

CARE1ST HEALTH PLAN

ANTI-FRAUD PLAN

This document contains (a) Care1st Health Plans’ programs to detect, deter and report fraud, waste and abuse in Medi-Cal/Medicaid, Medicare, and other health programs it participates in, (b) detailed information on federal and state false claims acts and other laws on health care fraud, waste and abuse, (c) responsibilities of providers, contractors and agents of Care1st in detecting and deterring fraud, waste and abuse in Medi-Cal and other health programs and (d) “whistleblower” protections under federal and state laws.

As a provider, contractor or agent of Care1st Health Plan for providing services in government funded and other health care programs, you and/or your business entity must abide by the policies and procedures in this Anti-Fraud Plan relevant to the interaction between Care1st Health Plan and you and/or your business entity. You must also make this Anti-Fraud Plan available to your employees and sub-contractors involved in performing work or duties under your contract, agreement or agency with Care1st Health Plan.

**December 2015
January 2007**

CARE1ST HEALTH PLAN ANTI-FRAUD PLAN

CONTENTS

1. Introduction

2. Prevention of Fraud, Waste and Abuse in Health Care

- (a) Federal and State laws (including those called “False Claims Acts”) that define health care fraud and abuse and civil and criminal penalties for False Claims**
- (b) What Care1st is doing to detect and prevent health care fraud, waste and abuse**
- (c) Your rights and responsibilities in detecting and preventing health care fraud, waste and abuse and whistleblower protections.**

3. Contractor/Agent Acknowledgement of Receipt and Compliance with Care1st Health Plan’s Anti-Fraud Plan

1. INTRODUCTION

The subject of health care fraud and abuse has undergone significant growth in the past twenty years or so, due to focused regulations at the federal and state levels and stepped up enforcement by DHHS, DOJ and state Medi-Cal Fraud units. Most of the initial legislation and enforcement has been in the Medicare/Medicaid and Hospital (Stark) areas. However, health care fraud and abuse in managed care is beginning to receive attention and inquiry.

For example, the California legislation passed SB 956 in the 1998 legislative session, which added Section 1348 to the Health & Safety Code, which was amended in 1999, and required every health care service plan licensed to do business in the state to establish an antifraud plan. The purpose of the antifraud plan should be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. The antifraud plan elements shall include, but not be limited to, all of the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency. For purposes of this law, "fraud" includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.



The recently enacted federal Deficit Reduction Act of 2005 requires any entity, including any Medicaid (Medi-Cal) managed care organizations such as Care1st to establish written policies for its employees, subcontractors and agents that give detailed information about federal and state false claims laws and whistleblower protections, and the organization's (Care1st's) policies and procedures for detecting and preventing fraud, waste and abuse.

This Anti-Fraud Plan is to address these requirements of federal and state laws.

2. PREVENTING FRAUD, WASTE AND ABUSE IN HEALTH CARE

This section will

- (a) Explain Federal and State laws (including those called “False Claims Acts”) that define health care fraud and abuse and civil and criminal penalties for False Claims;
- (b) What Care1st is doing to detect and prevent health care fraud, waste and abuse; and
- (c) Your rights and responsibilities in detecting and preventing health care fraud, waste and abuse without retaliation.

(a) Federal and State laws (including those called “False Claims Acts”) that define health care fraud and abuse and civil and criminal penalties for False Claims

Federal False Claim Act (FCA)

The Federal False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program including Medicaid (Medi-Cal) and Medicare.

The FCA establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term “knowingly” means that a person, with respect to information:

- had actual knowledge of falsity of information in the claim, or
- acted in “deliberate ignorance” of whether or not the information was true, or
- acted in “reckless disregard” of the truth or falsity of the information in a claim.

It is not necessary that the person had a specific intent to defraud the government.

The False Claims Act prohibits seven types of conduct:

1. **False Claim:** Filing false or fraudulent claims. A Claim includes any request or demand for money that is submitted to the U.S. government or its contractors (like Care1st). So a provider or hospital claim, or a vendor billing, submitted to Care1st involving Medi-Cal or Medicare programs counts as a claim.
2. **False Statement:** Making or using false statements or records.
3. **Conspiracy:** Conspiring with others to submit false claims that are actually paid by the government.
4. **Delivery of Less Property:** Delivering less property than the amount stated on the receipt or certificate.

5. **Delivery of Improper Receipt:** Delivering a receipt for property without knowing whether the information on the receipt is true.
6. **Unauthorized Seller:** Knowingly buying or receiving property from a government employee or official who is not authorized to sell it.
7. **Reverse false claims.** A reverse false claim involves using a false statement to conceal, avoid or decrease the amount of an obligation

Common violations include double billing for services or items, submitting bills for services or items never provided are examples of false claims under the FCA.

The FCA also permits private citizens to file lawsuits on behalf of the federal government in cases where there is a false or fraudulent claim against a government program. In essence, these individuals are acting as “private attorney generals,” and are often referred to as “whistleblowers.” When whistle blowers file such suits they are also called “relators”. The law that allows individuals to file such suits is called “Qui Tam – or Whistleblower – Provisions”. Whistleblowers

- may receive a percentage ranging from 15-30% of amount recovered by the government if the suit is successful and certain legal requirements are met., and
- are protected from retaliatory action (such as employment reinstatement, back pay, interest on back pay and special damages) taken for filing a whistleblower action, investigating a false claim, providing assistance or testimony in investigations of false claims.

Health care providers and suppliers who violate the FCA can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted. In addition to these civil penalties, providers and suppliers can be required to pay three times the amount of damages caused to the U.S. government. Criminal sanctions such as imprisonment also may be imposed. Finally, persons convicted under the FCA may be excluded from participating in federal health care programs.

California False Claims Act (CFCA)

The California False Claims Act (Government Code Section 12650, et seq.) was patterned after the Federal False Claims Act. Therefore, you will notice that a great deal of the text is the same or similar to the section which precedes this. There are some important differences, however, which are explained below.

The **California False Claims Act (CFCA)** is a state civil statute that was created to prevent and combat fraud in government programs. It does this, in part, by permitting the State and political

subdivisions of the state (such as cities and counties) to sue parties who file false claims for services that are or would be compensated by the government.

To make a case under the “false claims” provision of the CFCFA, one must show:

- the defendant (e.g., the one alleged to have filed the false claim) presented or caused to be presented a claim for payment to an agent of the State or political subdivision of the State,
- The claim was false **OR**
- The claim was fraudulent, **AND**
- The defendant knew or should have known that the claim was false or fraudulent.

A claim may be accurate on its face and otherwise legitimate, but still violate this section because it is a fraudulent one.

Under the California False Claims Act, the term “Claim” is defined broadly. A Claim is a request or demand for money, property or services made to an employee, officer or agent of the state or of any political subdivision where the state or any political subdivision provides any portion of the money or property requested or demanded. The term also includes claims to third parties, such as contractors or subcontractors, who are paid or reimbursed in whole or in part by the government. In California this also includes grantees or other recipients whether under contract or not. Therefore, almost any kind of document or communication that could be reasonably expected to cause California, or a political subdivision of California, to make or approve a payment is a claim.

Like the Federal FCA, the California False Claims Act also prohibits an array of (eight) types of conduct:

1. **False Claim:** Filing a false claim.
2. **False Statement:** Making or using false statements or records to get a claim paid by the government.
3. **Conspiracy:** Conspiring with others to submit false claims that are actually allowed or paid by the government.
4. **Delivery of Less Property:** Delivering less property than the amount stated on the receipt or certificate.
5. **Delivery of Improper Receipt:** Knowingly making or delivering a receipt that falsely represents the property used or to be used.
6. **Unauthorized Seller:** Knowingly buying or receiving public property from any person who lawfully may not sell or pledge the property.
7. **Reverse false claims.** A reverse false claim involves using a false statement or record to conceal, avoid or decrease the amount of an obligation owed to the government.

8. **Failure to disclose a false claim.** If one inadvertently submits a false claim to the government and later discovers it is false, he or she must disclose the false claim to the government within a reasonable time after discovery of the false claim.

Numbers one and two above, filing a false claim, and making or using a false statement, account for the majority of suits filed under the CFCA.

CFCA also requires that the one making the claim acts “knowingly.”

The definition of “knowingly” in the CFCA is similar to that in the Federal FCA.

The term “**knowingly**” means that the person either:

- had actual knowledge of the information, or
- acted in “deliberate ignorance” of whether or not the information was true, or
- acted in “reckless disregard” of the truth or falsity of the information.

Again, no specific intent to defraud is required.

Like the Federal FCA, CFCA also permits private citizens to file lawsuits on behalf of the State and political subdivisions of the state in cases where there is a false or fraudulent claim against a government program. In essence, these individuals are acting as “private attorney generals,” and are often referred to as “whistleblowers.” Whistleblowers enjoy the same advantages as before under the CFCA. They may be entitled to a percentage of the amounts collected by the government and this law prohibits employers from retaliation when an employee takes lawful acts to disclose information to a government or law enforcement agency. These acts could include investigating, testifying or assisting in any False Claims action. Employees may also get reinstatement with the same seniority status the employee had before, back pay, interest on back pay, compensation for any special damages incurred as a result of the discrimination., and punitive damages, if appropriate.

Difference Between Federal FCA and California FCA

The primary differences between the California and federal False Claims Acts are as follows:

1. More than one possible intervener in California: In California the Attorney General can bring an action or intervene in an action or a political subdivision such as a county or city can bring an action or intervene in one.
2. Civil Penalties: Under the federal law, a civil penalty of AT LEAST \$5500, but not more than \$11,000 per claim must be awarded. In California, there is no minimum penalty that must be awarded, and the maximum penalty is \$10,000 per claim.
3. The percentage of awards to whistleblowers in cases with government intervention can be greater in California: In California, the successful qui tam plaintiff will receive at least

15%, but no more than **33%** of the award or settlement. Under the federal law the range of award is from 15% to **25%** in a case where there is government intervention.

4. The percentage of non-intervention awards to whistleblower is greater in California: In California, the successful qui tam plaintiff will receive at least 25%, but no more than **50%** of the award or settlement. Under the federal law the range of award is from 25% to **30%** in nonintervention cases.

Other Health Care Fraud Laws

There are other laws too that are designed to deter health care fraud. These include:

1. The California *Health & Safety Code*, section 1348(e), which defines health care fraud as follows: “Fraud” includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, member, employee, supplier or other entity makes knowing that such action could result in an unauthorized payment, benefit, denial, or other illegal action would come under health care fraud.
2. Title 18, section 1347, of the United States Code which defines health care fraud as: “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice –
 - (1) to defraud any health care benefit program; or
 - (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,in connection with the delivery of or payment for health care benefits, items, or services...”

Common Fraud and Abuse Areas in Managed Care

Under capitated payment models Care1st practices, there is an economic incentive for some providers to control the number of services rendered. The following are potential fraud and abuse areas in managed care:

- ❖ Marketing violations such as practicing prohibited marketing activities;
- ❖ Use of another’s Medi-Cal, Medicare card;
- ❖ Providing services which are not medically necessary;
- ❖ Billing for services not provided;
- ❖ Up coding and bundling in billing;
- ❖ Duplicate billing and payments;
- ❖ Charging Medicare and HFP patients amounts other than legally allowed co-payments;
- ❖ Regularly not collecting co-payments;
- ❖ Billing and payment for capitated services;
- ❖ Inaccurate reporting of utilization and encounter data; and
- ❖ License violations and non-disclosure of actions affecting licensure.

(b) What Care1st is Doing to Detect and Prevent Fraud, Waste and Abuse in its Health Care Programs

Care1st Health Plan has implemented a **Corporate Compliance Plan** to help prevent fraud, waste and abuse in Medicaid (Medi-Cal) and other health programs such as Medicare, the Healthy Families Program, as well as its commercial employer group/individual enrollment plans.

The Care1st **Corporate Compliance Plan** includes the following components:

- Appointment of a Corporate Compliance Officer who has primary responsibility for Care1st's Compliance program.
- A Corporate Compliance Committee that meets regularly to review compliance issues, assists in monitoring and implementing audit plans and training activities, and reports to the Board.
- Training and education of employees and contractors.
- Written policies and procedures on preventing/detecting fraud, waste and abuse.
- An annual audit plan that includes a list of all the monitoring and auditing activities for the calendar year.

Care1st Corporate Compliance Plan includes this **Anti-Fraud Plan**. Although the Anti-Fraud Plan was initially formulated to comply with state laws relating to state programs, Care1st has since then expanded its Anti Fraud Plan to cover fraud, waste and abuse in all health care programs it is involved in including Medicare, Healthy Families Program, Dental Plan and Commercial Plans.

The responsibility for implementing the Care1st Antifraud Plan is with the Corporate Compliance Officer (“CCO”).

Under this Anti Fraud Plan, Care1st Corporate Compliance Officer and the Compliance Department:

1. Has established mechanisms for reporting suspected fraud, waste and abuse such as confidential and anonymous telephone hot lines;
2. Publicizes the mechanisms available to report fraud, waste and abuse to employees, providers and plan members;
3. Provides continuous training to staff on health care fraud, waste and abuse, and their role in detecting, deterring and reporting the same;
4. Ensures that health care providers are educated, through initial orientations, Joint Operations Committee meetings, newsletters and other such communications about health care fraud, waste and abuse and the providers’ role in detecting, deterring and reporting the same;

5. Ensures that Care1st members are informed of health care fraud, waste and abuse, and their role in detecting, deterring and reporting the same;
6. Has established mechanisms to investigate reported fraud, waste and abuse;
7. Reports to appropriate outside agencies cases of suspected fraud, waste and abuse;
8. Recommends to the CEO and the Board of Directors appropriate action(s) for violations;
9. Recommends to the CEO and the Board of Directors changes necessary in company policies and procedures to minimize incidences of health care fraud, waste and abuse; and
10. Requires all health care service providers, and service suppliers/vendors/independent contractors to agree in signed contracts to comply with Care1st Anti-Fraud Plan established under Section 1348 of the *Health & Safety Code*.

For details on any of these activities, please refer to Care1st's Anti-Fraud Plan which is part of its Corporate Compliance Plan.

Your Responsibilities in Preventing Health Care Fraud, Waste and Abuse and Whistleblower Protections

As a contractor or agent of Care1st, you must be familiar with the basic provisions of Federal False Claims Act, California False Claims Act, other laws relating to health care fraud, waste and abuse, and this Care1st's Anti-Fraud Plan.

If you have any questions on any of these or like to learn more about any of these, you should consult your supervisor or the Compliance Department.

If you have knowledge of activities that you believe may cause fraud, waste and abuse of government funds and other resources dedicated to health care, you have an obligation, promptly after learning such activities, to report the matter to Care1st's Corporate Compliance Officer or the Chief Executive Officer. Reports may be made anonymously and contractors and agents will be protected to the extent allowed by law from any retaliatory action for truthful reports. Failure to report or failure to detect violations due to negligence or reckless conduct and making false reports shall be grounds for contract or agency termination.

Care1st will not take any retaliatory action against you and your business entity for reporting suspected or actual health care fraud, waste and abuse, including fraud, waste and abuse committed by Care1st, to Care1st or a governmental agency. Also refer to federal and state whistleblower protections and possible awards discussed earlier.

The Office of Inspector General, the Department of Justice, and other Federal Regulators had issued several updates to various Federal Laws (e.g., the Stark Law, the False Claims Act). Please visit www.oig.gov or the Department of Health and Human Services (DHHS) at www.hhs.gov.

3. Provider/Contractor/Agent Acknowledgement of Receipt and Compliance with Care1st Health Plan’s Anti-Fraud Plan

_____, an individual/corporation/partnership (“Provider/Contractor/Agent”) that has entered into an agreement (“Agreement”) with Care1st Health Plan for the provision, or arranging the provision, of services to Care1st Health Plan’s health care programs and members/subscribers/enrollees in such programs, acknowledge the receipt of Care1st Health Plan’s Anti-Fraud Plan and agrees to abide by its provisions as to the work and duties performed under the Agreement. Provider/Contractor/Agent further agrees to make this Anti-Fraud Plan available to employees and sub-contractors of the Provider/Contractor/Agent involved in performing work or duties under the Agreement.

Provider/ Contractor/Agent

By: _____
Name

Title

Date