5.3 Fraud Waste and Abuse

It is the policy of Healthfirst to comply with all federal and state laws regarding fraud, waste, and abuse, to implement and enforce procedures to detect and prevent fraud, waste, and abuse regarding claims submitted to federal and state healthcare programs, and to provide protection for those who report in good faith actual or suspected wrongdoing. Healthfirst is also required to refer potential fraud or misconduct related to the Medicare program to the Health and Human Services Office of the Inspector General (HHS-OIG) and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste, and abuse related to the NY state-funded programs are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

5.4 The Compliance Policy

Healthfirst maintains a strict policy of ***zero tolerance*** toward fraud and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action up to and including termination.

As part of our commitment to this zero-tolerance policy, Healthfirst provides this information to vendors to achieve the following goals:

- Demonstrate its commitment to responsible corporate conduct
- Maintain an environment that encourages reporting of potential problems
- Ensure appropriate investigation of possible misconduct by the company

In general, Healthfirst has adopted various fraud prevention and detection programs for the purpose of protecting the member, the government, and/or Healthfirst from paying more for a service than it is obligated to pay. Therefore, Healthfirst established a Special Investigations Unit (SIU), which ensures that Healthfirst is in compliance with all applicable state and federal regulations.

The SIU

The SIU is chiefly responsible for accepting referrals from both outside the company and within the company for investigation to determine if fraud or abuse has occurred. Therefore, Healthfirst employees and contracted entities have a responsibility to report any inappropriate activities to the SIU and the Regulatory Affairs department or their immediate supervisor, if applicable.

For further information on our compliance program, please visit our provider web page at www.healthfirst.org and select *"A Guide to the Compliance Program."*

5.4a Definitions

Abuse—Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

Fraud—An intentional deception or misrepresentation made by a provider, person, or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Waste—The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.

Relevant Statutes and Regulations

Stark Law

The Stark Law, with several separate provisions, governs physician self-referral for Medicare and Medicaid patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which

he has a financial interest, be it ownership, investment, or a structured compensation agreement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship—unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a health service furnished as a result of a prohibited referral. Violations of the Stark Law and Physician Self-Referral are to be reported to the Centers for Medicare and Medicaid Services through an established self-disclosure process.

Anti-Kickback Statute

The Medicare and Medicaid Patient Protection Act of 1987 provides the basis for this statute. It provides for criminal penalties for certain acts which impact Medicare and Medicaid or any other federally funded or State-funded program. If you solicit or receive any remuneration in return for referring an individual to a person (doctor, hospital, and provider) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any other goods or services from any healthcare facilities, programs, and providers.

False Claims Act

31 U.S.C. §§ 3729–3733

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistleblowers) can help reduce fraud against the government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (the act does not cover tax fraud).

For the purposes of this policy, “knowing and/or knowingly” means that a person has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

Both federal and state False Claims Acts (FCA) apply when a company or person:

- Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government
- Conspires with others to get a false or fraudulent claim paid by the federal government
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by Healthfirst
- Knowingly failing to provide members with access to services for which Healthfirst has received premium payments
- Knowingly submitting inaccurate, misleading, or incomplete Medicaid cost reports

False Claims Act Penalties

Those that defraud the government can end up paying triple the damages done to the government, a fine (between $10,957 and $21,916) for every false claim, and the claimant's costs and attorneys' fees, as adjusted annually by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1). If the government takes on the case, the individual who brings the claim is usually entitled to receive 15% to 25% of the recovered funds. If the government decides not to intervene, the individual is entitled to 25% to 30% of the funds.

Protections for Whistleblowers

Whistleblower protection is provided by federal acts and related State and federal laws, which shield employees from retaliation for reporting illegal acts of employers. An employer cannot rightfully retaliate in any way, such as discharging, demoting, suspending, or harassing the whistleblower. If an employer retaliates in anyway, whistleblower protection might entitle the employee to file a charge with a government agency, sue the employer, or both.

To report information about fraud, waste, or abuse involving Medicare or any other healthcare program

involving only federal funds, call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is 1-800-HHS-TIPS (1-800-447-8477). For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to https://oig.hhs.gov/fraud/report-fraud/index.asp.

The following are the applicable False Claims Act regulations, for reference:

Federal False Claims Act Civil Remedies Act

31 U.S.C. 3801-3812

For a copy of this citation, please visit https://federalregister.gov/a/E9-12170.

This act provides federal administrative remedies for false claims and statements, including those made to federally funded healthcare programs. As of August 1, 2016, False Claims Act civil penalties increase to between $10,781 and $21,563 per claim, plus three times the amount of damages that the federal government sustains because of the false claim. It is important to note that when False Claims Act penalties increase, so do the financial rewards for whistleblowers, increasing their incentive to allege false or fraudulent claims. The amount of the false claims penalty is adjusted annually by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1).

For a copy of the New York citations listed below, visit the Law of New York website at http://public.leginfo.state.ny.us/menugetf.CGI?COMMONQUERY=laws.

NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is $10,781 to $21,563 per claim, and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The FCA allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25% to 30% of the proceeds if the government does not participate in the suit and 15% to 25% if the government participates in the suit.

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment, or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within five years, a penalty of up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's family's needs are not taken into account for six months if a first offense, 12 months if a second (or once if benefits received are over $3,900), and five (5) years for four or more offenses.

Social Services Law §145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b, Penalties for Fraudulent Practices

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation, or other fraudulent means is guilty of a Class A misdemeanor. Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Special Investigations Unit

The purpose of the Special Investigations Unit is to coordinate and direct the activities of Healthfirst in

regards to fraud, waste, and abuse awareness, detection, investigation, and reporting. The Special Investigations Unit will also ensure that Healthfirst is in compliance with state and federal regulations pertaining to fraud detection, investigation, prevention, and reporting.

Healthfirst-Contracted Vendor

Healthfirst contracts with a vendor to assist in the identification of potential fraud, waste, and abusive billing practices as mandated by federal and state regulations. Through the use of state-of-the-art detection software, this vendor identifies billing patterns that are not within industry norms. Providers selected for review will be asked to submit medical records for examination. Please note that it is important to provide the Healthfirst contracted vendor with all requested supporting documentation upon request. This will minimize any future disputes regarding any identified issues. Failure by a provider to provide the requested records within 30 (thirty) calendar days of a request or to send the requested records to the address indicated in the record request letter will result in the denial of payment and/or recoupment of previously paid claims.

If, after a complete review of all documentation provided, it is believed that the services billed are unsupported, they will be considered overpayments and Healthfirst will utilize an extrapolation methodology to determine the total overpayment and ask the selected provider to refund the monies paid. If appropriate, education will be provided to ensure further billings are submitted according to established guidelines. The results of these reviews are presented to the Healthfirst Fraud, Waste and Abuse Committee. Failure to cooperate may result in the non-renewal or termination of your contract with Healthfirst and/or additional reporting to state and/or federal authorities.

Fraud, Waste, and Abuse Committee

The Fraud, Waste and Abuse Review Committee (FWAC) is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers. The committee has the authority to make determinations and/or recommendations to the Healthfirst Credentialing Subcommittee regarding allegations including, but not limited to, placement of a provider on prepayment review, termination of the provider agreement according to the guidelines described in Section 3.8, referral of the provider to the applicable regulatory or law enforcement agencies, and recovery of overpayments.

Upon referral by the FWAC, the Credentialing Subcommittee will conduct a separate review of the allegations involving improper billing or potential fraudulent and/or abusive activity committed by a provider. The Credentialing Subcommittee will render the final decision as to whether a provider should be terminated. Except in instances of immediate termination, when termination is recommended, a Notice of Proposed Adverse Action will be issued to the provider, and the provider shall have the opportunity to appeal the decision, as outlined in Section 3.8.

The Fraud, Waste and Abuse Committee meets approximately 15 (fifteen) times during the year and comprises the following Healthfirst staff members:

- Vice President, Deputy General Counsel
- Chief Medical Officer (or his/her representative)
- Vice President, Claims
- Vice President, Regulatory Affairs
- Vice President, Compliance and Audit
- Vice President, Network Management
- Director, Special Investigations Unit

Prepayment Review

As part of its fraud, waste, and abuse prevention and detection program, Healthfirst maintains a prepayment review program (PPR) in which providers must submit records to support the claims billed prior to payment being issued. After a provider is placed on PPR via the below detailed procedures, no claim will be paid unless medical records (1) are submitted timely; (2) are submitted to Healthfirst at the address indicated in the record request letter; and (3) support the services billed, including, but not limited to, the medical necessity and the level of services billed.

Where the FWAC determines that a provider should be placed on PPR due to identification or reasonable suspicion of fraud, waste, or abuse, Healthfirst's vendor administrator (the "Vendor") will notify the provider of the FWAC's decision and that the provider will be on PPR for a period of at least six months. The FWAC will review the provider after at least each six-month period that a provider is on PPR to determine if the

provider has changed their behavior, is maintaining the required documentation, and, where applicable, has resolved any overpayment requests. The Vendor will also send a request(s) for medical records to the provider for all subsequently submitted claims to ensure that claims submitted for payment are supported by appropriate documentation meeting all applicable laws, rules, and regulations; coding; and contractual requirements. Providers will have a period of 30 days to submit requested records. In the event records are not submitted within 30 days of the request, the claims at issue will be denied. Records received after the 30-day deadline will not be considered.

All records must be sent to the address listed in the PPR medical record request letter from the Vendor. Records sent to any other address will not be considered. The submitted medical records will be reviewed to determine if the claim lines billed by the provider are supported by appropriate documentation. If the records support the claim (e.g., that the services billed were rendered, were medically necessary, and were appropriately performed and documented, etc.), the claim will be approved for payment. The provider should submit all necessary information and records, including, but not limited to, records to indicate that the services were rendered, all test results, records to indicate an ongoing course of treatment, evidence of a referral, etc. If the documents are not supportive of the services billed, the claim will be denied. Claim lines with no records—either because the provider failed to maintain such records or failed to provide such requested records—will be denied for payment. Providers will be informed of the PPR decisions through the provider portal or an explanation of payment.

If providers disagree with the PPR claim determination, they may submit a review and reconsideration (e.g., first-level appeal) within 90 (ninety) calendar days of the claim decision. Providers must submit additional supporting documentation directly to the Vendor at the address listed in the PPR medical record request letter for reconsideration and review in a timely manner. Thereafter, if a provider disagrees with the decision on review and reconsideration, a further appeal is available pursuant to the “Claims Appeal Process” detailed in Section 17.6 of the Provider Manual. All appeals must be submitted to Healthfirst at the address indicated in Section 17.6 of the Provider Manual and must include a cover letter noting that this is an appeal from a PPR determination. The review and reconsideration and the appeal processes shall otherwise be conducted in accordance with Section 17.6 of the Provider Manual.

Retrospective or Post-Payment Review

Periodically, the Vendor and the SIU conduct audits of claims that have previously been paid by Healthfirst. In such audits, the Vendor or the SIU will request documentation from providers which is required to be maintained in accordance with applicable laws, rules, and regulations; coding requirements; and contractual requirements. The Vendor then presents the audit outcome to the provider in an Audit Findings Report (AFR). If the provider disagrees with the findings in the AFR, the provider must follow the review and reconsideration and appeal processes noted in the above “Prepayment Review” Section. If a timely request for review and reconsideration or appeal is not initiated by the provider, the determination of the AFR will be deemed final and sent for overpayment recovery in accordance with Section 5.5 of this Provider Manual and any other available means of recovery (e.g., collections agency, litigation, etc.). Most retrospective reviews are based on a statistically valid sample; however, in some instances, audits may be conducted based on specific ICD 9/10 code issues.

The purpose of the Special Investigations Unit is to coordinate and direct the activities of Healthfirst in regards to fraud, waste, and abuse awareness, detection, investigation, and reporting. The Special Investigations Unit will also ensure that Healthfirst is in compliance with state and federal regulations pertaining to fraud detection, investigation, prevention, and reporting.

Prescription FWA – Premier Audit Meetings

In addition to the Fraud, Waste and Abuse Committee’s work discussed above, Healthfirst also conducts quarterly Premier Prescription FWA Audit meetings. This committee is concerned with fraud, waste, and abuse and potentially hazardous prescription use within the Prescription Drug Program. The committee meets to review reports prepared by CVS Caremark, the plan’s contracted Pharmacy Benefit Manager. The committee is responsible for directing all further investigative activities and reporting of suspect, questionable activities to the plan’s Fraud, Waste and Abuse Committee for further direction.

The committee is composed of the following Healthfirst staff members:

- Vice President, Pharmacy

- Pharmacy Director or pharmacist alternate
- Director, Special Investigations Unit
- Supervisor, Special Investigations Unit
- CVS Caremark Representatives

Restricted Recipient Program

Restricted Recipient Program (RRP) is a program whereby selected enrollees with a demonstrated pattern of abusing or misusing Benefit Package services may be restricted to one or more RRP providers for receipt of medically necessary services. Restricted Enrollee means an enrollee who has engaged in abusive practices or demonstrated a pattern of misuse of a category of Medicaid or FHP benefits and has been restricted by either the contractor or OMIG to receive certain services only from an assigned RRP provider. The amount, duration, and scope of the Medicaid or FHP benefit are not otherwise reduced.

Member Review and Restriction Committee (MRRC)

The Member Review and Restriction Committee oversees the Restricted Recipient Program (RRP), which is intended to reduce the cost of inappropriate utilization of covered services by identifying and managing enrollees exhibiting abusive or fraudulent behavior. Through increased coordination of medical services, the number of providers that the enrollee may select for care and the referrals to services, medications, and equipment is controlled; enrollees targeted for the Restricted Recipient Program are ensured access to medically necessary, quality healthcare, and unnecessary costs to the Medicaid program are prevented.

The MRRC is a professional team comprising, at a minimum, a physician, a registered professional nurse, and a pharmacist. The MRRC shall review and determine whether the enrollee has demonstrated a pattern of overuse, underuse, or misuse of services included in the Benefit Package and whether such behavior should be managed by the Restricted Recipient Program. The MRRC is also responsible for ensuring that the directives of the team regarding placing restriction of recipients are carried out. The MMRC consists of the following staff members:

- Vice President, Associate General Counsel
- Chief Medical Officer (or his/her representative)
- Vice President, Claims
- Vice President, Regulatory Affairs
- Vice President, Compliance and Audit
- Vice President, Network Management
- Pharmacy Director or pharmacist alternate
- Director, Special Investigations Unit

Common Methods of Fraud and Abuse

In order to assist you with understanding and/or identifying what may constitute fraud, waste, and/or abuse, we have provided some typical examples for your reference.

Fabrication of Claims: In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate member names and insurance information either to concoct entirely fictitious claims or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed. Examples are as follows:

- Submitting claims for services not rendered
- A provider who, using existing information on his or her members, creates claims for office visits or services that never took place
- A provider who, in the course of billing for actual member treatments, adds charges for X-rays or laboratory tests that were never performed
- A durable medical equipment provider submitting claims for equipment and supplies never delivered, or continuing to submit claims for rented equipment after it has been picked up

Falsification of Claims: In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim for the purpose of obtaining a payment to which he or she is not entitled. Examples are as follows:

- A provider performs medically unnecessary services solely in order to bill and be paid for doing so
- A provider falsifies symptoms or other diagnostic information in order to obtain payment for an uncovered service. This is somewhat more common in certain specialties, such as cosmetic surgery
- A provider falsifies the dates on which services were provided so that they fall within a given

eligibility period of the member

- A provider falsifies the identity of the provider of services so as to obtain payment for services rendered by a noncovered and/or nonlicensed provider (e.g., submitting claims for clinical social worker services as psychiatric treatment provided by a licensed psychiatrist, or billing fitness center massages as a licensed physical therapy)
- A provider upcodes the services rendered to obtain greater reimbursement
- Upcoding of Evaluation and Management services to indicate a greater complexity of medical decision-making than was actually rendered; encounters that required straightforward decision-making are reported as having required highly complex decision-making
- Reporting more intensive surgical procedures than were actually performed
- Anesthesiologist bill for more intensive surgical procedures than reported by the surgeon

Unbundling: Provider submits a claim reporting comprehensive procedure code (Resection of small intestine) along with multiple incidental procedure codes (Exploration of abdominal and Exploration of the abdomen) that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

Fragmentation: Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (Antepartum care, Vaginal delivery and Obstetric care) which includes the three components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

Duplicate Claim Submissions: Submitting claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

Fictitious Providers: Perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the CMS 1500 claim form.

Examples of FWA within the Prescription Drug Program

Plan Sponsor

- Failure to provide medically necessary services
- Marketing schemes offering beneficiaries inducements to enroll
- Unsolicited marketing
- Misrepresenting prescription drug products
- Payment for excluded drugs
- Multiple billing
- Inaccurate data submission

Pharmacy Benefit Manager (PBM)

- Prescription drug switching
- Steering a beneficiary to a certain plan or drug
- Inappropriate formulary decisions
- Failure to offer negotiated prices

Pharmacy

- Inappropriate billing practices
- Prescription drug shorting
- Bait-and-switch pricing
- Prescription drug forging or altering
- Payment for excluded drugs
- Dispensing expired or adulterated drugs
- Prescription refill errors
- Failure to offer negotiated prices

Prescriber

- Prescription drug switching
- “Script” mills
- Provision of false information
- Theft of DEA number or prescription pad

Wholesaler

- Counterfeit or adulterated drugs through black markets
- Drug diversions
- Inappropriate/false documentation of pricing information

Manufacturer

- Lack of data integrity to establish payment or determine reimbursement
- Kickbacks, inducement, or other illegal remuneration
- Inappropriate relations with formulary committee members
- Inappropriate relations with providers
- Illegal “off-label” promotion
- Illegal use of free samples

Beneficiary

- Misrepresentation of enrollment status
- Identity theft
- Prescription forging or altering
- Drug diversion or inappropriate use
- Prescription stockpiling
- “Doctor shopping” for drugs

FDR and Affiliates Compliance Requirements

Healthfirst's commitment to compliance includes ensuring that our First Tier, Downstream and Related Entities (FDRs) and Affiliates are in compliance with applicable state and federal regulations. Healthfirst contracts with these entities to provide administrative and healthcare services to our enrollees; we are ultimately responsible for fulfilling the terms and conditions of our contract with the Centers for Medicare and Medicaid Services (CMS) and meeting the Medicare and Medicaid program requirements. Therefore, Healthfirst requires each FDR and Affiliate to comply with the compliance and fraud, waste, and abuse expectations.

Failure to meet the requirements may lead to a Corrective Action Plan, retraining, or the termination of a contract and relationship with Healthfirst.

First Tier entities are responsible for ensuring that their downstream and related entities are in compliance with Healthfirst policy and applicable Federal and State statutes and regulations. A copy of the Healthfirst compliance attestation and the FDR and Affiliate Compliance Guide can be found at www.healthfirstfdr.org.

Reporting of Fraudulent, Wasteful, and Abusive Activities

Healthfirst wants to make sure that our providers understand that we expect members, vendors, providers, interns (volunteers), consultants, Board members, and First Tier, Downstream and Related Entities (FDRs) as well as others associated with the business of Healthfirst to bring any alleged inappropriate activity that involves Healthfirst to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following individuals/departments:

Healthfirst Compliance Officer at:

Special Investigations Unit (SIU) at:
100 Church Street, New York, NY 10007
By phone – 1-212-453-4495

By phone – 1-212-801-3292