CARE1ST HEALTH PLAN
ANTI-FRAUD PLAN FOR PROVIDERS

This document contains (a) Care1st Health Plans' programs to detect, deter and report fraud, waste and abuse in Medi-Cal, Medicare, and other health programs it participates in, (b) detailed information on federal and state false claims acts and other important laws on health care fraud, waste and abuse, (c) responsibilities of Care1st's first-tier, downstream, and related (FDRs) (providers, physicians, specialists, medical groups, hospitals, nursing homes, durable medical equipment prosthetics, orthotics, and supplies (DMEPOS), laboratories, hospices, other providers or contractors, and agents, including their/FDRs subcontractors, of Care1st in detecting and deterring fraud, waste and abuse in Medi-Cal, Medicare, 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.

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ANTI-FRAUD PLAN FOR PROVIDERS

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1. INTRODUCTION

The subject of health care fraud and abuse has undergone significant growth due to focused regulations at the federal and state levels and stepped up enforcement by the DHHS Office of Inspector General (OIG) and Centers for Medicare & Medicaid Services (CMS), the Department of Justice and state Medi-Cal and Medicare Fraud units like the Medicaid Fraud Control Unit (MFCU), the OIG's Health Care Fraud Prevention and Enforcement Action Team (HEAT), the Medicaid Integrity Contractors (MICs) and the Medicare Drugs Integrity Contractors (MEDICs). 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 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 that define health care fraud and abuse and civil, administrative, and criminal penalties for false claims and other fraudulent activities under:
- The False Claims Act
- The Anti-Kickback Statute
- The Physician Self-Referral ("Stark") Law
- The Exclusion Statute
- The Civil Monetary Penalties Law/Statute

(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 that define health care fraud and abuse and civil, administrative, and criminal penalties for false claims and other fraudulent or non-compliant activities:

(i) 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.

The Fraud Enforcement Recovery Act of 2009 (FERA) expands exposure under the FCA, making parties liable for any false claims paid with government funds and for the retention of money owed to the government. The Patient Protection and Affordable Care Act (PPACA), enacted March 23, 2010, states that FCA liability will arise if identified overpayment is not repaid within sixty days. The federal government, state attorneys' general or private individuals, via *qui tam* action may bring lawsuit under the FCA. To bring a *qui tam* action, the individual, referred to as a relator, must be an original source of the information concerning the false claim. The FCA was amended by PPACA, which now requires that to qualify as an original source, the relator must provide independent material information to the government before such information has been publicly disclosed. Additionally, the PPACA altered the FCA to provide that if the government opposes dismissal, the public disclosure bar is not jurisdictional and does not require dismissal. Moreover, public disclosure is not limited to federal suits and does not apply to State proceedings or private litigation. Previously, lawsuits based on the prior public disclosure of allegations or transactions were jurisdictionally barred. The statue of limitations for a FCA action is either six years from the date of the violation, or three years after the date when facts materials to the right of action are known or reasonably should have been known to the U.S. official charged with responsibility to act, whichever occurs later, but in no case longer than ten years after the violation.

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 CFCA, 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 not 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.

A civil action filed under the California Act may not be filed more than three years after the date of discovery by the official of the state or political subdivision charged with the responsibility to act in the circumstances, or, in any event, no more than 10 years after the date on which the violation is committed. Whoever brings an action under the California Act – the state, political subdivision or *qui tam* plaintiff – must prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

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 $5,500, 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;
- Upcoding and unbundling 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;
- License violations and non-disclosure of actions affecting licensure;
- Submitting false or inflated cost reports;
- Quality of care ("standard of care claims" or "worthless claims"); and
- False Claims Act cases based on violations of the Stark Law and/or the Anti-Kickback Statute ("tainted claims.").

(ii) Federal Anti-Kickback Statute (AKS) – Final Rule Effective July 29, 1991:

AKS prohibits anyone from purposely offering, soliciting, or receiving anything of value to generate referrals for items or services payable by any Federal health care program. It is knowing and willful payment of "remuneration" to 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 and Medicaid patients).

To determine whether a patient selects the services offered by a physician or other provider as a result of referral, it is necessary to examine the source of the alleged referral. Most patients rely heavily on direction from their treating physicians in selecting a facility or health care professional. In examining any business arrangements that directs the flow of health care to any specific provider, therefore, the ability of any one of the parties to the arrangement to exercise undue influence over a patient's health care decision can be a key issue.

Elements of the Anti-Kickback Statute:

- **Remuneration**
  - includes anything of value;
  - in cash or in-kind;
  - paid directly or indirectly; and
  - Examples: cash, free goods or services, discounts, free rent, expensive hotel stays and meals.
- **Offered, paid, solicited, or received**
  - By healthcare payors and payees (example, providers)
- **Knowing and willful**
  - Violation occurs when the individual or person meets the mental state and performs the conduct, not necessarily when they know they are violating the AKS; and
  - The government does not need to prove patient harm or financial loss to the programs to show that a physician violated the AKS.
- **To induce or in exchange for Federal program referrals**
  - Covers any act that is intended to influence and cause referrals to a Federal health care program;
  - Any Federal health care program (Medicaid or Medicare); and
  - One purpose test and culpability can be established without showing a specific intent to violate the statutory prohibitions

Kickbacks in health care can lead to:

- Overutilization;
- Increased health care costs;
- Corruption of medical decision making;
- Patient steering; and
- Unfair competition.

Fines and Penalties under AKS:

- **Criminal:**
  - Felony, imprisonment up to 5 years and a fine up to $25,000 or both; and
  - Mandatory exclusion from participating in Federal health care programs.
- **Civil:**
  - A violation of the Anti-Kickback Statue constitutes a false or fraudulent claim under the Civil False Claims Act
- **Administrative:**

- Monetary penalty of $50,000 per violation and assessment of up to three times the remuneration or amount of kickback involved
- Exclusion from participating in Federal health care programs

The kickback prohibition applies to all sources of referrals, even patients. Where Medicare and Medicaid programs require patients to pay copays for services, providers are required to collect these monies from their patients. **Routinely** waiving these copays could implicate the AKS.

Safe Harbors under AKS:

Safe harbor protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution but are deemed **not** to violate the AKS. 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 investments in ambulatory surgical centers. Commonly used Anti-Kickback Statute Safe Harbors include:

- Investment interest;
- Space rental;
- Equipment rental;
- Personal services and management contracts;
- Sale of practice;
- Referral Services;
- Discounts;
- Employees;
- Group purchasing organization;
- Waiver of beneficiary coinsurance and deductible amounts;
- Price reduction offered to health plans;
- Practitioner recruitment;
- Investment in group practices;
- Ambulatory surgical centers;
- Referral arrangements for specialty services;
- Price reductions offered to eligible managed care organizations;
- Price reductions offered by contractors with substantial financial risk to managed care organizations;
- Ambulance replenishing;
- Federally Qualified Health Centers; and
- Electronic health records items and services.

The PPACA amended a number of provisions under the Anti-Kickback Statute. One such amendment provides that an Anti-Kickback Statute violation may be established without showing that an individual knew of the statute's proscriptions or acted with specific intent to violate the Anti-Kickback Statute. The (new) standard could significantly expand criminal and civil fraud exposure for transactions and arrangements where there is no intent to violate the

AKS. PPACA further amended the AKS to explicitly provide that a violation of the statute constitutes a false or fraudulent claim under the False Claims Act.

(iii) Physician Self-Referral ("Stark") Law:

The final regulations governing the Stark Law were promulgated in January 2001 (Phase I), March 2004 (Phase II), September 2007 (Phase III), and August 2008. Additionally, in July 2007, April 2008, and July 2008, the Centers for Medicare & Medicaid Services proposed other revisions and additions to the Stark Law regulations.

This law is commonly referred to as the Stark Law. It 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.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals.

Financial relationships include any type of investment or compensation agreement between the referring physician and the DHS entity will qualify as a financial arrangement under the Stark Law. Examples include stock ownership, partnership of interest, rental contract, or salary.

Exceptions under the Stark Law:

General Exceptions Related to Ownership/Investment and Compensation Arrangements:

- Physician Services;
- In-Office Ancillary Services;
- Services furnished by an Organization to Enrollees;
- Academic Medical Centers;
- Implants furnished by an Ambulatory Service Center (ASC);
- Erythropoietin (EPO) and Other Dialysis-Related Drugs;
- Preventing Screening Tests, Immunizations, and Vaccines;
- Eyeglasses and Contact Lenses Following Cataract Surgery; and
- Intra-Family Rural Referrals.

Exceptions Related to Ownership and Investment Interest

- Publicly-Traded Securities;
- Mutual Funds; and
- Specific Providers (Rural Providers, Hospitals in Puerto Rico).

Exceptions Related to Compensation Arrangements:

- Rental Office Space;
- Rental of Equipment;
- Bona Fide Employment Relationships;
- Personal Services Arrangements;
- Physician Recruitments;
- Certain Arrangements with Hospitals (remuneration unrelated to DHS);
- Group Practice Arrangements with Hospitals;
- Payments by a Physician;
- Charitable Donations by a Physician;
- Nonmonetary Compensation;
- Fair Market Value Compensation;
- Medical Staff Incidental Benefits;
- Risk-Sharing Arrangements;
- Compliance Training;
- Referral Services;
- Obstetrical Malpractice Insurance Subsidies;
- Professional Courtesy;
- Retention Payments in Underserved Areas;
- Community-wide Health Information Systems;
- Electronic Prescribing Items and Services; and
- Electronic Health Records Items and Services.

"Designated health services (DHS)" are:

- Clinical laboratory services;
- Physical therapy, occupational therapy, and outpatient speech-language pathology services;
- Radiology services;
- Radiation therapy services and supplies;
- Durable Medical Equipment (DME) and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and,
- Inpatient and outpatient hospital services.

Fines and Penalties under the Stark Law:

- Civil Money Penalties of $15,000 for each service rendered plus an assessment of three times the amount of claims;
- Penalty of up to $100,000 for 'circumvention scheme"; and
- False Claims Act liability for submission of false claims resulting from Stark prohibited referral

- Exclusions from participation in the Federal health care programs

Difference between AKS and the Stark Law:

	The Anti-Kickback Statute	**The Stark Law**
Prohibition	Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business.	• Prohibits a physician from referring Medicare patients for designated health care services (DHS) to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies. • Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral.
Referrals	Referrals from anyone	Referrals from a physician
Items/Services	Any items or services	Designated Health Services
Intent	• **I**ntent must be proven (knowing and willful). • PPACA made an amendment that an AKS violation may be established without showing, that an individual knew of the statute's proscriptions or acted with specific intent to violate the AKS.	• No intent standard for overpayment (strict liability) • Intent required for civil monetary penalties for *knowing* violations.
Exceptions	*Voluntary* Safe Harbors	*Mandatory* exceptions
Federal Health Care Programs	All	Medicare and Medicaid

(iv) The Exclusion Statute:

The Office of Inspector General (OIG) is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid;
- Patient abuse or neglect;
- Felony convictions for other health-care-related fraud, theft, or other financial misconduct; and
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

If one is excluded by OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE (formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is a health care program of the U.S. Department of Defense Military Health System. TRICARE provides civilian health benefits for military personnel, military retirees, and their dependents), and Veterans Health Administration, **will not pay** for items or services that a provider furnishes, orders, or prescribes. Excluded providers may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice. Additionally, if a provider furnishes services to a patient on a private-pay basis, no order or prescription that the provider gives to the patient will be reimbursable by any Federal health care program.

Providers, health plans, and other entities participating in Federal programs like Medicare, Medicaid and TRICARE are responsible for ensuring that they do not employ or contract with excluded individuals or entities. This responsibility requires screening all current and prospective employees and contractors against the OIG's List of Excluded Individuals and Entities (LEIE) database. If a provider, health plan, or other entity participating in Federal programs employ or contract with an excluded individual or entity and Federal health care program payment is made for items or services that entity or individual furnishes, whether directly or indirectly, they may be subject to a civil money penalty and/or an obligation to repay any amounts attributable to the services of the excluded entity or individual. The online database for OIG's LEIE can be accessed at http://oig/hhs.gov/fraud/excusions.asp

(v) Civil Money Penalties Law (CMPL):

Another federal law governing financial relationships between physicians and health care entities is the CMPL. This law prohibits an entity from knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit items or services furnished to Medicare or Medicaid beneficiaries under the physician's direct care. The OIG guidance states that the payment does not have to be tied to a specific patient or a reduction in medically necessary care. Violation of this provision subjects the entity and the offending physician to civil monetary penalties of up to $2,000 per patient.

Additionally, the CMP Law imposes monetary penalties against any person who gives something of value to a Medicare or Medicaid program beneficiary that the person knows, or should know, is likely to influence the beneficiary's choice of a provider or supplier of an item or service paid for by a federal health care program.

The Office of Inspector General (OIG) may seek civil monetary penalties and exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation.

Some examples of CMPL violations include**:**

- Presenting a claim that an individual knows or should know is for an item or service that was not provided as claimed or is false or fraudulent;
- Violating the Anti-Kickback Statute;
- Violating Medicare assignment provisions and physician agreement;
- Providing false or misleading information expected to influence a decision to discharge;
- Failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency medical condition; and
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

(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.
- Providing training materials to first-tier, downstream, and other related contracted entities or FDRs on an annual basis. Attestations from FDRs are required.
- Written policies and procedures on preventing/detecting fraud, waste and abuse.
- A fraud risk assessment to be conducted on a periodic basis.
- Data mining activities on claims received and paid.
- An annual compliance risk assessment plan that includes a list of all the monitoring and auditing activities related to fraud, waste and abuse 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, provider 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.

(c) 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, the Anti-Kickback Statute (AKS), the Physician Self-Referral ("Stark") Law, the Exclusion Statute, the Civil Monetary Penalties Law/Statute and 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 your 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.

To report potential, suspected, or actual fraudulent activities, you may also:

- Call the Care1st's Hotline Number: **1-877-837-6057**. It is toll-free, anonymous, and available 24/7.
- Send an e-mail to: ComplianceDepartment@care1st.com

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.

ATTESTATION & ACKNOWLEDGEMENT OF RECEIPT

The Provider hereby acknowledges receipt of Care1st Health Plan's Anti Fraud Plan (AFP) and agrees to abide by it.

Provider Name: ____

Provider Representative's (Printed) Name:__________________________

Signature of Provider Representative's Name:________________________

Title of Provider's Representative: ______________________________

Date: ________________________