False Claims Recovery Policy

HMSA must provide information about the following subjects to all HMSA employees and HMSA contractors and agents, who, on behalf of The HMSA Plan for QUEST Members, furnish (or authorize the furnishing of) healthcare items, perform billing or coding functions, or are involved in monitoring of healthcare provided to HMSA QUEST members.

- The federal and state false claims acts
- Administrative remedies for false claims and statements
- State laws pertaining to civil or criminal penalties for false claims and statements
- Whistleblower protections
- The role of the federal and state false claims acts in preventing and detecting fraud, waste and abuse in federal healthcare programs
- HMSA policies and procedures for detecting and preventing fraud, waste and abuse

Federal False Claims Act

The federal False Claims Act is a federal law that applies to fraud involving any contract or program that is federally funded, including Medicare and Medicaid. The act established liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the United States government for payment.

The federal False Claims Act covers the following HMSA healthcare programs:

- The HMSA Plan for QUEST Members
- HMSA's 65C Plus and Medicare-based plans
- HMSA's Medicare Rx
- Federal Employee Program (FEP)
- Federal Plan 87

"Knowingly" defined

Under the federal False Claims Act, "knowingly" is defined to mean that a person

- Has actual knowledge of false information on the claim;

- Acts in deliberate ignorance of the truth or falsity of the information on the claim; or
- Acts in reckless disregard of the truth or falsity of the information on the claim.

The federal False Claims Act does not require proof of a specific intent to defraud the United States government. Instead, entities can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government. Examples include knowingly making false statements, falsifying records, double-billing for items or services, or submitting bills for services or items never furnished.

"Claim" defined

Under the federal False Claims Act, a claim includes any request or demand for money that is submitted to the United States government or its contractors.

Liability

Healthcare entities (persons and organizations) that violate the federal False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted to the United States government or its contractors.

Qui tam "whistleblower" provision

The federal False Claims Act includes a *"qui tam,"* or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the United States government.

Qui tam procedure

The whistleblower (also known as a relator) must file a lawsuit on behalf of the government in a federal district court. The lawsuit is kept confidential while the government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

Rights of parties to qui tam actions

If the government determines that the lawsuit has merit and decides to intervene, the U.S. Department of Justice will direct the prosecution of the lawsuit. The relator can continue the lawsuit on his or her own if the government decides not to intervene.

Award to qui tam relators

If the lawsuit is successful and certain legal requirements are met, the relator may receive an award that ranges from 15 percent to 30 percent of the amount recovered by the government. The relator may also be entitled to reasonable expenses, including attorney fees and costs for bringing the lawsuit.

Protection from retaliation

The federal False Claims Act protects relators from retaliation that results from filing an action under the Act, investigating a false claim, or providing testimony for (or assistance in) a federal False Claims Act action. In the event of retaliation, the relator is entitled to additional relief, including employment reinstatement, back pay and other compensation.

Hawaii False Claims Act

The state of Hawaii enacted the Hawaii False Claims Act to help the state government combat fraud and recover losses from fraud in state programs, purchases or contracts.

Actions that violate the Hawaii False Claims Act include:

- Submitting a false claim for payment
- Making or using a false record to get a false claim paid
- Conspiring to make a false claim or get one paid
- Making or using a false record to avoid payments owed to the state government

An individual (qui tam plaintiff) can sue for violations of the Hawaii False Claims Act. The individual may receive a percentage of the total amount recovered by the state government. The Hawaii Whistleblower Protection Act protects qui tam plaintiffs from retaliation.

HMSA's Benefits Integrity Department

HMSA combats healthcare fraud and abuse by investigating complaints, conducting proactive case development, raising awareness of new anti-fraud initiatives through internal training, and strengthening provider and vendor contract language. HMSA's Benefits Integrity Department (Benefits Integrity) is

responsible for spearheading efforts to detect, investigate and prevent fraud and abuse.

Benefits Integrity supports HMSA's compliance with contracts and government programs through activities that identify, prevent and reduce fraudulent and/or abusive conduct against all of HMSA's healthcare plans.

Benefits Integrity also reviews pertinent rules, regulations, policies and provisions, including but not limited to the following, to ensure compliance:

- Federal laws, regulations and agency instructions;
- Hawaii state statutes; and
- HMSA provider contracts, plan certificates, handbook and manuals.

HMSA's Benefits Integrity is responsible for the following activities:

Detection of potential fraud or abuse

Benefits Integrity uses the following mechanisms to detect potential fraud or abuse:

- HMSA's Fraud hotline, (808) 948-5166, is available for HMSA members and providers, and the general public to report possible fraud and abuse. Benefits Integrity staff monitors the hotline during business hours, and the hotline is connected to a voice mail system after business hours. A toll-free Compliance and Ethics hotline, 1 (800) 749-4672, may also be used to anonymously report potential fraud and abuse.
- Correspondence from HMSA members and providers, and other parties that indicate possible fraud and abuse
- Proactive review and analysis of claims and other types of data
- Referrals from other HMSA departments and outside entities, including Blue Cross Blue Shield plans and government agencies

Investigation of reported incidents involving fraud and abuse

HMSA's Benefits Integrity reviews reported incidents of fraud and abuse and performs the following:

- Conducts investigations to substantiate or refute the reported incidents
- Identifies overpayments for recovery

- Implements corrective actions, which may include, but are not limited to, contract termination and referral to the appropriate government or law enforcement agencies.

Prevention of fraud and abuse

HMSA's Benefits Integrity prevents fraud and abuse through:

- Recommending and implementing claims processing safeguards
- Utilizing an effective proactive investigation program using up-to-date technology and investigative techniques
- Conducting on-site provider visits
- Discussing fraud issues with external organizations such as the National Health Care Anti-Fraud Association (NHCAA) and the Blue Cross Blue Shield Anti-Fraud Advisory Board (NAAB)
- Conducting HMSA employee education on fraud and abuse prevention, recognition and reporting