BOSTON MEDICAL CENTER HEALTHNet PLAN		WELL SENSE HEALTH PLAN		
Policy Owner Matthew C. Pezzulich	Approved By Compliance Committee	Original Date 12/28/2006	Latest Review Date: 10/23/2018	Version Number Version 7.0
Subject **Fraud, Waste and Abuse Policy**				Policy Number Compliance 10 Page Number: 1 of 16
Related documents: Compliance Problem Reporting and Non-retaliation policy				

Purpose

The purpose of this policy is to set forth the manner in which Boston Medical Center Health Plan, doing business as Boston Medical Center HealthNet Plan and Well Sense Health Plan (collectively referred to as the "Plan") complies with the requirements of the Deficit Reduction Act of 2005 (DRA) and its obligations related to Fraud and Abuse under its state and federal contracts. The DRA became effective on February 8, 2006. Under this law, any entity who receives more than $5 million per year in Medicaid payments is required effective as of January 1, 2007 to provide information to its employees about the Federal False Claims Act, any applicable state False Claims Act, the rights of employees to be protected as whistleblowers, and the organization's policies and procedures for detecting and preventing fraud, waste and abuse.

This policy also provides guidance regarding the Plan's responsibilities under the DRA, Federal, Massachusetts and New Hampshire False Claims Acts, including Federal Laws such as the Health Care Fraud statute, the False Claims Act, Anti Kick Back statute, and exclusions provisions; responsibilities of Workforce members to report suspected or actual instances of fraud, waste or abuse, and whistleblower protections under these laws when such reports are made.

Scope

This policy applies to all members of the Plan's Workforce.

Definitions

Abuse – Provider or enrollee practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to state and federally funded programs, including, but not limited to practices that result in reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care. It also includes enrollee practices that result in unnecessary cost to state and federally funded programs.

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between a Managed Care Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

FDR: First Tier, Downstream or Related Entity.

First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with a Managed Care Organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

Fraud - An intentional deception or misrepresentation made by a person, corporation or entity with the knowledge that the deception could result in some unauthorized benefit under a state or federally funded program to himself, the entity, the corporation or some other person. It also includes any act that constitutes fraud under applicable federal or state health care fraud laws. Examples of Provider fraud include, but are not limited to: persistent improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and Providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include, but are not limited to, improperly obtaining prescriptions for controlled substances and card sharing.

OIG – Office of the Inspector General responsible for the overall fulfillment of the OIG's mission to fight waste, fraud, and abuse in Medicare, Medicaid and numerous other programs of the Department of Health & Human Services.

Related Entity: Any entity that is related to a Managed Care Organization or Part D sponsor by common ownership or control and:

1. Performs some of the Managed Care Organization or Part D plan sponsor's management functions under contract or delegation;

2. Furnishes services to Medicare enrollees under an oral or written agreement; or

3. Leases real property or sells materials to the Managed Care Organization or Part D plan sponsor at a cost of more than $2,500 during a contract period. (See, 42 C.F.R. §423.501).

Waste – An over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to federal and state funded programs. Waste is generally not considered to be caused by criminally negligent actions but rather misuse of resources.

Workforce - Employees, temporary employees, volunteers, trainees and First Tier, Downstream and Related Entities (FDRs) and other contracted vendors.

Policy

The Plan provides Fraud, Waste and Abuse training and information to its Workforce and protection as whistleblowers (summarized in Appendix I attached) and about the organization's policies and procedures for detecting and preventing fraud, waste and abuse.

The Plan is committed to complying with all applicable laws, including but not limited to the Fraud and Abuse laws described in this policy and Attachment I. As part of this commitment, The Plan has established and maintains a Corporate Compliance Program that includes a Fraud, Waste and Abuse Program. Workforce members are expected to immediately report any potential false, inaccurate or questionable claims to their supervisors, the Fraud and Abuse Prevention Coordinator, the Compliance Officer, or the Hotline **1-888-411-4959** in accordance with the Plan's policies.

The Plan is prohibited by law from retaliating in any way against any individual who in good faith reports a perceived problem, concern or fraud, waste, or abuse issue.

Examples of potential false claims include, but are not limited to, the following:

1. Claiming reimbursement for services that have not been rendered;
2. Characterizing the service differently than the service actually rendered;
3. Falsely indicating that a particular health care professional attended a procedure;
4. Billing for services/items that are not medically necessary;
5. Forging or altering a prescription or claim; and

The Plan's Workforce members who prepare, process and/or review claims should be alert for false claims or billing errors.

Procedure

The Plan has developed a comprehensive internal Fraud, Waste and Abuse Program, as part of its Compliance Program, to prevent and detect violations. As part of this program, and in compliance with federal and state requirements, The Plan provides annual fraud, waste and abuse training for all Employees.

Members of the Plan's Workforce must immediately report any false, inaccurate or questionable claims or actions as well as questions, concerns or potential Fraud, Waste or Abuse issues to:

- Their immediate supervisor;
- The Plan's Vice President of Provider Audit and Special Investigations;
- The Fraud and Abuse email box (FraudandAbuse@bmchp-wellsense.org);
- The Plan's Compliance Officer; or
- The Plan's confidential, toll free Hotline, 24 hours/day, 365 days/year

1-888-411-4959

(*Information may be left on the Hotline anonymously)*

All activity reported pursuant to this Policy will be investigated in accordance with the Plan's Fraud, Waste and Abuse Program.

The Plan will not discriminate or retaliate against any individual for reporting in good faith a potential or actual fraudulent activity or for cooperating in any government or law enforcement agency's investigation or prosecution.

The Plan will make diligent efforts to recover improper payments or funds misspent due to fraudulent or abusive actions by The Plan's Workforce, Providers, Enrollees, or any other person or entity. Such efforts include, but are not limited to:

- Monitoring for under-utilization or over-utilization of services;
- Working with the Compliance Department, conducting regular reviews and audits of operations to guard against fraud, waste and abuse;
- Working with the Compliance Department, receiving all referrals from employees, enrollees, or providers involving cases of suspected fraud, waste and abuse;
- Developing protocols to triage and investigate all referrals involving suspected fraud, waste and abuse;
- Educating employees, providers and enrollees about fraud, waste and abuse and how to report it, including information employees of their protections when reporting fraudulent activities; and,
- Working with the Compliance Department, establishing mechanisms to receive, process, and effectively respond to complaints of suspected fraud, waste and abuse from employees, providers and enrollees and reports such information to state and federal agencies.

The Plan will conduct its Fraud, Waste and Abuse Program in accordance with federal and state requirements as set forth in Appendix I and Appendix II (for Massachusetts contract specific requirements).

Roles and Responsibilities

The Plan's Workforce- All members of the Plan's Workforce is responsible for reporting any suspected or actual instances of fraud, waste or abuse.

The Plan's Compliance Department – The Compliance Department has oversight for the Fraud, Waste and Abuse Program, including but not limited to policies/procedures, communications, and ensuring that all reports of suspected fraud, waste or abuse are fully investigated and if appropriate, reported to the proper authorities. The Compliance Department will communicate with state and federal agencies on fraud, waste and abuse issues and will provide oversight and assistance with the fraud, waste and abuse regulatory reports to state and/or federal agencies.

The Plan's Fraud and Abuse Prevention Coordinator – The Fraud and Abuse Coordinator in Massachusetts is the Vice President of the Provider Audit and Special Investigations Department, and in New Hampshire, is the Manager of Special Investigations. Together they are responsible for assessing and strengthening internal controls to help ensure that claims are properly submitted and payments are properly made.

The Fraud, Waste and Abuse Coordinators will work with the Compliance Officer to meet these responsibilities.

Exceptions

None

References

Deficit Reduction Act of 2005, (Pub.L. 109-171)
False Claims Act 31 USC sect. 3279-3733:
Massachusetts False Claims Act, M.G.L. c.12, §§5A to 5O
New Hampshire False Claims Act, 167:61(b)-(e)
Medicare Advantage and Prescription Drug Plan Manual Chapters 9 and 21
The Anti-Kickback Statute (42 USC § 1320a-7b(b))
The Stark Law (42 USC §1395nn)

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Appendix I

The following is a summary of Federal and state False Claims laws and whistleblower protections under those laws:

The Federal False Claims Act
The Federal False Claims Act (the "FCA") helps the Federal government combat fraud and recover losses resulting from fraud in Federal programs, purchases, or contracts. A person or entity may violate the FCA by knowingly: (1) submitting a false claim for payment, (2) making or using a false record or statement to obtain payment for a false claim, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the U.S. Government (the "Government"). "Knowingly" means that a person: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

The FCA imposes penalties of $11,181* to $22,363* per claim plus three times the amount of damages to the Government for FCA violations. Lawsuits must be filed by the later of either: (1) three years after the violation was discovered by the federal official responsible for investigating violations (but no more than ten years after the violation was committed), or (2) six years after the violation was committed.

Whistleblower Protections and Private or Qui Tam Actions under the Federal False Claims Act
An individual also has the right to file a civil suit for him or herself and for the Government to challenge a FCA violation. The suit must be filed in the name of the Government. Such an individual is called a qui tam plaintiff or "relator." Successful relators may receive between fifteen and thirty percent of the total amount recovered (plus reasonable costs and attorney fees) depending on the involvement of the relator and whether the Government prosecuted the case. Individuals cannot file a lawsuit based on public information, unless he or she is the original source of the information.

The FCA contains important protections for whistleblowers that apply to The Plan's employees. Employees who in good faith report fraud and consequently suffer discrimination are entitled to all relief necessary to be made whole, including two times their back pay plus interest, reinstatement at the seniority level they would have had except for the discrimination, and compensation for any costs or damages they have incurred.

Federal Administrative Remedies for False Claims and Statements
Federal law also provides administrative remedies against any person who makes, or causes someone else to make, a false claim or a false statement in the amount of $11,181 for each false claim or statement. A "false claim" (for purposes of the civil remedies) is defined as a claim that the person knows or has reason to know: is false; includes or is supported by any written statement which asserts a material fact which is false; includes or is supported by any written statement that omits a material fact; is false as a result of such omission; and is a statement in which the person making such statement has a duty to include such material fact; or is for payment for the provision of property or services which the person has not provided as claimed). A "false statement" is defined as a statement that the person knows or has reason to know: asserts a material fact which is false; or omits a material fact that makes the statement false. The administrative remedies for false claims and statements are found at 31 U.S.C. 3801-3812.

Other Federal Laws Prohibiting False Claims and Statements
Another Federal law provides criminal and civil penalties specifically against anyone who (among other things) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program or knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment; presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that

the individual who furnished the service was not licensed as a physician. This law is found at 42 U.S.C. 1320a-7b, and a violation of the law can result in criminal fines of not more than $25,000 or imprisoned for not more than five years or both.

A related Federal law prohibits anyone from knowingly and willfully making or causing to be made any false statement or representation of a material fact about the conditions or operation of any institution, facility, or entity in order that it may qualify for Medicare or Medicaid certification as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, or other entity. This law is found at 42 U.S.C. 1320a-7b, and a violation of the law can result in criminal fines of not more than $25,000 or imprisoned for not more than five years or both.

The Stark Law

Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the physician self-referral law prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies. The Stark Law also prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services. It also establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

The following items or services are currently identified as DHS:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

The Anti-Kickback Statute

The federal Anti-Kickback Statute ("Anti-Kickback Statute") is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business. *See* 42 U.S.C. § 1320a-7b. The Anti-Kickback Statute is broadly drafted and establishes penalties for individuals and entities on both sides of the prohibited transaction. Conviction for a single violation under the Anti-Kickback Statute may result in a fine of up to $25,000 and imprisonment for up to five (5) years. *See* 42 U.S.C. § 1320a-7b(b). In addition, conviction results in mandatory exclusion from participation in federal health care programs. 42 U.S.C. § 1320a-7(a). Absent a conviction, individuals who violate the Anti-Kickback Statute may still face exclusion from federal health care programs at the discretion of the Secretary of Health and Human Services. 42 U.S.C. § 1320a-7(b). The government may also assess civil money penalties, which could result in treble damages plus $50,000 for each violation of the Anti-Kickback Statute. 42 U.S.C § 1320a-7a(a)(7). Although the Anti-Kickback Statute does not afford a private right of action, the False Claims Act provides a vehicle whereby individuals may bring qui tam actions alleging violations of the Anti-Kickback Statute. *See* 31 U.S.C. §§ 3729–3733. When a private citizen sues on behalf of the Federal government and is successful, they receive a percentage of the ultimate recovery for their "whistleblower" efforts.

In recognition of the broad range of transactions potentially implicated by the Anti-Kickback Statute, certain types of payments are excluded from consideration by statute. 42 U.S.C. § 1320a-7b(b)(3). In addition, the U.S. Department of Health & Human Services ("HHS") Office of Inspector General ("OIG") has been given authority to adopt "safe harbors" to protect specifically identified business and financial

practices from criminal and civil prosecution, provided they fall within parameters defined to minimize the risk for potential corruption. *See* 42 C.F.R. § 1001.952. Transactions not specifically excluded or granted safe harbor protection are not per se violations of the Anti-Kickback Statute but are evaluated by the OIG on a case-by-case basis.

The Massachusetts False Claims Law
The Massachusetts False Claims Law, M.G.L. c. 12, § 5A-5O, is very similar to the Federal False Claims Act. The Massachusetts law, among other things, establishes civil liability for any person who: (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to the Commonwealth, (2) knowingly makes, uses or causes to be made or used, a false record or statement to obtain payment or approval of a claim to the Commonwealth, (3) conspires to defraud the Commonwealth through the allowance or payment of a false or fraudulent claim, (4) enters into an agreement, contract or understanding with one or more officials of the Commonwealth knowing the information contained therein is false or fraudulent, (5) knowingly makes, uses or causes to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Commonwealth, and (6) is a beneficiary of an inadvertent submission of a false claim to the Commonwealth, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the Commonwealth within a reasonable time after the discovery of the false claim.

The Massachusetts False Claims Law provides that any person violating the False Claims Law shall be liable for a civil penalty of not less than $11,181* and not more than $22,363* per violation, plus three times the amount of damages, including consequential damages, sustained by the Commonwealth because of the person's conduct. The Massachusetts False Claims Law also requires a violator to pay the expenses of this civil action, including, without limitation, attorneys fees, expert's fees, and the costs of investigation.

Whistleblower Protections and Private or Qui Tam Actions under the Massachusetts False Claims Law
The Massachusetts False Claims Law prohibits employers from preventing employees from helping to prevent the submission of false claims. Under the Law, no employer may have any policy preventing an employee from disclosing information to the government or from acting to further a false claims action. No employer may require that any employee agree to limit the employee's rights to bring an action or provide information to a government or law enforcement agency pursuant to the Law.

No employer may discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee in the terms or conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a government or law enforcement agency or in furthering a false claims action. An employer who violates this rule may be liable for damages and may also be required to reinstate the employee and offer two times the amount of back pay, interest on the back pay, and compensation for any special damage sustained plus litigation costs and reasonable attorney's fees.

Like the Federal False Claims Act, the Massachusetts False Claims Law provides that individuals may serve as qui tam relators and bring an action on behalf of the Commonwealth against a person or entity that has violated the False Claims Law. If successful, the relator may be entitled to an award of between fifteen and thirty percent of the proceeds recovered and collected in the action or in settlement depending upon the extent to which the relator substantially contributed to the prosecution of the action and whether the Attorney General intervened in the case.

The New Hampshire False Claims Law:
The New Hampshire False Claims Law, RSA 167:61(b)-(e), is very similar to the Federal False Claims Act. The New Hampshire law, among other things, establishes civil liability for any person who: (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to the Department, (2) knowingly makes, uses or causes to be made or used, a false record or statement to obtain

payment or approval of a claim to the Department, (3) conspires to defraud the Department through the allowance or payment of a false or fraudulent claim, (4) enters into an agreement, contract or understanding with one or more officials of the Department knowing the information contained therein is false or fraudulent, (5) knowingly makes, uses or causes to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Department, and (6) is a beneficiary of an inadvertent submission of a false claim to the Department, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the Department within a reasonable time after the discovery of the false claim.

The New Hampshire False Claims Law provides that any person violating the False Claims Law shall be liable for a civil penalty of not less than $11,181* and not more than $22,363* per violation, plus three times the amount of damages, including consequential damages, sustained by the State because of the person's conduct. The New Hampshire False Claims Law also requires a violator to pay the expenses of this civil action, including, without limitation, attorneys fees, expert's fees, and the costs of investigation.

Whistleblower Protections and Private or Qui Tam Actions under the New Hampshire False Claims Law

The New Hampshire False Claims Law prohibits employers from preventing employees from helping to prevent the submission of false claims. Under the Law, no employer may have any policy preventing an employee from disclosing information to the government or from acting to further a false claims action. No employer may require that any employee agree to limit the employee's rights to bring an action or provide information to a government or law enforcement agency pursuant to the Law.

No employer may discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee in the terms or conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a government or law enforcement agency or in furthering a false claims action. An employer who violates this rule may be liable for damages and may also be required to reinstate the employee with the same seniority status such employee would have had but for the discrimination and offer two times the amount of back pay, interest on the back pay, and compensation for any special damage sustained plus litigation costs and reasonable attorney's fees.

Like the Federal False Claims Act, the New Hampshire False Claims Law provides that individuals may serve as qui tam relators and bring an action on behalf of the State against a person or entity that has violated the False Claims Law. If successful, the relator may be entitled to an award of between fifteen and twenty-five percent of the proceeds recovered and collected in the action or in settlement depending upon the extent to which the relator substantially contributed to the prosecution of the action and whether the Attorney General intervened in the case.

*The BBA of 2015 requires annual re-indexing of FCA penalties for inflation. The penalties will continue to be adjusted each year to reflect changes in the inflation rate.

Appendix II

The following is a summary of contract provisions for the State of Massachusetts.

MassHealth Provisions
The Plan shall:

- Comply with all federal requirements for education of employees, subcontractors and agents about false claims laws under 42 U.S.C. §1396a(a)(68) if Medicaid payments were made or received in the amount of at least $5 million during the prior Federal fiscal year. Written certification of compliance with such federal requirements will be provided April 30th annually, or at a time specified by EOHHS, in a form acceptable to MassHealth and, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. §1396a(a)(68), any employee handbook, and such other information as EOHHS may deem necessary to determine compliance will also be provided;
- Comply with all applicable state contract requirements concerning excluded providers;
- Upon receiving a complaint of Fraud or Abuse from any source or upon identifying any questionable practices, conduct a preliminary review to determine whether in the Plan's judgment, there is sufficient reason to believe that the provider or Enrollee has engaged in Fraud or Abuse, and where sufficient reason exists, report the matter in writing to MassHealth within five days;
- If such preliminary review, or any further review or audit of a provider suspected of Fraud involves contacting the provider in question, the Plan shall first notify MassHealth and receive its approval prior to initiating such contact;
- Require providers to implement corrective actions or terminate provider Agreements, as appropriate;
- Submit ad hoc and annual written reports on its Fraud & Abuse activities according to the format specified by MassHealth;
- Have the CEO or CFO certify in writing on an annual basis to MassHealth, using the required MassHealth template, that after a diligent inquiry, to the best of his/her knowledge and belief, the Plan is in compliance with its MassHealth contract and has not been made aware of any instances of Fraud & Abuse in any program covered by its MassHealth Contract, other that those that have been reported by the Plan in writing to MassHealth;
- Notify MassHealth upon contact by the Medicaid Fraud Control Unit (MFCU), the Bureaus of Special Investigations (BSI) or any other investigative authorities conducting Fraud & Abuse investigations unless specifically directed by the investigative authorities not to notify MassHealth. The Plan, and where applicable any Contractors (including any subcontractors or Material Subcontractors under the MassHealth Contract) shall cooperate fully with the MFCU, BSI, and any other agencies that conduct investigations, full cooperation includes but is not limited to timely exchange of information and strategies for addressing Fraud & Abuse, as well as allowing prompt direct access to information, free copies of documents and other available information related to program violations, while maintaining the confidentiality of any investigation. The Plan shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding;
- Notify MassHealth of all provider overpayments above $25,000, or any voluntary provider disclosures resulting in receipt of overpayments in excess of $25,000, even if there is no suspicion of fraudulent activity; and shall
- Designate a Fraud & Abuse Coordinator**.**

Accountable Care Organization (ACO) Provisions:
The Plan shall:

- Comply with all federal requirements for employee education about false claims laws under 42 U.S.C. §1396a(a)(68) if Medicaid payments were made or received in the amount of at least $5 million during the prior Federal fiscal year. Written certification of compliance with such federal requirements will be provided annually, in a form acceptable to MassHealth and, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. §1396a(a)(68), any employee handbook, and such other information as MassHealth may deem necessary to determine compliance will also be provided;
- Comply with all applicable state contract requirements concerning excluded providers and notify MassHealth within two business days of discovery or change in provider circumstance;
- Upon receiving a complaint of Fraud or Abuse from any source or upon identifying any questionable

practices, conduct a preliminary review to determine whether in the Plan's judgment, there is sufficient reason to believe that the provider or Enrollee has engaged in Fraud or Abuse, and where sufficient reason exists, report the matter in writing to MassHealth within five business days;
- If such preliminary review, or any further review or audit of a provider suspected of Fraud involves contacting the provider in question, the Plan shall notify MassHealth within two business days and receive its approval prior to initiating such contact;
- Require providers to implement corrective actions or terminate provider Agreements, as appropriate;
- Submit ad hoc annual written reports on its Fraud & Abuse activities according to the format specified by MassHealth;
- Have the CEO or CFO certify in writing on an annual basis to MassHealth, using the required MassHealth template, that after a diligent inquiry, to the best of his/her knowledge and belief, the Plan is in compliance with its MassHealth contract and has not been made aware of any instances of Fraud & Abuse in any program covered by its MassHealth Contract, other than those that have been reported by the Plan in writing to MassHealth;
- Notify MassHealth within two business days of contact by the Medicaid Fraud Control Unit (MFCU), the Bureaus of Special Investigations (BSI) or any other investigative authorities conducting Fraud & Abuse investigations unless specifically directed by the investigative authorities not to notify MassHealth. The Plan, and where applicable any Contractors (including any subcontractors or Material Subcontractors under the MassHealth Contract) shall cooperate fully with the MFCU, BSI, and any other agencies that conduct investigations, full cooperation includes but is not limited to timely exchange of information and strategies for addressing Fraud & Abuse, as well as allowing prompt direct access to information, free copies of documents and other available information related to program violations, while maintaining the confidentiality of any investigation. The Plan shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding;
- Notify MassHealth of all provider overpayments above $25,000, or any voluntary provider disclosures resulting in receipt of overpayments in excess of $25,000, even if there is no suspicion of fraudulent activity no later than two business days; and shall
- Designate a Fraud & Abuse Coordinator and maintain staff working on program integrity activities that are familiar with MassHealth and state and federal regulations on fraud, waste and abuse**.**

Senior Care Options

The Plan shall:

- In accordance with 42 CFR 438.608, the Plan shall have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designated to guard against fraud and abuse. The compliance plan must be submitted to EOHHS annually on the anniversary of the contract start date;
- Develop a comprehensive internal fraud and abuse program, as part of the Plan's compliance program to prevent and detect violations;
- Not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution in conformance with MGL c. 12, §5J;
- Upon a compliant of fraud or abuse from any source or upon identifying any questionable practices, conduct a preliminary review to determine whether in the Plan's judgment, there is reason to believe that a Provider, and Enrollee, or an Employee, has engaged in fraud or abuse. For each complaint of fraud and abuse that warrants a preliminary investigation, report to EOHHS the name and identification number of the Enrollee/Provider, the source of the complaint; the type of Provider; the nature of the complaint; the approximate dollars involved and the legal and administrative disposition of the preliminary investigation;
- Make diligent efforts to avoid or recover any improper payments or funds misspent due to fraudulent or abusive actions by the Plan, or its parent organization, its Providers or its Subcontractors;
- Require Providers to implement corrective actions or terminate Provider agreements, as appropriate;
- Notify EOHHS in writing within ten (10) calendar days if it or, where applicable, any of its Subcontractors receive or identify any information that gives them reason to suspect that a

MassHealth Provider or Member has engaged in fraud as defined under 42 CFR 455.2. In the event of suspected fraud, no further contact shall be initiated with the Provider or Member on that specific matter without EOHHS's approval;

- The Plan, and where applicable, its Subcontractors shall cooperate fully with the Office of the Attorney Generals Medicaid Fraud Unit (MFCU) and the Office of the State Auditor's Bureau of Special Investigations (BSI). Such cooperation shall, include, but not be limited to, providing at no charge, prompt access and copies of any documents and other available information determined necessary by such agencies to carry out their responsibilities regarding Medicaid fraud and abuse, maintaining the confidentiality of any such investigations, and making knowledgeable staff available at no charge to support any investigation, court, or administrative proceeding.
- Submit on an annual basis a fraud and abuse report according to the format specified by EOHHS, and submit ad hoc reports as needed, or as requested by EOHHS in accordance with Appendix D of the contract;
- Have the CEO or CFO certify in writing on an annual basis to EOHHS that after a diligent inquiry, to the best of his/her knowledge and believe, the Plan is in compliance with the contract and has not been made aware of any instances of Fraud and Abuse in any program covered by the contract, other than those that have been reported by the Plan in writing to EOHHS;
- Notify EOHHS of all Provider overpayments above $75,000, or any voluntary Provider disclosures resulting in receipt of overpayments in excess of $75,000, even if there is no suspicions of fraudulent activity;
- Comply with all federal requirements for employee education about false claims laws under 42 USC § 1396a(a)(68) if the Plan received or made Medicaid payments in the amount of at least $5 million during the prior Federal fiscal year;
    - If the Plan is subject to such federal requirements, the Plan must:
        - On or before April 30th of each Contract Year, or such other date as specified by EOHHS, provide written certification, in a form acceptable to EOHHS and signed under the pains and penalties of perjury, of compliance with such federal requirements;
        - Make available to EOHHS, upon request, a copy of all written policies implemented in accordance with 42 USC § 1396a(a)(68), any employee handbook, and such other information as EOHHS may deem necessary to determine compliance; and
        - Initiate such corrective action as EOHHS deems appropriate to comply with such federal requirements.
- Designate a Fraud and Abuse prevention coordinator.
- Require its Providers to use, the OIG List of Excluded Individuals Entities (LEIE) upon initial hiring or contracting and on an ongoing monthly basis to screen employees and contractors, including providers and subcontractors, to determine if any such individuals or entities are excluded from participation in federal health care programs. The Plan shall notify EOHHS of any discovered exclusion of any employee or contractor.

New Hampshire DHHS Provisions

The Plan shall:

- The Plan shall have a Program Integrity Plan in place that has been approved by DHHS and that shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse. The Plan is expected to be familiar with, comply with, and require compliance with, all state and federal regulations related to Medicaid Program Integrity, whether or not those regulations are listed herein, and as required in accordance with 42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008, and Section 1902(a)(68) of the Social Security Act.
    - Fraud, waste and abuse investigations are targeted reviews of a provider or member in which there is a reason to believe that the provider or member are not properly delivering services or not properly billing for services. Cases which would be considered investigations are as follows, but not limited to: :
        - review of instances which may range from outliers identified through data mining;
        - pervasive or persistent findings of routine audits to specific allegations that involve or

appear to involve intentional misrepresentation in an effort to receive an improper payment;
    - notification of potential fraud, waste, and abuse through member verification of services, or complaint filed; and.
    - any reviews as defined by CMS as fraud, waste, and abuse investigation.
  - Routine claims audits are random reviews conducted for the purpose of verifying provider compliance with contractual requirements including, but not limited to, quality standards, reimbursement guidelines, and/or medical policies.
- The Plan shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud, waste and abuse. The Plan procedures shall include, at a minimum, the following:
  - Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and State standards;
  - The designation of a compliance officer and a compliance committee that are accountable to senior management;
  - Effective training and education for the compliance officer and the MCO's employees;
  - Effective lines of communication between the compliance officer and the MCO's employees;
  - Enforcement of standards through well-publicized disciplinary guidelines;
  - Provisions for internal monitoring and auditing; and
  - Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's Agreement [42 CFR 438.608(a) and (b)]
- The Plan shall establish a Program Integrity Unit within the Plan comprised of:
  - Experienced Fraud, Waste and Abuse reviewers who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein; and
  - An experienced Fraud, Waste, and Abuse Coordinator who is qualified by having appropriate background, training, education, and experience in health care provider fraud, waste and abuse.
- This unit shall have the primary purpose of preventing, detecting, investigating and reporting suspected Fraud, Waste and Abuse that may be committed by providers that are paid by the Plan and/or their subcontractors. The Plan Program Integrity Plan shall also include the prevention, detection, investigation and reporting of suspected fraud by the Plan, the Plan's employees, subcontractors, subcontractor's employees, or any other third parties with whom the Plan contracts. The Plan shall refer all suspected provider fraud to the DHHS Program Integrity Unit upon discovery. The Plan shall refer all suspected member fraud to DHHS Special Investigations Unit.
- The Plan shall report provider fraud, waste and abuse information to DHHS' Program Integrity Unit, which is responsible for such reporting to federal oversight agencies pursuant to [42 CFR 455.1(a)(1)].
  - The Plan shall perform a preliminary investigation of all incidents of suspected fraud, waste and abuse internally. The Plan shall not take any of the following actions as they specifically relate to claims involved with the investigation unless prior written approval is obtained from DHHS' Program Integrity Unit, utilizing the Plan Request to Open Investigation form:
    - Contact the subject of the investigation about any matters related to the investigation, either in person, verbally or in writing, hardcopy, or electronic;
    - Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
    - Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- The Plan shall provide full and complete information on the identity of each person or corporation with an ownership or controlling interest (five (5) percent or greater) in the Plan, or any sub-contractor in which the Plan has a five percent (5%) or greater ownership interest.
- The Plan shall not knowingly be owned by; hire or contract with an individual who has been

debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State.

- As an integral part of the Program Integrity function, and in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438, the Plan shall provide DHHS or its designee real time access to all of the Plan electronic encounter and claims data from the Plan's current claims reporting system. The Plan shall provide DHHS with the capability to access accurate, timely, and complete data as specified in section 24.5.16.
  - Plans shall provide any additional data access upon written request from DHHS for any potential fraud, waste, or abuse investigation or for Plan oversight review. The additional access shall be provider within 3 business days of the request.
- The Plan shall make claims and encounter data available to DHHS (and other State staff) using a reporting system that is compatible with DHHS' system(s).

- The Plan, their subcontractors, their contracted providers, their subcontractor's providers, and any subcontractor's subcontractor's providers shall cooperate fully with Federal and State agencies and contractors in any program integrity related investigations and subsequent legal actions. The Plan, their subcontractors and their contracted providers, subcontractor's providers, and any subcontractor's subcontractor's providers shall, upon written request and as required by this Agreement or state and/or federal law, make available any and all administrative, financial and medical records relating to the delivery of items or services for which Plan monies are expended. In addition, and as required by this Agreement or state and/or federal law, such agencies shall, also be allowed access to the place of business and to all Plan records of any contractor, their subcontractor or their contracted provider, subcontractor's providers, and any subcontractor's subcontractor's providers.
  - The Plan is responsible for program integrity oversight of its subcontractors.

In accordance with federal regulations, CMS requires Plan contracts to contain provisions giving states' Program Integrity Units audit and access authority over Plans and their subcontractors to include direct on site access to ordinal policies and procedures, claims processing, and provider credentialing for validation purposes at the expense of the Plan.

- The Plan shall have a written process approved by DHHS for Recipient Explanation of Medicaid Benefits, which shall include tracking of actions taken on responses, as a means of determining and verifying that services billed by providers were actually provided to members. The Plan shall provide DHHS with a quarterly EOB activity report, including, but not limited to, tracking of all responses received, action taken by the Plan, and the outcome of the activity. The timing, format, and mode of transmission will be mutually agreed upon between DHHS and the Plan.
- The Plan shall maintain an effective fraud, waste and abuse-related provider overpayment identification, recovery and tracking process. This process shall include a methodology for a means of estimating overpayment, a formal process for documenting communication with providers, and a system for managing and tracking of investigation findings, recoveries, and underpayments related to fraud, waste and abuse investigations. DHHS and the AG Medicaid Fraud Unit shall have unrestricted access to information and documentation related to the NH Medicaid program for use during annual Plan Program Integrity audits and on other occasions as needed as a means of verifying and validating Plan compliance with the established policies, procedures, methodologies, and investigational activity regarding provider fraud, waste and abuse.
- The Plan shall provide DHHS with a monthly report of all Program Integrity, in process and completed during the month, including fraud, waste and abuse by the Plan, the Plan's employees, subcontractors, subcontractor's employees, and contracted providers. [42 CFR 455.17]. The Plan will supply at a minimum:
  - provider name/ID number,
  - source of complaint,

  - type of provider,
  - nature of complaint,
  - review activity,
  - and approximate dollars involved,
  - Provider Enrollment Safeguards related to Program Integrity;
  - Overpayments, Recoveries, and Claim Adjustments;
  - Audits/Investigations Activity;
  - MFCU Referrals;
  - Involuntary Provider Terminations; and
  - Provider Appeal/Hearings Activity resulting from, or related to, Program Integrity.
- All fraud, waste and abuse reports submitted to DHHS shall be mutually developed and agreed upon between DHHS and the Plan. The reports will be submitted to DHHS in a format and mode of delivery, mutually agreed upon between DHHS and the Plan.
- In the event DHHS is unable to produce a desired Ad Hoc report through its access to the Plan's data as provided herein, DHHS shall request in writing such Ad hoc report from the Plan and, within three (3) business days of receipt of such request, the Plan shall notify DHHS of the time required by the Plan to produce and deliver the Ad hoc report to DHHS, at no additional cost to DHHS.
- The Plan shall be responsible for tracking, monitoring, and reporting specific reasons for claim adjustments and denials, by error type and by provider. As the Plan discovers wasteful and or abusive incorrect billing trends with a particular provider/provider type, specific billing issue trends, or quality trends, it is the Plan's responsibility, as part of the provider audit/investigative process, to recover any inappropriately paid funds, and as part of the resolution and outcome, for the Plan to determine the appropriate remediation, such as reaching out to the provider to provide individualized or group training/education regarding the issues at hand. The Plan shall still notify Program Integrity unit to request approval to proceed with a suspected fraud or abuse investigation. The Plan shall notify Program Integrity unit of actions taken in the monthly investigation activity report.
- DHHS reserves the right to conduct peer reviews of final program integrity investigations completed by the Plan and submit an annual report of overpayments recovered, certified by the CFO
- DHHS will perform an annual program integrity audit, conducted on-site at the Plan (at the expense of the Plan) to verify and validate the Plan's compliance. The review will include, but not limited to, the plan's established policies and methodologies, credentialing, provider and staff education/training, provider contracts, and case record reviews to ensure that the Plan is making proper payments to providers for services under their agreements, and pursuant to 42 CFR 438 6(g). The review will include direct access to Plan system while on site and hard copy of documentation while on site as requested. Any documentation request at the end of the onsite shall be delivered to Program Integrity within 3 business days of request. The Plan shall provide DHHS staff with access to appropriate on-site private work space to conduct DHHS's program integrity contract management reviews.
- The Plan shall meet with DHHS monthly, or as determined by DHHS, to discuss audit and investigation results and make recommendations for program improvements. DHHS shall meet with both Plans together quarterly, or as determined by DHHS, to discuss areas of interest for past, current and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities, and to discuss and share provider audit information and results.
- The Plan shall provide DHHS with an annual report of all investigations in process and completed during the Agreement year within thirty (30) calendar days of the end of the Agreement year. The report shall consist of, at a minimum, an aggregate of the monthly reports, as well as any recommendations by the Plan for future reviews, changes in the review process and reporting process, and any other findings related to the review of claims for fraud, waste and abuse.
- The Plan shall provide DHHS with a final report within thirty (30) calendar days following the termination of this Agreement. The final report format shall be developed jointly by

DHHS and the Plan, and shall consist of an aggregate compilation of the data received in the monthly reports.

- The Plan shall refer all suspected provider Medicaid fraud cases to DHHS upon discovery, for referral to the Attorney General's Office, Medicaid Fraud Control Unit.
- The Plan shall institute a Pharmacy Lock-In Program for members which has been reviewed and approved by DHHS.
  - If the Plan determines that a member meets the Pharmacy Lock-In criteria, the Plan shall be responsible for all communications to members regarding the Pharmacy Lock-In determination.
- Plans may, with prior approval from DHHS, implement Lock-In Programs for other medical services.
- The Plan shall provide DHHS with a monthly report regarding the Pharmacy Lock- In Program. Report format, content, design, and mode of transmission shall be mutually agreed upon between DHHS and the Plan.
- DHHS retains the right to determine disposition and retain settlements on cases investigated by the Medicaid Fraud Control Unit or DHHS Special Investigations Unit.
- Subject to applicable state and federal confidentiality/privacy laws, upon written request, the Plan will allow access to all NH Medicaid medical records and claims information to State and Federal agencies or contractors such as, but not limited to Medicaid Fraud Control Unit, Recovery Audit Contractors (RAC) the Medicaid Integrity Contractors (MIC), or DHHS Special Investigations Unit.
  - The Plan shall cooperate fully in any further investigation or prosecution by any duly authorized government agency (State and Federal) or their contractors, whether administrative, civil, or criminal. Such cooperation shall include providing, upon written request, information, access to records, and access to interview Plan employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
- The Plan's MCIS system shall have specific processes and internal controls relating to fraud, waste and abuse in place, including, but not limited to the following areas:
  - Prospective claims editing;
  - NCCI edits;
  - Post-processing review of claims; and
  - Ability to pend any provider's claims for pre-payment review if the provider has shown evidence of credible fraud [42 CFR 455.21] in the Medicaid Program.
- The Plan and their subcontractors shall post and maintain DHHS approved information related to Fraud, Waste and Abuse on its website, including but not limited to provider notices, updates, policies, provider resources, contact information and upcoming educational sessions/webinars.
- The Plan and their subcontractors shall be subject to on-site reviews by DHHS, and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests as a result of an annual or targeted on-site review (at the expense of the Plan).
- DHHS shall conduct investigations related to suspected provider fraud, waste, and abuse cases, and reserves the right to pursue and retain recoveries for any and all types of claims older than six months for which the Plan does not have an active investigation.
- DHHS shall validate the Plan and their subcontractors' performance on the program integrity scope of services to ensure the Plan and their subcontractors are taking appropriate actions to identify, prevent, and discourage improper payments made to providers, as set forth in 42 CFR 455 – Program Integrity.
- DHHS shall establish performance measures to monitor the Plan compliance with the Program Integrity requirements set forth in this Agreement.

- DHHS shall notify the Plan of any policy changes that impact the function and

responsibilities required under this section of the Agreement.

- DHHS shall notify the Plan of any changes within its agreement with its fiscal agent that may impact this section of this Agreement as soon as reasonably possible.
- The Plan(s) shall report to DHHS all identified providers prior to being investigated, to avoid duplication of on-going reviews with the RAC, MIC, MFCU and, using the Plan Request to Open Investigation Form. DHHS will either approve the Plan to proceed with the investigation, or deny the request due to potential interference with an existing investigation.
- The Plan(s) shall maintain appropriate record systems for services to members pursuant to 42 CFR 434.6(a)(7) and shall provide such information either through electronic data transfers or access rights by DHHS staff, or its designee, to Plan(s) NH Medicaid related data files. Such information shall include, but not be limited to:
  - Recipient – First Name, Last Name, DOB, gender, and identifying number;
  - Provider Name and number (rendering, billing and Referring);
  - Date of Service(s) Begin/End;
  - Place Of Service;
  - Billed amount/Paid amount;
  - Paid date;
  - Standard diagnosis codes (ICD-9-CM and ICD-10-CM), procedure codes (CPT/HCPCS), revenue codes and DRG codes, billing modifiers (include ALL that are listed on the claim);
  - Paid, denied, and adjusted claims;
  - Recouped claims and reason for recoupment;
  - Discharge status;
  - Present on Admission (POA);
  - Length of Stay;
  - Claim Type;
  - Prior Authorization Information;
  - Detail claim information;
  - Provider type;
  - Category of Service;
  - Admit time and discharge date;
  - Admit code;
  - Admit source;
  - Covered days;
  - TPL information;
  - Units of service;
  - EOB;
  - Plan ID#;
  - Member Plan enrollment date;
  - If available, provider time in and time out for the specific service(s) provided;
  - Data shall be clean, not scrubbed; and
  - Any other data deemed necessary by DHHS.
- The Plan shall provide DHHS with the following monthly reports as required by CMS:
  - Date of Death.
- The Plan shall provide DHHS with any new reports as identified and required by state and federal regulation. The timing, format, content and mode of transmission will be mutually agreed upon between DHHS and the Plan.