INDEPENDENT CARE HEALTH PLAN

Policy Number: CO-013	**Department: Compliance**
Policy & Procedure Name: Fraud, Waste and Abuse Prevention and Detection Program	
Cross Reference: CO-003 Investigating Violations; CO-028 DHS Payment Suspension/Reinstatement Notification	

Policy Description: 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.

Policy:
Detecting and preventing FWA is the responsibility of everyone, including employees, members, providers, and sub-contractors. Independent Care (herein after *i*Care) utilizes Humana written policies and procedures to address the prevention, detection, and investigation of suspicious activity. In addition, *i*Care utilizes Humana compliance training. Independent Care provides information related to FWA on the *i*Care intranet site. Independent Care utilizes the Humana Special Investigations Unit (SIU) and employees can report suspected FWA by emailing siureferrals@humana.com. Members may report FWA through their Care Coordinator / Care Manager or anonymously through the SIU hotline **(800) 614-4126**, or via mail addressed to the WI Medicaid Compliance Officer. Ethics and privacy issues may be reported via the Humana Ethics Help Line: : **(877) 584-3539** (877-5-THE KEY) or via the web: Ethics Help Line. FDRs may report FWA utilizing the same communication channels.

Definitions:
Abuse includes actions that may result in unnecessary costs to Programs, improper payment, payment for services that fail to meet professionally recognized standards of care, services that are medically unnecessary, provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs in reimbursement. Abuse also involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment; includes member practices that result in unnecessary costs to the Programs.

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

Waste is the overutilization of services and/or inefficient use of resources resulting in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather a misuse of resources.
Some examples of potential FWA:
1) Falsifying/altering claims
2) Incorrect coding

Owner: Kristy Koontz	**Accountable VP/Director: Tony Mollica**
Reviewing Department(s): Compliance; Regulatory Compliance	**Revision Number: 12**
Effective Date: 11/30/2009	**Last Review Date: January, 2024**
Last Revision Date: January, 2024	**Next Review Date: 1/31/2025**
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3) Double billing
4) Billing for services not provided
5) Kickback/Stark Violations
6) Member eligibility fraud/residency
7) Fraudulent enrollment practices
8) Misrepresentation of medical condition
9) Billing for services not furnished or drugs not provided
10) Billing expired drugs
11) Dispensing without a prescription
12) Billing for brand when generics are dispensed
13) Altering scripts or data to obtain a higher payment amount
14) 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:

1) Knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program.
2) 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.
3) 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 $5,000 but no more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-210), plus three times the amount of damages which the Government sustains because of each false claim. The courts can also impose criminal penalties against individuals and organizations for intentional violations of the FCA. 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 FCA 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: Medical Assistance fraud, Wis Statute 946.91, states persons in connection with a medical assistance program are prohibited from:

1) Intentionally making or causing to be made a false statement or misrepresentation of a material fact in any application for any Medical Assistance benefit or payment.
2) Intentionally making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to such Medical Assistance benefits or payments.
3) Having knowledge of an act affecting the initial or continued right to any such Medical Assistance benefit or payment, or the initial or continued right to any such benefit or payment of any other individual on whose behalf someone has applied for or is receiving the benefit or payment, concealing or failing to disclose such event with an intent to fraudulently secure such benefit or payment, whether in a greater amount or quantity than is due or when no benefit or payment is authorized.
4) Making a claim for any such Medical Assistance benefit or payment 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/or fined not more than $25,000.

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.

Whistleblowers can report program integrity concerns to DHS Office of Inspector General (OIG) either through the hotline (877-865-3432) or through the online portal: www.reportfraud.wisconsin.gov/rptfrd/default.aspx

Role of False Claims Laws

The false claims laws discussed above are an important part of preventing and detecting FWA 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.

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.

Independent Care adheres to fraud memos issued from CMS. 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. Independent 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.

Independent 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. Independent 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. Independent Care 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, as defined in 42 C.F.R. §455.2, may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

1) Fraud hotline complaints

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2) Claims data mining
3) Patterns identified through provider audits, civil false claims cases and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

Independent Care shall suspend payments to a 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. Please see *CO-028 DHS Payment Suspension/Reinstatement Notifications*, regarding the process of suspension and reinstatement.

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.

During the suspension of payment phase, *i*Care:
1) Continues to perform any investigative duties as necessary by working with the Department and any other entity legally authorized to investigate;
2) Suspends claims payments within the *i*Care payment system;
3) Confirms the suspension of provider payment by reviewing the Weekly Provider File (field 27);
   a) A = ACA suspension is currently Active
   b) C = Provider has been cleared of the suspension of payment hold
   c) T = Provider has been terminated as a Medicaid provider due to the outcome of the credible allegation investigations
4) Responds to emails as directed; and
5) Prepares and submits a risk assessment and contingency plan if requested

Fraud Detection
Independent Care is committed to developing initiatives designed to prevent, detect, and correct FWA.

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.

Owner: Kristy Koontz	**Accountable VP/Director: Tony Mollica**
Reviewing Department(s): Compliance; Regulatory Compliance	**Revision Number: 12**
Effective Date: 11/30/2009	**Last Review Date: January, 2024**
Last Revision Date: January, 2024	**Next Review Date: 1/31/2025**
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Auditing and Monitoring of FWA may be performed utilizing any of the following:
1) Internal audits
2) Informal monitoring
3) Investigations from compliance referrals or regulatory agencies
4) Anonymous reports
5) Claim reviews
6) Review of compliance issues
7) Potentially fraudulent areas determined during a risk assessment

Part D Auditing
Independent 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.

Program Integrity Annual Plan
The program integrity plan must be submitted to the Department and approved on an annual basis prior to the effective date of the new contract year. Annually, the MCO must submit a program integrity report on the results of the program integrity annual plan within 45 days of the end of the calendar year to the BRS mailbox at DHSLTCFiscalOversight@dhs.wisconsin.gov.

References:
DHS contract; Wis. Stats s. 49.49(1); 939.50(3)(h); 946.91; 31 U.S.C 3729-3733 31 U.S.C. 3801-3812; Deficit Reduction Act of 2005

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