5.3 Fraud Waste and Abuse

It is the policy of Senior Health Partners 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.

Potential fraud or misconduct related to the Medicare program is reported to 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).

The Compliance Policy

Senior Health Partners 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, Senior Health Partners provides this information to vendors to achieve the following goals:

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

Senior Health Partners has adopted various fraud prevention and detection programs whose purpose is to protect the member, the government, and/or Senior Health Partners from paying more for a service than it is obligated to pay. In addition, Healthfirst established a Special Investigations Unit (SIU), who ensures that Healthfirst is in compliance with all applicable state and federal regulations. Senior Health Partners may utilize the services of the Healthfirst Special Investigation Unit (SIU) for assistance in investigating alleged fraud events.

Definitions

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and 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 person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. 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

False Claims Act

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 a 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:

a) Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment,

b) Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government,

c) Conspires with others to get a false or fraudulent claim paid by the Federal Government,

d) 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 Senior Health Partners;
- Knowingly failing to provide members with access to services for which Senior Health Partners has received premium payments; and
- Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports.

What Money Can Be Recovered?

Those that defraud the government can end up paying triple the damages done to the government, a fine (between $5,000 and $10,000) for every false claim, and the claimant's costs and attorneys' fees.

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 Whistle Blowers

Whistle blower protection is provided by Federal acts and related State and Federal laws that 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 whistle blower. If an employer retaliates in any way, whistle blower protection might entitle the employee to file a charge with a government agency, sue the employer, or both.

If you suspect that fraud, waste or abuse is taking place against New York's Medicaid program, call the fraud hotline toll free at **1-877-87 FRAUD (1-877-873-7283)** to make an anonymous report.

To report information about fraud, waste or abuse involving Medicare or any other health care program involving only federal funds you can 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/

The following are the applicable false claim act regulations for further reference:

Federal Program Fraud Civil Remedies Act

31 U.S.C. 3801-3812

For a copy of this citation, please visit

https://www.federalregister.gov/articles/2009/06/04/E9-12170/program-fraud-civil-remedies-act

Provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the Government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

For a copy of the New York citation listed below, you may find them on 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 tracts 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 health care programs such as Medicaid. The penalty for filing a false claim is $6,000 -$12,000 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 Act 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 25-30% of the proceeds if the government does not participate in the suit and 15-25% 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 5 years, a penalty 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 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and five (5) years for 4 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 and 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.

Responsible Parties – Health Care Fraud

Senior Health Partners conducts annual focused, audits on high volume, high risk service vendors. Results of audits are shared with vendors. Plans of corrections or quality improvement activities are developed to enhance operational practice and support member satisfaction.

If, after a review of all documentation provided, it is believed that the services billed are unsupported, they will be considered overpayments and Senior Health Partners will determine the total overpayment and ask the selected provider to refund the monies paid. In addition, education will be provided to ensure further billings are submitted according to established guidelines. The results of these audits are presented to the Senior Health Partners Audit, Fraud, Abuse and Compliance Committee (AFAC). Failure to cooperate may result in

the non-renewal of your contract with Senior Health Partners and/or additional reporting to state and/or federal authorities.

Senior Health Partners Audit, Fraud, Abuse and Compliance Committee (AFAC)

The AFAC Committee is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers; and has the authority to make recommendations to the Senior Health Partners Board of Directors regarding the allegation including, but not limited to, termination of the provider agreement according to the guidelines described in the provider contract and any other applicable regulatory or law enforcement agencies; and recovery of overpayments.

In addition, the AFAC committee reviews and updates its annual compliance plan. The Plan describes the responsibilities of the Compliance Officer, employees and contractors to act in a lawful and ethical manner. Each is expected to fully comply with applicable standards, recognize and avoid actions and relationships that might violate those standards and seek counsel in situations raising legal and ethical concerns.

Senior Health Partners AFAC Committee meets at least three times a year and is comprised of the following Senior Health Partners and Healthfirst staff members:

- Senior Health Partners, Executive Director
- Senior Health Partners, Vice President of Clinical Excellence, Compliance Officer
- Senior Health Partners, Medical Director
- Senior Health Partners Community Board Representative
- Healthfirst , Senior Vice President and General Counsel
- Healthfirst, Vice President Compliance and Audit

Common Methods of Fraud and Abuse

In order to assist you with understanding and/or identifying what may constituent 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 patient 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, in the course of billing for actual authorized services submits additional charges for services 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 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 non-covered and/or non-licensed provider
  - For example, 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.

Unbundling: Provider submits a claim reporting comprehensive procedure code or with multiple incidental procedure codes 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. 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.

Reporting of fraudulent, wasteful and abusive activities

Senior Health Partners maintains a strict policy of ***zero tolerance*** toward fraud and abuse and other inappropriate activities. As part of our commitment to this "**zero-tolerance**" policy, Senior Health Partners wants to ensure that our providers understand that we expect vendors to bring any alleged inappropriate activity which involves Senior Health Partners to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following departments:

Corporate Compliance Officer at Healthfirst

100 Church Street

New York, NY 10007

By Phone: (212) 453-4495

E-Mail: **compliance@healthfirst.org**

Anonymously - to the Confidential Compliance Hotline at **1-877-879-9137**