archcare

The Continuing Care Community
of the Archdiocese of New York

COMPLIANCE AND FRAUD, WASTE AND ABUSE TRAINING

Vendor - 2023

Compliance Learning Objectives

Elements of ArchCare's Compliance Program

Review appliable laws and regulations

Explain the expectations for all affected individuals

Introduction

Welcome to ArchCare's Mandatory Training for vendors.

ArchCare established and maintains a Compliance Program to support and ensure that our employees and vendors comply with all applicable laws, rules, regulations, ArchCare Policies, and program requirements.

It demonstrates ArchCare's commitment to integrity and responsibility. It encourages all affected individuals to report potential compliance issues for remediation.

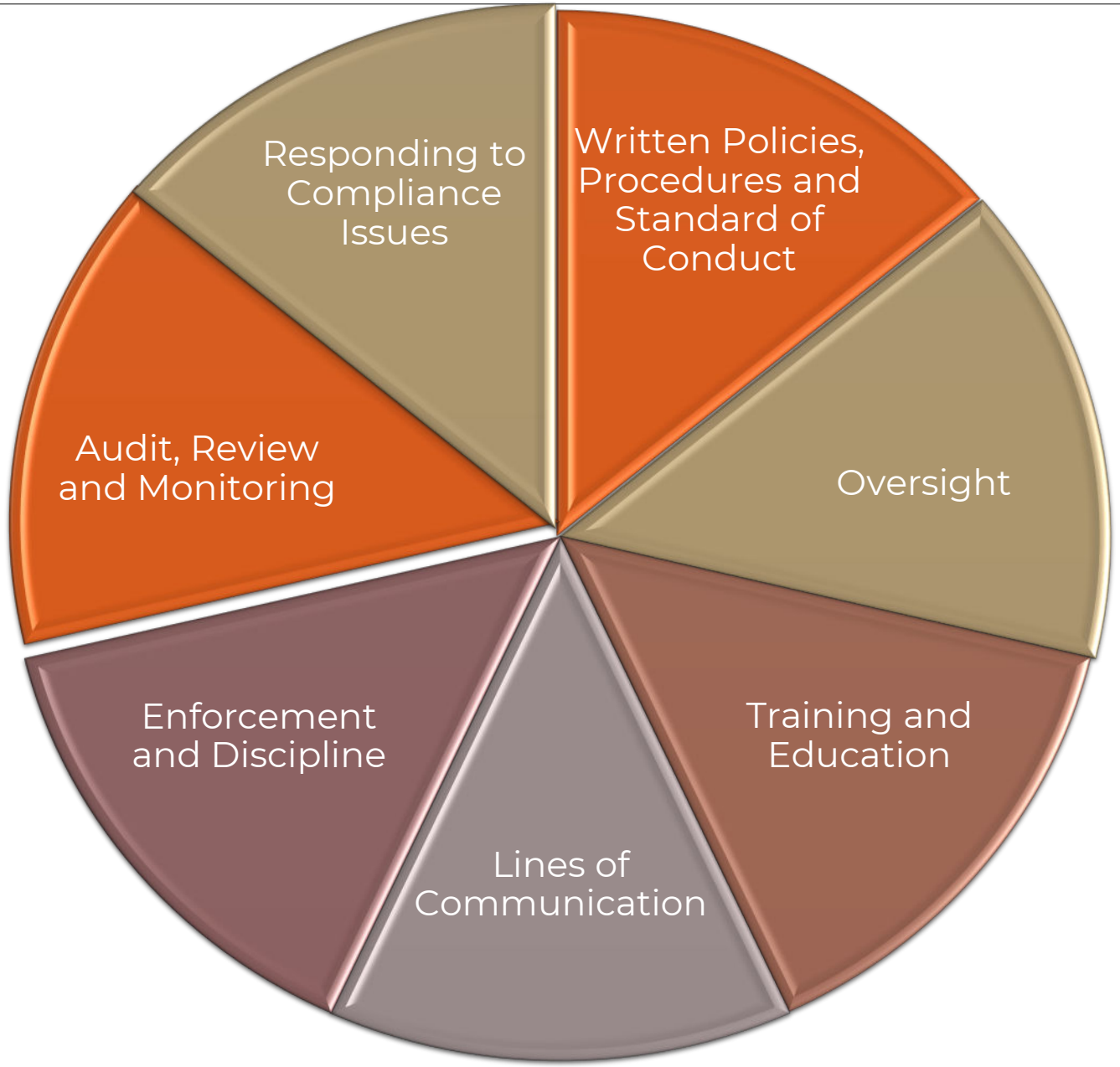
This training will cover the elements of ArchCare's Compliance Program, the laws, rules and regulations that apply to ArchCare and methods of reporting.

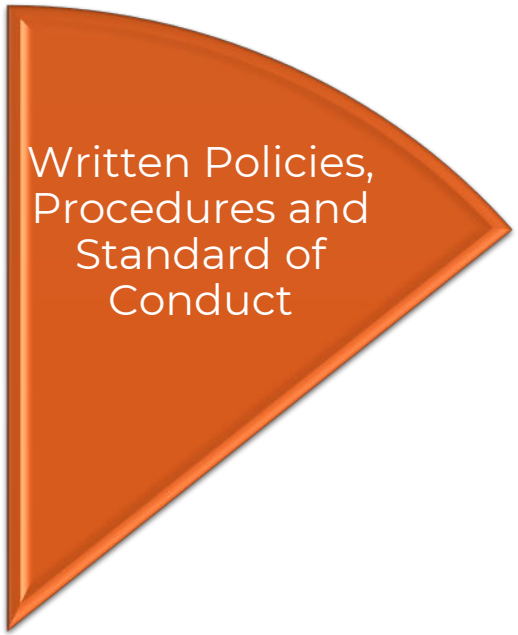
What is compliance?

Compliance is an organizational culture that fosters the prevention, identification, and remediation of conduct that fails to comply with applicable law and/or an organization's own ethical and business standards of conduct.

It is a way of preventing and responding to Fraud, Waste and Abuse in our healthcare operations.

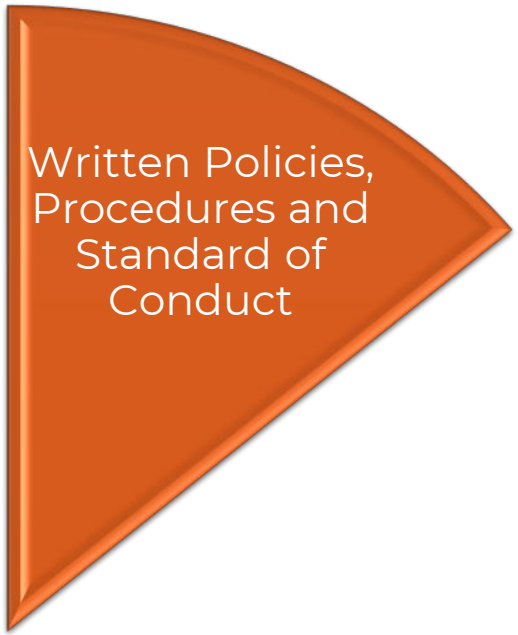
It is doing the right thing in the right way!


Written Policies, Procedures and Standard of Conduct
Oversight
Training and Education
Lines of Communication
Enforcement and Discipline
Audit, Review and Monitoring
Responding to Compliance Issues



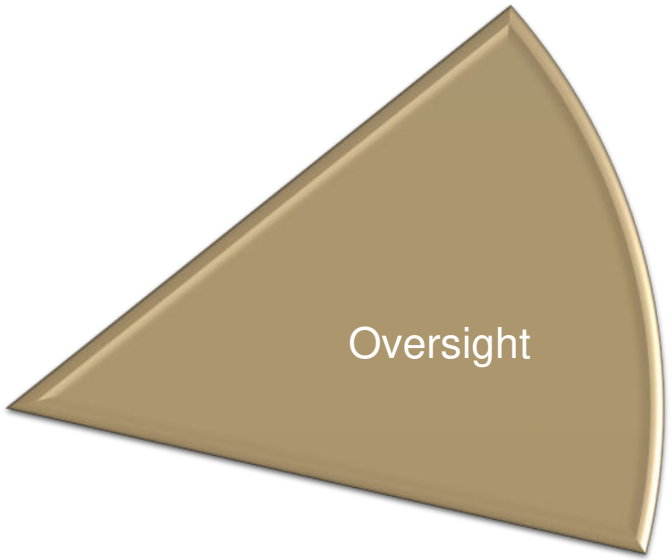
ArchCare Written Policies, Procedures and Code of Conduct have been developed to address all relevant federal and state laws related to fraud, waste and abuse. The policies are available online on the ArchCare Compliance webpage.

Each affected individual is responsible for knowing and following ArchCare's Code of Conduct as well as laws, regulations and ArchCare policies specific to their role in the organization.



ArchCare's Code of Conduct provides a broad overview of important legal and ethical stands we set for our organization and expect of our Care members

You can familiarize yourself with the Code of Conduct by visiting the compliance section of ArchCare's website.



ArchCare has a Chief Compliance Officer, who is a member of Senior Management. In addition, each line of business has a Compliance Officer/Liaison. There are also **Operational Compliance Committees** for each line of business and an **Executive Compliance Steering Committee.**

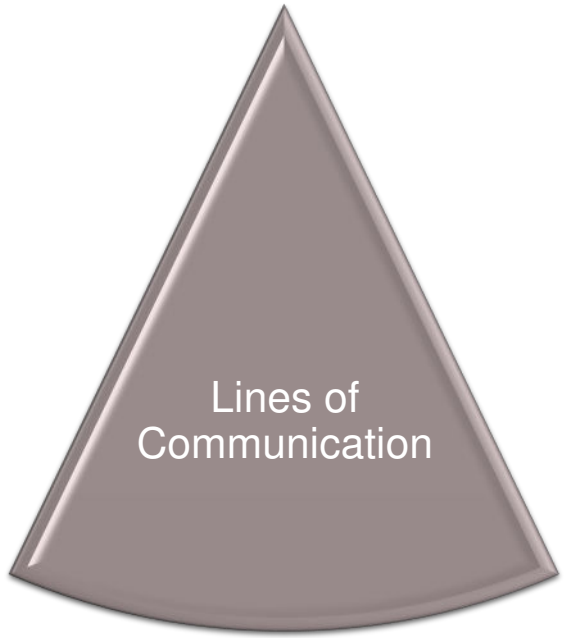
The training is conducted when a new vendor is onboarded and subsequently every year.

Vendors are responsible for ensuring that employees who report to them are educated on performing their jobs responsibilities in accordance with law, regulation and ArchCare policies.

Compliance & Corporate Ethics 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.

ArchCare expects all affected individuals to report appropriately if they become aware of a compliance issue and to assist in the intervention and resolution of compliance issues



ArchCare implements disciplinary action upon employees and contractors in response to compliance violations on a fair, equitable and prompt basis, regardless of title or position.

All ArchCare vendors are expected to adhere to the Code of Conduct, the Compliance Program, and applicable ArchCare compliance policies and procedures.

ArchCare will take disciplinary action, up to and including termination, for employees and terminate contracts with associates who are found to have violated law, regulation or policy or have take actions to undermine investigations following up on compliance concerns

ArchCare has established a system for the routine identification and assessment of compliance risk areas relevant to its operations. This process includes internal, and as appropriate, external reviews, audits, and other practices to evaluate ArchCare's compliance with federal and NYS health care program requirements and the overall effectiveness of the Compliance Program.

A compliance problem may be uncovered as the result of a report to the CCO or Compliance Hotline, an internal compliance assurance review, the review of a new regulation or governmental fraud alert, or from another source. Depending on the nature of the potential compliance issue, an investigation may include interviews with workforce members, documentation reviews and a root cause analysis. If an issue or violation does exist, then the investigation will attempt to determine its root cause so that appropriate and effective corrective action may be instituted.

FRAUD, WASTE AND ABUSE

Fraud, Waste and Abuse

ArchCare is committed to conducting our business with integrity and in compliance with applicable laws and regulations.

The **ArchCare FWA** prevention program is designed to identify and eliminate FWA.

There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.

Fraud

Fraud involves making false statements or misrepresentation of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. The acts may be committed for the person's own benefit or for the benefit of another party. In order to be considered fraud, the act must be performed knowingly, willfully and intentionally.

Examples:

- To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.
- Misrepresenting who provided the services, altering claim forms, electronic claim records or medical documentation.

Waste

Waste is spending that can be eliminated without reducing quality of care, i.e. deficient management, practices, or controls.

Waste also refers to useless consumption or expenditure without adequate return, or an act or instance of wasting.

Example:

- providing services that are not medically necessary.

Abuse

Abuse describes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in: (1) an unnecessary cost to the Medicaid and Medicare program; (2) reimbursement for services that are not medically necessary; or (3) services that fail to meet professionally recognized standards for health care.

Examples:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or
- Inappropriately allocating costs on a cost report.

LAWS

Federal and State

False Claims Act - 31 U.S.C. § § 3729-3733

The FCA imposes liability on any person or entity that submits a claim to the government that is known to be false.

Honest mistakes are not considered fraud. However, any overpayment from the government can be considered a violation of the FCA, if it is not returned to the government within 60 days of its discovery.

Additionally, the FCA provides protection for whistleblowers, or *qui tam* plaintiffs. *Qui Tam* lawsuits refer to actions taken by private citizens to help recover overpayments from the government or respond to fraudulent practices related to government contracts.

False Claims Act - 31 U.S.C. § § 3729-3733

Criminal Penalties

- imprisonment for up to five years, as well as substantial fines and possible exclusion from the Medicare and Medicaid programs

Civil Penalties

Criminal Health Care Fraud Act - 18 U.S.C. § 1347[a][1-2]

In addition to civil liability under FCA, the Criminal Health Care Fraud Act, in relevant part, makes it a federal crime to "knowingly and willfully execute, or attempt to execute, a scheme or artifice to:

- Defraud any health care benefit program; or

- Obtain by means of false or fraudulent pretenses, representations, or promises any …money or property … owned by, or under the custody or control of, any health care benefit program in connection with the delivery of or payment for health care benefits, items, or services."

Criminal Health Care Fraud Act - 18 U.S.C. § 1347[a][1-2]

Criminal Penalties

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

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).

Some arrangements have been excepted because they were viewed as unlikely to result in a violation of the statute. Compliance Officer or Legal Counsel should be consulted as to whether an arrangement falls within a safe harbor.

Anti-Kickback Concerns include contracts, arrangements with providers and waive of co-insurance and deductible.

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

Criminal Penalties

- imprisonment for up to five years, as well as substantial fines and possible exclusion from the Medicare and Medicaid programs

Civil Penalties

- as much as $50,000 per violation and triple the amount of the kickback

The Stark Law – 42 U.S.C. § 1395nn

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.

The Stark Law – 42 U.S.C. § 1395nn

Civil Penalties

- Up to a **$15,000** fine for each service provided. Up to **a $100,000** fine for entering into an arrangement or scheme.

Stark Concerns

- claims tainted by an arrangement that does not comply with Stark are not payable.

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:

- Arranging for services or items from an excluded individual or entity
- Providing services or items while excluded
- Failing to grant OIG timely access to records
- Knowing of and failing to report and return an overpayment
- Making false claims
- Paying to influence referrals

Civil Monetary Penalties (CMP) Law

Civil Penalties

New York State False Claims Act, N.Y.S. Fin. Law §§ 187-194

- Allows the Attorney General or any other person to file a lawsuit against a person or a company that obtains or withholds funds or property from the state or local government through false or fraudulent conduct.
- A person or company found liable under the act must generally pay treble damages, civil penalties, plus costs and attorneys' fees. Individuals who file suits may be eligible to keep a percentage of the funds they help recover.
- The state False Claims Act also protects employees from being retaliated against for filing qui tam suits against employers who may be engaged in activities or practices that defraud the government of money or property.

New York State, Social Services Law, at § 145-b

- Makes it 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 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.
- A penalty of up to $30,000 per violation may be imposed if repeat violations occur within five years and involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

New York State, Social Services Law, at § 145-c

- States that if any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement.
- six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least $1,000 but not more than $3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of $3,900), and five years for any subsequent occasion of any such offense.

New York State, Penal Law Article, at § 176

Applies to claims for insurance payments, including Medicaid or other health insurance, and establishes six crimes ranging from Insurance Fraud in the 5th degree (a class A misdemeanor) through Insurance Fraud in the 1st degree (a class B felony). Furthermore, Aggravated Insurance Fraud (committing Insurance Fraud more than once) is a class D felony.

New York State, Penal Law, at § 177

Addresses health care providers, including any publicly or privately funded health insurance or managed care plan or contract, who defraud the system. It also includes crimes ranging from Health Care Fraud in the 5th degree (a class A misdemeanor) through Health Care Fraud in theist degree (a class B felony).

Excluded Providers

42 U.S.C. § 1320a-7 and

18 NYCRR § 515.3 and/or 18 NYCRR § 515.7

OIG/OMIG 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

If an individual is on one of these lists, they may not participate in any Federal or State Government programs, including Medicare and Medicaid.

In other words, you might not be able to remain a vendor with ArchCare if you are on an exclusion list.

Examples of FWA/Compliance Issues

Duplicate billing for the same service	Billing for services not provided	Misrepresenting the identity of the provider, the date of service or description of services provided	Identity Theft
Misuse of authority for personal gain	Vendor kickbacks	Overusing medical services and products	Accepting gifts from vendors or patients
Providing services or products that are not medically necessary	Providing services inconsistent with professional standards	Authorizing or receiving payments for goods not received or services not performed	Authorizing or receiving payment for hours not worked

Retaliation

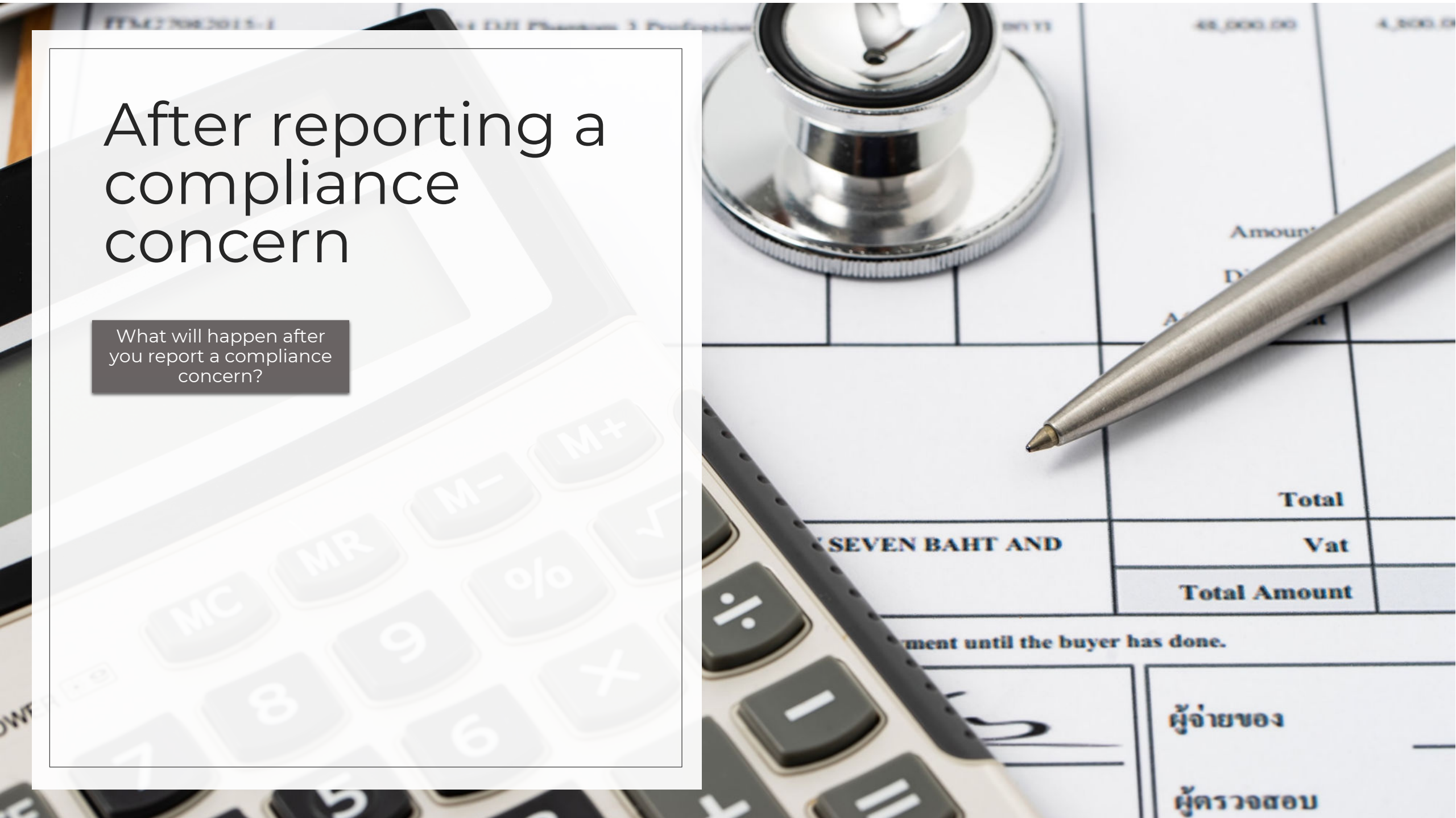
Any affected individual engaged in “protected Activity” is protected from being intimidated or retaliated against.

This includes:

- Reporting in good faith a compliance concern to your supervisor or compliance officer; and
- Participating or cooperating with an investigation following up on a compliance concern.

After reporting a compliance concern

What will happen after you report a compliance concern?



THE CORPORATE & CORPORATE ETHICS HOTLINE

REPORTING FWA AND COMPLIANCE VIOLATIONS

1-800-443-0463

www.archcare.ethicspoint.com

toll free

anonymous

always available

Persons reporting a breach cannot be subjected to retaliation.