

## POLICY AND PROCEDURE ON ANTI-FRAUD

### **PURPOSE**

The purpose of this policy is to provide information regarding the prevention, elimination, monitoring, and reporting of fraud, abuse, and improper activities of government funding in order to obtain and maintain integrity of public funds.

### **POLICY**

A holder of a license that is issued by Minnesota Department of Human Services (DHS), pursuant to MN Statutes, chapter 245A [Human Services Licensing Act], and who has enrolled to receive public governmental funding reimbursement for services is required to comply with the enrollment requirements as a licensing standard (MN Statutes, sections 245A.167 and 256B.04, subdivision 21). PHASE is a provider of services to persons whose services are funded by government/public funds.

Government funds may be from state or federal governments, to include, but not be limited to: Minnesota's Medical Assistance, Medicaid, Medicare, Brain Injury (BI) Waiver, Community Alternative Care (CAC) Waiver, Community Alternatives for Disabled Individuals (CADI) Waiver, Developmental Disability (DD) Waiver, Elderly Waiver (EW), and Minnesota's Alternative Care (AC) program. PHASE has a longstanding practice of fair and truthful dealing with persons served, families, health professionals, and other businesses. Management, staff, contractors, and other agents of the company shall not engage in any acts of fraud, waste, or abuse in any matter concerning the company's business, mission, or funds.

### **I. PROCEDURE**

- A. Definition: Types of fraud, abuse, or improper activities include, but are not limited to, the following:
  - 1. Billing for services not actually provided.
  - 2. Documenting clinical care not actually provided.
  - 3. Paying phantom vendors or phantom staff.
  - 4. Paying a vendor for services not actually provided.
  - 5. Paying an invoice known to be false.
  - 6. Accepting or soliciting kickbacks or illegal inducements from vendors of services, or offering or paying kickbacks or illegal inducements to vendors of services.
  - 7. Paying or offering gifts, money, remuneration, or free services to entice a Medicaid recipient to use a particular vendor.
  - 8. Using Medicaid reimbursement to pay a personal expense.
  - 9. Embezzling from the company.
  - 10. Ordering and charging over-utilized medical services that are not necessary for the person served.
  - 11. Corruption.
  - 12. Conversion (converting property or supplies owned by the company to personal use).
  - 13. Misappropriation of funds of the company or person served by the company.
  - 14. Personal loans to executives.
  - 15. Illegal orders.
  - 16. Maltreatment or abuse of persons served by the company (See Policy and Procedure on Reporting and Review of Maltreatment of Vulnerable Adults and/or Policy and Procedure on Reporting and Review of Maltreatment of Minors for reporting guidance).
  
- B. Public Funds Compliance Officer (i.e., Corporate Compliance Officer): This Company has designated the CEO as their Public Funds Compliance Officer/Corporate Compliance Officer. The HR Director acts as the Company's Co-Corporate Compliance Officer.
  
- C. Reporting responsibility: The Company has a Corporate Compliance policy and Code of Ethics, which encourages and provides the positions and/or parties to whom staff can share their questions, concerns, suggestions, or complaints regarding the company and its operations. In most cases, this will be a staff person's supervisor. However, the Company identifies alternative parties the staff can report to, including the Corporate Compliance Officers and those outlined in the Employee Handbook. At any time, the staff may speak with an applicable external agency to express their concerns if it is believed that it is not possible to speak with any of the parties identified above. Examples of applicable external

agencies are local social service agency's financial manager or law enforcement. This policy is intended to encourage and enable persons to raise serious concerns within the company prior to seeking resolution outside it.

- D. Requirement of good faith: Anyone filing a complaint concerning a violation or suspected violation of the law or regulation requirements must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.
- E. Confidentiality: Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.
- F. No retaliation: No staff person who in good faith reports a violation of a law or regulation requirements will suffer harassment, retaliation, or adverse employment consequences. A staff that retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.
- G. Report acknowledgement: The Public Funds Compliance Officer/Corporate Compliance Officer, or designee, will acknowledge receipt of the reported violation or suspected violation by writing a letter (or email) to the complainant within ten (10) business days, noting that the allegations will be investigated. The Company shall work to complete the complaint investigation, including providing a direct response to the individual lodging the complaint, within fifteen (15) business days.
- H. Responding to allegations of improper conduct: The Public Funds Compliance Officer is responsible for responding to allegations of improper conduct related to the provision or billing of Medical Assistance services. This may include, but is not limited to: investigating, interviewing applicable individuals involved, reviewing documents, asking for additional assistance, seeking input on process of the investigation, or seeking input on Medical Assistance laws and regulations interpretations to address all staff complaints and allegations concerning potential violations. The CEO will take on functions of the Public Funds Compliance Officer role if the complaint involves the COO, HR Director or the CFO. If the complaint involves the CEO, the HR Director will carry out the functions of the Public Funds Compliance Officer/Corporate Compliance Officer, and may enact the services of outside legal counsel, Board Chair Person or an applicable external agency to carry out these functions. The Board of Directors shall respond as appropriate to the investigation results and recommendations.
- I. Evaluation and monitoring for internal compliance: On a regular schedule and as needed, the CFO will run routine financial reports to review financial information for accuracy and compliance. On a regular schedule and as needed, the CEO, or its designee, will review standard operations and procedures to ensure that they remain compliant.
- J. External auditing for compliance: On a regular schedule, the company will have an external financial audit.
- K. Promptly reporting errors: The Public Funds Compliance Officer shall immediately notify appropriate individuals of all reported concerns or complaints regarding corporate accounting practices, internal controls, or auditing. The CEO will promptly report to DHS any identified violations of Medical Assistance laws or regulations.
- L. Recovery of overpayment: Within 60 days of discovery by the company of a Medical Assistance reimbursement overpayment, a report of the overpayment to DHS will be completed and arrangements made with DHS for the Department's recovery of the overpayment.
- M. Training: Staff members are trained on this policy and as needed, they may be re-trained. As determined by the company, staff may need to demonstrate an understanding of the implementation of this policy.
- N. Documentation: The provider must maintain documentation that, upon employment and annually thereafter, staff providing a service have attested to reviewing and understanding the following statement: "It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49."

