility to prevent and detect fraud, waste and abuse in federal health care programs. All workforce members must report any actual or suspected fraud, waste and abuse, or any misconduct, which potentially violates Federal or State laws.
- b. We will report to governmental authorities any workforce member who knowingly and intentionally submits any false claim to the State or Federal government.
- c. To report concerns, workforce members should contact the Compliance Officer in person, at 620.665.2203, via email to compliancereports@hutchregional.com , or without giving out your name, to the Compliance Hotline at 855.998.9907 (English) or 800.216.1288 (Spanish). In addition, any person may also report concerns to his or her chain of supervision (e.g., Administration, a Director, or HRHS Officers), or directly to government authorities.
- d. HRHS will make this Policy and its Compliance Program available to all workforce members. Information regarding individual protections and rights are included within this Policy, the Employee Handbook and our Non-Retaliation policy, SYS:CCE006.

III. SCOPE:

The policy applies to all workforce members. The Compliance Officer (or designees) are responsible for implementing this Policy.

IV. GUIDELINES:

By not engaging in the following, we decrease the chances of violating the FCA. You should not view these guidelines, however, as a complete list. Whenever a question arises concerning the propriety of any course of conduct, seek guidance from the Chief Financial Officer (or designee), the Compliance Officer, a Compliance Committee member or outside legal counsel. Generally, covered persons should report the following:

1. **Billing for Items or Services Not Actually Rendered:** No patient or his or her payor should be billed for services that are not actually rendered or performed.
2. **Providing Medically Unnecessary Services:** Claims should not be submitted to a patient or his or her payor that seek reimbursement for a service that is not warranted by the patient's current or documented medical condition.
3. **Upcoding and DRG Creep:** We should not use billing codes and the assignment of DRGs that provides for a higher payment rate than the coding that actually reflects the service furnished to the patient.
4. **Outpatient Services Rendered in Connection with inpatient stays:** We should not submit claims for non-physician outpatient services that are included in inpatient payment under the Prospective Payment System.
5. **Duplicate Billing:** We should avoid duplicate billings. This occurs when we submit more than one claim to more than one payor at the same time, or for the same service.
6. **False Cost Reports:** False cost reports should not be submitted. Statistics, financial data, and payor information should be accurate and supported by auditable documentation.
7. **Unbundling:** We should never submit bills in a piecemeal or fragmented fashion to maximize the reimbursement. In some cases, we are required to bill tests or procedures together.
8. **Billing for Discharge in Lieu of Transfer:** When HRMC transfers a patient to another Inpatient Prospective Payment System hospital, we are required to bill using the correct discharge code to prevent receiving an overpayment.
9. **Failing to Refund Credit Balances:** We should refund credit balances on a timely basis.
10. **Falsely Billing Physician Services:** Claims for physician services should reflect the service provided, and may not be presented if the person providing the service is not a physician.
11. **Transactions with Physicians and Others in violation of AKS or the Stark Law:** Any transaction with a physician or other provider must be in writing and satisfy other requirements of fraud and abuse laws.
12. **Overlapping Claims:** We must file certain inpatient and outpatient claims together. In some cases, we must bill two outpatient claims provided on the same date together.
13. **Miscellaneous:** For other examples of illegal conduct, see Fraud Alerts, OIG Audit Reports, OIG Work Plan, etc.

V. ADDITIONAL INFORMATION:

- a. **PROTECTIONS:** Information regarding employee protections and rights is contained in the Employee Handbook, our Non-Retaliation policy, SYS:CCE006, and summarized below. Any person can obtain information regarding our Compliance Program, this Policy or SYS:CCE006 by contacting the Compliance Officer.
- b. **FEDERAL FALSE CLAIMS ACT (FCA):** This Act imposes civil liability on persons or companies who, among other things: "(1) knowingly present or cause to be presented a false or fraudulent claim for payment to the government; (2) knowingly use a false record or statement to obtain payment on a false or fraudulent claim paid by the government; or (3) engage in a conspiracy to defraud the government to obtain allowance for, or payment of, a false or fraudulent claim. The FCA defines "knowing" or "knowingly" as having actual knowledge of the information; acting in deliberate ignorance of the truth or falsity of the information; or acting in reckless disregard of the truth or falsity of the information; and requires no proof or specific intent to defraud. FCA civil penalties may include fines of up to three times the amount of damages, which the government sustains because of the act of that person plus up to \$21,916.00

(in 2017¹) per false claim filed. The amount of damages sustained is the amount paid for each false claim that is filed. Examples of activities prohibited by the Federal FCA include billing a federally funded program, such as Medicare or Medicaid, for services that were not provided and/or upcoding, i.e., billing for a highly reimbursed service in lieu of service actually provided. Another example is retaining improper overpayments from a federally funded program. The Federal FCA applies to billing and claims sent to any government payor program, including Medicare and Medicaid, other Federal healthcare programs, and other State healthcare programs funded, in whole or in part, by the Federal government.

- c. **FEDERAL ANTI-KICKBACK LAW:** An Anti-Kickback statute (AKS) violation is also a false claim. The AKS forbids the knowing or willful offer, payment, solicitation, or receipt of any type of remuneration to induce or in return for referrals of items or services paid for by Medicare or Medicaid. An example of an illegal “kick-back” would be allowing a physician who refers patients to Hutchinson Regional Medical Center, or its affiliates, to lease space within HRMC’s facility or an affiliate building without paying rent. The government sees the free rent as a payment for that physician’s referral of patients to the system. The law is also violated in the event inappropriate inducements are made to patients, such as waiving co-insurance or deductibles without regard to financial need.

AKS civil penalties may include penalties of up to \$74,792.00 (in 2017) per kickback plus three times the amount the kickbacks. Criminal penalties for violating the AKS may include fines, imprisonment, or both.

- d. **STARK LAW:** A Stark Law violation may also, under some circumstances, result in a violation of the Federal FCA. The Stark Law prohibits physicians from referring Medicare and Medicaid patients for certain “designated health services” reimbursable by the Medicare and Medicaid programs to entities with which the physicians (or their immediate family members) have a financial relationship. A financial relationship may be an ownership interest or a compensation arrangement, and may be direct or indirect. In addition to prohibiting the referral for services, the Stark Law bans billing and collecting for services rendered pursuant to prohibited referrals.

Billing in violation of the Stark Law subjects the parties, both the referring physician and the billing entity, to civil monetary penalties up to \$24,253.00 (in 2017) for each service, repayment of claims, and potential exclusion from the Medicare and Medicaid programs. Other civil monetary penalties apply for failing to report information and for circumvention schemes, which can be substantial. There are exceptions to Stark Law, but they are complex and require legal analysis before entering into any such relationship.

- e. **CIVIL ACTIONS UNDER THE FCA:** Enforcement of the Federal FCA is the responsibility of the U.S. Attorney General, but the law also includes a qui tam or whistleblower provision. Qui tam actions are brought by private individuals on behalf of the government. More specifically, a “qui tam action” is a claim brought by a relator or informer under a statute that establishes a penalty for the commission or omission of a certain act. If wrongdoing is found, part of the penalty paid by the wrongdoer is paid to the relator or informer, with the remainder going to the government.

¹ At the beginning of each calendar year, the Federal government adjusts civil penalties for inflation.

A relator files a qui tam action in the Federal District Court for false or fraudulent claims submitted to and reimbursed by the United States government. The lawsuit is filed and remains under seal for a period of sixty (60) days to allow the government to investigate and decide whether it will pursue the action. At the end of the 60-day period, the complaint is unsealed and the Department of Justice or the U.S. Attorney General's office begins prosecuting the claim. If the government decides not to pursue the case, the relator has the right to continue with the case on his or her own. The government may join the action later, if it can demonstrate good cause for doing so. If the government proceeds with the lawsuit and is successful, the person who filed the action will receive between 15% and 25% of any proceeds of the action, plus attorney's fees and costs. The amount of the award depends on the individual's contributions to the success of the case. If the government declines to pursue the case, the qui tam plaintiff will be entitled to between 25% and 30% of the proceeds if successful, plus reasonable expenses and attorney's fees and costs awarded against the defendant. On the other hand, if the qui tam plaintiff is unsuccessful and the court finds that the lawsuit was clearly frivolous, clearly vexatious, or primarily for the purpose of harassment, it may reward the defendant in the action reasonable expenses and attorney's fees. Whether or not the government proceeds with the lawsuit, if the court finds that the qui tam plaintiff planned and initiated the violation upon which the lawsuit was brought, the court may reduce the share of the proceeds, which the person would have otherwise received. If the qui tam plaintiff is convicted of criminal conduct arising from his or her role in the violation, he or she will be dismissed from the civil lawsuit and shall not be paid any proceeds.

- f. **ANTI-RETALIATION PROTECTIONS FOR WHISTLEBLOWERS UNDER THE FCA:** *Any individual associated with an organization who observes activities or behavior that may violate the law in some manner and who reports their observations either to management or to governmental agencies is provided protections under the law.* Whistleblowers initiating a qui tam action may not be discriminated or retaliated against in any manner by their employer. Any employee, who is discharged, demoted, suspended, threatened, harassed, or confronts discrimination in furtherance of a qui tam action, or as a consequence of whistleblowing, are entitled to all relief necessary to make the employee whole.
- g. **SOCIAL SECURITY ACT:** The Social Security Act allows the Secretary of Health and Human Services to seek civil monetary penalties and assessments for many types of conduct. The Secretary of Health and Human Services has delegated many of these civil monetary penalties to the Office of Inspector General (OIG). In most of the cases permitting civil monetary penalties, the OIG may also seek exclusion from participation in all federal healthcare programs.
- h. **ADDITIONAL FRAUD AND ABUSE PENALTIES:**
 - 1) Exclusion: Under the Exclusion Statute, the OIG must exclude from participation in all Federal health care programs any provider and suppliers convicted of certain offenses, e.g., Medicare fraud, felony health care-related fraud, theft or other financial misconduct. The OIG also has discretion to impose permissive exclusion on other grounds, e.g., misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud, submission of false or fraudulent claims to a Federal health care program, engaging in unlawful kickback arrangements.

Excluded providers may not participate in Federal health care program for a designated period. We may not bill for an excluded provider's services.

- 2) Civil Monetary Penalties Law: The Civil Monetary Penalties Law authorizes CMPs for a variety of health care fraud violations. This law authorizes different penalties and assessments based on the type of violations.

i. STATE FALSE CLAIMS LAWS:

- 1) The Kansas False Claims Act (KFCA) allows the Kansas Attorney General (KAG) to file civil lawsuits to recover funds obtained fraudulently from State and Local governments, including Medicaid payments.
- 2) Under the KFCA, individuals and entities can be liable for: (1) knowingly making a false or fraudulent claim for payment or approval; (2) knowingly using or submitting false records or statements to get a false or fraudulent claim for payment; (3) knowingly using or submitting false records or statements to conceal, avoid, or decrease an obligation to pay; (4) knowingly delivering less property or money than commissioned; (5) knowingly making or delivering a receipt that falsely certifies property; (6) knowingly buying or accepting an obligation for public property from a person not authorized to sell or pledge the property; (7) benefitting from a fraudulent claim and failing to disclose the false claim; and (8) conspiring to commit any of these actions.
- 3) The KFCA defines “knowingly” as actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, or acting in reckless disregard of the truth or falsity of the information, but proof of specific intent to defraud is not required.
- 4) The KAG’s Office may bring an action up to three (3) years after the date material facts become known, or should be known, to the State, or up to six (6) years after a violation, but in no event more than ten (10) years. Any wrongdoer will be liable for three (3) times the amount of actual damages, a civil penalty of up to \$11,000 per violation, and costs and fees associated with the civil litigation. The court may not fine a wrongdoer more than two (2) times the amount of damages in cases where the wrongdoer provides complete information within thirty (30) days of the violation, the wrongdoer fully cooperates with the investigation, and no legal action has already commenced.
- 5) **ANTI-RETALIATION PROTECTIONS FOR WHISTLEBLOWERS UNDER THE KFCA:** *The KFCA establishes specific protections for employees or whistleblowers who report a violation of the State law. Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner retaliated against by the employer shall be entitled to all relief necessary to make the employee whole. Unlike the Federal FCA, the KFCA does not include any qui tam provisions.*

6) KANSAS MEDICAID FRAUD CONTROL ACT:


- a. The Kansas Medicaid Fraud Control Act (KMFC) allows the KAG’s Office to file lawsuits to recover Medicaid payments. The KMFC defines a false claim to the Medicaid program as “knowingly and with the intent to defraud, engaging in a pattern of making, presenting, submitting, offering or causing to be made, presenting, submitting, or offering any false or fraudulent claim, statement, representation, report, book, record, document, data, or instrument.” The KMFC also defines unlawful acts related to the Medicaid program as “knowingly and

intentionally soliciting or receiving any remuneration, including a kickback, bribe or rebate, directly or indirectly, in cash or in any kind for certain acts.”

- b. The KMFC also requires HRHS to maintain records, which fully disclose the nature of goods, services, items, facilities or accommodations for which a claim is submitted or a payment received, or the income or expenditures upon which rates of payment were based. Negligence in maintaining records along with intentional destruction or concealment of records can all lead to punishment.
- c. KMFC violations are criminal offenses punishable by imprisonment, fines and payment of full restitution to the State of Kansas, plus interest and all reasonable expenses.

VI. REFERENCES:

Section 1902 (68) of the Social Security Act
Federal False Claims Act, 31 U.S.C. §§ 3729-3733.
Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812.
Anti-kickback Statute, 42 U.S.C. §1320a-7b(b)
Stark Laws, 42 U.S.C. §1395nn
Criminal Health Care Fraud, 18 U.S.C. §1347
Exclusion, 42 U.S.C. §1320a-7
Civil Monetary Penalties Law, 42 U.S.C. §1320a-7a
Kansas False Claims Act, K.S.A. §§ 75-7501 through 75-7511.
Kansas Medicaid Fraud Control Act, K.S.A. §§ 21-3844 through 21-3855.

	Manual	HRHS
	Section (Department)	Compliance/Legal
	Title	Fraud, Waste and Abuse
	Number	SYS:CCE012
	First Approved Date	09/27/2017
	Most Recent Revision	July 10, 2020
	Most Recent Review	

I. PURPOSE

This policy explains fraud, waste and abuse (“FWA”) and your obligation to report FWA.

II. POLICY

1. We conduct our business by legal and ethical means. We do not allow FWA. Accordingly, the following apply to all workforce members:

- A. We do not knowingly present, or cause to be presented, false claims to obtain reimbursement for our services.
- B. We only submit claims (i) For medically necessary services; (ii) Coded to the level supported by our medical records; (iii) For services actually provided; and (iv) That comply with regulatory or contractual requirements.
- C. We do not give or accept anything of value in exchange for referrals or as an inducement for referrals. We only accept referrals based on our ability to render the needed services. Similarly, when we make referrals, we do not consider the volume or value of referrals the provider has made (or may make) to us.
- D. Unless approved by the Compliance Officer, we do not offer or give anything of value to any person eligible for Federal health care program benefits.

2. Workforce members must report violations of the above, or any other real or suspected FWA.

3. We prohibit workforce members from intimidating, or taking any retaliatory action against any person who makes a good faith report of FWA.

4. We cooperate with federal or state agencies conducting fraud and abuse investigations.

A. Definitions (if applicable)

Abuse means careless practices that result, directly or indirectly, in unnecessary costs to a health care benefit program. This includes improper payment, payment for substandard care, or services that are medically unnecessary.

Chain of Supervision means the order in which we assign authority, e.g., your immediate supervisor, his or her supervisor and so on through all other supervisory personnel (e.g., Chief

Administrative Officer, other corporate officers (e.g., Vice Presidents, Horizons' CEO), and Human Resources.

Federal health care programs mean Medicare (including Part C), Medicaid and any other plans or programs that provide health benefits, whether directly through insurance, or otherwise, which the United States Government funds directly, in whole or in part.

Fraud¹ means the intentional submission of false statements or making misrepresentations of fact to obtain payment from a health care benefit program for which there is no entitlement.

Health care benefit program means any insurance company or other payer, especially Federal health care programs.

HRHS means Hutchinson Regional Medical Center, Inc.; Hospice and Home Care of Reno County; Horizons Mental Health Center, Inc.; and Health-E-Quip. "HRHS", "our", "us" or "we" means each company, either by itself or together, as the usage requires.

Waste means the over use or misuse of resources, or other practices that, directly or indirectly, result in unnecessary costs to a health care benefit program.

Workforce Members mean all officers, supervisory personnel, employees, contractors, agents and any other persons who work on our behalf. It includes volunteers, business associates, Medical Staff, and Board members.

III. SCOPE

This policy applies to all workforce members and all HRHS entities.

IV. GUIDELINES

For examples of other possible false claims or other unlawful acts, see our Deficient Reduction Act Section 6032 Compliance Policy.

V. PROCEDURE

A. What to Report.

1. Abuse. Abuse involves payment for items or services when there is no legal entitlement to the payment, but only if the provider has not knowingly misrepresented facts to obtain payment. The distinction between "fraud" and "abuse" depends on a person's intent and prior knowledge.

Examples include, but are not limited to the following:

¹ Fraud is statutorily defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

- Billing for medically unnecessary services
- Billing for brand name drugs when generics are dispensed
- Misusing codes on a claim, such as unbundling or upcoding

2. Fraud. Fraud requires “knowledge” that you are not entitled to receive any requested payments. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to a health care benefit program, but they do not require the same intent or knowledge as fraud.

Examples include, but are not limited to the following:

- Billing for services not provided
- Intentional incorrect coding to maximize payment
- Paying for referrals of Federal health care program beneficiaries
- Knowingly billing for services at a higher level of services than actually provided
- Knowingly altering claims forms, medical records, or receipts to receive a higher payment

3. Waste. Waste does not result from criminal actions, but rather from the misuse of resources. Instances of waste are typically unintended and would be considered abuse, or fraud if found to be done intentionally.

Examples include, but are not limited to the following:

- Unintentionally filing duplicate claims
- Performing unnecessary diagnostic procedures

B. Why We Report.

1. It is the right thing to do.

2. The federal and state governments have enacted criminal, civil and administrative laws that prohibit the submission of false or fraudulent claims. **These laws also make it unlawful to retaliate against any person who reports FWA.**

Federal laws governing fraud and abuse include:

- False Claims Act (FCA);
- Anti-Kickback Statute (AKS);
- Physician Self-Referral Law (Stark Law);
- Social Security Act; and
- United States Criminal Code.

The Federal government uses these laws to impose criminal and civil remedies against persons who commit fraud and abuse. Violating these laws may result in nonpayment of claims, Civil Monetary Penalties (CMPs), exclusion from participation in Federal health care programs, and

criminal and civil liability. This liability can exist without proof of actual knowledge or a specific intent to violate the law.

To learn more about these laws, see our 2005 Deficit Reduction Act (DRA) Section 6032 Compliance Policy (DRA policy); and our policy entitled “Compliance with the Federal Anti-Kickback Statue and Stark Law”, # SYS:CCE128.

C. How to Report.

1. Right to Report. Workforce members must report suspected fraud, waste or abuse. *However, we cannot require you to report to us.* You have the right to report FWA directly to federal or state authorities. However, we encourage you to consider reporting to us first, but the choice is up to you.

2. Internal Reporting.

A. You may report to the Corporate Compliance & Ethics (CCE) Department, your chain of supervision, or to RL6 or the Compliance Hotline (*especially if you do not want us to know who you are, or you are not comfortable discussing it with us directly*).

B. In addition, you may report to any member of the HRHS Compliance Committee (you can find a listing of the current members of this committee – and contact information – on the Intranet’s Corp. Compliance tab).

3. External Reporting. If you do not report to us, you may report FWA to the government. If the FWA involves a Medicare program, report to the Office of Inspector General (OIG). The OIG Hotline allows you to report without telling them your name. If the FWA involves a Medicaid program, report to the Kansas Attorney General’s Office.

OIG Hotline: 1-800-HHS-TIPS (1-800-447-8477); TTY: 1-800-377-4950

Mail: US Department of Health and Human Services, Office of Inspector General ATTN: OIG HOTLINE OPERATIONS P.O. Box 23489 Washington DC 20026

KS Attorney General – Medicaid Fraud and Abuse Division: 1-866-551-6328, or 785-368-6220

4. We log all FWA allegations that we receive.

D. Internal Efforts.

1. We develop policies and procedures to prevent and detect FWA. This includes promoting our Core Values, our Code of Conduct, training and our use of internal and external audits.

2. We provide copies of this policy and the DRA policy to our contractors and agents. We ask them to promote our confidential reporting mechanisms to the staff they assign to work on our behalf.
3. We provide the appropriate authorities with information they need to prosecute fraud and abuse.

E. FWA Investigations.

1. We investigate all FWA allegations.
2. The CCE Department or outside legal counsel will investigate all FWA allegations.
3. We prohibit any effort to interfere with FWA investigations.
4. After an investigation, the CCE Department (or outside legal counsel) will report actual fraud or abuse to appropriate authorities. Once we complete an investigation, we will provide a summary of our findings to the person who told us about the FWA.
5. We will promptly develop a corrective action plan to resolve actual FWA. See SYS:CCE005.

F. Non-Retaliation.

1. We do not retaliate against anyone who (in good faith) reports actual or suspected FWA. See Non-Retaliation policy, # SYS:CCE006.
2. We protect workforce members from retaliation for assisting appropriate authorities or us with a FWA investigation.
3. Federal and State laws also provide for other remedies if someone suffers retaliation for lawful acts done under these laws.

VI. REFERENCES

Code of Conduct
18 U.S.C. 1347
Chapter 21, Medicare Managed Care Manual
Business Courtesies & Vendor Relations, SYS:CCE008
Conflicts of Interest – Employees, SYS:CCE010