Care1st Health Plan Arizona, Inc.

Anti-Fraud Plan

This document contains Care1st Health Plan, Inc. (Care1st) programs to detect, deter and report fraud, waste and abuse by detailing the following information:

A. Information on the federal false claims act, applicable state laws/regulations and other important laws/regulations on health care fraud, waste and abuse.
B. The responsibilities of contractors and agents of Care1st in detecting and deterring fraud, waste and abuse in Medicaid, Medicare, and other health programs
C. The "whistleblower" protections under federal and state laws/regulations.

CARE1ST HEALTH PLAN
ANTI-FRAUD PLAN

CONTENTS

1. Introduction

The subject of health care fraud and abuse has undergone significant growth due to focused regulations at the federal and state levels. Enforcement has increased by the DHHS Office of Inspector General (OIG) and Centers for Medicare & Medicaid Services (CMS), the Department of Justice and state Medicaid 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.

The federal Deficit Reduction Act of 2005 requires any entity, including any Medicaid 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 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

        - These above-referenced federal laws apply to Medicare (including Part C and D, and Medicaid, including fraud and abuse related to "dual eligibles" (those entitled to or enrolled in Medicare part A or enrolled in part B, and who are eligible for Medicaid (Medicare Fraud & Abuse: Prevention, Detection, and Reporting, October 2011, ICN 006827))

b) The Civil Monetary Penalties Law/Statute
c) What Care1st is doing to detect and prevent health care fraud, waste and abuse; and
d) Your rights and responsibilities in detecting and preventing health care fraud, waste and

abuse without retaliation.

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.

These laws include:

i **Federal False Claim Act (FCA) / 31 USC §§ 3729-3733**

The Federal False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program including Medicaid 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 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 Medicaid 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 "realtors". 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 realtor, 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 realtor 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.

Arizona rule/law relating to false claims and whistleblower provisions under Arizona Revised Statutes (ARS) and the Arizona Administrative Code (AAC):

While Arizona does not have its own "False Claims Act," there are several state laws and regulations that relate to submitting fraudulent claims with the state of Arizona.

- References
    - ARS 13-1802: Theft
    - ARS 13-2002: Forgery
    - ARS 13-2310: Fraudulent schemes and artifices, classification, definition
    - ARS 13-2311: Fraudulent schemes and practices; willful concealment, classification
        - Synopsis: "In any matter related to business conducted by any department, agency or political subdivision of Arizona, it is a class 5 felony for **any** person, pursuant to a scheme or artifice to defraud or deceive, to knowingly falsify, conceal, or cover up a material fact by any trick, scheme or device or makes or to use any false writing or document knowing that it contains false or fraudulent statement" (emphasis added; Summary of Fraud and Abuse Statutes & Regulations, American Health Lawyers Association, 8/3/2009).
    - **ARS 36-2918: Prohibited acts; penalties; subpoena power**
        - Synopsis: "A person may not present or cause to be presented a claim for medical or other service under the Arizona Health Care Cost Containment System to the State or to a contractor that the person has reason to know was not provided as claimed or is false or fraudulent or that the person knows or has reason to know that the person was terminated or suspended from the program or was not a member of the program when the service was made, the service was substantially more than was needed or of a quality that does not meet professionally recognized standards of care. A person who violates this section is subject to, in addition to other penalties, a civil penalty not to exceed $2000 for each item or service claimed and is subject to an assessment not to exceed twice the amount claimed for each item or service" (Summary of Fraud and Abuse Statutes & Regulations, American Health Lawyers Association, 8/3/2009).
    - **ARS 36-2918.01 Duty to report fraud or abuse; immunity**
        - Synopsis: "All contractors, subcontracted providers of care and noncontracting providers shall notify the director of the Arizona Health Care Cost Containment System (AHCCCS) administration or director's designee immediately in a written report of any cases of suspected fraud or abuse involving the AHCCCS. Failure to do so is considered an act of

unprofessional conduct, subject to disciplinary action by the appropriate professional regulatory board or department. Information or records furnished in good faith pursuant to this section grants the person immunity from civil liability for the reason of providing the information" (Summary of Fraud and Abuse Statutes & Regulations, American Health Lawyers Association, 8/3/2009).

- ARS 23-1501 Severability of employment relationships; protection from retaliatory discharges; exclusivity of statutory remedies in employee
  - Synopsis: "An employee may not have a claim against an employer for termination of employment if termination occurred in retaliation for disclosure by the employee in a reasonable manner that the employee has information or a reasonable belief that the employer, or an employee of the employer, has violated, is violating or will violate the Constitution of Arizona or a statute of the state. This statute protects disclosure to either the employer or a representative of the employer who the employee reasonably believes is in a managerial or supervisory position and has the authority to investigate the information provided by the employee and to take action to prevent further violation. Additionally, the statute protects disclosure to an employee of a public body or political subdivision of Arizona or any agency of a public body or political subdivision" (Summary of Fraud and Abuse Statutes & Regulations, American Health Lawyers Association, 8/3/2009).
- ARS 12-1502 Constructive Discharge (Labor-Employment Protection Act)
  - Synopsis: "Constructive discharge can be established through evidence of difficult or unpleasant working conditions or evidence of outrageous conduct by the employer" (Summary of Fraud and Abuse Statutes & Regulations, American Health Lawyers Association, 8/3/2009).

ii **<u>Federal Anti-Kickback Statute (AKS) – Final Rule Effective July 29, 1991 / 42 USC §1320a-7b(b):</u>**

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, contractors, agents)
- **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

Finales 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 Statute 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 or 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 protects 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.

Arizona rule/law relating to Kickbacks

- ARS 13-3713 Consideration for referral of patient, client or customer; fraud; violation; classification
  - It is unlawful for a person to knowingly offer, deliver, receive, or accept any rebate, refund, commission, preference or other consideration in exchange for a patient, client or customer referral to any individual, pharmacy, laboratory, clinic or health care institution providing medical or health-related services or items under A.R.S. § 11-291 et seq., providing for indigent care, or A.R.S. § 36-2901 et seq., or providing for the Arizona Health Care Cost Containment System, other than specifically provided under those sections. Certain payments in connection with clinical trials regulated by the United States FDA from a medical researcher to a physician licensed by the Arizona Medical Board or the Board of Osteopathic Examiners in Medicine and Surgery are not violations of this section. A violator is guilt[y] of: a class 3 felony for payment of $1000 or more; a class 4 felony for payment of more then [sic] $100 but less than $1000; or a class 6 felony for payment of $100 or less." (Summary of Fraud and Abuse Statutes & Regulations, American Health Lawyers Association, 8/3/2009)
- ARS 36-472 Rebates, fee-splitting and solicitation of referrals prohibited (Public Health and Safety – Clinical Laboratories)
- ARS 36-427 Suspension or revocation; intermediate sanctions (Public Health and Safety – Health Care Institutions)
- ARS 36-446.07 Disciplinary actions; grounds for disciplinary action; renewal; continuing education; inactive status; hearings; settlement; judicial review (Public Health and Safety – Health Care Institutions / Licensing of Nursing Care Institution Administrators and Certification of Assisted Living Facilities Managers)
- AAC R4-33-208 Standards of conduct; disciplinary action (Professions and Occupations – Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers)
- AAC R4-33-407 Standards of conduct; disciplinary action (Professions and Occupations – Board of Examiners for Nursing Care Institution Administrators

and Assisted Living Facility Managers
- ARS 32-1201 Definitions (Professionals and Occupations – Dentistry)
- ARS 32-1401 Definitions (Professionals and Occupations – Medicine and Surgery)
- ARS 32-1696 Unlawful acts; grounds for disciplinary action; classification (Professionals and Occupations – Dispensing Opticians)
- ARS 32-1701 Definitions (Professionals and Occupations – Optometry)
- ARS 32-1854 Definitions of unprofessional conduct (Professionals and Occupations – Osteopathic Physicians and Surgeons)
- ARS 32-1901.01 Definition of unethical and unprofessional conduct; permittees; licensees (Professionals and Occupations – Pharmacy)
- AAC R4-23-404 Unethical practices (Professionals and Occupations – Board of Pharmacy)
- ARS 32-2044 Grounds for disciplinary action (Professionals and Occupations – Board of Physical Therapy)

iii Physician Self-Referral ("Stark") Law / 42 USC § 1395nn:

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 and 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 that 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
- Exclusion from participation in the Federal health care programs.

Differences 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	• Intent must be proven (knowing and willful). • PPACA made an amendment that an AKS	• No intent standard for overpayment (strict liability) • Intent required for civil

	violation may be established without showing, that an individual knew of the statute's proscriptions or acted with specific intent to violate the AKS.	monetary penalties for *knowing* violations.
Exceptions	*Voluntary* Safe Harbors	*Mandatory* exceptions
Federal Health Care Programs	All	Medicare and Medicaid

Arizona rule/law regarding prohibitions on Self-Referral

- ARS 32-1401 Conduct (Professions and Occupations-Medicine and Surgery)
- AAC R4-21-303 Affirmative disclosures in advertising and practice; warranties, or ophthalmic goods replacement agreements (Professions and Occupations – Board of Optometry)
- ARS 32-1854 Definitions of unprofessional conduct (Professions and Occupations-Osteopathic Physicians and Surgeons)
- ARS 32-2044 Grounds for disciplinary action (Professions and Occupations- Board of Physical Therapy)
- ARS 32-2501 Conduct (Professions and Occupations-Physician Assistants)

iv The Exclusion Statute / 42 USC §1320a-7:

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 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 the 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 **https://oig.hhs.gov/exclusions/index.asp**.

Arizona rule/law regarding exclusion

- See ARS §36-2918(C). AHCCCS makes a determination of assessing civil penalties. In the same proceeding, AHCCS may also terminate or suspend a person from system participation. See section below for additional information on civil penalties under applicable Arizona rule/law.

- AAC R9-22-714. Payments to Providers
    - AHCCCS mandates providers meet several factors when considering reimbursement to a provider. Under section 2(B), providers must verify individuals who have provided services to AHCCCS members have not been placed on the List of Excluded Individuals/Entities (LEIE) maintained by the United States Department of Health and Human Services Office of the Inspector General (OIG)

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.

Arizona rule/law regarding Civil Monetary Penalties:

- AAC R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions:
    - A. Scope: This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).
    - B. Purpose. This Article describes the circumstances AHCCCS considers and the process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and time frames used by a person to request a State Fair Hearing.
    - C. Definitions. The following definitions apply to this Article:

      1. "Assessment" means a monetary amount that does not exceed twice the dollar amount claimed by the person for each service.

      2. "Claim" means a request for payment submitted by a person for payment for a service or line item of service, including a submission of an encounter.

      3. "Day" means calendar day unless otherwise specified.

      4. "File" means the date that AHCCCS receives a written acceptance, request for

compromise, request for a counter proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.

5. “Penalty” means a monetary amount, based on the number of items of service claimed or reported, that does not exceed $2,000 times the number of line items of service.

6. “Person” means an individual or entity as described under A.R.S. § 1-215.

7. “Reason to know” or “had reason to know” means that a person, acts in deliberate ignorance of the truth or falsity of, or with reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

- AAC R9-22-1102. Determining the Amount of a Penalty and Assessment
  - AHCCCS determines the amount of a penalty and assessment based on A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.
  - AHCCCS includes in the amount of the penalty and assessment the cost incurred by AHCCCS for conducting the following;
    1. An investigation,
    2. Audit, or
    3. Inquiry.

- AAC R9-22-1104. Mitigating Circumstances
  - AHCCCS considers the following circumstances when determining the amount of a penalty, assessment, or penalty and assessment (refer to the code for additional information):
    1. Nature and circumstances of a claim
    2. Degree of culpability
    3. Financial condition
    4. Other matters as justice may require

- AAC R9-22-1105. Aggravating Circumstances
  - AHCCCS considers any of the following to be aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment (refer to the code for additional information):
    1. Nature and circumstances of each claim
    2. Degree of culpability
    3. Prior offenses
    4. Effect on patient care
    5. Other matters as justice may require

- AAC R9-22-1106. Notice of Intent
    - AHCCCS will send a notice of intent if imposing a fine on a person (this includes a corporation). Refer to the code for complete description of what comprises a notice of intent, including the right to challenge the notice via the state fair hearing process.

- AAC R9-22-1108 Request for a compromise
    - A recipient of a Notice of Intent can request a compromise. The request must include reasons for reduction or modification of the imposing penalty, assessment or both if applicable. AHCCCS has 30 days to issue a written decision to the request.

- AAC R9-22-1109. Failure to Respond to Notice of Intent
    - AHCCCS will uphold the original penalty, assessment, or both (if applicable) for failure to timely respond to the Notice of Intent.

- AAC R9-22-1110. Request for State Fair Hearing
    - Describes the process for filing a State Fair Hearing regarding a dispute of penalty, assessment or both (if applicable) as delineated in the Notice of Intent or Notice of Compromise Decision.

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

Care1st has implemented a **Compliance Plan** to help prevent fraud, waste and abuse in Medicaid and other health programs such as Medicare.

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

- Appointment of a Market Compliance Officer who has primary responsibility for Care1st's Compliance program.
- A Market Compliance Oversight Committee that meets regularly to review compliance issues, compliance oversight and assists in monitoring of corrective action plans.
- Training and education of employees and contractors.
- Written policies and procedures on preventing/detecting fraud, waste and abuse.
- 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.

Care1st 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 other health programs, such as Medicare.

The responsibility for implementing the Care1st Anti-Fraud Plan is with the Compliance Officer.

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

1. Has established mechanisms for reporting suspected fraud, waste and abuse such as confidential and anonymous telephone hotlines;
2. Publicizes the mechanisms available to report fraud, waste and abuse to employees, providers, plan members, and other related contracted entities;
3. Provides continuous training to staff on health care fraud, waste and abuse to employees, providers, plan members, and other related contracted entities;
4. Ensures that Care1st members and other contracted entities are informed of health care fraud, waste and abuse, and their role in detecting, deterring and reporting the same;
5. Has established mechanisms to investigate reported fraud, waste and abuse;
6. Reports to appropriate outside agencies cases of suspected fraud, waste and abuse;
7. Recommends to the State President and the Chief Corporate Compliance Officer appropriate action(s) for violations;
8. Recommends to the State President and the Chief Corporate Compliance Officer changes necessary in company policies and procedures to minimize incidences of health care fraud, waste and abuse; and

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

As a contractor, agent or employee of Care1st, you must be familiar with the basic provisions of Federal False Claims Act, applicable Arizona rule(s)/law(s), 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 immediately (within one business day) report the matter to Care1st's Compliance Officer or the State President. 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.

How to report potential, suspected, or actual fraudulent activities:

- Call the Ethics and Compliance (FWA) Hotline Number: 1-866-678-8355
- Report directly to AHCCCS at www.azahcccs.gov/fraud/reportfraud
- **Report suspected FWA by mailing Care1st at:**
  Care1st Health Plan Arizona
  Attn: Compliance Department
  432 N 44th Street, Suite 100
  Phoenix, AZ 85008
- **AHCCCS Office of Inspector General (OIG)**
  Report suspected Medicaid fraud
  Phone: (602) 417-4193 (Maricopa County)
  Phone: 1-888-ITS NOT OK (888-487-6686 - outside Maricopa County)
  Report directly to AHCCCS OIG online: https://www.azahcccs.gov/Fraud/ReportFraud/
  Address:
  Office of Inspector General
  701 E. Jefferson St., MD 4500
  Phoenix, AZ 85034
- **Department of Health & Human Services Office of Inspector General Hotline**
  Report suspected Medicare fraud:
  Phone: 1-800-447-8477 (1-800-HHS-TIPS)
  TTY: 1-800-377-4950 | FAX: 1-800-223-8164
  Submit Report Online: OIG.HHS.gov/fraud/hotline

Care1st will not take any retaliatory action against any person 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.