| Inter Valley Health Plan | Dept: Office of the President |
|---|---|
| POLICIES AND PROCEDURES | Effective Date: September 1999<br>Policy No: P202<br>Revised: September 2010, October 2011, December 2012, January 2014, Sept 2015, March 2017, March 2018, May 2019, May 2021, Sept 2021<br>Page 1 of 7 |
| **Subject: Reporting Potential Issues or Areas of Non-Compliance, Fraud , Waste and or Abuse** | |

**Reviewed and Accepted By:**
(Committee or Department Head) Corporate Compliance Committee
**Authorized Signature:** _____ **Date:** 9-17-2021

**PURPOSE:**

- To outline required reporting by employees for potential fraud, waste or abuse (FWA) ;; and instances of suspected non-compliance
- the process by which an individual may file a report regarding a potential fraudulent activity or any other violation of Inter Valley Health Plan's Corporate Compliance Program (CCP) and corresponding Standards of Conduct anonymously and without fear of retaliation,
- To outline sanctions/penalties imposed on violators

**DEFINITIONS:**

**Abuse** - includes 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 knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

**Employee(s)** refers to those persons employed by the sponsor or a First Tier, Downstream or Related Entity (FDR) who provide health or administrative services for an enrollee.

**Fraud** is 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.

**FWA** means fraud, waste and abuse.

**Reviewed and Accepted By:**
(Committee or Department Head) Corporate Compliance Committee
**Authorized Signature:** _____ **Date:** 9-17-2021

**Waste** is 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.

**Governing Body** means that group of individuals at the highest level of governance of the sponsor, such as the Board of Directors or the Board of Trustees, who formulate policy and direct and control the sponsor in the best interest of the organization and its enrollees. As used in this chapter, governing body does not include C-level management such as the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, etc., unless persons in those management positions also serve as directors or trustees or otherwise at the highest level of governance of the sponsor.

**POLICY:**

Employees, governing body, FDRs, contractors and providers are required to report if he/she believes he/she has been part of, or witnessed a fraudulent activity, potential non-compliance, or suspected violation of the Company's Corporate Compliance Program or Standards of Conduct or suspected or known violation involving a state or federal program. Any person or entity who becomes aware of conduct that constitutes fraud or that violates the CCP should file a report as quickly as possible or prudent, but no later than 45 days of witnessing or determining that a violation may have occurred. Fraud may be reported anonymously and without fear of retaliation.

Strict adherence to the Corporate Compliance Program is vital. Violators will be subject to discipline as outlined in this policy, the Standards of Conduct, and the Corporate Compliance Program.

**I. Procedure:**

**Reporting**

- Individuals are expected to report any suspected violations of the Corporate Compliance Program, Standards of Conduct, or other irregularities to their

- supervisor, a Compliance Officer, and/or Vice President of Human Resources promptly, but no later than 45 days of the alleged incident.

- If the individual wishes to remain completely anonymous, he/she may submit a report through the Corporate Compliance Fraud Alert hotline, website, or mails as follows:

  - Placing a telephone call to 1-888-FRAUD ALERT (1-888-372-8325) and/or

  - Mailing a report to "Fraud Alert Compliance Dept" at P.O. Box 6002 , Pomona CA. 91769-6002 and/or

- Submitting a report via the Fraud Alert website at www.reportlineweb.com/ivhpInformation about contacting Fraud Alert are posted in all Inter Valley Health Plan lunchrooms and each employee receives a desk card with Fraud Alert reference and who to report and how to report. Additionally, all contracting entities have access to the Plan's Corporate Compliance program, detailing how to file a report when witnessing a potentially fraudulent activity.

- The Plan's Fraud Hotline and Fraud website is available 24 hours a day, 7 days a week, and 365 days a year. Reporting of fraud to the hotline and website are immediately forwarded to the Compliance Officer and VP of Human to begin investigation. Mailing of fraud information is sent directly to the Compliance Department for investigation. All fraud may be reported anonymously and without the fear of retaliation!

- All reports must contain sufficient information for the Inter Valley Health Plan Supervisor, Compliance Officer and/or Vice President of Human Resources, to investigate the concerns raised. Reporting information may include, but is not limited to:

- A description of the alleged activity of noncompliance and when it occurred;
- The names of the entity/entities involved in the alleged activity
- Relevant supporting documentation

**Compliance Officer Investigation and Reporting:**

- When an individual reports fraud and does not want to remain anonymous, informational updates will be provided as part of the investigation process to be completed in 60 days.
  - Reports to NBI MEDIC (federal law enforcement intermediary), when required are completed within 30 days.
- FWA incidences are reported to Senior Management, the Corporate Compliance Committee, the Board Compliance Committee, and Plan Board of Directors.
- All fraud investigation will be shared with CMS Regional Account Manager.
- Any pertinent FWA that poses risk to the Plan's reputation, delivery of quality healthcare, illegal or MEDIC referral is reported through the Plan's governance structure.

- The Compliance Officer will work with the Vice President of Human Resources, and/or relevant department head in cases where an employee has had an allegation filed against him/her.
  - The employee will be given the opportunity, as appropriate, to state his/her position before any disciplinary action is imposed.

- A Compliance Officer shall begin an investigation within 3 days of notification, and involve legal, the fraud investigation team
- The Compliance Officer's investigation shall include interviews and review of relevant documents including pertinent practices and policies as well as consideration of the circumstances under which the act of noncompliance occurred.

- Compliance Officer will issue reports, as necessary, to appropriate designated personnel and report all case information through the Plan's governance structure. While the Compliance Officer will strive to keep all concerns/complaints confidential to the extent possible

The Compliance Officer may seek advice and guidance from Legal Counsel or the Plan's contracted Special Investigation Unit (SIU), Vicenti Lloyd and Stutzman and/or Regulatory Consultant to Conduct and conclude any possible investigation.

Ultimately, the Compliance Officer must report all concerns/complaints and the resolution of these concerns/complaints in accordance with the policies set forth in the Corporate Policy & Procedure P201 "Duties of Compliance Officer & Compliance Committee".

- The Compliance Officer will report alleged fraudulent activities related to Medicare Part D Program to the Medicare Drug Integrity Contractor (MEDIC) within 30 days after a determination that a violation occurred. Should the MEDIC and/or any CMS or law enforcement official require additional information to conduct an investigation, Inter Valley Health Plan will fully cooperate in any way.

  Examples of Part D fraud may be found in Chapter 9 Prescription Drug Benefit Manual 21 Part D Program to Control Fraud Waste and Abuse" Fraud and abuse activities may be perpetrated by a Part D sponsor, or contracted pharmacy, and a Medicare beneficiary.

- If the Compliance Officer determines that an employee, business associate or provider entity, agent, independent contractor, or enrollee has clearly violated the law, the Corporate Compliance Program, or the Standards of Conduct, that individual shall be subject to the appropriate disciplinary action that is timely and consistent.

- The disciplinary action includes counseling and retraining but may vary based on the offense to include, but is not limited to the following:
  - Verbal warning with training if required
  - Written warning with training if required
  - Impaired raises or promotions
  - Probation
  - Suspension
  - Demotion
  - Dismissal and/or
  - Termination and/or termination of contract or Board term with the organization.

- Reporting to Law Enforcement shall occur where criminal activity has been confirmed. Disciplinary action will depend on the seriousness of the offense, repeat offenses, maliciousness of the act, innocence of the violation, and cooperation with any investigation.
- A record of the event and the discipline imposed shall be maintained by the relevant department within Inter Valley Health Plan with a copy to be filed in a master file maintained by a Corporate Compliance Officer.
- The Compliance Officer and Corporate Compliance Committee will be responsible for determining the procedures or actions taken to prevent similar occurrences of misconduct in the future.
- The Compliance Officer, along with any other relevant parties, will tailor a corrective action plan to address the misconduct identified and will provide structure with timeframes so as not to allow continued misconduct.
  - The corrective action plan will be initiated by the Compliance Officer and will continually be monitored for its effectiveness.

**Reviewed and Accepted By:**
(Committee or Department Head) Corporate Compliance Committee
**Authorized Signature:** _____ **Date:** 9-17-2021

- In the event that an employee is found to be non-compliant, immediate retraining will also be required based on the level of disciplinary action;
  - for example termination would not require retraining.

- Disciplinary action will be taken against a violator's department head to the extent that circumstances reflect inadequate supervision or a lack of due diligence.
- Disciplinary action will be taken against any department head who retaliates, directly or indirectly, against an employee who reports a violation of law, or the Corporate Compliance Program, or the Standards of Conduct.
- In addition, department heads may be disciplined for failing to detect non-compliance with applicable policies and legal requirements, where reasonable diligence on their part would have led to the discovery of any problems or violations and would have given Inter Valley Health Plan the opportunity to correct them earlier.

References: -Prescription Drug Benefit Manual Chapter 9 Compliance Program Guidelines; Chapter 21 Medicare Managed Care Manual.
-Corporate Compliance Program
-Policy and Procedure P201 Duties of Compliance Officers-Corporate Compliance Committee Charter