POLICY TITLE **Fraud, Waste, and Abuse Control**	POLICY NUMBER **NATL.EC.011**
ACCOUNTABLE DEPARTMENT **Ethics and Compliance**	EFFECTIVE DATE **01/16/2024**
DOCUMENT OWNER **Vice President, Compliance Investigations**	PAGE **1 of 7**

1.0 Policy Statement

Kaiser Permanente (KP) does not tolerate behaviors or activities that attempt or conspire to perpetrate, aid, abet, or conceal fraud, waste, and abuse. KP assets are used to support the organization's mission of providing high-quality, affordable health care services and improving the health of our members and communities we serve.

2.0 Purpose

KP is committed to complying with all laws and regulations associated with the control of fraud, waste, and abuse, including, but not limited to, the Antikickback Statute and the False Claims Act. This policy sets forth expectations for employees, supervisors, and managers regarding preventing, detecting, and reporting the fraud, waste, and abuse of KP's organizational and government assets.

3.0 Scope/Coverage

This policy applies to all employees who are employed by the following entities (collectively referred to as "Kaiser Permanente"):

3.1 Kaiser Foundation Health Plan, Inc. (KFHP);

3.2 Kaiser Foundation Hospitals (KFH);

3.3 KFHP/H subsidiaries;

3.4 The Permanente Medical Group, Inc. (TPMG); and

3.4.1 This policy does not apply to physicians, podiatrists, vice presidents, or members of the TPMG Executive Staff, who are covered by separate TPMG policies.

3.5 Southern California Permanente Medical Group (SCPMG).

3.5.1 This policy does not apply to physicians of SCPMG.

3.6 This policy also applies to all KFHP/H vendors, contingent workers, subcontractors, volunteers, agents, and directors.

4.0 Definitions

4.1 **Abuse —** Wrongful or improper use of KP or government assets that is inconsistent with accepted, sound medical, business, or fiscal practices and directly or indirectly results in unnecessary costs to KP or the government. Abuse may include abuse of position or authority that causes the loss or misuse of KP assets and may be intentional or unintentional.

4.2 **Asset —** Can be both tangible (physical) and intangible (intellectual). Assets include equipment (for example, cameras, ergonomic equipment, ultrasound equipment, and blood pressure cuffs), furniture, supplies, organization funds (including purchasing cards), electronic devices, voicemail and instant messages, email, knowledge,

information, buildings, identification cards, time, and media sites (including KP's Facebook pages and YouTube channels).

4.3 **Contingent Worker —** An individual who provides services to KP but is not on the KP payroll. Contingent workers are paid pursuant to a contract with an external vendor or supplier and are not eligible to participate in any KP benefit plans or pay plans. Such workers may include, but are not limited to, individuals who provide patient care and allied health services (e.g., registry personnel), administrative/clerical (e.g., temporary agency personnel), IT professional, marketing, light industrial, engineering, telecommunications, and various business professional services. There are six contingent worker types: (1) Temporary Contractors, (2) Independent Contractors, (3) Consultants, (4) Offshore Workers, (5) Offsite Service Workers, and (6) On-Premises Service Workers.

4.4 **Fraud —** Deception or misrepresentation made intentionally or with reckless disregard of the truth, with knowledge or indifference that the deception or misrepresentation could result in some unauthorized or improper benefit for the perpetrator, another individual, or an entity. Fraud occurs when an entity or individual uses deception or misrepresentation to acquire something that does not belong to them. Examples of fraud include, but are not limited to, embezzlement, false claims, kickbacks, bribery, false financial reporting, software piracy, credit card fraud, expense account fraud, identity theft, check fraud, false Worker's Compensation or other false insurance claims, fraudulent vendor billing, member fraud, identity fraud and mail fraud.

4.5 **Suppliers or Vendors —** Includes any individual or organization that offers to supply or sell products or services to KP, including consultants.

4.6 **Waste —** Extravagant, careless, or needless expenditure of KP's or government funds or the improper use of KP assets that results from deficient or negligent practices, system controls, or decisions. Examples of waste include ordering excess inventory or paying a higher price for supplies and services by not using and approved vendor.

5.0 Provisions

5.1 **Employee Responsibilities.** Employees are required to safeguard KP's assets and use them for health care and business purposes in accordance with this policy, the *Electronic Asset Usage, NATL.HR.025* policy, and the *Principles of Responsibility, Kaiser Permanente's Code of Conduct*.

5.1.1 Employees are required to report any suspected fraud, waste, and abuse.

5.2 **Manager and Supervisor Responsibilities.** Managers and supervisors are required to implement and maintain effective internal controls to prevent and detect fraud, waste, and abuse of KP's assets.

5.3 **Ethics and Compliance Investigator.** Investigators are required to submit fraud and/or waste referrals to CMS and other regulatory agencies in accordance with reporting requirements, see details in *Appendix A — Regulatory Agency Notification Requirements*.

5.4 Employee Privileges. Managers and supervisors are required to determine which employees have privileges to access KP's assets and the extent of those privileges.

5.4.1 Establishing Employee Privileges. Employee privileges should be:

5.4.1.1 Position specific (e.g., signing authority, issuance of company credit cards, use of computer and software passwords, keys, cash handling and equivalents).

5.4.1.2 Established to provide an appropriate segregation of duties (e.g., employees may not approve their own invoices).

5.4.1.3 Effectively communicated to the employee along with the responsibilities attendant to the use of KP assets, as well as the limitations of those privileges.

5.5 Accounting of KP Assets. Managers and supervisors are expected to conduct accounting activities for assets under their responsibility.

5.6 Administrative Controls. Managers and supervisors are expected to implement administrative controls to detect the abuse and misuse of KP assets. Such controls include, but are not limited to, proper documentation, approval, and supervision.

5.7 Reports Made to Supervisors and Managers. Supervisors and managers who receive reports from employees or detect known or suspected fraud, waste, and abuse are required to contact their compliance officer (or compliance physician lead, as applicable) to evaluate the allegation or detected concern for appropriate investigation.

6.0 Appendices/References

6.1 Appendices

6.1.1 Appendix A — Regulatory Agency Notification Requirements

6.2 Attachments

6.2.1 Mid-Atlantic States Addendum to KP Fraud, Waste & Abuse Control Policy

6.2.2 National Fraud Risk Assessment Tool

6.2.3 National Fraud, Waste, & Abuse Fact Sheet

6.2.4 One Compliance

6.3 Kaiser Permanente Policies

6.3.1 *Corrective / Disciplinary Action, NATL.HR.014*

6.3.2 *Internal Reporting of Ethics and Compliance Concerns, NATL.EC.004*

6.3.3 *Internal Reporting of Overpayments, Self-Disclosure, and Repayment for Federal Health Program and ACA Funds, NATL.EC.013*

6.3.4 *Non-Retaliation, NATL.EC.003*

6.4 References

6.4.1 Anti-Kickback Statute, 42 U.S.C. §1320a-7b

6.4.2 False Claims Act, 31 U.S.C. §§ 3729-3733

7.0 Approval

This policy was digitally approved by the following representative of Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and their subsidiaries.

Approver:

Jacqueline Baratian
Senior Vice President and Chief Ethics and Compliance Officer

Approval Date: 01/15/2024

Appendix A — Regulatory Agency Notification Requirements

Region	Regulatory Agency and Contractual Plans	Notification Requirements
Contact National Special Investigations Unit (NSIU) to coordinate regulatory referrals		
ALL	Centers for Medicare & Medicaid Services (CMS)	**Fraud:** Any **substantiated** fraud cases involving Medicare member.
ALL	Federal Employee Health Benefit Plan (FEHBP)	**Fraud:** Any **substantiated** fraud Investigation involving a FEHBP member. Report any fraud investigation within **30 business days**.
ALL	KPIC	**Fraud:** Any reasonable reportable fraud Investigation involving a KPIC member. Report, when there is reasonable belief of fraud, within **60 calendar days**.
California	California Department of Insurance (CA DOI)	**Fraud:** Any **substantiated** fraud investigation involving a fully insured KPIC member. Report within **60 days** after determining that a claim appears to be fraudulent.
California	California Department of Managed Care (DMHC)	**Fraud:** Any **substantiated** fraud Investigation in the California, IT, and Program Office regions. (California State Only including other CA Shared Services).
California	California Department of Health Care Services (DHCS)	**Fraud:** Report within **10 business days** when KP was made aware of any fraud Investigation involving a Medi-Cal member.
California	California Public Employees Retirement System (CalPERS)	**Fraud:** Any **substantiated** fraud Investigation involving a CalPERS member.
California	Exchange (CoveredCA)	**Fraud:** Any **substantiated** investigation involving Covered CA Exchange members.

Region	Regulatory Agency and Contractual Plans	Notification Requirements
Contact National Special Investigations Unit (NSIU) to coordinate regulatory referrals		
Colorado	Medicaid (Colorado Access, Colorado Community Health Alliance and Child Health Plan Plus)	**Fraud:** Any **substantiated** fraud Investigation involving a Medicaid (Colorado Access, Colorado Community Health Alliance, and/or Child Health Plan Plus) member. Report any fraud investigation within **10 business days** of case being substantiated **(Colorado Access)**. Report within **3 business days** for member or provider FWA **(Child Health Plan Plus)**. No reporting requirement for **Colorado Community Health Alliance**.
District of Columbia	Medicaid	No reporting requirement.
Hawaii	Medicaid (Med-Quest)	**Fraud:** Any fraud Investigation involving a Hawaii Medicaid (Med-Quest) member. Report any fraud investigation within **14 calendar days** of identifying a suspected fraud.
Northwest	Northwest Medicaid (Health Share of Oregon and CareOregon; PacificSource)	**Fraud**: Any fraud investigation involving a Northwest Medicaid (Health Share of Oregon and CareOregon; PacificSource) member. Report any fraud investigations within **7 calendar days** of suspected fraud, waste or abuse for **Health Share of Oregon and CareOregon (subdelegate) and PacificSource**.
Maryland	Maryland Medicaid (Department of Health)	**Fraud:** Any fraud Investigation involving a Medicaid member and provider. Report any fraud investigation within **15 calendar days** of case being opened.
Virginia	Medicaid (Virginia Premier – Medallion, DMAS)	**Fraud:** Any fraud Investigation involving a Virginia Medicaid (Virginia-Premier, DMAS) member and/or provider. Report any fraud investigation within **48 hours** of case being opened.

Region	Regulatory Agency and Contractual Plans	Notification Requirements
Contact National Special Investigations Unit (NSIU) to coordinate regulatory referrals		
Northwest and Washington	Medicaid (Molina)	Fraud: Any fraud (fraud or abuse, not waste) investigation involving a Northwest or KPWA Medicaid (**Molina**) member. Report any fraud investigations within **5 business days** from when KP was made aware of any fraud Investigation involving a suspected fraud or abuse for **Molina Healthcare of Washington**.