CATHOLIC MANAGED LONG TERM CARE INC.,
D/B/A ARCHCARE SENIOR LIFE (ASL) AND D/B/A ARCHCARE COMMUNITY LIFE (ACL)

FRAUD, WASTE & ABUSE

DETECTION MANUAL

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Introduction

Catholic Health Care System d/b/a ArchCare[1] and its affiliated managed care plans (Catholic Managed Long Term Care Inc., d/b/a ArchCare Senior Life (ASL) and d/b/a ArchCare Community Life (ACL)) are committed to a culture that promotes prevention, detection and remediation of Fraud Waste and Abuse ("FWA"). Accordingly, ArchCare maintains a robust Compliance Program to prevent, detect and remediate fraud, waste and abuse for all of its affiliated entities. The goal of the ArchCare FWA Program, as with the Compliance Program, is to promote understanding of and adherence to applicable laws and regulations and guidance and to make a sincere effort to prevent, detect, and resolve situations that do not conform to applicable regulatory requirements.

The Compliance Program is designed in accordance with Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York as well as provisions of federal and state law and regulations governing Medicare Parts A, B, C, and D, as well as Medicaid.

Fraud, Waste and Abuse (FWA) is a significant concern for ArchCare, therefore ArchCare has developed this FWA Detection Manual for ArchCare Community Life and ArchCare Senior Life (PACE) which are both Medicaid Managed Long Term Care Plans[2]. In addition, ArchCare has established a Special Investigation Unit ("SIU")[3] to help investigate and identify FWA.

This Fraud, Waste and Abuse Detection Manual outlines how everyone at ArchCare can do their part to address FWA and describes the robust systems that ArchCare has in place, and in prevention, detection and remediation of FWA.

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[1]Carmel Richmond Healthcare and Rehabilitation Center, Ferncliff Nursing Home, Mary Manning Walsh Home, Providence Rest Nursing Home (ArchCare just became active parent of this nursing home) , San Vicente de Paúl Skilled Nursing and Rehabilitation Center, Terence Cardinal Cooke Health Care Center, Catholic Special Needs Plan, LLC dba ArchCare Advantage, Catholic Managed Long Term Care, Inc. dba ArchCare Community Life and ArchCare Senior Life, and Dominican Sisters Family Health Services, Inc. dba ArchCare at Home.

[2] ArchCare Senior Life is a program under a Managed Long Term Care Partial Capitation Contract with New York State.
[3] A full SIU is only maintained for ACL, investigations for all other plans are conducted by the Compliance Department.

What is Fraud?

Fraud includes obtaining a benefit through an intentional false statement, misrepresentation or concealment of material facts. **Fraud** is defined as an intentional deception, false statement, or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law. It is a crime to defraud the Federal Government and its programs.[4]

Examples of Fraud:

- Providing false statements on an enrollment application to obtain coverage or concealing information about past medical history/preexisting conditions.
- Using someone else's ID card or loaning your ID card to someone not entitled to use it.
- Failing to report other insurance or to disclose claims that were a result of a work-related injury.
- Billing for services that were not rendered.
- Providing services that are not medically necessary for the purpose of maximizing reimbursement.
- "Upcoding" - billing for a more costly service than was actually provided.
- "Unbundling" - billing each step of a test or procedure as if it were separate instead of billing the test or procedure as a whole.
- Submitting claims with false diagnoses to justify tests, surgeries or other procedures that are not medically necessary.
- Accepting kickbacks for member referrals.
- Fabricating claims.

What is Waste?

Waste is spending that can be eliminated without reducing quality of care, i.e., deficient management, practices, or controls. Waste is defined as failure to control costs or regulated payment associated with federal program funding. Furthermore, waste results in taxpayers not receiving reasonable value for their money. Waste relates primarily to mismanagement, inappropriate actions, or inadequate oversight.

Examples of Waste

- Poor execution or lack of widespread adoption of best practices, such as effective preventive care practices or patient safety best practices.

[4] 18 U.S.C. § 1001. Punishment may involve imprisonment, significant fines, or both. Criminal penalties for health care fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate fraud prevention. In some states, providers and health care organizations may lose their licenses. Convictions also may result in exclusion from participation for a specified length of time. Fraud may also result in civil liability.

- Unnecessary hospital readmissions, avoidable complications, and declines in functional status, especially for the chronically ill.
- Overtreatment.
- Administrative complexity.

What is Abuse?

Abuse includes excessively or improperly using government resources; providing substandard quality of care. Abuse is defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices.

Examples of Abuse:

- Billing for services that were not medically necessary
- Charging excessively for services or supplies

EXAMPLES OF FRAUDULENT ACTIVITIES

Health Plan Fraud

Fraud committed by the health plan is defined as acts committed through deception, misrepresentation or concealment by the health plan's employees as directed by leadership of the health plan. Such acts can include:

- Failure to provide medically necessary services
- Marketing schemes
- Improper bid submissions
- Payments for excluded drugs
- Multiple billing
- Inappropriate formulary decisions
- Inappropriate enrollment/disenrollment
- False information
- Inaccurate data submission

Fraud by Agents/Brokers

Fraud committed by agents/brokers is defined as deception, misrepresentation or concealment by a licensed representative to obtain something of value for which he/she would not otherwise be entitled.

Some examples of agent/broker fraud can include:

- Helping individuals fill out their enrollment information so they will be eligible for insurance
- Enrolling a group of individuals to form a nonexistent company
- Falsifying location of a group to gain insurance or obtain lower premium rates
- Adding false individuals to the group to avoid being medically underwritten
- False advertising
- Fraud Due to Misrepresentation of Enrollment Information
- Fraud due to misrepresentation of enrollment information is defined as commission of an act of deception, misrepresentation or concealment, or allowing it to be done by someone else, to obtain coverage for which one would not otherwise be entitled.

Examples of eligibility fraud can include:

- Individuals joining to form a nonexistent group for insurance purposes
- Members not meeting the eligibility requirements (e.g., not working the required number of hours, not receiving a wage)
- Dependents not meeting the definition of a dependent (e.g., a girlfriend, grandchildren or a child who is not a full-time student)
- Not disclosing medical conditions on an application.

Claims Fraud

ArchCare associates are trained in fraud prevention and how to recognize

typical fraud technique red flags such as:

- Provider is not in the insured's geographic region
- Member is in a different state than the company and no group affiliations exist for that state
- Large bills incurred just prior to term date or immediately after effective date
- Inconsistencies in company information versus medical records.

Provider Fraud

Provider fraud is defined as "the devising of any scheme by any provider of health care or services to defraud for the purpose of personal or financial gain by means of false or fraudulent pretenses, representations, or promises." Examples of provider fraud can include:

- Billing for services not rendered
- Providing "free" services and billing the insurance company
- Nonqualified practitioners billing as qualified practitioners
- Providers being rewarded for writing prescriptions for drugs or products
- Billing for noncovered services using an incorrect code (American Medical Association (AMA) Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and/or diagnosis codes) to have the services covered.

Dental Fraud

Examples of dental fraud can include:

- Billing for dental services not rendered
- Providing excessive dental work that is not needed by the patient
- Falsifying the date of service to correspond with the member's coverage period
- Billing for noncovered services using an incorrect code (Current Dental Terminology (CDT) and/or diagnosis codes) to have the services covered.

Pharmacy Fraud

Examples of pharmacy fraud can include:

- Filling less than the prescribed quantity of a drug
- Billing for brand when generic drugs are dispensed
- Billing multiple payors for the same prescriptions
- Dispensing expired or adulterated prescription drugs
- Forging or altering prescriptions
- Refilling prescriptions in error.

Examples of pharmacy benefit management fraud can include:

- Prescription drug switching
- Unlawful remuneration
- Prescription drug shorting
- Failure to offer negotiated prices.

Examples of wholesale fraud can include:

- Inappropriate documentation of pricing information

- Speculative buying
- Counterfeit and adulterated drugs through black market purchases.

Examples of pharmaceutical manufacturer fraud can include:

- Kickbacks, inducements and other illegal remuneration
- Inappropriate relationships with physicians
- Illegal usage of free samples
- Lack of integrity of data to establish payment and/or determine reimbursement.

Pharmacies may not reward health care providers for writing prescriptions for drugs or products.

Member Fraud

Member fraud is defined as the commission of acts of deception, misrepresentation or concealment by any policyholder or group of policyholders in order to obtain something of value to which they would not otherwise be entitled.

Examples of member fraud can include:

- Alteration of bills
- Submission of false claims
- Applying for insurance when you know you are not eligible
- Reselling drugs on the black market
- Doctor shopping
- Identity theft
- Forging or altering prescriptions
- Prescription stockpiling
- Improper coordination of benefits
- Failure to disclose information on applications, accident inquiries, continuation of benefits (COB) and full-time student information requests, etc.

Ways to report FWA?

ArchCare is committed to the timely identification and resolution of all violations of the law or of ArchCare policy. Affected individuals who are aware of or suspect acts of fraud, waste or abuse or violations of the code of conduct are required to report them. Several independent reporting paths are available:

- Affected individuals, who are employed by ArchCare, may report to their supervisor or managers. Supervisors and managers will refer the report to program specific Compliance Officer as soon as the report is made.

- Other affected individuals may report directly to the ArchCare Department of Compliance and/or the Chief Compliance Officer.

- ArchCare has contracted with an independent company to operate the Compliance & Corporate Ethics Hotline. The Hotline is accessible by phone - **800-443-0463** and or online - **www.archcare.ethicspoint.com**. The Hotline is available 24 hours a day, seven (7) days a week. Individuals may use this line anonymously.

All affected individuals are advised that anyone reporting suspected violations in good faith will be protected from any intimidation, harassment, discrimination, retaliation or adverse consequences. ArchCare policy is that acts of retaliation or intimidation should be immediately reported to the CCO or to the Compliance & Corporate Ethics Hotline and, if substantiated, the individuals responsible will be appropriately disciplined.

Federal Laws

False Claims Act [31 U.S.C. §§ 3729 – 3733]

The False Claims Act ("FCA") provides, in pertinent part, that: Any person who (1) knowingly presents, or causes to be presented, to an office or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;...or (7) knowingly makes, uses, or causes 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, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, 5 plus 3 times the amount of damages which the Government sustains because of the act of that person.

For purposes of this section: the term "claim"— means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—(i) is presented to an officer, employee, or agent of the United States; or
(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—provides or has provided any portion of the money or property requested or demanded; or will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

The terms "knowing" and "knowingly mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

1. the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship,

[5] Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between $5,000 and $10,000, those amounts have been adjusted for inflation. As of January 30, 2023, the minimum False Claims Act penalty increased from $12,537 to $13,508 per claim. The maximum penalty has increased from $25,076 to $27,018 per claim.

from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

2. the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property
3. While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act.
4. In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment form the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.
5. In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement
6. Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

Administrative Remedies for False Claims

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim.[6] The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also, unlike the False Claims Act, the determination of whether a claim

[6] Although the statutory provisions of the Program Fraud Civil Remedies Act authorizes a penalty up to $5,000, that amount has been adjusted for inflation. Violations assessed after January 30, 2023, civil False Claims Act penalties will range from $13,508 to $27,018.

is false, and the imposition of fines and penalties is made by the administrative agency not by prosecution in the federal court system.

Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]

The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or 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 or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration. Each party's intent is a key element of their liability under the AKS.

Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the CMPL, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.

Safe harbors protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution. 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, investments in ambulatory surgical centers, and payments to bona fide employees.

For additional information on safe harbors, see "OIG's Safe Harbor Regulations."

As a physician, you are an attractive target for kickback schemes because you can be a source of referrals for fellow physicians or other health care providers and suppliers. You decide what drugs your patients use, which specialists they see, and what health care services and supplies they receive.

Many people and companies want your patients' business and would pay you to send that business their way. Just as it is illegal for you to take money from providers and suppliers in return for the referral of your Medicare and Medicaid patients, it is illegal for you to pay others to refer their Medicare and Medicaid patients to you.

Kickbacks in health care can lead to:

- Overutilization
- Increased program costs
- Corruption of medical decision making
- Patient steering
- Unfair competition

The kickback prohibition applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid programs require patients to pay copays for services, you are generally required to collect that money from your patients. Routinely waiving these copays could implicate the AKS and you may not advertise that you will forgive copayments. However, you are free to waive a copayment if you make an individual determination that the patient cannot afford to pay or if your reasonable collection efforts fail. It is also legal to provide free or discounted services to uninsured people.

Besides the AKS, the beneficiary inducement statute (42 U.S.C. § 1320a-7a(a)(5)) also imposes civil monetary penalties on physicians who offer remuneration to Medicare and Medicaid beneficiaries to influence them to use their services.

The Government does not need to prove patient harm or financial loss to the programs to show that a physician violated the AKS. A physician can be guilty of violating the AKS even if the physician actually rendered the service and the service was medically necessary. Taking money or gifts from a drug or device company or a durable medical equipment (DME) supplier is not justified by the argument that you would have prescribed that drug or ordered that wheelchair even without a kickback.

Physician Self-Referral Law [42 U.S.C. § 1395nn]

The Physician Self-Referral Law, commonly referred to as the Stark law, 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. For example, if you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

Exclusion Statute [42 U.S.C. § 1320a-7]

OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances. OIG has discretion to exclude individuals and entities on several other grounds, including misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud or misdemeanor convictions in connection with the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; and defaulting on health education loan or scholarship obligations.

If you are excluded by OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration, will not pay for items or services that you furnish, order, or prescribe. 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.

You are responsible for ensuring that you do not employ or contract with excluded individuals or entities, whether in a physician practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors. This responsibility requires screening all current and prospective employees and contractors against OIG's List of Excluded Individuals and Entities. This online database can be accessed from OIG's Exclusion Web site. If you employ or contract with an excluded individual or entity and Federal health care program payment is made for items or services that person or entity furnishes, whether directly or indirectly, you may be subject to a civil monetary penalty and/or an obligation to repay any amounts attributable to the services of the excluded individual or entity.

Civil Monetary Penalties Law [42 U.S.C. § 1320a-7a]

OIG may seek civil monetary penalties and sometimes 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[7] per violation. Some examples of CMPL violations include:

- presenting a claim that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent;
- presenting a claim that the person knows or should know is for an item or service for which payment may not be made;
- violating the AKS;
- violating Medicare assignment provisions;
- violating the Medicare 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 or in labor; and
- making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims, and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

NY False Claims Act (State Finance Law §§187–194)

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is equal to the amount that may be imposed under the federal FCA (as may be adjusted for inflation) and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover up to 25-30% of the proceeds.

Social Services Law §145-b - False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false

[7] Amount has been adjusted for inflation and violations assessed after January 30, 2023 are $27,018.

statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within 5 years, a penalty up to $ 30,000 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for six months if a first offense, 12 months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

Social Services Law §145 – Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b – Penalties for Fraudulent Practices

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

Any person, who with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor

Penal Law Article 155 – Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

1. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.
2. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.
3. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.
4. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

Penal Law Article 175, False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

1. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.
2. §175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.
3. §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.
4. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second-degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud

1. Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.
2. Insurance fraud in the 5gh degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
3. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.
4. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.
5. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.
6. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.
7. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

1. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
2. Health care fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.
3. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.
4. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

5. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

Whistleblower Protections

Federal False Claims Act (31 U.S.C. §3730(h))

The FCA provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

N.Y. False Claim Act

The New York False Claim Act also provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law §740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

New York Labor Law §741

Certain health care employers may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or

activities to a regulatory, law enforcement or other similar agency or public official, to a news media outlet or to a social media forum available to the public at large. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care or improper quality of workplace safety. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public, a specific patient or a specific employee and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

INVESTIGATING FWA

The SIU investigates all reports of suspected FWA[8] in accordance with the ArchCare Policies and Procedures on the Special Investigations Unit and Fraud Waste and Abuse. Any allegations of potential Fraud, Waste and Abuse identified internally by ArchCare will be referred to the SIU for further review. This includes any FWA issues identified internally by different ArchCare departments and hotline calls. These allegations will be sent to the SIU Director or Lead Investigator for further review and action. The Director or Lead Investigator shall determine whether a referral of fraudulent, wasteful, abusive, or other improper conduct warrants further review. Upon determination that a further review is warranted, the matter shall be promptly assigned to an Investigator for a preliminary assessment. The preliminary assessment shall generally consist of one or more of four basic steps to determine if the referral warrants further investigation by the SIU.

The Investigator shall review all the documentation relating to the referral involving an allegation of fraud or abuse, including, but not limited to, claims, correspondence, copies of bills/benefit statements, and internal notes related to telephoned reports and/or data analysis reports.

In addition to the quantitative review of money paid to the provider, the Investigator shall review the provider's claims history for any previous unusual activity, complaints, or scrutiny by the SIU.

At the same time, the Investigator may review external information related to the provider including, but not limited to, the following:

- State or professional disciplinary boards.
- Other insurers (either directly or via a regional or national anti-fraud organization);
- Law enforcement agencies (on a general basis as to any prior actions against the provider);
- The US Department of Health & Human Services records of provider sanctions for fraud- related Medicaid/Medicare violations; and
- Court records of prior civil and criminal litigation.

Based on the preliminary assessment, the Director in consultation with the Compliance Department, shall then decide among the following courses of action:

- Conduct a formal fraud, waste or abuse investigation;
- Place the provider on a "watch list" for an indefinite period; or
- Educate the member or provider of what appears to be simply a misunderstanding or miscommunication.

[8] SIU only investigated possible FWA as it relates to ACL or in certain circumstances for ASL. All other instances are investigated by the Compliance Department.

The SIU Director reviews all reports of potential allegations of FWA and determines—within five (5) days of receipt by the SIU, preliminary findings and recommended next steps. If the SIU Director determines that a case must be initiated in response to an allegation.

The Director shall have the overall responsibility for the development and implementation of the ArchCare Fraud, Waste and Abuse Prevention Plan. The SIU Program includes (i) the oversight of the day to day operations of the SIU which shall include all activities related to preventing, detecting and investigating allegations of fraud or abuse consistent with ArchCare's internal policies and procedures, and federal, state and local laws and regulations; (ii) coordination of all investigations of the SIU; (iii) reporting established goals, internal and external policies and compliance standards to CEO, CCO, Compliance Committee, and, when appropriate and necessary, to executive management; and (iv) assisting in coordinating fraud and abuse awareness activities for employees, members, providers, and contracted entities of ArchCare. The responsibility of the Lead Investigator is to investigate allegations of fraud, waste or abuse assigned to them by the SIU Director.

In addition, the SIU will be datamining to identify providers for further investigations, conducting investigations, preparing written reports detailing findings and outcomes of fraud, waste or abuse investigations and assisting in the preparation of regulatory reports as required by ArchCare. The SIU will coordinate fraud, waste and abuse awareness activities for employees, members, providers, and contracted entities of ArchCare.

All SIU staff must conduct themselves in accordance with ArchCare policies and procedures and the Fraud, Waste and Abuse Policy Manual.

The Director and Lead Investigator shall meet regularly with the Chief Compliance Officer and/or the Compliance team including monthly meetings with the Compliance team. In addition, Quarterly and Annual meetings will be held with the SIU and Directors of various ArchCare departments. The purpose of these meetings is to coordinate and facilitate the communications between and among the ArchCare departments and the SIU. The Chief Compliance Officer and/or ACL Compliance Officer will convey SIU efforts through representation at ArchCare departmental meetings. In addition, the annual meetings will be used to present the SIU Workplan to ArchCare along with the previous year's FWA statistics. The Director and Lead Investigation shall further utilize these meetings to assist with ongoing fraud, waste and abuse investigations, including periodic review of claims, member services, utilization management and grievance and appeals for purposes of enhancing the ability to detect fraud, waste and abuse.

Reporting to Federal and State Agencies

The SIU is responsible for notifying applicable federal and state agencies, and law enforcement as appropriate, of suspected FWA. Notified agencies may include OIG, DFS, the OMIG, MEDIC, or the New York State Medicaid Fraud Control Unit (MFCU). If during an investigation the SIU Director determines that potential FWA or other misconduct has occurred, the SIU Director forwards the potential referral to the Chief Compliance Officer. If Chief Compliance Officer agrees with the SIU Director's assessment, the SIU Manager then reports that misconduct to the appropriate agency (MEDIC, DFS, the OMIG, OIG or MFCU) in a timely manner.

If potential FWA or other misconduct is discovered, the SIU will forward the potential FWA or other misconduct to Chief Compliance Officer for review and will direct the SIU to refer the conduct to the appropriate agency (or agencies), so that notified agencies can help identify and address any scams or schemes.

For each case of FWA confirmed by the SIU, the ArchCare Chief Compliance Officer reports to OMIG the following information:

- The name of the individual or entity that committed the FWA;
- The source that identified the FWA;
- The type of provider, entity or organization that committed the FWA;
- A description of the FWA;
- The approximate range of dollars involved;
- The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data/information as prescribed by NYSDOH.

The Chief Compliance Officer will file Part I of the FWA Prevention Plan with DOH no later than January 15 and Part II by May 1st annually. In addition, the Chief Compliance Officer will file Managed Care Plan Annual Reports between February 1 and February 28 each year. Lastly, the SIU will prepare and submit the Annual SIU Report for Managed Care Organizations.

Proactive Detection of Fraud, Waste And Abuse

ArchCare devotes significant resources and effort to proactive detection of potential FWA which includes audits and/or investigations specific to the Medicaid line of business. These audits and/or investigations will involve at least one percent (1%) of Medicaid claims each calendar year. The SIU will track the information related to the Medicaid specific audits and investigations conducted each year and will make such report available to DOH and OMIG upon request as part of the Provider Investigative Report. This information will be captured monthly to ensure 1% of claims are being reviewed annually. Based on the initial assessment, the Director in consultation with ArchCare's CCO will determine if a formal fraud investigation is warranted, if a provider should be monitored,

if corrective action should be implemented, if a referral to the DOH or OMIG is warranted because of the potential for fraud, or if no further action is necessary.

The SIU has a suite of over 75 dashboards delivering suspect leads from Medical, Pharmacy, Vision, and Dental claims. These dashboards present the investigator with prioritized leads based on composite results and risk scores from different detection models. Risk scores are provided with each model within the associated dashboard. SIU uses a statistically sound methodology that scores each subject on the likelihood of being suspicious or an outlier. Every subject receives a score between 0-100 for their risk. The SIU will audit both the claims and medical records to determine that documentation supports the codes billed and the services rendered. SIU will identify inappropriately coded claims, determine the proper coding and identify and report on errors resulting in overpayment (reductions and denials) to ArchCare. All final determination will be made by ArchCare. SIU will review the claims against the medical records provided by SIU and indicate on a claims spreadsheet if the service billed should be allowed, changed or denied. In those instances where a claim has been determined to be changed or denied, the reviewed will annotate the claims spreadsheet to reflect the reasons for such a determination. In an instance where the services are being changed by the reviewer, the reviewed will indicate what code the originally claimed service should have been coded for correct billing purposes. After review, an audit letter will be drafted documenting all the FWA findings and shared with ArchCare for approval prior to sending and discussing with the provider.

Awareness and Education

ArchCare employs a variety of approaches to promote the awareness and the education of employees and affected individuals/vendors/providers about FWA:

- The ArchCare Compliance Department performs formal new employee orientation and annual training.

- In addition, the Compliance Department and the SIU perform informal trainings throughout the year.

- ArchCare website includes FWA webpage publicized internally and externally. The webpage provides information regarding FWA and tips on reporting FWA.

- All vendors and providers are required to review ArchCare training, Compliance policies and procedures, ArchCare Code of Conduct and ArchCare Compliance Charter on a yearly basis.

- The Compliance Department and leadership maintain an open-door policy to communicate compliance concerns, suspected Code of Conduct violations.

- The Compliance Departments attends conferences, webinars and trainings on the latest developments in Compliance and FWA.

Compliance Committee and Reporting to the Board

On a quarterly basis, the Chief Compliance Officers reports compliance and FWA issues to the Audit Committee of the Board of Directors. In addition, the Chief Compliance Officer also reports trends, patters, investigations and outcomes raised by the SIU to the Operational Compliance Committees and the Executive Compliance Steering Committee.

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Collaboration with Law Enforcement

SIU will function as a liaison for all law enforcement interactions which includes, OMIG, MFCU and other law enforcement agencies and prosecutors. In addition, the SIU will make all regulatory referrals to state and local regulatory agencies, as necessary.

EXCLUSIONS CHECKS AND RELATED MONITORING

ArchCare performs monthly checks of all employees against exclusionary lists to ensure that it does not hire or employ persons who have committed FWA or present a program integrity concern. These exclusionary lists include, as appropriate:

- The Excluded Parties System / System for Award Management;
- The Social Security Administration Death Master File;
- The National Plan Provide Enumeration System;
- The OMIG List of Restricted, Terminated or Excluded Individuals or Entities;
- The OIG Most Wanted Fugitives List;
- The New York State Office of the Professions Misconduct Enforcement System
- The New York State Office of Professional Medical Conduct Misconduct Enforcement System; and
- The CMS Preclusion List.

Any checks that raise a potential concern or that involve a question of correct identity are escalated to ArchCare Corporate Compliance.

ArchCare also checks new medical and institutional providers and re-enrolled providers, and performs monthly verifications on all participating providers, against excluded provider lists including those listed above.

ArchCare collects ownership and control disclosure information from managing employees for conflict-of-interest purposes.