



## Anti-Fraud

### I. 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.

### II. 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). Intercommunity Home Health Care is a provider of Government funds may be from state or federal governments, to include, but not be limited to: Minnesota's Medical Assistance, Medicaid, Medicare, Brian 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. Intercommunity Home Health Care 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 Intercommunity Home Health Care shall not engage in any acts of fraud, waste, or abuse in any matter concerning Intercommunity Home Health Care business, mission, or funds.

### III. 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.



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8. Using Medicaid reimbursement to pay a personal expense.
  9. Embezzling from Intercommunity Home Health Care.
  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 Intercommunity Home Health Care to personal use).
  13. Misappropriation of funds of Intercommunity Home Health Care or person served by Intercommunity Home Health Care.
  14. Personal loans to executives.
  15. Illegal orders.
  16. Maltreatment or abuse of persons served by Intercommunity Home Health Care.
- B. Public Funds Compliance Officer: This organization has designated The Chief Compliance Officer as their Public Funds Compliance Officer.
- C. Reporting responsibility: Intercommunity Home Health Care has an open door policy and encourages staff to share their questions, concerns, suggestions, or complaints regarding Intercommunity Home Health Care and its operations with someone who can address them properly. In most cases, this will be a staff person's supervisor. However, if the staff person is not comfortable speaking with their supervisor or is not satisfied with the supervisor's response, the staff person is encouraged to speak with the Public Funds Compliance Officer. If the staff is not comfortable speaking with the Public Funds Compliance Officer, the staff is encouraged to speak with the CEO/Board of Directors. 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 the CEO/Board of Directors. 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 Intercommunity Home Health Care 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.



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- 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 who 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, 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.
- 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 Chief Compliance Officer. If the complaint involves both the CEO and The Chief Compliance Officer, outside legal counsel or an applicable external agency will carry out the functions of the Public Funds Compliance Officer. The Chief Compliance Officer or designee will implement corrective action to remediate any resulting problems
- I. Evaluation and monitoring for internal compliance: On a regular schedule and as needed, The Chief Compliance Officer, or designee, will run routine financial reports to review financial information for accuracy and compliance. On a regular schedule and as needed, The Chief Compliance Officer, or designee, will review standard operations and procedures to ensure that they remain compliant
- J. External auditing for compliance: On a regular schedule, Intercommunity Home Health Care will have an external financial audit



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- 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. This may include the Chief Financial Officer, the CEO, or the Chairperson of the Board of Directors. The Chief Compliance Officer will promptly report to DHS any identified violations of Medical Assistance laws or regulations.
- L. Recovery of overpayment: Within 60 days of discovery by Intercommunity Home Health Care 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 are trained on this policy and as needed, they may need to be re-trained. As determined by Intercommunity Home Health Care, staff may need to demonstrate an understanding of the implementation of this policy.

### *Acknowledgement of Receipt*

As the Worker, I have reviewed the above policy in the Manual. I understand that Intercommunity Home Health Care requires that I be trained on the rights of consumers and duties of workers related to the use and disclosure of protected health information. I agree to comply with all policies and procedures. I understand that severe civil and criminal penalties (up to ten years imprisonment and a \$250,000 fine) may be imposed for violation of these regulations.

Worker Signature:

Date:

Representative Signature:

Date: