Mayo Clinic Anti-Retaliation Policy

Content Applies To: Arizona, Florida, Rochester, Mayo Clinic Health System

Scope

Mayo Clinic

Purpose

To put forth protections for individuals who report – either internally or externally – violations or other wrongdoings. This includes, but is not limited to, privacy, revenue, finance, research, and employment related concerns.

Policy

Definitions

Retaliatory Behavior

Any behavior intended to intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals who in good faith and in a reasonable manner exercises their rights to report or otherwise disclose compliance concerns or other wrongdoing.

Individual

For the purposes of this policy, an individual includes employees, management, vendors, contractors, patients, volunteers, trainees, and other persons whose conduct is under the direct control of Mayo Clinic, whether or not they are paid.

Policy Statements

Policy Statements

1. Mayo Clinic is committed to its institutional integrity. It is the policy of Mayo Clinic to conduct business in a manner that complies with applicable federal and state laws and meets the highest standards of business and professional ethics. To further encourage this institutional integrity, and to ensure compliance with all applicable state and federal laws, Mayo Clinic does not tolerate retaliatory behavior against any individual who raises a compliance concern.

2. In addition to Mayo Clinic policy, several state and federal laws offer protections for individuals who report concerns related to fraud, waste, or abuse. In compliance with Section 6032 of the Federal Deficit Reduction Act of 2005 and research statutes, Mayo has summarized the role of various federal and state laws in preventing and detecting fraud, waste, and abuse in federal and state health care programs. See attached addendum.

Violations of this Policy

Any employee, regardless of position or title, whom Human Resources determines has engaged in retaliation in violation of this policy will be subject to discipline, up to and including termination of employment.

Procedures

Procedures for reporting fraud, waste, abuse, and other compliance issues:

Any individual who knows of or reasonably suspects an incident of fraud, waste, or abuse regarding Medicare, Medicaid, or any other federal or state health care program, or a violation of any other law or policy, by any Mayo employee, contractor, or agent should immediately report such incidents by using one of the resources below.

- Contact an immediate supervisor, administrator, division or department chair, or appropriate physician leader.

- Contact the Integrity and Compliance Office directly:
Contact the Compliance Office at the employee’s site
Call the toll-free Compliance Hotline:
1-888-721-5391
Calls are anonymous and confidential
Submit a report online:
Reports are anonymous and confidential
Call the Mayo Clinic Director for Compliance:
507-284-9029

Mayo Clinic will make this policy available to all employees as well as contractors and agents. Furthermore, Mayo Clinic will maintain its internal systems and controls to monitor compliance with the laws outlined in this policy and accompanying addendum.

Related Documents

Integrity and Compliance Program Booklet, including Code of Conduct
Animal Welfare Act Reporting Procedure
Research Misconduct Policy

References

Integrity and Compliance Office

Contact

Brenda Mickow
Morgan Vanderburg

Approved by

Legal Department
Privacy Officers
Compliance and Enterprise Risk Management Committee

Addendum: Related Statutes, Rules, and Regulations

Mayo Clinic devotes many resources to preventing and correcting errors. The federal government and many states have enacted False Claims Act laws or other statutes to pursue fraud, waste, and abuse.

- Federal Laws Pertaining to Fraud, Waste, and Abuse

a. Federal False Claims Act:

Summary:
The federal False Claims Act imposes liability on any person or entity who knowingly files a false or fraudulent claim for payment to Medicare, Medicaid or other federally funded government program.

i. “Knowingly” means that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard for whether the information is true or false.
ii. Enforcement of this Act occurs through the filing and prosecution of civil complaints. A person or entity found to have violated the False Claims Act is subject to a civil monetary penalty of not less than $5,500 and not more than $11,000, plus three times the amount of damages the federal government sustained.

iii. The statute allows any private citizens to file a qui tam action, a lawsuit in the name of the United States. If the government elects to pursue the case in its own name, the person who filed the action will generally receive between 15% and 25% of any recovery, depending on the contribution of that person to the prosecution of the case. If the government elects not to pursue the case, the person who filed the action has the right to continue with the case on his or her own and is entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys’ fees.

iv. The law also provides protection for employees who bring or assist with false claims lawsuits if an employer discharges, demotes, suspends, threatens, harasses, or discriminates against the employee based on the employee’s lawful actions with regard to the false claims law. These protections may include reinstatement of the employee at his/her former seniority level, back pay, and compensation for damages.


b. Federal Program Fraud Civil Remedies Act:

Summary:

The Program Fraud and Civil Remedies Act (“PFCRA”) creates administrative remedies for making false claims and false statements to certain federal agencies, including the U.S. Department of Health and Human Services. These penalties are separate from and in addition to any liability that may be imposed under the False Claims Act.

i. Any person who makes, presents, or submits, or causes to be made, presented, or submitted a claim that the person knows or has reason to know is false, fictitious, or fraudulent is subject to civil monetary penalties of up to $5,000 per false claim and an assessment of up to twice the amount claimed.

ii. Any person who makes, presents, or submits or causes to be made, presented, or submitted, a written statement containing a certification of accuracy that the person knows or should know (1) asserts a material fact that is false, fictitious, or fraudulent; or (2) omits a material fact that they had a duty to include and the omission causes the statement to be false, fictitious, or fraudulent is also subject to civil monetary penalties of up to $5,000 per false statement.


c. Research Statute

Summary:

An employee of a contractor, subcontractor, or grantee may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing to a person or body, information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract or grant.

Reference: 41 U.S.C §4712.

II. State Laws Pertaining to Fraud, Waste, and Abuse

The following sections provide the key state laws that pertain to fraud, waste, and abuse across the six different states in which Mayo operates – Arizona, Florida, Georgia, Iowa, Minnesota, and Wisconsin.

a. Arizona

Summary:

While Arizona does not have its own “False Claims Act,” several statutes apply to filing fraudulent claims with the government.

i. It is unlawful for a person to make a claim to the state or to a contractor for an item or service the person knows or has reason to know were not provided, is false or fraudulent, or may not be made by the health care system for reasons such as medical necessity. Civil and/or criminal penalties may apply for violation.

ii. The Arizona Health Care Cost Containment System (“AHCCCS”), the state Medicaid agency, determines the amount of a penalty and assessment for violation.

iii. If an employee is terminated in retaliation for making such a claim or disclosing information in a reasonable manner, the employee may make a claim against the employer.

iv. All Medicaid contractors and non-contracted providers must notify AHCCCS of suspected fraud or abuse. Persons making a complaint of providing information in good faith are immune from civil liability (unless that person is charged with or suspected of fraud or abuse). Failure to report constitutes unprofessional conduct and the appropriate regulatory board may impose discipline.
**b. Florida**

**Summary:**

The Florida False Claims Act ("FFCA") prohibits conduct similar to that addressed under the federal False Claims Act for claims paid from state government funds.

i. It is unlawful to knowingly make, or aid and abet the making of a false statement or false representation of a material fact, by commission or omission, in any claim for payment.

ii. Florida False Claims Act imposes civil fines and treble damages for knowing submission of false claims or knowingly making/using false records or statements to obtain payment for false claim. The penalty for violating the FFCA can range from $5,500 to $11,000 per claim, plus three times the amount of damages that the state sustains because of the act of that person.

iii. Individuals are allowed to file qui tam lawsuits to enforce the FFCA on behalf of the state and are entitled to a portion of the proceeds.

iv. Employees who are discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in terms of their employment because they took lawful acts to stop a violation of this act are protected and can bring suit to recover relief necessary to make them whole, including reinstatement and lost compensation.

References:

Florida False Claims Act, Fla. Stat. § 68.081-.09

Oversight of the integrity of the Medicaid program, Fla. Stat. § 409.913.

Medicaid Provider Fraud, Fla. Stat. § 409.920.


c. Georgia

**Summary:**

Georgia law, specifically the State False Medicaid Claims Act ("SFMC") prohibits conduct similar to that addressed in the federal False Claims Act for payments by the state’s Medicaid program. Sets forth the procedures whereby the state and private citizens acting on behalf of the state, may bring civil actions against entities or individuals who have submitted false or fraudulent claims to the Medicaid program.

i. The SFMCA provides for actions by a private person (a “whistleblower”) who can bring a civil action in the name of the government for a violation of the FCA.

ii. The SFMCA protects whistleblowers from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in the terms and conditions of employment because of lawful acts done by the employee in furtherance of an action under the SFMCA may bring an action in the appropriate court in Georgia seeking reinstatement at the same seniority status, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees.

iii. Under the Medicaid Fraud Statute, it is unlawful for any person or provider to obtain, attempt to obtain, or retain for himself, herself, or any other person any medical assistance or other benefits or payments under this article, or under a managed care program operated, funded, or reimbursed by the Georgia Medicaid program, to which the person or provider is not entitled, or in an amount greater than that to which the person or provider is entitled, when the assistance, benefits, or payment is obtained, attempted, or retained by: knowingly and willfully making a false statement or false representation; deliberate concealment of any material fact; or any fraudulent scheme or device.

iv. It is also unlawful for any person or provider knowingly and willfully to accept medical assistance payments to which he or she is not entitled or in an amount greater than that to which he or she is entitled, or knowingly and willfully to falsely any report or document required under the Medicaid program.

References:

d. Iowa

Summary:

The Iowa False Claims Act ("IFCA") is designed to help the state government combat fraud and recover losses resulting from fraud against public agencies, much like the federal False Claims Act.

i. It is unlawful to knowingly present or cause to be presented false or fraudulent claims for payment or approval; or to knowingly make or use, or cause to be made or used, a false record or statement material to false or fraudulent claim.

ii. Individuals are allowed to file qui tam lawsuits to enforce the IFCA on behalf of the state and are entitled to a portion of the proceeds. If the state decides to pursue the lawsuit, it has the authority to limit the individual's participation if it would interfere or unduly delay the state's prosecution of the case.

iii. Employees, contractors, or agents who are discharged, demoted, suspended, harassed, or otherwise discriminated against in terms of their employment because they took lawful acts to stop a violation of this act are protected and can bring suit to recover relief necessary to make them whole, including reinstatement, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination. The civil action must be brought within three years of the date when the retaliation occurred.

iv. Penalties for violation of the IFCA range from $5,000 to $10,000 for each violation, plus three times the amount of damages sustained by the state as a result of the violation.

In addition to the IFCA, Iowa has additional statutes specific to Medicaid fraud:

i. A person who knowingly makes or causes to be made false statements or misrepresentations of material facts or knowingly fails to disclose material facts in an application for payment of services rendered by a medical assistance provider commits a fraudulent practice.

ii. Regulations provide for sanctions against medical assistance providers for presenting or causing to be presented any false or fraudulent claim for services or merchandise or submitting or causing to be submitted false information for the purposes of obtaining greater compensation than that to which the provider is entitled or to meet preauthorization requirements. Sanctions can include termination or suspension from the program, or suspension or withholding of future payments.

References:


Sanctions Against Provider of Care, Iowa Admin. Code § 441-79.2.

e. Minnesota

Summary:

The Minnesota False Claims Against the State Act ("MFCASA") is a civil statute to help combat fraud and recover losses resulting from fraud against Minnesota.

i. It is unlawful to knowingly present, or cause to be presented, to an officer or employee of the state a false or fraudulent claim for payment or approval; to knowingly make or use, or cause to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state; to knowingly conspire to either present a false or fraudulent claim to the state for payment or approval or make, use, or cause to be made or used a false record or statement to obtain payment or approval of a false or fraudulent claim.

ii. The penalty for violating the MFCASA can range from $5,500 to $11,000 per claim, plus three times the amount of damages that the state sustains because of the act of that person.

iii. Individuals are allowed to file qui tam lawsuits to enforce the MFCASA on behalf of the state and are entitled to a portion of the proceeds.

iv. Employees who are discharged, demoted, suspended, threatened, harassed, denied promotion, or otherwise discriminated against in terms of their employment because they took lawful acts to stop a violation of this act are protected and can bring suit to recover relief necessary to make them whole, including reinstatement, twice the amount of lost compensation, interest on the lost compensation, and special damages sustained as a result of the discrimination, and, if appropriate, punitive damages.

In addition to the MFCASA, Minnesota also has several other provisions applicable to fraud, waste, and abuse:

i. Minnesota’s criminal statute for theft defines theft the act of obtaining property or services by intentionally deceiving a third person with a "false representation" with intent to defraud. "False representation" includes preparing or filing a claim for reimbursement, a rate application, or a cost report used to establish a rate or claim for
payment for medical care provided to a medical assistance recipient, which intentionally and falsely states the costs of or actual services provided by a vendor of medical care.

ii. Any person who, with intent to defraud, submits a false (in whole or in part) claim for reimbursement, a cost report or a rate application relating to the payment of medical assistance funds is guilty of an attempt to commit theft of public funds.

iii. Grounds for sanctions against medical assistance vendors include fraud, theft or abuse in connection with the provision of medical care; a pattern of presentation of false or duplicate claims or claims for services not medically necessary; and a pattern of making false statements of material facts to obtain greater compensation.

iv. Any vendor of medical care who willfully submits a cost report, rate application or claim for reimbursement for medical care which the vendor knows is a false representation and results in payment shall be subject to an action by the state for civil damages of three times the payments resulting from the false representation, plus costs and attorneys’ fees.

v. Department of Human Services outlines rules for investigating vendors regarding allegations of fraud, abuse or theft and what sanctions may be imposed.

References:

Minnesota False Claims Against the State Act, Minn. Stat. §§ 15C.01-.16.

Theft, Minn. Stat. § 609.52, Subd. 2.

Medical Assistance Fraud, Minn. Stat. § 609.466.

Medical Assistance for Needy Persons, Sanctions, Minn. Stat. § 256B.064

Medical Assistance for Needy Persons, Treble Damages, Minn. Stat. § 256B.21

Surveillance & Integrity Review Program, Minn. Rules § 9505.2200-2245

f. Wisconsin

Summary:

The Wisconsin False Claims for Medical Assistance Act ("WFCMA") is a civil statute to help combat fraud and recover losses resulting from fraud against the state’s Medical Assistance program.

i. It is unlawful to present or cause to be presented a false claim for medical assistance to an officer, employee, or agent of the state; to make or use, or cause to be made or used, a false record or statement to obtain approval or payment of a false claim for medical assistance; to conspire to defraud the state by obtaining allowing or payment of a false claim for medical assistance, or by knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Medical Assistance program.

ii. The penalty for violating the WFCMA ranges from $5,000 to $10,000 per claim, plus three times the amount of damages that the state sustains because of the act of that person.

iii. Individuals are allowed to file qui tam lawsuits to enforce the WFCMA on behalf of the state and are entitled to a portion of the proceeds.

iv. Employees who are discharged, demoted, suspended, harassed, or otherwise discriminated against in terms of their employment because they took lawful acts to stop a violation of this act are protected and can bring suit to recover relief necessary to make them whole, including reinstatement with the seniority status they would have had, two times the amount of back pay, interest on the back pay, and special damages sustained as a result of the discrimination.

In addition, Wisconsin has the same prohibitions noted in connection with public assistance and children and family services.

i. It is a Class H felony to knowingly and willfully make or cause to be made any false statement or representation of material fact in any application for medical assistance payment. Penalties include fines and imprisonment as well as treble damages.

ii. Termination or suspension from Medicaid participation is permitted for false statements concerning application for certification or recertification, nature and scope of services provided or costs of services, cost reports, or false statements on claims. Intermediate sanctions are also permitted, including audits and restriction of participation in Medicaid. Permits program to recover payments or withhold future payments.

iii. Withholding of payments to providers upon receipt of reliable evidence of fraud or willful misrepresentation is permitted.

References:

Wisconsin False Claims for Medical Assistance, Wis. Stat. § 20.931.

Medical Assistance Offenses, Wis. Stat. § 49.49