



CORPORATE POLICY

Subject: Fraud, Waste and Abuse Prevention and Detection - NM		
Primary Department: Office of Business Ethics	Secondary Department(s): Corporate Investigations	Prior Policy Reference(s):
Effective Date of Policy: July 1, 2008	Date Policy Last Reviewed:	Date Policy Last Revised:
Plan CEO Approval/Signature:	Corporate Dept Sr Mgmt Approval/Signature:	Check Only One: Policy is Corporate Owned <input checked="" type="checkbox"/> Policy is Health Plan Owned <input type="checkbox"/>
Check All That Apply: Policy is applicable to: Corporate <input type="checkbox"/> All Health Plans <input type="checkbox"/> Only the following Health Plans (please list): <u>New Mexico</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 of New Mexico, Inc. (AMERIGROUP), its officers, directors and associates obligations and efforts to detect and prevent fraud, waste and abuse under the requirements of the New Mexico 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 and/or 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 New Mexico 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) As part of its Corporate Compliance Program, AMERIGROUP 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 or to the State (Government) a false or fraudulent claim for payment or approval;
 - b) Presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program;
 - c) 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;
 - d) Conspiring to defraud the Government by getting a false or fraudulent claim allowed or paid;
 - e) 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;

- f) 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;
 - g) 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
 - h) 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; or
 - i) As a beneficiary of an inadvertent submission of a false claim and having subsequently discovered the falsity of the claim, fail to disclose the false claim to the state within a reasonable time after discovery.
- 6) The federal government may impose penalties of not less than \$5,500 and not more than \$11,000 plus three (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 thirty (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 New Mexico statute is based upon the following actions:
- a) Paying, soliciting, offering or receiving:
 - i) A kickback or bribe in connection with the furnishing of treatment, services or goods for which payment is or may be made in whole or in part under the program, including an offer or promise to, or a solicitation or acceptance by, a health care official of anything of value with intent to influence a decision

- ii) A rebate of a fee or charge made to a provider for referring a recipient to a provider;
- iii) Anything of value, intending to retain it and knowing it to be in excess of the amounts authorized under the program, as a precondition of providing treatment, care, services or goods or as a requirement for continued provision of treatment, services or goods; or
- iv) Anything of value, intending to retain it and knowing it to be in excess of the rates established under the program for the provision of treatment, services, or goods;
- b) Providing with intent that a claim be relied upon for the expenditure of money:
 - i) Treatment, services, or goods that have not been ordered by a treating physician;
 - ii) Treatment that is substantially inadequate when compared to generally recognized standards within the discipline or industry; or
 - iii) Merchandise that has been adulterated, debased or mislabeled or is outdated;
- c) Presenting or causing to be presented for allowance or payment with intent that a claim be relied upon for the expenditure of public money any false, fraudulent, excessive, multiple or incomplete claim for furnishing treatment, services, or goods; or
- d) Executing or conspiring to execute a plan or action to:
 - i) Defraud a state or federally funded or mandated managed health care plan in connection with the delivery of or payment for health care benefits, including engaging in any intentionally deceptive marketing practice in connection with proposing, offering, selling, soliciting, or providing any health care service in a state or federally funded or mandated managed health care plan, or
 - ii) Obtain by the means of false or fraudulent representation or promise anything of value in connection with the delivery of or payment for health care benefits that are in whole or in part paid for or reimbursed or subsidized by a state or federally funded or mandated managed health care plan. This includes representations or statements of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered and the qualifications of persons rendering health care or ancillary services.

11) Record Retention

- a) Whoever receives payment for treatment, services or goods under the program shall retain all medical and business records in relation to:
 - i) The treatment or care of any recipient;
 - ii) Services or goods provided to any recipient;
 - iii) Rates paid by the department under the program on behalf of

- any recipient; and
- iv) Any records required to be maintained by regulation of the department for administration of the program.
- b) Failure to retain records consists of intentionally failing to retain the records specified in Subsection A of this section for a period of at least five years from the date payment was received or knowingly destroying or causing those records to be destroyed within five (5) years from the date payment was received.

12) 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.

13) Non-retaliation: In addition to the non-retaliation provisions under the Federal False Claims Act and the New Mexico 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.

Exceptions	None
References	30-44-1 NMSA et al. 27-14-1 NMSA et al.
Related Policies and Procedures	Compliance Reporting; Code of Business Conduct & Ethics; Fraud Waste and Abuse Prevention & Detection
Related Materials	None