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<p align="center">Fraud, Waste and Abuse Policy</p>				Policy Number
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				Page Number:
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<p>Related documents: Non Compliance Reporting and Investigation Policy and Non-retaliation policy</p>				

Purpose

The purpose of this policy is to set forth the manner in which WellSense Health Plan ("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 Manager of Special Investigations;
- The Plan's Vice President of Business Operations;
- The Fraud and Abuse email box (FraudandAbuse@bmchp-wellsense.org);
- The Plan's Compliance Department;
- EthicsPoint (wellsense.ethicspoint.com); 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 informing 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 and New Hampshire is the Manager of Special Investigations. This role is 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)
Chapter 21 – Rev 109
Chapter 9 – Rev 15

42 C.F.R. § 422.503(b)(4)(vi)(G)

42 C.F.R. § 423.504(b)(4)(vi)(G)

Policy Revision History

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Revision 07/19/2022 – update notification of provider overpayments and reference the Federal Register for monetary penalties, add three (3) business days to provide any data access or detail records upon written request to NH DHHS

Review 07/18/2023

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07/2024

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 according to the Federal Register* 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 identified in the Federal Register 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 identified in the Federal Register* 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, attorney’s 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 identified in the Federal Register* 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, attorney's 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

Please refer back to the actual contract for all contractual requirements regarding Program Integrity and Fraud, Waste and Abuse. The following are summaries of the contract requirements and may not include all contract requirements or references.

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 than 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;
- For the amount defined in the contract, notify MassHealth of all provider overpayments or any voluntary provider disclosures resulting in receipt of overpayments, related to any suspected fraud investigations within the deadline noted in the contract;
- For the amount defined in the contract, notify MassHealth via regulatory reporting, at a frequency designated by the contract, of all provider overpayments or any voluntary provider disclosures

- resulting in receipt of overpayments 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;
- For the amount defined in the contract, notify MassHealth of all provider overpayments or any voluntary provider disclosures resulting in receipt of overpayments, related to any suspected fraud investigations within the deadline noted in the contract;
- For the amount defined in the contract, notify MassHealth via regulatory reporting, at a frequency designated by the contract, of all provider overpayments or any voluntary provider disclosures resulting in receipt of overpayments even if there is no suspicion of fraudulent activity; 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 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 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 General's 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;
- As defined in the contract, notify EOHHS of all Provider overpayments or any voluntary Provider disclosures resulting in receipt of overpayments 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.
- The Plan shall refer cases involving potential fraud or abuse that meet any of the following criteria to the NBI MEDIC using the Qlarant Investigations MEDIC Complaint form:
 - Suspected, detected or reported criminal, civil or administrative law violations;
 - Allegations that extend beyond the Parts C and D plans, involving multiple health plans, multiple states, or widespread schemes;
 - Allegations involving known patterns of fraud;
 - Pattern of fraud or abuse threatening the life or well-being of beneficiaries; and
 - Scheme with large financial risk to the Medicare Program or beneficiaries.

New Hampshire DHHS Provisions

The Plan shall:

- The Plan shall have Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plans that are designed to guard against fraud, waste and abuse in place that have been approved by DHHS and 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 by its Subcontractors with all the state and federal regulations related to Medicaid program integrity, whether or not those regulations are listed herein, and as required in accordance with Section 1902(a)(68) of the Social Security Act, 42 CFR Section 438, 42 CFR Section 455, 42 CFR Section 456, 42 CFR Section 1000 through 1008 and CMS Toolkits.
- The Plan shall ensure compliance with the program integrity provisions, including proper payments to providers or Subcontractors, methods for detection and prevention of fraud, waste and abuse and all program integrity reporting requirements to DHHS.
- The Plan shall work with DHHS on program integrity issues and with the MFCU as directed by DHHS, on fraud, waste or abuse investigations. This shall include, at a minimum:
 - Participation in program integrity meetings with DHHS following the submission of the monthly allegation log submitted by the Plan;
 - The Plan shall ensure Subcontracts attend monthly meetings when requested by DHHS;
 - Participation in bi-annual Plan and Subcontractor forums to discuss best practices,

- performance metrics, provider risk assessments, analytics and lessons learned;
- Participation in meetings with MFCU, as determined by MFCU and DHHS; and
- Provide any data access or detail records upon written request from DHHS within three (3) business days of the request for any potential FWA investigation, provider or claims audit, or for MCO oversight review.
- The Plan, or Subcontractor, which has been delegated responsibility for coverage of services and payment of claims shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse [42 CFR 438.608(a)].
- The Plan shall document the process to monitor their marketing representative activities to ensure that the Plan does not engage in inappropriate activities, such as inducements and the Plan shall report on staff terminations for engaging in prohibited marketing conduct or fraud, waste and abuse to DHHS within thirty (3) business days.
- The Plan shall implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about the rights of employees to be protected as whistleblowers.
- The Plan, and if required by the Plan's Subcontractors, shall post and maintain DHHS-approved information related to fraud, waste and abuse on its website, including but not limited to, provider notices, current listing of Participating Providers, providers that have been excluded or sanctioned from the Medicaid Care Management Program, any updates, policies, provider resources, contact information and upcoming educational sessions/webinars.
- The Plan shall maintain an effective fraud, waste and abuse-related Provider overpayment identification, recovery and tracking process and shall perform ongoing analysis of its authorization, utilization, claims, Provider's billing patterns, and encounter data to detect improper payments,. The Plan shall perform audits and investigations of Subcontractors, Providers and Provider entities. The Plan and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all overpayments, specifically forth recovery of overpayments due to fraud, waste and abuse, and for reporting and returning overpayments as required [42 CFR 438.608(d)(1)(i)]. The Plan and its subcontracts shall report to DHHS within sixty (60) calendar days when it has identified Capitation Payments or other payment amounts received are in excess to the amounts specified in the contract [42 CFR 438.608(c)(3)] and DHHS may recover overpayments that are not recovered by or returned to the Plan within sixty (60) calendar days of notification by DHHS to pursue.
- The Plan shall complete a DHHS "Request to Open" form for any potential fraud, waste, or abuse case, including those that lead to a credible allegation of fraud. DHHS Program Integrity Unit shall have fifteen (15) business days to respond to the Plan's "Request to Open" form and when the Plan or its Subcontractor has concluded that a credible allegation of fraud or abuse exists, the Plan shall make a referral to DHHS Program Integrity Unit and any potential fraud directly to MFCU within five (5) business days of the determination on a template provided by DHHS. [42 CFR 438.608(a)(7)].
- If DHHS, MFCU or another law enforcement agency accepts the allegation for investigation, DHHS shall notify the Plan's Compliance Officer within two (2) business days of the acceptance notification, along with a directive to suspend payment to the affected Provider(s) if it is determined that suspension shall not impair MFCU's or law enforcement's investigation.
- Upon receipt of notification from DHHS, the Plan shall send notice of the decision to suspend program payments to the Provider within the following timeframe:

- Within five (5) calendar days of taking such action unless requested in writing by DHHS, the MFCU, or law enforcement to temporarily withhold such notice; or
- Within thirty (30) calendar days if requested by DHHS, MFCU, or law enforcement in writing to delay sending such notice.
- The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.
- The Provider shall have the right to file an appeal with the Plan related to program integrity. The Provider shall have the right to file an appeal within thirty (30) calendar days of the date of the Plan's notice of adverse action to the Provider.