GOVERNMENT PROGRAMS COMPLIANCE POLICY

Title: Federal and State False Claims Acts and Whistleblower Protections	**Policy No**: **014**
	Effective Date: 12/8/15

Policy Applies to the Following Products with an "X":					
X	Medicare Part D (PDP) (as applicable includes Group)	X	Medicare Advantage and Part D (MAPD) (as applicable includes Dual-Special Needs Plan (D-SNP) and Group)	X	Medicare Medicaid Plan (MMP)
X	TX - State of Texas Access Reform (STAR) STAR Kids/Children's Health Insurance Plan (CHIP) (TX Medicaid)	X	NM - Turquoise Care (NM Medicaid)		
X	IL - Blue Cross Community Health Plans (IL Medicaid)				

Owners:		
Kim Green	Government Programs Compliance Officer	Government Programs Compliance

Approved:

HCSC Board of Directors

Purpose

The purpose of this policy is to articulate Health Care Service Corporation's (HCSC) commitment to compliance with Sections 6031 and 6032 of the Deficit Reduction Act and 1902(a)(68) of the Social Security Act relating to the establishment and communication of policies and information concerning Federal and State False Claims Acts and Whistleblower Protections.

Scope

This policy applies to HCSC employees, contractors, agents, and contingent workers who administer or deliver a benefit of the government programs referenced in the Policy Application section above, including the chief executive and senior administrators, managers, governing body members, subcontractors, temporary workers, and first-tier, downstream, and related entities (FDRs).

Policy

HCSC is committed to operating its business in a manner that respects and obeys all applicable laws, regulations, and contractual obligations, including but not limited to the Deficit Reduction Act of 2005, the Federal False Claims Act (FCA), applicable state false claims acts, and the Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Program.

HCSC expects a high level of ethics and integrity from its employees, contractors, agents, and temporary workers every day, including adherence to the principles of the Compliance Program Charter (Compliance Program) and the Code of Ethics and Conduct (Code) when making business decisions.

The HCSC Workforce and Employment Policies are located on the company intranet web site, The Hub, and contain employee-specific policies and procedures.

HCSC maintains information about the Federal FCA, state false claims acts, and other laws implicating fraud, waste, and abuse (FWA) or other wrongdoing in Appendix B to the Compliance Program.

HCSC provides general compliance as well as FWA training to all employees, temporary workers, agents, and contractors upon hire and annually thereafter. This training is mandatory for all employees and is

closely monitored to ensure compliance. This training includes information on the federal and state false claims acts, as applicable, and the role of such laws in preventing and detecting FWA in federal health care programs. Employees, contractors, and agents performing services under a Medicare, MMP, DSNP, or Medicaid contract also receive training, as applicable, including additional education related to the Federal FCA and whistleblower protections under those laws upon hire and annually thereafter. In addition, the Special Investigations Department (SID) has developed web-based fraud awareness training programs, as well as providing instructor-led education on FWA including how to report suspected cases.

The Compliance Program outlines the activities taken to prevent, detect, and deter FWA in our government programs. SID plays an integral role in administering the FWA Program and works closely with Medicare, MMP, DSNP, the state Medicaid operations staff, and Audit Services to administer this program.

HCSC encourages all employees, contractors, agents, and temporary workers to report any concerns regarding the Federal FCA, FWA, or any other potential ethical or compliance matter to a member of the management team or directly to the Corporate Compliance Department by calling the Corporate Integrity Hotline at 1-800-838-2552, sending an email to the department at corporatecompliance@bcbsil.com or using the web reporting tool at www.ethicspoint.com.

HCSC will ensure that all reports of potential FWA are thoroughly investigated, and actions taken to resolve and mitigate any potential problem. All reports to the Corporate Integrity HOTLINE are investigated to determine whether or not a violation of law, federal or state regulations, policy, procedure, or the Code has occurred. Violations are reported to government agencies, as warranted. HCSC cooperates fully with state and/or federal agencies investigations.

Employees, contractors, agents, and temporary workers of HCSC have the right to be protected as whistleblowers. HCSC will not retaliate against any employee, contractor, agent, or temporary worker for reporting any potential compliance concern, in good faith, in accordance with HCSC's policies, procedures, and Code. Additionally, HCSC will not retaliate against any employee, contractor, agent, or temporary worker for taking action under the Federal FCA or any state equivalent. This does not insulate the reporter from disciplinary action if he or she is involved in the reported wrongdoing.

The following information is provided to satisfy the requirements of §6032 of the Deficit Reduction Act of 2005 and 1902(a)(68) of the Social Security Act by providing information related to certain federal and state laws relating to liability for false claims and statements; and protections against reprisal or retaliation for those who report potential wrongdoing. These laws are intended to prevent and control FWA in federal and state health care programs by giving appropriate government agencies the authority to seek out, investigate, and prosecute violations in the three available forums: criminal, civil, and administrative.

Federal False Claims Act – 31 USC §§3729 – 3733 as revised by the Fraud and Enforcement Recovery Act of 2009 (FERA)- Public Law No. 111-21, and the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, 28 USC §2461.

The Federal FCA imposes civil liability on any person or entity who:

- Files a false or fraudulent claim for payments to Medicare, Medicaid, or other federally funded health care program,
- Uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid, or other federally funded health care program,
- Conspires to defraud Medicare, Medicaid, or other federally funded health care program by attempting to have a false or fraudulent claim paid, or
- Knowingly retains an overpayment, improperly avoids an obligation to pay, or decreases an amount of obligation to pay or transmit money to the government.

FERA eliminates the need for the government to show knowledge or an intent to defraud as long as an entity's false statements were material; that is, capable of influencing the payment or receipt of government funds for liability to attach.

If a claim is paid or government funds are received falsely or fraudulently and the wrongdoer knows that

federal funds are at stake, the Federal FCA can be enforced whether or not statements were made to the government, whether or not the government had custody of the money or property at issue, and whether or not the entity intended to get the government to pay or approve the claim.

Liability

A person or entity found liable under the Federal FCA is subject to a civil monetary penalty of between $13,508 to $27,018 as of January 30, 2023 (adjusted annually under 45 C.F.R. Part 102) for each false claim, plus an assessment up to three times the amount of each claim submitted. In addition, criminal penalties may be imposed, including a fine not more than $25,000, imprisonment up to five years, or both. If a person or entity is found liable under the Federal FCA, the Department of Health and Human Services Office of the Inspector General (OIG) may seek to exclude the person or entity from participation in federal health care programs.

Qui Tam and Whistleblower Provisions §3730

A qui tam action allows any private citizen with actual knowledge of allegedly false claims to file a lawsuit on behalf of the United States government. Such persons are referred to as "relators" or "whistleblowers." As an incentive to bring these cases, the law provides that whistleblowers who file a qui tam action may receive a percentage of the money recouped as a reward. This reward, which is a percentage of any monetary recovery, may be reduced, if the court finds that the whistleblower planned and initiated the violation. If the whistleblower is convicted of criminal conduct related to his or her role in preparing or submitting the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds. The act also provides that whistleblowers who prosecute clearly frivolous qui tam claims can be held liable to a defendant for its attorneys' fees and court costs. The amount of the reward also depends on the contribution of the whistleblower to the prosecution of the case.

The qui tam case is initiated by filing the complaint in a federal district court. The complaint remains under seal (confidential) for at least 60 days and will not be served on the defendant. During this time, the government investigates the complaint and gathers additional evidence as necessary to determine if it wishes to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

Anti-discrimination

The Federal FCA also offers whistleblowers certain protection against retaliation. This applies to any employee, contractor, or agent who is terminated, demoted, suspended, or in any way discriminated against because of acts in support of an action under the Federal FCA. Anyone initiating a qui tam case may not be discriminated against or retaliated against in any manner by their employer, including termination, demotion, suspension, or harassment. The employee, contractor, or agent is authorized under the Federal FCA to initiate court proceedings to make themselves whole for any job-related losses resulted from any such retaliation or discrimination. The whistleblower may bring an action in the appropriate federal district court for reinstatement, back pay, and other damages.

Federal Program Fraud Civil Remedies Act of 1986, as revised by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, 28 USC §2461.

The Program Fraud Civil Remedies Act of 1986 (PFCRA) (aka Administrative Remedies for False Claims and Statements) is a statute that establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know:

- Is false, fictitious, or fraudulent,
- Includes or is supported by any written statement that contains false, fictitious, or fraudulent information,
- Includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting statement has a duty to include the omitted fact, or
- Is payment for property or services not provided as claimed.

The federal government may investigate and, with the Attorney General's approval, begin proceeding if the value of money or services involved is $150,000 or less. A hearing must begin within six years from the

submission of the claim. The Act allows for civil monetary sanctions to be imposed in administrative hearings, including penalties of $13,508 to $27,018 as of January 30, 2023 (adjusted annually for inflation) for each claim or statement made and an assessment, in lieu of damages, of not more than twice the amount of the original claim. These penalties are separate from and in addition to any liability that may be imposed under the Federal FCA.

Additionally, a person or entity violates the PFCRA if they submit a written statement which they know or should know:

- Asserts a material fact that is false, fictitious, or fraudulent, or
- Omits a material fact that they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.

Definitions

Abuse: Actions that may, directly or indirectly, result in: unnecessary costs to a Government Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

CHIP: Children's Health Insurance Program.

CMS: Centers for Medicare & Medicaid Services.

(The) Code: Code of Ethics and Conduct. HCSC document, including the Government Programs section, outlining the standards of behavior expected to be followed to maintain compliance to policies and regulations, operate with integrity, and make good and ethical decisions when serving our members and communities.

Debarment: The status of being sanctioned, excluded, prohibited from participation in or terminated from any government program by any government agency.

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (42 C.F.R. §, 423.501).

DRA: Deficit Reduction Act of 2005.

FCA: False Claims Act.

FERA: Fraud and Enforcement Recovery Act.

First-Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare-eligible individual under the Medicare Advantage program or Part D program. (42 C.F.R. § 423.501).

Fraud: 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. (18 U.S.C. § 1347).

FWA: Fraud, waste, and abuse.

Government Contracts Holders: applies specifically to the operations of any Medicare Advantage [including Dual Eligible Special Needs Plans (D-SNPs)], Medicare Part D, Medicare Medicaid Plans (MMPs), held by Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") or any other HCSC subsidiary or affiliate that holds, either now or in the future a contract with CMS.

Government Programs: Operations of any Medicare Advantage, Medicare Part D, Medicare Medicaid Plan (MMP), or Medicaid Contracts.

PFCRA: Program Fraud Civil Remedies Act.

Qui Tam: Short for the Latin phrase "qui tam pro domino rege quam pro se ipso in hac parte sequitur," which roughly translates to "he who brings an action for the king as well as for himself." It is used to describe the court action brought by a whistleblower.

Related Entity: Any entity that is related to a Medicare Advantage Organization (MAO) or Part D sponsor by common ownership or control and:

- Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation,
- Furnishes services to Medicare enrollees under an oral or written agreement, or
- Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period (42 C.F.R. §423.501).

SID: Special Investigations Department.

(The) State: State Medicaid Program.

Temporary Workers: For the purposes of this policy, are defined as HCSC contingent workers classified by HCSC's Procurement and Support Services area as "Staff Augmentation" or "Independent Contractors."

TMFPA: Texas Medicaid Fraud Prevention Act.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Whistleblower: Someone who shares information about potentially fraudulent activity with government officials with the intent to share in the proceeds of any money recouped. Also known as a "relator."

Governing Authorities

Senate Bill 1932 (109th Congress), sections 6031, 6032, 6034, codified at United States Code, Title 42, Sections 1396a(a)(68) and 1396h (the "Deficit Reduction Act of 2005" or "DRA"); United States Code, Title 31, sections 3729 through 3733 (the "Federal False Claims Act"); United States Code, Title 31, sections 3801-3812 (the "Program Fraud Civil Remedies Act"); Public Law No. 111-21 (the "Fraud Enforcement and Recovery Act of 2009" or "FERA"); United States Code, Title 42, Section 1320a-7a ("Civil Monetary Penalties"); United States Code, Title 28, Section 2461 (the "Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015"); 45 C.F.R. Part 102 ("Adjustment of Civil Monetary Penalties for inflation"); [New Mexico] 27-14-1 through 27-14-15 NMSA 1978 New Mexico Medicaid False Claims Act; 30-44-1 through 30-44-8 NMSA 1978 Medicaid Fraud Act; 44-9-1 through 44-9-14 NMSA 1978 Fraud Against Taxpayers Act; [Texas] Texas Human Resources Code, Title 2, Subtitle C, Chapter 32 Medical Assistance Program; 42 C.F.R. Section 1001.952; Texas Medicaid Fraud Prevention Act, Texas Human Resources Code, Title 2, Subtitle C, Chapter 36 Medicaid Fraud Prevention; [Illinois] 740 ILCS 175 (P.A. 96 1304, eff. 7/27/2010, amended 8/17/2012); [Montana] Montana False Claims Act – Mont. Code Ann. 17-8-401, et. seq. [Oklahoma] Oklahoma Stat. tit. 63, § 5053.1(B)

HCSC Government Programs Fraud, Waste and Abuse Program

42 C.F.R. § 438.608(a)(1)(iv)

Review Date	Ratification Date	Author	Description of Changes
04/10/2025	05/28/2025	Lou Crognale, Katie Klein, Jeanene Kerestes, Yvonne Yang	Updated scope, definitions, titles, Committee names & changes relevant to the acquisition
08/29/2024	11/21/2024	Angela McCullough Roni Rierson	Updated NM Medicaid contract name.
09/30/2023	11/14/2023	Denise Anderson	Standardization of language used in all GPC policies, updated Definitions section to ensure inclusion of applicable words/phrases, and minor clarification of language in content.
09/21/2022	11/15/2022	Melissa Lupella	Updated name of Compliance Program, removed unnecessary references to information contained in FYI Blue and removed old reference to an employee handbook.
05/07/2021 04/27/2021	12/07/2021	Melissa Lupella Roni Rierson	Changed name of policy and updated to include Medicare and all Medicaid products. Added OK requirements, regulatory reference to MMP.
09/4/2020	12/08/2020	Suzy Rickard	Updated penalty amounts under False Claims Act and Federal Program Fraud Civil Remedies Act of 1986 per published inflationary adjustments. Added Government Contracts Holders information.
07/03/2019	12/03/2019	Angela Broadway	Removed Medicaid Plans – created new Medicaid specific GPC Policy. Minor grammatical corrections.
8/20/2018	12/04/2018	Meredith Fahrner	Removed reference to MT HELP. Modified section related to the FYIBlue website contents.
10/30/2017	12/05/2017	Chris Buley	Updated penalties for False Claims Acts and update name of IL Medicaid Plans.
09/01/2016	12/06/2016	Chris Buley	Updated policy to include new Montana Medicaid program, added relevant federal and state statutory references, and revised monetary penalties language to include annual inflation increase from recent legislation and regulations.
05/27/2015	12/08/2015	Chris Buley	Created consolidated Government Programs DRA policy to replace individual state policies.