INDEPENDENT CARE HEALTH PLAN
POLICY/PROCEDURE

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POLICY:

This Policy outlines the responsibilities and obligations of all employees regarding Fraud Waste and Abuse ("FWA") in the Medicare and Medicaid programs. In addition, this policy is intended to apply to business arrangements with all first-tier, downstream and related entities ("FDRs") that may be subject to State and Federal FWA requirements.

Detecting and preventing FWA is the responsibility of everyone, including employees, members, providers and sub-contractors. Independent Care (herein after *i*Care) has written policies and procedures to address the prevention, detection, and investigation of suspicious activity. In addition, *i*Care conducts compliance training and provides information related to FWA on the *i*Care Intranet site. *i*Care also has an AlertLine via phone: **(877) 564-9614** or via the web: ***https://icare.alertline.com*** for employees to report suspected FWA anonymously. Members may report FWA through their Care Coordinator or anonymously through the *i*Care website or via mail addressed to the Compliance Department. FDRs may report FWA directly to the Compliance Department or anonymously through the *i*Care website.

DEFINITIONS:

Abuse occurs when an individual or entity unintentionally provides information to Medicare which results in higher payments than the individual or entity is entitled to receive.

Fraud means an intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes, knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person.

Waste is the inappropriate utilization and/or inefficient use of resources.

Some examples of potential FWA:

- Falsifying/Altering Claims
- Incorrect Coding
- Double Billing
- Billing for Services not provided
- Kickback/Stark Violations
- Member Eligibility Fraud/Residency
- Fraudulent enrollment practices
- Misrepresentation of medical condition
- Billing for Services not furnished or drugs not provided

- Billing expired drugs
- Dispensing without a prescription
- Billing for brand when generics are dispensed
- Altering scripts or data to obtain a higher payment amount
- Loaning Forward Health Card to others to obtain benefits

Federal False Claims Act (31 U.S.C. §§ 3729-3733): The False Claims Act ("FCA") is a Federal statute that imposes civil penalties on any person or entity who:

- Knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program.
- Knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program.
- Conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.

When submitting claims to the federal government, all claims must be closely reviewed to assure accuracy. The FCA provides civil penalties of not less than $5,500 but no more than $11,000, plus three times the amount paid for each false claim. The courts can also impose criminal penalties against individuals and organizations for intentional violations of the False Claims Act. Intent to defraud is not necessary for a violation to occur. A false claim may be found if the party submitting the claim had knowledge of the information and acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Examples of potential false claims include knowingly billing Medicare for services that were not provided, submitting inaccurate or misleading claims for actual services provided, or making false statements to obtain payment for services.

The False Claims Act allows individuals with original information about fraud involving federal health care programs to file a complaint under seal with a federal court. If the government proceeds with the case, the person who filed the action may receive a portion of the recoveries depending upon the contribution of that person to the prosecution of the case. The person who filed the action also has the right to continue with the case on his or her own.

Wisconsin False Claims Law: Medicaid Fraud Statute s. 49.49 (1), Wis. Stats. prohibits any person from:

- Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in a claim for Medicaid benefits or payments.

- Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments.
- Having knowledge of an act affecting the initial or continued right to Medicaid benefits or payments, or the initial or continued right to Medicaid benefits or payments of any other individual on whose behalf someone has applied for or is receiving the benefits or payments, concealing or failing to disclose such event with an intent to fraudulently secure Medicaid benefits or payments, whether in a greater amount or quantity than is due or when no benefit or payment is authorized.
- Making a claim for Medicaid benefits or payments for the use or benefit of another, and after receiving the benefit or payment, knowingly and willfully converting it or any part of it to a use other than for the use and benefit of the intended person.

Anyone found guilty of the above may be imprisoned for up to six years, and fined not more than $25,000, plus three times the amount of actual damages.

WHISTLEBLOWER PROTECTIONS

The Federal and State False Claims Act protect whistleblower employees from retaliation by their employer. Employees that are discharged, demoted, suspended, threatened, harassed, or in any way discriminated against in the terms and conditions of employment by their employer for "blowing the whistle" are entitled to recover relief necessary to make the employee whole.

*i*Care expects employees and FDRs to report, through appropriate channels, concerns regarding actual or potential non-compliance with applicable federal and state laws and/or *i*Care's internal policies and procedures. Employees may report suspected fraud, waste or abuse using the anonymous AlertLine if they are uncomfortable reporting to their supervisor.

ROLE OF FALSE CLAIMS LAWS

The false claims laws discussed above are an important part of preventing and detecting fraud, waste and abuse in federal and state health care programs. They provide government agencies the authority to search for, investigate and prosecute fraudulent activities. Enforcement activities can take place in the criminal, civil and administrative areas providing a variety of remedies to battle these problems.

Anti-retaliation protections encourage reporting and provide more opportunities to prosecute

violations. Employment protections provide the security employees need in order to help the government investigate reported activities.

ROLE OF *i*CARE COMPLIANCE PROGRAM

*i*Care is committed to ethical behavior and full compliance with all laws and regulations that apply to our health care business. We have an obligation to act in a way that merits the trust, confidence, and respect of those we serve. We have a Compliance Program ("Program") to support our commitment to operating with the highest degree of integrity. Our Program includes a Compliance Officer, Compliance Committee, the Code of Conduct, Compliance Program Workplan, policies and procedures, training and education, auditing and monitoring, and mechanisms for individuals to raise issues and concerns without fear of retaliation.

Whether you are an employee, contractor, intern, or temporary staff member with *i*Care, **you are expected to**:

A. Be alert to potential compliance issues.
B. Act with honesty and integrity in all of your business activities.
C. Follow all laws and regulations that apply to your work activities, including the requirements of Medicare, Medicaid and other federal health care programs. The requirements generally include maintaining complete and accurate documentation, and medical records, and submitting only complete and accurate claims for services provided.
D. Cooperate in the investigation of compliance reports.
E. Contact any of the following resources, *immediately,* if you have knowledge or concern regarding a potential FWA concern:
    1. Your manager/director/supervisor.
    2. AlertLine
    3. Compliance Officer
    4. General Counsel
    5. The Human Resource Department

*i*Care takes reasonable measures to protect the confidentiality of anyone making a report. Unless the identity of a person reporting a compliance or ethics issue is necessary to conduct an investigation, the identity of that person will not be disclosed. However, if it must be disclosed to conduct the investigation, that person's identity will be disclosed only on a need-to-know basis. Allegations are investigated by the Compliance Department in accordance with Policy CO-003, Investigating Violations.

*i*Care is committed to providing a workplace conducive to open discussion of its business practices and regulatory compliance. Any retaliation against an employee, who in good faith reports a suspected violation of company policies, the law, or contractual obligations, is not allowed and should be immediately reported to the Human Resource Department or the Director of Compliance.

We hope that our Program encourages you to share your thoughts and ideas with others, to anticipate problems before they occur and to report any concerns you may have. Compliance is everyone's responsibility. We all have an important role to play in the continued success of our Corporate Compliance Program.

CMS FRAUD ALERTS

Periodically CMS issues alerts to health plans including *i*Care concerning fraud schemes identified by law enforcement officials. Often these notices describe pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes (prescribers receiving payment as an inducement or reward for writing prescriptions). CMS provides these notices so that *i*Care can take appropriate steps to ensure that the Company is not making payments for fraudulent claims.

The Compliance Department forwards Fraud Alert memos from HPMS to both the Pharmacy Director and Operations Director. The Pharmacy Director, with the assistance of the PBM, and Operations Director ensure no fraudulent claims are paid. The fraud alerts usually describe alleged schemes for which the parties have not yet been found legally responsible. Therefore, *i*Care takes action (including denying or reversing both past and/or future claims) in instances where analysis of its own claims activity indicates that fraud may be occurring or has occurred. *i*Care's decisions to deny or reverse claims are made on a claim specific basis.

To help ensure that *i*Care pays no further fraudulent claims, *i*Care reviews the contractual arrangements made with the pharmacy or prescribers and may terminate such relationship if appropriate.

*i*Care establishes edits on certain providers if potential fraudulent claims are identified, and uses data analysis to identify trends and develop more focused audits as appropriate. The alert is not sufficient grounds to take action without additional analysis. *i*Care makes its best efforts to identify claims that may have been part of the alleged fraud scheme and remove them from the

PDE data submissions. iCare also reverses the affected pharmacy claims and reduces the members' TrOOP and drug-spend amounts accordingly.

CREDIBLE ALLEGATIONS OF FRAUD

A credible allegation of fraud is, as defined in 42 C.F.R. § 455.2, one considered by DHS to have indicia of reliability based on a careful and judicious review by the Department of all assertions, facts and evidence on a case-by-case basis.

*i*Care shall suspend payments to a sub-contracted provider pursuant to 42 C.F.R. 455.23 if DHS informs *i*Care that DHS has suspended fee-for-service Medicaid payments to the provider because of a credible allegation of fraud, unless *i*Care believes there is good cause for not suspending its payments.

1. DHS notifies the Director of Compliance when a Credible Allegation of Fraud is identified. The Director of Compliance then notifies the Claims Department, Network Development, V.P. of Accountable Care, QI Department, Credentialing Manager, Prior Authorization Department, CFO, General Counsel and CEO.
2. The Director of Network Development determines whether the provider is contracted. The Claims Department updates the claims system to ensure payments are not made to the provider until the suspension is lifted.
3. Contingency planning is made for continuation of services for members on a case by case basis.
4. If *i*Care believes that based on the criteria under 42 CFR 455.23 (e) or (f) that there is good cause for not suspending its payments or for only suspending them in part, *i*Care submits written documentation to DHS describing the basis for such a good cause exception to suspend payment. DHS approves or disapproves *i*Care's request within ten (10) business days. If DHS disapproves the request, *i*Care suspends payments to the provider.
5. If *i*Care suspends payments in whole or in part to a subcontracted provider because DHS has determined that there is a credible allegation of fraud and there fails to be good cause to not suspend payments, *i*Care:
    a. Provides notice to the provider that meets the timeframe and content requirements of 42 CFR 455.23 (b).
    b. Terminates the suspension when DHS or a prosecutorial authority determines there is insufficient evidence of fraud by the provider or legal proceedings related to the alleged fraud are completed, or when DHS determines there is good cause under 42 C.F.R. § 455.23 (e).

c. Maintains documentation for at least five (5) years of all payment suspensions, instances where a payment suspension was not imposed, imposed only in part or discontinued for good cause, as provided in 42 C.F.R. § 455.23 (g).

6. During the Suspension of Payment phase, *i*Care:
   a. Continues to perform any investigative duties as necessary by working with OIG, MCFU and BFM/OFCE;
   b. Suspends claims payments within the *i*Care payment system;
   c. Confirms the suspension of provider payment by reviewing the Weekly Provider File (field 27);
      i. A = ACA suspension is currently Active
      ii. C = Provider has been cleared of the suspension of payment hold
      iii. T = Provider has been terminated as a Medicaid provider due to the outcome of the credible allegation investigations
   d. Responds to emails as directed;
   e. Prepares and submit a risk assessment and contingency plan if requested; and
   f. Collaborates with OFCE on the health and safety of any members affected by the allegation/investigation.

FRAUD DETECTION

*i*Care is committed to developing initiatives designed to prevent, detect and correct fraud, waste and abuse.

Auditing

To prevent FWA, *i*Care has developed and continues to develop and refine procedures to effectively monitor and audit FWA, and develop ways to detect and prevent FWA.

Auditing and Monitoring of FWA may be performed utilizing any of the following:

- Internal Audits
- Informal Monitoring
- Investigations from compliance referrals or regulatory agencies
- Anonymous Reports
- Claim reviews
- Review of Compliance issues
- Potentially fraudulent areas determined during a risk assessment

Part D Auditing
*i*Care's Pharmacy Benefits Manager (PBM), audits and monitors its pharmacies, as well as prescribing physicians and our members to allow for accurate billing and dispensing practices while reducing or eliminating fraudulent, wasteful and abusive practices.

Training and Education
*i*Care creates awareness and shares knowledge with employees, members and providers through the following:

- Code of Conduct
- Employee training
- Provider training
- Website
- Newsletters

*i*Care provides FWA training to all employees in accordance with Policy CO-002, Compliance Training. FDR's must provide Fraud, Waste and Abuse training meeting CMS requirements to all employees and applicable subcontractors within 90 days of hire and annually thereafter, unless deemed.* To reduce the potential burden on FDRs, CMS has developed and provided a standardized FWA training and education module. The module is available through the CMS Medicare Learning Network (MLN) link (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo/).

*Regulations effective June 7, 2010 implemented a "deeming" exception which exempts FDRs who are enrolled in Medicare Parts A or B from annual FWA education and training (42 CFR § 422.503(b)(4)(vi)(C)(2) and 42 CFR§ 423.504(b)(4)(vi)(C)(3)). Therefore, if an entity or an individual is enrolled in Medicare Parts A or B, the FWA training and education requirement has already been satisfied. In the case of chains, such as chain pharmacies, each individual location must be enrolled in Medicare Part A or Part B to be "deemed".

Responsible Department: Compliance Department
References: DHS contract, CMS Medicare Manual; Wis. Stats s. 49.49(1); 31 U.S.C 3729-3733 31 U.S.C. 3801-3812; Deficit Reduction Act of 2005
Recommended Distribution: All Staff via Independent Care Intranet, FDRs

Approval:

Thomas H. Lutzow, President/CEO — **Date** 10-29-15

Kim Mellen, Director of Compliance — **Date** October 26, 2015