POLICY NUMBER: 22

POLICY TITLE: Fraud, Waste and Abuse Compliance Policy

POLICY STATEMENT:

Medical Associates Health Plan, Inc., is a for-profit Iowa corporation operating in the states of Iowa and Illinois. Medical Associates Clinic Health Plan of Wisconsin is a not-for-profit Wisconsin corporation, operating in the state of Wisconsin. Collectively, the entities do business as Medical Associates Health Plans ("MAHP").

Medical Associates Health Plan, Inc., is a wholly owned subsidiary of Medical Associates Clinic, P.C., ("MAC") and Medical Associates Realty, LLC. MAC also has an exclusive contract with Medical Associates Clinic Health Plan of Wisconsin to provide or arrange for health care services for Wisconsin members. A joint MAHP Board of Directors serves the Iowa and Wisconsin entities. Through an intercompany agreement, MAC provides staff for all MAHP functions and operations. The MAHP Compliance Committee provides reports and meeting minutes to the MAHP Board of Directors as well as the MAC Compliance Oversight Committee and MAC Board of Directors.

Preferred Health Choices, LLC, (Health Choices) is a licensed Third Party Administrator in the states of Iowa, Wisconsin, and Illinois, providing claims adjudication services to employers with self-funded employee benefit plans. Health Choices has entered into contractual relationships with MAHP for the provision of operational systems and all services necessary for and related to the adjudication of benefit plans.

MAHP and Health Choices are committed to conducting their affairs in accordance with all applicable federal and state laws, regulations, and contract obligations. MAHP has established and implemented a Compliance Program to assure that compliance-related activities are carried out in furtherance of the prevention, detection and correction of practices and conduct inconsistent with legal and contractual obligations. The MAHP Compliance Program also assists in the prevention and detection of violations by any of its contracted providers or vendors and service providers.

As outlined herein, MAHP maintains this Fraud, Waste, and Abuse Compliance Policy to demonstrate its important and serious commitment to prevent, detect and correct incidents, activities and conduct that constitutes or could reasonably lead to Fraud, Waste and/or Abuse (FWA). This FWA Compliance Policy identifies important fraud, waste and abuse laws; informs and reinforces the obligation of all employees, contractors and agents to report suspected FWA promptly and in good faith; and describes the procedures and steps taken by MAHP to identify and correct FWA.

I. Definitions; Selected Fraud and Abuse Laws

Fraud is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR 455.2).

Abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Waste is defined as deficient practices, systems controls, or decisions that result in using, consuming, spending, or expending goods, services, or funds extravagantly, needlessly, thoughtlessly or carelessly.

Examples of important health care fraud and abuse laws are set forth in Exhibit A.

II. Monitoring for and Reporting Fraud, Waste and Abuse

A. Overview, Training and Obligation to Report.

The MAC Human Resources Department conducts initial background checks for all potential employees, officers, Board members, and all MAC physicians and practitioners to discover felony convictions, or sanctions or exclusions by the Office of Inspector General (OIG) or General Services Administration (GSA), prior to employment. All employees, officers, Board Members, physicians and practitioners also must agree on their first day, and updated on an annual basis, to comply with the Medical Associates Clinic Code of Conduct and to conduct themselves in accordance with the Compliance Program and all applicable Compliance Program policies and procedures.

All individuals who have involvement in the delivery of services to beneficiaries of MAHP's Medicare Cost Plan must receive FWA training. This includes all MAHP employees, directors, officers, and Board members, as well as all First Tier Downstream and Related Entities (FDR) who perform Medicare-related services on behalf of MAHP. FWA training includes information and instruction in laws and regulations specifically related to FWA in federal health care programs, including Medicare (e.g., False Claims Act, Anti- Kickback Statute, etc.), and occurs at the following times:

- upon employment,
- annually,
- when requirements or regulations change,
- when concerns of noncompliance are identified,
- as a corrective action to address substantiated noncompliance,
- when an employee works in an area implicated in past FWA activities

All MAHP employees, directors and FDRs play an important role in the MAHP fraud prevention program. It is the responsibility of everyone to abide by applicable laws and regulations and support compliance efforts by reporting in good faith any suspected FWA. This means each employee and FDR must:

- Be alert to potential compliance issues relevant to their activities;
- Seek advice from a manager, Compliance Officer, or Privacy Officer regarding compliance issues, as needed and appropriate;
- Report in good faith any suspected, actual or potential compliance violation, including FWA;

- Cooperate in the investigation of any report of non-compliance or FWA; and
- Be completely honest in all dealings with federal and state agencies and representatives.

These responsibilities apply not only to MAHP employees but to independent contractors who are performing core functions on behalf of MAHP, such as marketing, claims payment, and utilization management. MAHP requires that all FDRs adopt MAHP policies and procedures or maintain similar policies and procedures that comply with Medicare regulations or guidance from CMS.

MAHP also maintains a Compliance Hotline for anonymous reporting of Fraud, Waste, and Abuse; and MAHP investigates all reports of potential Fraud, Waste and/or Abuse reported via the Hotline.

At the request of an employee who reports suspected or identified FWA, anonymity will be provided to the extent possible under the circumstances and consistent with the organization's obligations to investigate employee concerns and take necessary corrective action. There will be no retaliation in the terms and conditions of employment as a result of a good faith report or as a result of an employee's cooperation in the investigation of a report.

If a report of suspected noncompliance from any source qualifies as Fraud or Abuse, the MAHP Compliance Officer will oversee investigation and/or referral of the matter to the appropriate governmental agency, if applicable.

- For suspected or substantiated fraud related to Medicare, a FWA Reporting Tool is available in the Health Plan Management System (HPMS).
- To report insurance fraud in Iowa, see https://iid.iowa.gov/reporting-insurance-fraud
- To report insurance fraud in Illinois, an insurance complaint form is available at: http://www.dph.illinois.gov/topics-services/health-care-regulation/complaints. To report insurance fraud in Wisconsin, contact OCI at 800-236-8517 or fill out an online complaint form at https://ociaccess.oci.wi.gov/complaints/public/

The MAHP Compliance Department will report all Fraud, Waste and Abuse issues to the Compliance Committee and/or Compliance Officer.

B. Examples of Fraud Waste and Abuse.

Providers:

a) Falsification of provider credentials;
b) Billing for services not provided;
c) Double billing, up-coding, and unbundling; and
d) Under-utilization (not ordering medically necessary covered services).
e) Altering Claims
f) Incorrect Coding
g) Misrepresentation of services or supplies
h) Over-utilization
i) Failure to refer for needed services
j) Falsifying claims and encounters

Members:

a) Altering a prescription;
b) Altering of medical records;
c) Altering referral forms; and
d) Allowing another individual use of a Medicare or MAHP card or ID number for the purpose of obtaining medical benefits.
e) Failure to report third-party liability
f) Denying or limiting access to services or benefits
g) Falsifying eligibility requirements
h) Misrepresentation of medical conditions
i) Falsifying citizenship status
j) Misrepresentation of residency

Employees:

a) Falsification of provider credentials or provider network—forged signatures, pre or post-date);
b) Submitting incorrect information on MAHP's Medicare cost report that results in an inappropriate increase in reimbursement.
c) Fraudulent contractor or subcontractor (intentionally submits false claims).
d) Self-dealing (contract awarded based solely on friend or family relationship).
e) Misuse of MAHP position to obtain funds (Setting up a false provider file, billing, and receiving payment for false claims).
f) Misuse of MAHP member financial or health information.
g) Embezzlement
h) Altering claims or medical records

Subcontractors and Agents (brokers, pharmaceutical benefit manager, FDRs):

a) Using or disclosing member or beneficiary financial or health information in a manner not authorized or otherwise in violation of privacy laws.
b) Misleading potential members in order to get them to enroll in the plan.
c) Falsifying claims information.
d) Fraudulent Recoupment Practices
e) Fraudulent Enrollment Practices
f) Kickback/Stark Violations
g) Fraudulent Credentials

C. Detecting Fraud, Waste and Abuse by Providers, Members, Subcontractors and Agents

Any MAHP department, individual or contracted entity/FDR responsible for performing the following tasks is required to report any suspected, actual, or potential FWA concern to the Compliance Department, Compliance Committee or Compliance Officer for investigation. FWA may be identified through processing or review of:

- medical or pharmacy claims
- Provider profiling reports
- Approvals or denials of health services to beneficiaries, members, and participants
- Complaints or grievances submitted by beneficiaries, members, or participants
- Customer service inquiries
- Medical record reviews
- Credentialing file reviews
- Utilization reviews or audits

Examples of activities and procedures by which MAHP identifies potential Fraud, Waste and Abuse include:

a) Medical Auditing
   1. Routine Quality Audits; and/or
   2. Complaints by providers, members, employees and Board members

b) Claims Department
   1. Processing and adjudicating all claims submitted by providers. Built into the claims processing system are various edits to help prevent claims from being inappropriately reimbursed. Types of edits include those relating to member eligibility, coordination of benefits, duplicate claims, and referral or other authorization requirements. Code Review software has also been implemented to assist in compliance with national and local correct coding policies.
   2. If a particular provider appears to have a pattern of inappropriate billings, an audit of past billings may be conducted by MAHP and/or the Quality Improvement Department.

c) Provider Relations
   1. MAHP's Credentialing Department is responsible for credentialing and re-credentialing activities, which include periodic verification of necessary licenses, board certification and DEA licensing according to the Credentialing Program and policies and procedures.

d) Quality Improvement Department
   1. MAHP Quality Department maintains a process to document, track and investigate possible quality of care or quality of service concerns. Fraud and Abuse concerns that are discovered during the review of reported concerns or during any medical record documentation review or upon review of potential quality issues are forwarded for review.
   2. Complaints by providers, members, and employees.
   3. Review of complaint log for issues relating to underutilization of services, refusal to refer, and potential Fraud and Abuse.
   4. Review of medical record audits for and quality of care Healthcare Effectiveness Data and Information Set (HEDIS) annual reports with provider profiling and comparison to national standards.
   5. Coding/Documentation audits are conducted on participating providers.
   6. If a quality issue is identified, information is documented in the Potential Quality Issues (PQI) database by the Health Care Services (HCS) staff located under reports on the Intranet. HCS staff will also inform the QI Department via email or verbally of the potential findings for additional review and investigation.

e) Member Services Department
   1. Inquiry and Complaint Identification Procedure (Formal Member Grievance Policy)
   2. The member may indicate that they have been involved in some type of fraudulent behavior.
   3. Health care providers may notify MAHP of a member's fraudulent behavior or misrepresentation, usually when a member is discharged from a provider's care.

4. Members informing MAHP of balance billing. Balance billing members for services covered by MAHP is prohibited.
5. Other complaints by providers, members, employees, including complaints regarding unauthorized use or disclosure of a member's financial or health information.
6. Review of complaint logs and customer call logs. All calls to Member Services, Claims and Health Care Services are recorded in the MAHP Phone system. Each call is coded in Amisys according to the reason for the call. Calls are forwarded in a summary report to QI for review.
7. Support Staff enters non-contracted providers in Amisys and the provider NPI is entered in the CMS HPMS Program Integrity Portal FWA Reporting Module to determine if the provider is identified in the portal. If a non-contracted provider is identified in the PI portal, the non-contracted provider will be placed on review in Amisys.

f) Health Care Services Department
   1. Initial authorization requests are reviewed
   2. Under and Over Utilization
   3. Medical Necessity Determination
   4. Reviewing Emergency Room Utilization reports
   5. Through communication with members and providers during case management.
   6. Other complaints by providers, members and employees.

g) Clinical Pharmacist; Contracted Pharmacy Benefit Manager (PBM)
   1. Review of prescription drug claims
   2. PBM conducts audits of the pharmacies in its contracted network. *See* Exhibit B, OptumRx Anti-Fraud Waste and Abuse (Anti-FWA) Plan Description

III. Disciplinary actions for infractions:

For Employees: Non-compliant behavior by employees is subject to the following disciplinary action, as implemented by MAC Human Resources (HR). All steps are documented and kept in the employee's HR file. Depending on the seriousness of the incident, discipline may be imposed without following the specific sequence or steps below.

First step: verbal warning
Second step: written warning
Third step: suspension or termination of employment

For Members: All interactions with members are documented in the Amisys system. Depending on the issue, the following steps may occur:

a) Pharmacy lock in (PCP or one Specialist must approve all prescriptions written for member)
b) Take necessary steps to dis-enroll member

For Providers: All interactions are documented in the Quality Improvement Department's individual provider file. MAHP may impose the following disciplinary actions:

a) Closing Provider's practice to new members
b) Terminating provider
c) Reporting Provider to National Practitioner Data Bank (NPDB)

For Contractors, Subcontractors and Agents:

a) Fraud, Waste or Abuse by a contractor or agent will be considered a violation of contract and will be subject to any remedies set forth in the contract and/or under applicable law.
b) Fraud, Waste and Abuse activities will be reported to the applicable government and law enforcement authorities.

IV. Compliance Officer Responsibilities

The Compliance Officer is responsible for advising the MAHP Board of Directors regarding issues and concerns with health care Fraud, Waste and Abuse in its service area, as well as the steps MAHP has taken to investigate and report potential FWA to enforcement authorities.

Karen Hoffmann — 1-20-23
Karen Hoffmann — Date
Director of Operations

Barb Koerperich — 1-23-23
Barb Koerperich, MSN — Date
Director of Quality and Health Care Services

Jill Mitchell — 1-23-23
Jill Mitchell — Date
Director of Finance/Interim COO

Original Effective Date:	09/11
Revised Dates:	10/12, 09/15, 09/16, 06/17, 9/18, 5/20, 5/21, 12/22
Reviewed Dates:	11/13, 09/14, 9/19

REQUIRED DISTRIBUTION LIST

☐Administration	☐EDI	☐Member Services
☐Claims	☐Facilities	☐Provider Relations
☐Commercial Sales	☐Finance	☐Physicians/Practitioners
☒Compliance	☐Health Care Services	☐Pharmacy
☐Configuration	☐Marketing	☐Quality Improvement
☐Credentialing	☐Medicare Sales	

Exhibit A

False Claims Act [Civil False Claims Act (31 U.S.C. ss 3729-3733); Criminal False Claims Act 18 USC 287]

The Civil False Claims Act ("FCA") is a federal statute that imposes civil penalties (between $5,500 and $11,000 plus three times the total damages per claim) on any person or entity who:

- Knowingly submits a false claim to the Federal government for payment or a false claim to a contractor of the Federal government if the claim includes funds that had been provided by the Federal government;
- Knowingly makes or uses a false record or statement to obtain payment or approval of a claim by the Federal government;
- Uses a false statement to decrease an obligation to the government; and/or
- Conceals or avoids repaying an overpayment received from the Federal government.

When processing claims, all claims must be closely reviewed to assure accuracy. Intent to defraud is not necessary for a violation of the law 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.

This law is sometimes known as the "whistleblower law," as *qui tam* plaintiffs (informers who may sue on their own behalf as well as for the government) may also bring actions under the law alleging the filing of a false claim. The statue was designed to protect the government in business dealings.

The False Claims Act contains language protecting whistleblower employees from retaliation by their respective employer. Employees that are discharged, demoted, suspended, threatened, harassed, or in any way discriminated against in terms and conditions of employment by their employer for "blowing the whistle" are entitled to recover all relief necessary to make the employee whole. Damages available to an employee that proves retaliation include: reinstatement with the same seniority status, two times back pay, interest on the back pay, compensation for any special damages (i.e., emotional distress), litigation costs and attorney's fees (s3730(h))

The Criminal False Claims Act provides for criminal prosecution of a person who knowingly makes or presents any false, fictitious, or fraudulent statements, representations, or claims against the United States. Violations carry a maximum sentence of 5 years imprisonment and/or fines up to $250k (individuals) and $500k (corporations).

MAHP expects employees, vendors, contractors and others to report, through appropriate channels, concerns regarding actual or potential non-compliance with applicable federal and states laws and/or the Company's internal policies and procedures. Appropriate channels means that individuals are encouraged to make an initial report to their immediate supervisors. However, if an individual is reluctant to report their concerns due to the threat of possible retaliation, retribution or harassment; and therefore, in order to facilitate the reporting process, supervisors, managers, co-workers or those in a similar position are forbidden from engaging in knowing retaliation, retribution or harassment directed again an individual who in good faith reports a concern. Examples of retaliation include discharging, demoting, suspending, threatening or harassing an employee. Knowing retaliation, retribution or harassment means that the supervisor was motivated by his or her knowledge that the individual made a good faith disclosure of alleged non-compliance. Employees are trained to report suspected Fraud, Waste or Abuse using the anonymous hotline if they are uncomfortable reporting to their supervisor or contacting any member of the Compliance Committee.

False Statements [18 USC §1035 and 42 USC §1320a-7b(a)]

The Federal false statements law (18 USC §1035) imposes fine and imprisonment on anyone who knowingly and willfully makes materially false, fictitious, or fraudulent statements or representations, or who knowingly and willfully falsifies, conceals, or covers up a material fact, in connection with payment for health care benefits. In addition, there is a Medicare-specific false statements law, (42 USC §1320a-7b(a)) which imposes fine and imprisonment for knowingly and willfully making or causing to be made a false statement or representation of a material fact in an application for Medicare benefit or payment.

These laws underscore the importance of assuring that information submitted to a Federal agency is not knowingly false.

Legal obligations to report receipt of overpayments [42 USC §1320a-7b(a)]

The Medicare law that prohibits false statements also prohibits anyone having knowledge of an event affecting the initial or continued right to a payment or benefit under a Federal health care program and who conceals or fails to disclose such event. Thus, it is necessary to report overpayments to the appropriate government agency. Concealing an overpayment is also a violation of the False Claims Act, discussed above.

Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]

The Anti-Kickback Statute is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks—those who offer or pay remuneration— as well as the recipients of kickbacks—those who solicit or receive remuneration. Each party's intent is a key element of their liability under the AKS. Criminal penalties and administrative sanctions for violating the Anti-Kickback Statute include fines, jail terms, and exclusion from participation in the Federal health care programs. Safe harbors protect certain payment and business practices that could otherwise implicate the Anti-Kickback Statute from criminal and civil prosecution. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor and satisfy all of its requirements. Some safe harbors address personal services and rental agreements and payments to bona fide employees.

The kickback prohibition applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid programs (or a Medicare cost plan) requires patients to pay copays for services, providers and suppliers are generally required to collect that money from the patients. Routinely waiving these copays could implicate the AKS. Providers and suppliers may not advertise that they will forgive copayments. However, they are free to waive a copayment if they make an individual determination that the patient cannot afford to pay or if their reasonable collection efforts fail. It is also legal to provide free or discounted services to uninsured people.

Beneficiary Inducement Law [42 U.S.C. § 1320a-7a(a)(5)]

The beneficiary inducement statute also imposes civil monetary penalties on providers who offer remuneration to Medicare and Medicaid beneficiaries to influence them to use their services. This provision does not apply to health plans.

Physician Self-Referral Law [42 U.S.C. § 1395nn]

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:
- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

Exclusion Statute [42 U.S.C. § 1320a-7]

OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of certain types of criminal offenses, such as Medicare or Medicaid Fraud. If someone is excluded from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration, will not pay for items or services that they furnish, order, or prescribe. In addition, excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice. In addition, if an excluded provider furnishes services to a patient on a private-pay basis, no order or prescription that the excluded provider gives to that patient will be reimbursable by any Federal health care program.

MAHP has the responsibility for ensuring that we do not employ or contract with excluded individuals or entities, whether in a physician practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse us for the items or services furnished by those employees or contractors. This responsibility requires screening all current and prospective employees and contractors against OIG's List of Excluded Individuals and Entities. If MAHP employs or contracts with an excluded individual or entity and Federal health care program payment is made for items or services that person or entity furnishes, whether directly or indirectly, we may be subject to a civil monetary penalty and/or an obligation to repay any amounts attributable to the services of the excluded individual or entity.