

---

## Fraud and Abuse Policy

### Definitions

The Plan only includes those definitions in a policy when they do not overlap with other documents. For a comprehensive listing of Plan definitions, please access the Plan's definition page on the main policy page of the website.

Abuse – Provider and Plan practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the MassHealth and/or Commonwealth Care program, including, but not limited to practices that result in MassHealth and/or Commonwealth Care 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 the MassHealth and/or Commonwealth Care program.

Fraud - An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the MassHealth and/or Commonwealth Care program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or state health care fraud laws.

Contractor or Agent - Includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performing billing or coding functions, or is involved in the monitoring of health care provided by the entity.

Employee - Includes any employee of BMCHP and for purposes of this policy only any BMCHP officer.

### Purpose

The purpose of this policy is to set forth the manner in which BMCHP complies with the requirements of the Deficit Reduction Act of 2005 (DRA) and its obligations related to Fraud & Abuse under its MassHealth and Commonwealth Care contracts. The DRA was signed into law by the President on February 8, 2006. Under this law, any entity who receives more than \$5 million per year in Medicaid payments is required by 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 provides guidance regarding BMC HealthNet Plan's (BMCHP) responsibilities under the DRA, the Federal and Massachusetts False Claims Acts and the contracts with MassHealth and the Connector. This policy also provides detailed

information about the whistleblower protections under these laws and contracts, and the roles of these laws to prevent and detect fraud, waste and abuse in Federal and state health care programs.

### **Policy**

BMCHP provides information to its Employees and Contractors about the Federal and Massachusetts False Claims Acts (summarized in Appendix I attached and incorporated by this reference), and about the organization's policies and procedures for detecting and preventing fraud, waste and abuse and the rights of its Employees and Contractors to protection as whistleblowers.

BMCHP is committed to complying with all applicable laws, including but not limited to the Fraud & Abuse laws described in this policy and Attachment I. As part of this commitment, BMCHP has established and will maintain a Corporate Compliance Program that includes a Fraud & Abuse program. Employees and Contractors are expected to immediately report any potential false, inaccurate or questionable claims to their supervisors, the Fraud & Abuse Coordinator, or the Chief Compliance Officer or the Hotline **1-888-411-4959** in accordance with this Policy.

BMCHP is prohibited by law from retaliating in any way against any Employee or Contractor who reports a perceived problem, concern or Fraud & Abuse issue in good faith.

Examples of potential false claims may include the following; when they are done intentionally and knowingly:

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. Failing to provide medically necessary services/items;
6. Forging or altering a prescription; and
7. Improperly obtaining prescriptions for controlled substances or card sharing.

BMCHP's Employees, affiliates, professional staff members, Contractors or agents who prepare, process and/or review claims should be alert for these and other errors.

### **Procedure**

BMCHP has developed a comprehensive internal Fraud & Abuse program, as part of its Compliance Program to prevent and detect program violations. As part of this program, and in compliance with federal requirements, BMCHP provides annual Fraud & Abuse training for all employees.

Employees and Contractors must immediately report any false, inaccurate or questionable claims or actions as well as questions, concerns or potential Fraud or Abuse to:

- Immediate supervisor
- BMCHP's Fraud & Abuse Prevention Coordinator
- BMCHP's Chief Compliance Officer
- BMCHP'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 BMCHP Fraud & Abuse program.

BMCHP will not discriminate or retaliate against any Employee or Contractor for reporting a potential fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution

BMCHP will make diligent efforts to recover improper payments or funds misspent due to fraudulent or abusive actions by BMCHP or its Contractors.

BMCHP will conduct its Fraud & Abuse program in accordance with the MassHealth and Commonwealth Care requirements, which are set forth in Appendix I.

### **Responsibility and Accountability**

BMCHP Employees and Contractors- All BMCHP Employees and Contractors are responsible for reporting any potential false, inaccurate or questionable claims or actions as well as questions, concerns of potential Fraud or Abuse.

BMCHP's Internal Audit Department – The Internal Audit Department is responsible for ensuring that all reported suspected Fraud or Abuse are fully investigated and if appropriate, are reported to the proper authorities.

BMCHP's Compliance Department – The Compliance Department has oversight for the Fraud & Abuse program, including but not limited to policies/procedures and communications. The Compliance Department will communicate with MassHealth and the Connector on Fraud & Abuse issues and will provide oversight and assistance with the Fraud & Abuse regulatory reports to MassHealth and the Connector.

BMCHP's Fraud & Abuse Prevention Coordinator – The Fraud & Abuse Coordinator is responsible for assessing and strengthening internal controls to insure that claims are submitted and payments properly made; including:

- developing and maintaining an automated reporting protocol within the claims processing system to identify billing patterns that may suggest Provider and/or Enrollee Fraud ;
- monitoring for under-utilization or over-utilization of services;
- conducting regular reviews and audits of operations to guard against Fraud and Abuse;
- receiving all referrals from employees, Enrollees or Providers involving cases of suspected Fraud and Abuse and ;
- developing protocols to triage all referrals involving suspected Fraud and Abuse;
- educating employees, Providers and Enrollees about Fraud and how to report it, including informing employees of their protections when reporting fraudulent activities per Mass. Gen. Laws. c. 12, §5J; and;
- establishing mechanisms to receive, process, and effectively respond to complaints of suspected Fraud and Abuse from employees, Providers and Enrollees and reports such information to EOHHS.

The Fraud & Abuse Coordinator will work with the Chief Compliance officer to meet these responsibilities.

### **Scope**

This policy applies to all Employees and Contractors of BMCHP.

### **References**

Deficit Reduction Act of 2005, (Pub.L. 109-171)

False Claims Act 31 USC sect. 3279-3733:

Massachusetts False Claims Law, M.G.L. c.12, §§5A to 5O

BMCHP Non-Retaliation Policy

### **Policy History**

12/28/2006 – Initial approval received

8/08/2008 – Revised

---

## Appendix I

The following is a summary of Federal and state False Claims laws, whistleblower protections and the MassHealth and Commonwealth Care Fraud & Abuse requirements:

### **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 of \$5,500 to \$11,000 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 BMCHP 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 of \$5,500 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 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 of not less than \$5,000 and not more than \$10,000 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, attorneys 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.

### **MassHealth Provisions**

BMCHP 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;

- At a minimum, check the BORIM website at least twice per month and the BORID and OIG websites at least monthly, and have a process in place to immediately terminate a provider when BORIM, BORID or OIG actions necessitate such a termination. When BMCHP makes a provider determination based on BORIM, BORID or OIG action, or any other independent action, BMCHP shall notify MassHealth, who will in turn notify appropriate MassHealth provider operations staff and other MCOs;
- 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 BMCHP'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 ten days;
- If such preliminary review, or any further review or audit of a provider suspected of Fraud involves contacting the provider in question, BMCHP 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 semi-annual written reports on its Fraud & Abuse activities according to the format specified by MassHealth;
- Have the CEO, CFO, or compliance officer 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, BMCHP 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 BMCHP 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. BMCHP, 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. BMCHP shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding;
- Notify MassHealth of all provider overpayments above \$75,000, or any voluntary provider disclosures resulting in receipt of overpayments in excess of \$75,000, even if there is no suspicion of fraudulent activity; and shall
- Designate a Fraud & Abuse Coordinator.

### **Commonwealth Care**

BMCHP shall:

- Have the CEO or the CFO certify in writing on an annual basis to the Connector, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with this Contract and has not been made aware of any instances of Fraud and Abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to the Connector; and
- Notify the Connector promptly upon contact by any state or federal investigative authorities, including but not limited to, the Medicaid Fraud Control Unit (MFCU) or the Bureau of Special Investigation (BSI), conducting Fraud and Abuse investigations related to Commonwealth Care funded plans, unless specifically directed by investigative authorities not to notify the Connector. The Contractor, and where applicable any subcontractors or Material Subcontractors, shall cooperate fully with any federal or state agency that conduct investigations, full cooperation includes, but is not limited to timely exchange of information and strategies for addressing Fraud and 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 the investigation. The Contractor shall make knowledgeable employees available at no charge to support any investigation, court or other administrative proceeding.
- Notify the Connector of all Provider overpayments above \$75,000, or any voluntary Provider disclosures resulting in receipt of overpayments in excess of \$75,000, even if there is no suspicion of fraudulent activity. The Contractor shall notify the Connector of all Provider overpayments above \$75,000, or any voluntary Provider disclosures resulting in receipt of overpayments in excess of \$75,000, even if there is no suspicion of fraudulent activity. For the purposes of this Section 2.2.L., the term overpayment shall mean claims payments in excess of rates or fee schedule agreed to by the Contractor and Network Providers and any payments made for services not performed. Overpayments shall not include incorrect payments that have been identified and recovered by the Contractor, provided those payments are not included in any financial reporting and/or Encounter Data submitted to the Connector.