COMPLIANCE AND FRAUD, WASTE AND ABUSE

Neighborhood requires compliance with all laws applicable to the organization's business, including insistence on compliance with all applicable federal and state laws dealing with false claims and false statements. It is the policy of Neighborhood to aggressively prevent, detect, and eliminate fraud, waste, and abuse. Eliminating fraud, waste, and abuse in the delivery of healthcare is an obligation, a responsibility, and a legal requirement of all Neighborhood employees, including our contracted providers. Neighborhood employees, providers, contractors, consultants, and agents may report issues of suspected or potential fraud, waste and abuse to their supervisor, the Compliance Hotline (888-579-1551) or the Neighborhood Compliance Department as applicable. Such reports may be made anonymously.

Neighborhood will not retaliate, nor will it tolerate retaliation against those who, in good faith, report suspected ethics violations or who participate in an investigation of suspected ethics violations. An act of retaliation should be reported immediately to the Neighborhood Compliance Department for referral to the Compliance Officer, who will investigate any such report as a potential ethics violation. In addition, those who bring such matters to the Neighbor Compliance Department are protected through federal and state laws.

HOW DO WE DEFINE "FRAUD, WASTE AND ABUSE"?

Fraud is a crime that involves knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or 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. 18 U.S.C. §1347. Fraud is punishable by imprisonment and/or fines and can result in the exclusion of individuals and organizations from participation in government health care programs, such as Medicare and Medicaid. Exclusion means that you could be barred (i.e., not able to work for any company in the health care industry that contracts for government health care programs) for a number of years or permanently.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to a government healthcare program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment. Typically, situations categorized as abusive may be characterized as inconsistent with accepted medical or business practices, or which are improper or excessive. Abuse includes provider practices that are inconsistent with sound fiscal, business, or medical services that are not medically necessary or that fail to meet professionally recognized standards of health care. It also includes member practices that result in unnecessary cost to a government healthcare program resulting in increased costs or utilization of medical services or products. Abuse can result in fines and other penalties.

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Waste includes overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a government healthcare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Waste can result in fines and other penalties.

The following are common examples we recognize as fraud, waste, and abuse by providers:

- Billing for services that were not rendered
- Misrepresenting the diagnosis to justify the services
- Altering claims forms to receive a higher level of payment or circumvent a denial
- Soliciting, offering, or receiving a kickback for referral of patients in exchange for other services
- Concealing ownership of related companies (i.e., the physician also owns the radiological service)
- Deliberate duplicate billing to more than one payer source
- Unbundled or exploded charges in which the provider bills for components of a procedure instead of using a comprehensive code
- Providing Certificates of Medical Necessity for members ineligible
- Falsifying plans of treatment or medical records
- Misrepresenting the services provided or the person receiving the care
- Billing for non-covered benefits by using a different diagnoses
- Gang visit billing at a skilled nursing facility or other group domicile for members that did not receive any care
- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Over-utilization of medical or health care services
- Underutilization of services
- Solicitation for payment for covered services outside of co-payment amounts
- Duplicate billing defined as repetitive billing less than 30 days from original submission date and/ or after a claim has already been adjudicated and finalized

The following are common examples we recognize as fraud, waste, and abuse by members:

- Excessive use or overuse of benefits
- Using another individual's benefits card or information
- Lending, altering or duplicating a benefit card or information
- Altering or forging prescriptions
- Providing incorrect eligibility information to obtain services
- Simultaneously receiving benefits in Rhode Island and other states
- Knowingly assisting providers in furnishing services to defraud Medicaid
- Residing outside the State of RI and receiving RI Medicaid coverage

FEDERAL FALSE CLAIMS ACT

The False Claim Act (FCA) is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system. Under FCA, "knowingly" does not require proof of specific intent to defraud. "Actual knowledge of the information" or acting "in deliberate ignorance of the truth or falsity of the information" or "in reckless disregard of the truth or falsity of the information" is enough.

Examples of the types of activities prohibited by the FCA include billing for services that were not actually rendered, double-billing for items or services, upcoding (the practice of billing for a more highly reimbursed item or service than the one provided) or unbundling (the practice of billing services separately to secure a higher reimbursement).

Moreover, the Affordable Care Act (ACA) mandates that providers and suppliers who are aware that they have retained Medicare or Medicaid funds in error must report and return those funds within 60 days. Under the ACA, "overpayments" are defined as "any [Medicare or Medicaid] funds that a person receives or retains . . . to which the person, after applicable reconciliation, is not entitled." Any overpayment retained after the deadline becomes an "obligation" for purposes of the FCA. Accordingly, a failure to return any overpayments by the deadline may result in false claim liability for the provider.

Violation under the federal False Claims Act can result in significant fines and penalties. Financial penalties may be imposed on a person or organization including recovery of three times the amount of the false claim(s), plus an additional penalty of $5,500.00 to $11,000.00 per claim. An individual (called a qui tam plaintiff or relator) who is an original source of information can sue for violations of the False Claims Act. Under both the federal False Claims Act a qui tam plaintiff can receive between 15-25% of the total amount recovered if the government prosecutes and 25-30% if litigated by the qui tam plaintiff. The federal False Claims Act has provisions to protect individuals who report a violation of the law in good faith.

STATE OF RHODE ISLAND FALSE CLAIMS ACT

In addition to the federal law, the state has adopted similar laws under the Rhode Island False Claims Act. The Rhode Island False Claims Act is designed to prevent fraud, kickbacks and conspiracies in connection with government healthcare programs (e.g. Medicare/Medicaid).

Any person or entity that violates the provisions of the Rhode Island False Claims Act is liable to the state for a civil penalty of not less than five thousand five hundred dollars ($5,500) and not more than eleven thousand dollars ($11,000), plus three (3) times the amount of damages which the state sustains because of the act of that person. In addition, the person that violates this law will also be liable to the state for the costs of a civil action brought to recover any such penalty or damages.

The Rhode Island False Claims Act allows whistleblowers to bring suit in the name of the State of Rhode Island where an individual is identified as engaging in conduct that defrauds the state or local governments of taxpayer dollars. The Rhode Island False Claims Act provides protection for whistleblowers against retaliation for filing a claim or assisting the state with its own claim.

OTHER FRAUD, WASTE AND ABUSE LAWS

Civil Money Penalties for False Claims in Federal Health Care Programs ("CMPL") CMPL provides for monetary penalties against anyone who presents a claim to a federal or state officer, employee or agency that he or she knows or should have known was not provided as claimed. CMPL can also be imposed on a provider who: 1) submits a bill for services provided by a person who is not licensed or is excluded from federal or state health care programs; 2) violates the anti-kickback statute, or 3) violates the prohibition on physician self-referral, or Stark Laws.

Criminal Penalties for False Claims in Federal Health Care Programs A fine of up to $25,000.00 and/or imprisonment of up to five years may be imposed on any person in connection with the furnishing of items or services under a federal health care program and who is convicted of a felony for knowingly and willfully:

- Making a false statement or representation of material fact in any application for a benefit or payment under or for use in determining rights to such benefit or payment in a federal health care program; Concealing or failing to disclose, with intent to defraud, any event affecting his or her initial or continued right to any benefit or payment;

- Presenting or causing to be presented a claim for a provider's service for which payment may be made under a federal health care program and knowing that the individual who furnished the service was not a licensed provider; or

- For a fee, counseling or assisting an individual to dispose of assets in order for the individual to become eligible for medical assistance under a state Medicaid program if disposing of the assets results in the imposition of a period of ineligibility for such assistance.

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Federal Anti-Kickback Statute The Anti-Kickback Statute was designed to prevent fraud and abuse in federal health care programs by making it a crime for anyone who knowingly and willfully solicits, receives, or pays anything of value (remuneration) including any kickback, bribe, or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. Punishment for felony conviction for violating the anti-kickback law is a fine of not more than $25,000 or imprisonment for not more than five years, or both, administrative civil money penalties of up to $50,000 per violation, and exclusion from participation in federal health care programs. The law contains several "safe harbors" that provide protection from prosecution for certain transactions and business practices with further guidelines provided in 42 C.F.R. §1001.952. A violation of the Federal Anti-Kickback Statute constitutes a false and fraudulent claim under the Federal False Claims Act.

Federal Anti-Self-Referral Statute (Stark Laws) Subject to specific exceptions, the law prohibits a physician from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. No specific intent is required. A financial relationship is either a direct or indirect ownership interest or compensation arrangement. Certain regulatory exceptions apply. The law prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral. A physician who violates the Stark Laws is subject to substantial civil money penalties and exclusion from participation in the federal health care program for improper claims. The Stark Laws impose specific reporting requirements on entities that receive payment for services covered by federal health care programs. Failure to report would subject the entity to civil money penalties of up to $10,000 for each day which reporting is required to have been made. There is a potential for $15,000 civil money penalties for each service and exclusion from participation in federal health care programs for knowing violations. Intent is required for civil monetary penalties.

Health Insurance Portability and Accountability Act (HIPAA) As part of the Health Insurance Portability and Accountability Act (HIPA A), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347)

To report suspected fraud, waste or abuse, please contact Neighborhood's Compliance Officer, Camille Bressler at 1-401-427-6799 or call the Compliance Hotline at 1-888-579-1551

PROVIDER AUDITS

Neighborhood reserves the right to perform any retroactive claim dollar retractions resulting from fraud and abuse as dictated by the False Claims Act. There is no statute of limitations to recovering funds associated with fraudulent billing.

Applicable state agencies overseeing the Medicaid Program have a right to conduct audits, where duties under Neighborhood's Agreement with the State are being performed, to inspect, monitor and evaluate compliance with state law.

LEGALLY RESPONSIBLE INDIVIDUALS

For Medicaid products, Neighborhood does not make payments to legally responsible individuals for furnishing any health care related services. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or (b) a spouse. Except at the option of the State and under extraordinary circumstances specified by the State, Neighborhood cannot make payment to a legally responsible individual for the provision of any health care related services that the legally responsible individual would ordinarily perform on behalf of a Medicaid beneficiary regardless of the professional qualifications of the legally responsible individual.

SANCTION MONITORING

As part of detecting and preventing fraud, providers are responsible to ensure that they are not employing or contracting with individuals or entities that are excluded from participation in state or federal health care programs. Providers are expected to conduct initial and ongoing monthly checks of employees, consultants, subcontractors, and governing individuals, including any individual with a direct or indirect controlling interest of any percentage in the provider or anyone else performing services on behalf of the provider, against OIG LEIE & SAM databases to ensure that individuals or entities are not excluded from participation in state and federal health care programs. Provider will notify Neighborhood immediately of any identified excluded individuals or entities.