HEALTH PLAN POLICY		
Policy Title: Fraud, Waste and Abuse		**Policy Number:** AC16 **Revision:** F
Department: Administration	**Sub-Department:** Compliance	
Applies to Product Lines: ☐Medicaid ☐Children's Health Insurance Plan ☒Health Insurance Exchange ☒Medicare		☒USFHP ☒Commercial Insured ☒Non Insured Business
Origination/Effective Date: 04/01/2015		
Reviewed Date(s):	**Revision Date(s):** 03/04/2016, 09/28/2017, 08/23/2018, 10/09/2019, 09/28/2020, 09/16/2021	

SCOPE:

The purpose of this policy is to provide guidance for the health plan associates, contracted or employed, board members, vendors/contractors, agents or other entities/persons performing services for and/or conducting business with the health plan to play an active role in preventing, detecting and eliminating fraud, waste and abuse (FWA).

DEFINITIONS AND ACRONYMS:

- **Abuse** - actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not intentionally misrepresented facts to obtain payment.[1]
- **Fraud** - knowingly and willfully executing, or attempting to execute, a scheme to defraud any health care benefit program by means of false or fraudulent pretenses, representations, or promises) for the purpose of financial gain.
- **Health and Human Services Commission (HHSC)**
- **NBI MEDIC** means National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.
- **Office of Inspector General (OIG) -** OIG Excluded Individuals/Entities, lists individuals and entities that are currently excluded from participation in Medicare, Medicaid and all other Federal health care programs.
- **Special Investigations Unit (SIU)**
- **Waste** - the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

POLICY:

[1] TAC § 371.1601

A. General

1. The health plan has a Compliance Program. One of the foundations of this Compliance Program is the commitment everyone assumes when they become an Associate, contracted or employed provider or clinician, volunteer, board member, vendor/contractor, or other entity conducting business with the health plan. Part of this commitment includes an affirmative obligation to report any suspected Fraud, Waste and Abuse activities.

2. The health plan has a system in place to receive, record, respond to and track compliance questions or reports of suspected or detected non-compliance or potential Fraud, Waste and Abuse. An internal FWA referral form is distributed to all health plan business areas for the purpose of referring any potential cases for investigation. Additionally, internal FWA training is provided to all business areas on identifying when and how to report potential FWA, and how to populate the referral form. Our reporting systems maintain confidentiality allow anonymity if desired (e.g., through telephone hotlines or virtual, and emphasize our policy of non-intimidation and non-retaliation for good faith reporting of compliance concerns and participation in the Compliance Program). We have a no-tolerance policy for retaliation or retribution against any individuals cited in policy AC06 Reporting Misconduct who, in good faith, report suspected Fraud, Waste and Abuse. Further, associates are protected from retaliation for False Claims Act complaints made in good faith, as well as any other applicable anti-retaliation protections. See policy AC13 Deficit Reduction Act and False Claims Act Compliance Regulation.

3. As part of the health plan's Compliance Program, we have several policies and resources directly targeted at preventing and detecting potential and/or actual Fraud, Waste and Abuse. See policy AC06 Reporting Misconduct, and policy AC13 Deficit Reduction Act and False Claims Act, Compliance Regulation. Additionally, whenever a CMS Fraud Alert is received, the Plan reviews its contract with the identified parties. The Plan needs to determine whether they need to terminate the contract under the circumstance presented. The Plan reviews the past paid claims in an effort to identify claims that may or may not have been part of alleged fraud scheme and remove them from their sets of prescription drug event data submissions.

B. Training

1. The health plan will provide compliance training and education to Associates, contracted or employed, board members, vendors/contractors, volunteers, agents and other identified persons within 90 days of initial hire/appointment/contract.

2. After the initial compliance training and education, the health plan will provide annual training about its Compliance Program including Fraud, Waste and Abuse. Upon any regulatory updates, FWA training will be provided to all associates.

3. As the health plan management and/or the Compliance Officer deems necessary, the health plan will provide compliance training about Fraud, Waste and Abuse and the Compliance Program to selected individuals or groups/departments.

C. Special Investigations Unit (SIU)

1. The health plan takes affirmative action to ensure that responsibilities generally performed by a SIU, such as the following, are conducted:
   a. Reducing or eliminating plan benefit costs due to Fraud, Waste and Abuse;
   b. Reducing or eliminating fraudulent or abusive claims paid for with federal dollars;
   c. Preventing illegal activities;
   d. Identifying enrollees with overutilization issues;
   e. Identifying and recommending providers for exclusion, including those who have defrauded or abused the system;
   f. Referring suspected, detected or reported cases of illegal drug activity, including drug diversion to law enforcement and conducting case development and support activities for law enforcement investigations; and
   g. Assisting law enforcement by providing information needed to develop successful prosecutions.
2. SIU functions are accessible through multiple channels, and we take measures to ensure that suspicions of Fraud, Waste and Abuse can be reported anonymously.

D. Provider Payment Suspensions

1. The health plan will cooperate with HHSC OIG in identifying, suspending payment to and reporting on identified health care and pharmacy providers. In doing so, the health plan will ensure suspension of payment to providers identified by HHSC OIG within 1 business day of receiving notice of such payment suspension and will respond to HHSC OIG within 3 business days of receiving notice informing HHSC OIG of whether the suspension has been implemented. The health plan will follow the requirements of the settlement agreement regarding the identified provider and HHSC OIG, including withholding requisite funds and forwarding such funds to HHSC OIG upon request along with itemized spreadsheet detailing the provider's claims paid.
2. The health plan will deliver the following in the form of reports when HHSC OIG imposes a provider payment suspension:
   a. Date suspension imposed
   b. Date suspension discontinued
   c. Reason for discontinuing suspension
   d. Outcome of any appeal
   e. Amount of payment held
   f. If applicable, good cause rationale for not suspending payment or imposing a partial payment suspension
3. The health plan will deliver the following in the form of reports when the health plan imposes a provider payment suspension:
   a. Nature of the suspected fraud
   b. Basis for suspension
   c. Date suspension imposed

d. Date suspension discontinued

e. Reason for discontinuing suspension

f. Outcome of any appeal

g. Amount of payment held

h. If applicable, good cause rationale for imposing a partial payment suspension

E. Auditing and Monitoring

In accordance with the health plan's policies and procedures, it will conduct periodic audits to evaluate compliance with the measures it has in place to detect and prevent FWA. This includes, but is not limited to, auditing compliance with compliance training (ex: attendance and substance), following Corrective Action Plans and reviewing compliance work plans. Please reference CHRISTUS Health Plan 2021 Compliance Program description.

REFERENCES:

- 18 U.S.C. § 1347.
- Medicare Managed Care Manual, Chapter 21
- Prescription Drug Benefit Manual, Chapter 9
- TAC § 371.1601

RELATED DOCUMENTS:

- AC06 Reporting Misconduct
- AC13 Deficit Reduction Act and False Claims Act, Compliance Regulation
- AC24 Special Investigations Unit Group
- CHRISTUS Health Plan 2018 Compliance Program

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	04/01/2015	Initial release.	Board of Directors
A	03/04/2016	Yearly review – updated to current template. Made minor edit to grammar.	Board of Directors
B	09/28/2017	Yearly review – corrected typographical error. Changed signatory to reflect change to CEO.	Board of Directors
C	08/23/2018	Compliance review.	Executive Leadership
D	10/09/2019	Yearly review. Removed Medicaid and CHIP from lines of business.	Executive Leadership

E	09/28/2020	Yearly review. No change to policy content.	Executive Leadership
F	09/16/2021	Yearly review. Updated Definitions and Acronyms. Updated section A.3.	Executive Leadership