7.0 Compliance & Regulatory Policy

7.1 Our Commitment to Compliance

Kaiser Permanente is committed to meeting the many compliance and regulatory guidelines which are implemented in the best interest of patient quality service and overall care. These compliance and regulatory policies are enforced on the federal, state and/or local government, and health plan levels.

Compliance and regulatory policies represent guidelines, which are both monitored and reported to many outside agencies.

For questions regarding any compliance policy or to obtain a copy of "Principles of Responsibility", a compliance guide available to Participating Providers of Kaiser Permanente, please contact the Provider Experience Department at ☎ 877-806-7470.

7.2 Medical Record-Keeping Practices

All Participating Providers are responsible for maintaining a complete medical record for patients who elect to receive their health care through their offices. The Kaiser Permanente Medical Care Program has developed specific criteria for maintaining the medical record. These standards are a part of the periodic site review done within each network office. The standards for medical record-keeping practices are described in Section 10.8.

7.3 Provider Responsibility for Patient Confidentiality

As providers of Kaiser Permanente, ensuring member confidentiality is the responsibility of all providers. **Before a Kaiser Permanente member is seen in your office, please request Kaiser Permanente ID Card and photo identification to ensure member identification.**

As part of their contract with Kaiser Permanente, all Health Plan members are assured that their personal and medical information remains confidential. Providers must follow the level of confidentiality as stated below in the Confidential Information section. Pursuant to applicable law, Kaiser Permanente protects members' rights to privacy and confidentiality.

The following information is shared with Kaiser Permanente members regarding their rights to privacy and confidentiality:

Confidential Information Distributed to Members
Everyone at Kaiser Permanente knows that protecting your right to privacy is important. You have entrusted us with your personal and medical information. Therefore, we believe that you have the right to know how we keep your information confidential and how we may use it. We also want you to know the many policies and procedures we have in place throughout the entire health care system to protect your right to privacy and confidentiality.

Here are just a few examples of how we manage appropriate and confidential treatment of your information:

1. Kaiser Permanente physicians and employees sign confidentiality statements affirming their commitment to protect your information. Your medical record may only be viewed by those who "need to know" to make decisions about your health treatment.
2. Contractors sign a non-disclosure statement ensuring that they will also protect your information.
3. Your right to confidentiality of your medical records is part of Kaiser Permanente's Member Rights and Responsibilities.
4. You have the right to deny release of personal or medical information, except when required by law.
5. Your right to review your medical records is included in contracts with Kaiser Permanente providers.
6. Before discussing use or the cost of services with your employer or employer representative, we remove any information that could identify you.

We must have your permission or consent to release any information before we can share it for the reasons below. The release must be in writing, explain the exact information to be shared, and signed by you. Member Services can give you more information and a release form:

1. Giving your employer or employer representative information on the status of your claims.
2. Sharing your medical information with an outside party, except when required for legal, regulatory, or plan administration reasons.

We may use your protected information in the following day-to-day functions of Kaiser Permanente:

1. Discussing changes to your membership information with your employer representatives.
2. Giving parents the status of their child's claim (if the child is less than 18 years of age).
3. Providing your name and address to Kaiser Permanente contracted mail houses so you can receive our health education materials as part of our disease management, and self-care and prevention programs, and other health care information.
4. Sharing information with government agencies or other insurers for determining our liability and payment.
5. Supporting medical research for clinical reasons.
6. Using information for professional, tracking, or quality improvement activities.

Note: References to "You" also refer to your authorized representative.

In addition, it is the shared responsibility of all providers and their staff to maintain patient confidentiality as described in the following sections.

7.4 Provider Responsibility to the Member

1. All medical records are confidential, secure, current, authenticated, legible and complete.
2. Medical records are the property of the provider and are maintained for the benefit of the patient, the medical staff and the provider.
3. The provider is responsible for safeguarding both the record and its informational content against loss, defacement, tampering, and from use by unauthorized agents.
4. The patient's written consent (or that of his/her legally qualified representative) is required prior to the release of medical information to persons/entities not otherwise authorized to receive the information.

Authorized uses of medical records include but are not limited to:

1. Automated data processing of designated information.
2. Use in activities concerned with the monitoring and evaluation of the quality and appropriateness of patient care
3. Kaiser Permanente review of work performance
4. Official surveys for compliance with accreditation, regulatory, and licensing standards
5. State and federal regulatory audits
6. Educational purposes

7.5 Discrimination Prohibited

Every Kaiser Permanente Participating Provider is responsible for providing services to members without discrimination on account of race, sex, color, religion, national origin, age, physical or mental disability, or veteran's health status. As a governmental contractor, Kaiser Permanente is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which may be applicable to Participating Providers. Kaiser Permanente is required to give notice to Participating Providers subject to certain federal laws, executive orders, and regulations by incorporating herein by reference the following clauses from the Federal Acquisition Regulation (FAR) at 48 CFR Part 52: (a) Equal Opportunity (Feb. 1999) at FAR 52.222-26; (b) Affirmative Action for Disabled Veterans of the Vietnam Era (April 1998) at FAR 52.222-35; (c) Affirmative Action for Workers with Disabilities (June 1998) at FAR 52.222-36, and (d) Small Business Subcontracting Plan (Oct. 1999) at FAR 52.219-9.

7.6 Notification to Members of Participating Provider Termination

A Specialty Care Physician must give ninety (90) days notice or other as specified in the contract of termination to either the MAPMG Human Resources department (for a MAPMG physician) or to the Provider Experience Department (for a Network physician). Once notice is received, the Personal Physician Program department is responsible for the written notification to all effected members communicating the termination. This written notification must be delivered to effected members thirty (30) days prior to the physician change (effective date)." Primary Care Physicians or Behavioral Health Providers who serve Medicare Advantage patients must provide impacted members with forty-five (45) days written notification prior to the physician termination date.

7.7 Provider Appeals & Grievances Policy

For pre-service and concurrent denials, Participating Providers may act on behalf of a member and may file an appeal or grievance following the procedures listed in Section 5.6 – Member Complaints and Grievances / Appeals. An expedited process is available for appeals and grievances where anticipated services are related to the treatment of a condition that, left untreated, will endanger the life or well-being of the member. Detailed procedures for filing an appeal or grievance are listed in all denial letters.

Each appeal or grievance is reviewed and resolved through the consolidated efforts of all appropriate KPMAS departments in a timely manner, while complying with established Kaiser Permanente operations and regulatory guidelines.

As described in Section 9.7 – Pre-Authorization Denials and Appeals, Participating Providers who disagree with a pre-service or concurrent UM denial may request a reconsideration or may speak with an UM physician, by calling ☎ 800-810-4766, within 24 hours of the verbal

notification of the denial. If more than 24 hours have elapsed, Participating Providers who are acting on behalf of a member may file a grievance or appeal.

Important Note: For Virginia jurisdiction members, a Participating Provider may request a reconsideration using the same process as described in Section 5.6 - Member Appeals and Grievances. A decision will be made as quickly as the member's health requires, but no longer than fourteen (14) business days after receipt of the reconsideration request. For Medicare members, a reconsideration appeal for medical services (pre-service) is 30-calendar days.

Online submission of claim disputes and appeals via Online Affiliate
Kaiser Permanente allows providers to submit disputes and appeals using Online Affiliate. When filing a dispute or appeal online, you will be prompted to complete a form with key information such as:

- Dispute amount
- Dispute reason (drop-down selection)
- Additional details regarding submission
- You may also submit PDF attachments to support your dispute

By submitting online, you will receive an online auto-acknowledgment letter and resolution letter.

To submit electronically or enroll for access to Online Affiliate, navigate to kp.org/providers/mas and select **Online Provider Tools** from the Provider Resources menu.
For Online Affiliate enrollment support or navigation assistance, you may reach out to KP-MAS-OnlineAffiliate@kp.org.

Expedited & Emergency Appeals
Participating Providers may request an expedited appeal or grievance on behalf of a member when anticipated services are related to the treatment of a condition that, left untreated, will endanger the life or well-being of the member. Detailed procedures for filing an appeal or grievance are listed in all denial letters.

Both the member and Participating Provider are eligible to utilize the Expedited Appeal process by calling:

Member Services Department	☎ 800-777-7902
Medicare Members	☎ 888-777-5536
TTY	☎ 711

Written appeals may be faxed to ☎ 404-949-5001 or mailed to the following address:

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305

Post-Service Denials:
For post-service denials, the Participating Provider or member may file a payment dispute request related to a decision to deny all or part of a claim, or the level of payment made on a claim. Payment dispute requests must be filed within one hundred eighty (180) calendar days from the original date of denial or explanation of payment.

Post-service appeals for Medicare are submitted to Member Relations in writing at the address/fax noted above. Medicare appeals are required to be submitted within 60-calendar days from the date of the denial notice.

When acting on behalf of a member, Participating Providers may file an appeal or grievance following the procedures in Section 5.6 – Member Complaints and Appeals/Grievances. Providers will be asked to provide an appointment of representative or other documentation showing written permission from the member to act on their behalf.

Written Appeals & Grievances:
Provider disputes and appeals submitted in writing will need to be sent to:

> **Mid-Atlantic Claims Administration**
> **Kaiser Permanente**
> **PO Box 371860**
> **Denver, CO 80237-9998**

Providers are encouraged to submit provider disputes and appeals using the Kaiser Permanente Online Affiliate portal referenced above and in Section 5.2 – Additional Resources for Providers.

Post-service claim denial provider disputes and appeals are not accepted via fax. That number is only for processing Member Appeals and Expedited and Emergency Appeals on behalf of a member.

Verbal Appeals & Grievances:
Participating Providers and members may file verbal appeals and grievances by calling the Member Services Department at ☎ 800-777-7902.

Medicare grievances and expedited appeals are accepted verbally by calling ☎ 888-777-5536. Standard provider appeals must be submitted in writing following the same procedures outlined in Section 5.6 – Member Complaints and Appeals/Grievances.

Complaint filed at Kaiser Permanente Medical Centers:
Members may also choose to file an appeal or grievance with a Member Services Representative located in most Kaiser Permanente Medical Centers. Members should visit the Administration Office at these Medical Centers.

7.8 Advance Directives

Advance Directives are defined by the Centers for Medicare and Medicaid Services (CMS) as a written instruction, such as a living will or durable power of attorney for health care, recognized under appropriate state law. This section addresses Advance Directives in order to assure compliance with the Federal Patient Self-Determination Act of 1990, which mandates patients' rights to participate in determining the course of their medical care.

The law requires that all hospitals, hospice programs, and home health programs comply with the following:

1. Assure compliance with the law
2. Document whether a patient has an advance directive
3. Provide written information regarding advance directives
4. Provide staff and member education.

The law also requires that new enrollees in HMOs be provided information regarding the Patient Self-Determination Act and Advance Directives. Legal applicability to minors includes only those minors who are emancipated.

Informing Your Patient
A pamphlet regarding Advance Directives is available through the Member Services Department at ☎ 800-777-7902 (Medicare Members - ☎ 888-777-5536). Members with medical questions related to advance directives should be referred to their personal physician. Patients / members with legal questions should be advised to consult their attorneys. For more information on Advance Directives, electronic copies of state forms and to learn about Life Care Planning, Kaiser Permanente's branded Advance Care Planning service, visit www.kp.org/lifecareplan

Filing of Advance Directives
A copy of the member's advance directive should be placed in the member's medical records. The member is advised to maintain a copy of his/her advance directive and to provide one to his/her surrogate decision-maker, in order to assure that a copy is available should the patient be admitted to a hospital.

Physician Involvement with the Patient Decision-Making Process
Federal law strongly encourages physician involvement with the patient in the decision-making process regarding advance directives.
The attending physician reviews the advance directive with the patient or his/her surrogate decision-maker at the time of admission, and periodically thereafter at the patient's request.

All discussions between the patient/surrogate and his/her physician regarding advance directives must be documented in the medical record.

7.9 Medicare Compliance Policy

The Centers of Medicare and Medicaid Services (CMS) have enacted the Balanced Budget Act of 1997 governing Medicare plans. All KPMAS contractors must comply with its provisions when treating Kaiser Permanente Medicare Advantage members. If you provide care to Medicare Advantage members, it is important that you be aware of and comply with the requirements. Please read this section carefully to understand your obligations as a Participating Provider. Some requirements may be found in the standard KPMAS provider agreement and some requirements are mentioned only in this section. Policy and procedures that appear elsewhere in this manual that relate to a specific requirement have been cross-referenced. Please consult all cross-references.

7.10 Medicare Member Rights

Access to Services
Access to benefits must be provided to Medicare Advantage members in a manner described by CMS, such as during hours of operation that are convenient to members. KPMAS monitors its Participating Provider Network to ensure that adequate access to covered services is maintained. Members will be surveyed on a regular basis to help assess the accessibility of services and the adequacy of the Participating Provider Network. Patients of all KPMAS Providers are subject to survey. The results of member surveys help KPMAS evaluate the performance of its Participating Providers.

Advance Directives
Information about advance directives must be provided to all adults and must be documented in a prominent place in the medical record, whether or not one has been executed. Advance directives are formal documents signed by a patient that explain the patient's wishes concerning a given course of medical care should a situation arise in which he or she is unable to make these wishes known.

A pamphlet on Advance Directives is available by contacting the Member Services Department at ☎ 800-777-7902.

Confidentiality
Participating Providers are required by law to safeguard the confidentiality and accuracy of member records, including both medical documents and enrollment information. Additionally, Participating Providers must maintain such records in an accurate and timely manner, and ensure timely access to members who wish to examine their records. Confidential patient information that is protected against disclosure by federal or state laws and regulations may only be released to authorized individuals.

Discrimination Prohibited
Participating Providers may not discriminate against any KPMAS member based on race, religion or any other factor prohibited by law. In addition, Participating Providers may not discriminate in the provision of medical services for Medicare Advantage members based on health status. Participating Providers may not restrict their practice to individuals perceived to be healthy or refuse to accept members as a patient on the contention that the payment methodology would not compensate them for providing services to this population.

KPMAS is a Medicare contractor and is therefore a recipient of federal payments. As a contractor of an organization that receives federal funds, Participating Providers are subject to the same laws applicable to individuals and entities that receive federal funds.

7.11 Medicare Provider Rights & Responsibilities

Adherence to Grievance and Appeals Procedures
Medicare has developed an appeal process to help members resolve disputes regarding coverage determinations made by KPMAS. Participating Providers are required to participate in the appeals process as requested by KPMAS.

Adherence to CMS Laws, Regulations and Instructions
KPMAS is a Medicare contractor and is therefore a recipient of federal payments. As a contractor of an organization that receives federal funds, Participating Providers are subject to the same laws applicable to individuals and entities that receive federal funds. You and your subcontractors must comply with all rules and regulations that are applicable to federal contracts. These include the specific laws noted above, general rules that might apply, and policies, procedures, manual provisions, and other program requirements issued by CMS. These also include KPMAS' policies and procedures that are applicable to Participating Providers.

Compliance with Policies and Programs
Participating Providers must review, participate in and comply with KPMAS' medical policy, quality assurance program, and medical management program.

Continuation of Services after Termination
Participating Providers acknowledge that services to Medicare Advantage members will not be interrupted should KPMAS be unable to pay its debts or terminates its contract with CMS or another provider. In cases when the member is hospitalized, the obligation to provide services continues until discharge.

Cooperate with Independent Quality Review
Quality review is a material part of KPMAS' contract with CMS. Participating Providers must participate in quality review and are obligated to participate in any quality review function KPMAS designates.

Cultural Competence
Participating Providers must ensure that services are provided in a culturally competent manner to all members. Kaiser Permanente expects Participating Providers to provide health care that is sensitive to the needs and health status of different population groups. This includes members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities. KPMAS is developing material that will provide more guidance on culturally competent care.

Delegation
If you have entered into a delegation agreement with KPMAS, you are obligated to perform those services in a satisfactory manner.

Disclosure of Quality and Performance Indicators
KPMAS conducts ongoing studies and surveys of member satisfaction and health outcomes. Participating Providers must participate in these studies and surveys as requested by KPMAS.

Follow-Up Care and Training in Self-Care
Participating Providers must provide members with the information they need to participate fully in their own care, including information on such subjects as: self-care, medication management, use of medical equipment, potential complications and when these should be reported to providers, and scheduling of follow-up services.

Marketing Material
Informational materials intended to inform Medicare patients about KPMAS Medicare Advantage or its services must be submitted to KPMAS for review and approval. Marketing materials developed by Participating Providers that are intended for Medicare beneficiaries may require CMS approval and should be submitted to KPMAS for review and approval.

No Recourse Against Members
CMS requires that Medicare Advantage members be protected from incurring financial liability for charges that are the obligation of KPMAS to pay. Participating Providers must look solely to KPMAS for the cost of covered services provided to Medicare Advantage members. Medicare Advantage members are liable only for cost-sharing amounts that are specified in KPMAS' membership contract.

Payment and Incentive Arrangements
Payment arrangements between KPMAS and its Participating Providers must be set forth in contracts. Your contract specifies payment arrangements. In addition to KPMAS' contract with you, all subcontracts you enter into after reaching agreement with KPMAS, with other individuals or entities to provide healthcare services to Medicare Advantage members must specify payment arrangements. No contract provision, payment or otherwise, can create an incentive to reduce or limit services to a specific member.

Professionally-Recognized Standards of Care
Services to members must be provided in a manner consistent with professionally recognized standards of care.

Prohibition Against Contracting with Sanctioned and Opt-Out Providers
KPMAS is prohibited from employing or contracting with providers excluded from participation in, or who have opted out, of Medicare. Participating Providers are also prohibited from employing or contracting with such providers. Contracts are terminable for these reasons. Contractors must certify to KPMAS that its contractors are able to be credentialed by KPMAS and are eligible to participate in Medicare.

Prompt Payment of Compensation
Payment provisions, including a provision for timely payment, are set forth in this Provider Manual in Section 8. Any subcontracts that you have with providers or entities that will provide services to Medicare Advantage members must likewise contain a prompt payment provision.

Requirements Binding on Contractor's Subcontractors
KPMAS generally contracts directly with Participating Providers. However, in limited instances, Participating Providers with prior approval from KPMAS, subcontract for care provided to Kaiser Permanente Medicare Advantage members. KPMAS requires that specific provisions be included in subcontracts. Consult with KPMAS about specific provisions that must be included in your contracts with other practitioners serving Medicare Advantage members.

Termination as to Medicare Contract between KPMAS and CMS
Since CMS may choose to terminate its contract with KPMAS, KPMAS must be able to terminate the Medicare Advantage provisions in its contracts without breach or termination of the remainder of the contract. Likewise, KPMAS may choose not to renew its contract with CMS.

7.12 Medicare Record-Keeping and Reporting

Certification of Data
You and your subcontractors must certify the completeness and truthfulness of the data you provide to KPMAS. The data you and your subcontractors supply is subject to audit by KPMAS or CMS.

Disclosure of Information to CMS
Participating Providers must provide KPMAS and/or CMS with all information that is necessary for CMS to administer and evaluate the Medicare Advantage program. Participating Providers must cooperate with KPMAS in providing CMS with the information needed to establish and facilitate a process to enable current and potential beneficiaries to make informed decisions with respect to Medicare coverage.

Encounter Data
Participating Providers must submit to KPMAS complete, accurate and timely data, including medical records, necessary to characterize the content and purpose of each encounter with a member. Participating Providers must submit data in the format prescribed by KPMAS.

Maintenance and Audit of Records
CMS evaluates the quality, appropriateness and timeliness of services provided to Kaiser Permanente Medicare Advantage members, facilities used to deliver services, and other

functions and transactions. CMS requires that Medicare Advantage organizations provide CMS access to books, records, and other documents related to the operation of a Medicare Advantage contract. Participating providers and their related entities, including subcontractors, are to maintain records and allow CMS access to them for 10 years from the termination date of the contract or the date of the completion of any audit.

7.13 Office of the Inspector General (OIG)

Compliance Program Guidance for Medicare Managed Care Plans
The Office of the Inspector General (OIG) has implemented a federal initiative to engage the health care community in combating health care fraud and abuse. The OIG is working closely with the Centers for Medicare and Medicaid Services (CMS), the Department of Justice and many sectors of the health care industry to provide clear guidance on such issues.

The goal of the OIG Compliance Program is to offer health care providers internal controls to efficiently monitor adherence to federal statues, regulations and program requirements. The OIG has identified the fundamental elements required to create an effective compliance program. Those fundamental elements are:

- Implementing written policies, procedures and standards of conduct
- Designating a Compliance Officer and Compliance Committee
- Conducting effective training and education
- Developing effective lines of communication
- Enforcing standards through well-publicized disciplinary guidelines and developing policies dealing with sanctioned individuals
- Conducting internal monitoring and audits
- Responding promptly to detected offenses
- Developing corrective actions and reporting to the government

The OIG is offering specific compliance measures to Medicare Managed Care Plans for Compliance Program implementation. The Kaiser Permanente Organization is committed to the highest ethical standards in business practices and incorporates the seven elements of a successful compliance program into its practices.

If you would like more information regarding any compliance policy or would like to obtain a copy of “Principles of Responsibility”, compliance guide to Participating Providers of Kaiser Permanente, please contact the Provider Experience Department at ☎ 877-806-7470.

7.14 Release of Information Policy Guidelines for Release of Health Information

Procedures have been developed to address the release of health information and medical records to the patient or the patient’s representative.

- All patients have the right to access their medical records.
- This includes the right to inspect and obtain copies of their medical record, and to amend any incorrect information.
- Patient access may be restricted if the health information would adversely affect the health and well-being of the patient.
- The physician should make an entry in the patient’s record specifying what information is not to be released.
- A written authorization to release information must be received from the patient before any information from the medical record is released (fax copy is acceptable). (The health plan makes standardized forms available.)

- The authorization for release must contain:
  - Patient’s Name
  - To whom the information is being released
  - Reason for release
  - Description of specific information to be released
  - Patient’s (or responsible person’s) signature and the date of the request (proper legal documentation when applicable)
- Legal guardians, natural and foster parents may sign for the release of information contained within a minor’s medical record, unless the minor was seen on his own accord for such services as venereal disease, birth control, pregnancy, abortion or HIV status.
- Requests for the release of health record information to patients must be coordinated through the KPMAS Health Information Systems Department.

Guidelines for Release of Mental Health Information

A written authorization to release information must be received from the patient before any information from the medical record is released (fax copy is acceptable). The health plan makes standardized forms available.

- The authorization for release must contain:
  - Patient’s Name
  - Name of organization, institution or person being asked to make disclosure
  - To whom the information is being released
  - Reason for release
  - Description of specific information to be released
  - Patient’s (or responsible person’s) signature and the date of the request (proper legal documentation when applicable
- Legal guardians, natural and foster parents must sign for the release of information contained within a minor’s medical record, if the patient is under 16 years of age, unless the minor was seen on his own accord for such services as venereal disease, birth control, pregnancy, abortion or HIV status.
- A physician may refuse access to the medical record by a patient only in cases of a psychiatric or psychological problem and access is contraindicated in the physician’s medical judgment. In cases where access is denied the patient, the physician may provide a summary of the contents of the record to the patient upon request. The patient may also request to have the record be reviewed by another provider for a second opinion.
- The physician should make an entry in the patient’s record specifying why the information is not to be released.
- Requests for the release of health record information to patients must be coordinated through the Health Information Systems Department.

Health Information Facsimile Policy

Only certain materials may be transmitted via facsimile and specific procedures must be followed to safeguard the confidentiality of the information and preserve the integrity of the data. Only the information requested should be included in the transmission. Documentation of facsimile transmission should be incorporated into the permanent medical record of the patient if faxed to a requestor other than KPMAS. A cover sheet with a confidentiality notice statement should be used for all facsimile transmissions.

Permitted Transmissions:

- Provider progress notes and consultation
- Diagnostic and laboratory studies
- Patient authorization for release of information, including a statement indicating the faxed copy may be deemed as having the same force and effect as the original document

Prohibited Transmissions:

- Patient care documentation reflecting any of these conditions or diagnoses:
    - Drug or Alcohol Abuse
    - Mental Health Records
    - HIV/AIDS related services
- Any document reflecting peer review, risk management or quality assurance activities
- Any other document marked “confidential”

Fraud, Waste and Abuse
Kaiser Permanente will investigate allegations of Provider fraud, waste or abuse, related to services provided to Members, and where appropriate, will take corrective action, including but not limited to civil or criminal action. The Federal False Claims Act and similar state laws are designed to reduce fraud, waste and abuse by allowing citizens to bring suit on behalf of the government to recover fraudulently obtained funds (i.e. "whistleblower" or "qui tam" actions). Kaiser Permanente employees may not be threatened, harassed or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.