



# CORPORATE POLICY

<b>Subject:</b> Ohio Fraud, Waste and Abuse Prevention & Detection		
<b>Primary Department:</b> Office of Business Ethics	<b>Secondary Department(s):</b> Corporate Investigations	<b>Prior Policy Reference(s):</b>
<b>Effective Date of Policy:</b> December 1, 2006	<b>Date Policy Last Reviewed:</b> June 28, 2007	<b>Date Policy Last Revised:</b> June 28, 2007
<b>Plan CEO Approval/Signature:</b>	<b>Corporate Dept Sr Mgmt Approval/Signature:</b>	<b>Check Only One:</b> Policy is Corporate Owned <input checked="" type="checkbox"/> Policy is Health Plan Owned <input type="checkbox"/>
<b>Check All That Apply:</b> Policy is applicable to: Corporate <input type="checkbox"/> All Health Plans <input type="checkbox"/> Only the following Health Plans (please list): <u>Ohio</u> (Note: If there are multiple Health Plans within a state, please list each specific Health Plan directly above, as appropriate)		

**Purpose** To provide an outline of Amerigroup Community Care, Ohio (AMERIGROUP), its officers, Directors and associates obligations and efforts to detect and prevent fraud, waste and abuse under the requirements of the Ohio Medicaid Program.

**Definitions** Abuse: Means provider practices that are inconsistent with sound fiscal, business or medical practices and that result in the unnecessary cost to the government healthcare program, or in reimbursement for services medically unnecessary, or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the healthcare program.

Fraud: An intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or to some other person.

Knowingly: Meant that a person, with respect to information, has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information.

Waste: Means the over-utilization of services not caused by criminally negligent actions; waste also involves the misuse of resources.

**Policy** AMERIGROUP, its officers, directors and associates have an affirmative obligation to participate in efforts to detect, mitigate and/or prevent fraud, waste and abuse within the health care system. Participation includes reporting suspected fraud, waste and abuse as described below. AMERIGROUP's participating providers and agents, as outlined under the Federal False Claims Act, also have an affirmative obligation to abide by AMERIGROUP's policies and procedures to detect, mitigate and/or prevent fraud, waste and abuse within the health care system.

## Responsibilities

- 1) AMERIGROUP, as the cornerstone of its Corporate Compliance Program, requires annual acknowledgement and training of its associates on the Code of Business Conduct and Ethics.
- 2) AMERIGROUP also requires its associates to complete the annual Fraud and Abuse training provided by the Corporate Investigations Department (CID).
- 3) AMERIGROUP maintains a mechanism for the reporting of suspected misconduct, fraud, waste and/or abuse as defined in the Fraud Plans.
- 4) AMERIGROUP's anti-fraud plan for Ohio includes the following steps:
  - a) Health Plan and Corporate Operational Departments review controls to mitigate financial risks, utilization, denials, authorizations, quality assurance, marketing compliance, case management, enrollment, credentialing and other functions related to the operation of the various health plans;
  - b) The CID receives notice of and/or identifies suspicious activity and coordinates an investigation with the appropriate departments as outlined in the Fraud Plan;
  - c) If fraud, waste or abuse is identified, the CID coordinates with the appropriate departments and state or federal agencies to report and resolve the fraud, waste or abuse;
  - d) Corrective actions are implemented as appropriate.
- 5) AMERIGROUP as part of its Corporate Compliance Program requires its associates and affiliates to abide by federal and state laws and regulations governing the administration and operations of managed care entities within the health care program. This includes compliance with the federal and state false claims acts which establish liability for the following activities:
  - a) Knowingly presenting or causing to be presented to an officer or employee of the United States (Government) a false or fraudulent claim for payment or approval;
  - b) Knowingly making, using or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the Government;
  - c) Conspiring to defraud the Government by getting a false or fraudulent claim allowed or paid;
  - d) Possessing, having custody of, or controlling property or money used, or to be used by the Government and intending to defraud the Government or to willfully conceal the property, delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt;
  - e) After being authorized to make or deliver a document certifying receipt of property used, or to be used by the Government and with the intent to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

- f) Knowingly buying or receiving as a pledge an obligation or debt, public property from an officer or employee of the Government or any person who lawfully may not sell or pledge the property; or
  - g) Knowingly making, using or causing to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Government.
- 6) The federal government may impose penalties of not less than \$5,500 and not more than \$11,000 plus 3 times the amount of damages sustained by the Government if there is a finding of a violation of the False Claims Act.
- 7) The Government may reduce the damages if there is a finding that the person committing the violation reports it within 30 days of discovering the violation and if the person cooperates fully with the federal government's investigation and if there are no criminal prosecutions, civil or administrative actions commenced at the time of the report and the person reporting does not have any knowledge of any such investigations.
- 8) The Government, or an individual, may bring a civil action for a violation of the applicable false claims act. If a person brings an action on behalf of the Government then that person may be entitled to a portion of any recovery under the False Claims Act. The recovery is governed by the person's involvement in the claim and/or the litigation as well as whether the Government intervened in the litigation.
- 9) The Federal Government via the Office of Inspector General may also utilize administrative remedies for the submission of false statements and or claims which include administrative penalties of not more than \$5,500 per false claim as well determine whether suspension or debarment from the healthcare program is warranted.
- 10) Medicaid fraud under Ohio statute is based upon the following actions:
- a) Knowingly making or causing to be made a false or misleading statement or representation for use in obtaining reimbursement from the medical assistance program;
  - b) Charging, soliciting, accepting or receiving for goods or services that the person provides under the medical assistance program any property, money or other consideration in addition to the amount of reimbursement due under the medical assistance program and the provider agreement in a manner that is contrary to the terms of the person's provider agreement and with the intent to commit fraud or while knowing that the person is facilitating a fraud;
  - c) Soliciting, offering or receiving any remuneration, other than allowable deductibles or co-payments, in cash or in kind, including but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the medical assistance program with the intent to commit fraud or while knowing that the

- person is facilitating a fraud;
- d) If a person knowingly makes a false statement or knowingly swears or affirms the truth of a false statement in order to obtain a payment from the department of job and family services under Section 5110.17 of the Revised Code, then the person may be guilty of a misdemeanor of the first degree.

11) Record retention:

- a) Ohio requires any person who has submitted a claim for or provided goods or services under the medical assistance program to maintain, for a period of six years following payment, without altering, falsifying, destroying, concealing or removing any records that are necessary to fully disclose the nature of all goods and services for the which the claim was submitted and for which reimbursement was received. Ohio also prohibits the knowing alteration, falsification, destruction, concealment or removal of any records that are necessary to fully disclose all income and expenditures upon which rates of reimbursement were based for the person.
- b) Failure to follow this requirement is Medicaid fraud. A general failure to follow this requirement is a misdemeanor. For matters involving funds expended from \$5,000 up to \$100,000, failure to follow this requirement results in a felony in the fourth degree. For matters in which funds over \$100,000 are expended, the potential conviction is a felony in the third degree.

12) Medicaid Eligibility Fraud:

- a) Prohibits any person from knowingly in an application for Medicaid benefits or in a document that requires disclosure of assets for the purpose of determining eligibility
  - (i) Making or causing to be made a false or misleading statement;
  - (ii) Concealing an interest in property;
  - (iii) Failing to disclose transfer of property that occurred during the period beginning thirty-six (36) months before submission of the application or document for Medicaid benefits and ending on the date the application or document was submitted;
  - (iv) Failing to disclose a transfer of property that occurred during the period beginning sixty (60) months before submission of the application or document and ending on the date the document or application was submitted and that was made to an irrevocable trust a portion of which is not distributable to the applicant for Medicaid benefits or the recipient of Medicaid benefits or to a revocable trust.

b) Anyone who violates this section is guilty of Medicaid eligibility fraud which is generally subject to a finding a misdemeanor of the first degree. However, if the value of the benefit is at least \$500 but less than \$5000, the person is subject to conviction of a felony in the fourth degree. For matters greater than \$5,000 but less than \$100,000, the person may be convicted of a felony in the third degree.

13) Reporting obligations: AMERIGROUP maintains anonymous hotlines for the reporting of suspected fraud, waste and abuse. The reporting requirements are outlined in the Compliance Reporting policy. In addition to the anonymous hotlines, the CID maintains an email address at Corporate-Investigations on the internal email system or [corpinvest@amerigroupcorp.com](mailto:corpinvest@amerigroupcorp.com).

14) Non-retaliation: In addition to the non-retaliation provisions under the Federal False Claims Act and the Ohio statutes outlined below, AMERIGROUP maintains the following non-retaliation provisions under its Policies and Procedures: Protections against retaliation exist under AMERIGROUP Policies for anyone providing a good faith report under the Corporate Compliance Program or filing and/or participating in litigation or other investigations under the various false claims acts. (Ohio statute also protects state employees from retaliation for reporting a violation of state or federal rules, or regulations, or the misuse of public resources.)

<b>Exceptions</b>	None
<b>References</b>	ORC § 5111.101, 2913.40, 2913.401, 2921.13, 124.341 31 USC § 3729 et al., 3801 et al.
<b>Related Policies and Procedures</b>	Compliance Reporting; Code of Business Conduct & Ethics; Fraud Waste and Abuse Prevention & Detection
<b>Related Materials</b>	None