Overview

It is the policy of MVP Health Care, Inc. and its affiliates (collectively referred to as "MVP") to comply with all applicable federal and state laws regarding fraud, waste and abuse. MVP acknowledges its participation as a Government Programs contractor in federal and state sponsored health care programs, including Medicare Advantage and Part D, Medicaid, and Child Health Plus (collectively "Government Programs"). As a Government Programs Contractor, MVP is subject to specific state and federal regulatory requirements related to these programs.

To comply with Section 6032 of the Deficit Reduction Act of 2005, MVP provides this policy, which includes information about its policies and procedures and the role of certain federal and state laws in preventing and detecting fraud, waste and abuse in government-sponsored health care programs.

Procedures

I. Procedures for Detecting and Preventing Fraud, Waste and Abuse

The Company maintains a Corporate Compliance Program that includes activities for the detection, prevention and investigation of fraud, waste and abuse. The Company's Special Investigations Unit (SIU) is charged with maintaining a program to detect, investigate, prevent, and recover the loss of corporate, government and customer assets resulting from fraudulent and abusive actions committed by providers, members, subcontractors and employees. The SIU maintains a toll-free, 24-hour hotline, 1-877- 835-5687, where potential fraud and abuse issues can be reported directly. SIU acts on referrals received from internal and external sources of potential fraud and/or abuse. Additionally, SIU uses other methods to identify potentially fraudulent activity such as claim data extracts. The Company also maintains an Ethics & Integrity Hotline that can be used by employees, contractors and agents to report compliance concerns anonymously at 1-888-357-2687.

A. Federal Laws Governing Fraud, Waste and Abuse (FWA)

1. False Claims Act; 31 U.S.C. §§ 3729 – 3733

The federal False Claims Act imposes liability on any person or entity who:

- Knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program;
- Knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program; or
- Conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.
- Knowingly avoids or decreases an obligation to pay or transmit money or property to the government.

"Knowingly" means:

- Having actual knowledge that the information on the claim is false;
- Acting in deliberate ignorance of whether the claim is true or false; or
- Acting in reckless disregard of whether the claim is true or false

A person or entity found liable under the False Claims Act is, generally, subject to civil money penalties of between $11,463 and $22,927 per claim and three times the amount of damages that the government sustained because of the illegal act.

Under the False Claims Act, individuals with knowledge of potential violations may file suit on behalf of the government in federal court. These individuals may be entitled to a percentage of the amount recovered by the government. The False Claims Act also provides protection from retaliation and discrimination for individuals that bring action under this law.

2. Patient Protection and Affordable Care Act ("PPACA") 42 U.S.C. 1301 et seq.

Section 6402: Enhanced Medicare and Medicaid Program Integrity Provisions. This requires that a provider of services, supplier, Medicaid managed care organization, Medicare Advantage organization, or prescription drug plan sponsor, who receives an overpayment, must report and return the overpayment within 60 days of discovering the overpayment or the date a corresponding cost report is due. Repayment is owed to the entity who made the overpayment (e.g., State, insurance carrier, contractor). Civil monetary penalties may be imposed by the Secretary of Health and Human Services of up to $50,000 or triple the total amount of the claim involved for those who knew of an overpayment and did not return it.

3. Program Fraud Civil Remedies Act; 31 U.S.C. §§ 3801- 3812

The Program Fraud and Civil Remedies Act ("PFCRA") creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the False Claims Act.

The PFCRA imposes liability on individuals or entities that file a claim that they know or have reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement that contains false, fictitious or fraudulent information;
- Includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious or fraudulent, and the individual or entity submitting the statement has a duty to include the omitted fact; or
- Is for payment for property or services not provided as claimed.

A violation of this section of the PFCRA is punishable by a $5,000 civil penalty for each wrongfully filed claim and an assessment of twice the amount of any unlawful claim that has been paid.

4. Civil Monetary Penalties Law (42 USC § 1320a–7a)

The Civil Monetary Penalties Law (CMPL) imposes CMPs for a variety of health care fraud violations, and different amounts of penalties and assessments may be authorized based on the type of violation at issue. The CMPL authorizes penalties of up to $50,000 per violation,

and assessments of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received. Violations that may give rise to CMPs include: (1) knowingly presenting a claim to a federal department or agency that is for a medical or other item or service that the person knows or should know was not provided as claimed; (2) is a service knowingly provided by a non-licensed physician; (3) is knowingly provided by a provider excluded from a Federal health care program; (4) is a claim that is part of a known pattern of services that are not medically necessary; (5) arranges or contracts with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program; or (6) refuses to grant timely access to the Inspector General of the Department of Health and Human Services for the purpose of audits, investigations, evaluations, or other statutory functions.

5. Anti-Kickback Statute

The federal anti-kickback statute prohibits MVP, its employees, and contractors from offering or paying remuneration in exchange for the referral of Government Programs business. Under the anti-kickback statute remuneration is considered to be anything of value that is exchanged. Penalties that may be imposed under this statute for violations include criminal penalties, exclusion from participation in government programs and civil monetary penalties.

6. Stark Laws

The Physician Self-Referral Act or Stark Laws prohibit physicians from making referrals for certain health services that are payable by Medicare or Medicaid to any entity with which the physicians have a financial relationship. A financial relationship means either an ownership interest or a compensation arrangement. The purpose of the Stark Laws is to ensure that referrals for services are made in the best interests of the patient.

7. Health Care Fraud (18 U.S.C. § 1347)

It is illegal to knowingly and willfully execute or attempt to execute a scheme to either defraud a health care benefit program or to obtain money or property from a health care benefit program by means of false pretenses or representations. Penalties can include fines and/or imprisonment.

B. State Laws Governing Fraud, Waste and Abuse

1. New York State False Claims Act (State Finance Law, §§ 187-194)

The New York State False Claims Act is modeled after the federal False Claims Act. This Act provides liability for knowingly presenting a false claim or record to the state or local government or a Medicaid managed care plan for payment or approval. Violators of the Act can be subject to civil penalties of $6,000 to $12,000 per claim as well as three times the amount of damages that the government sustained because of the illegal act. As with the federal False Claims Act, individuals with knowledge of false claims may bring action on behalf of the state or the local government, are entitled to a percentage of the proceeds collected, and are protected from retaliation and discrimination.

2. False Statements Relating to the Medicaid Program (Social Services Law § 145-b)

Under New York state law, it is illegal for a person, firm or corporation to knowingly obtain or attempt to obtain payment from public funds for social services, including medical services by:

- making a false statement or representation:
- deliberately concealing a material fact; or
- a fraudulent scheme.

3. Unacceptable Practices in the Medicaid Program (18 NYCRR Part 521)

Under Medicaid provider regulations, false claims and false claim statements are unacceptable practices. Sanctions that the Department of Health may impose on a provider for unacceptable practices include censure, repayment, and exclusion from participation in the Medicaid program.

4. Criminal Prohibitions under New York Law

In certain circumstances, a person who makes false statements may be charged criminally under New York law. Each of the following crimes may be a misdemeanor or a felony, depending on the intent of the perpetrator and the amount involved. Penalties include fines or imprisonment, or both.

- **Fraudulent Practices (New York Social Services Law § 366-b)**
  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 commits a fraudulent practice.

- **Falsifying Business Records (New York Penal Law § 175.00-175.15)**
  Business records are defined as writings, including computer data that are kept or maintained by an enterprise to evidence its condition or activity. A person may be found guilty of falsifying business records if, with the intent to defraud, he or she:

  - makes or causes a false entry in the business records;
  - alters, erases, obliterates, deletes, removes or destroys a true entry in the business records;
  - omits to make a true entry in business records when required to do so by law or his or her position; or
  - prevents the making of a true entry or causes the omission of a true entry in business records.

- **Tampering with Public Records (New York Penal Law §§ 175.20-175.25)**
  A person may be found guilty of tampering with public records if he or she knowingly removes, mutilates, destroys, conceals, makes a false entry in or falsely alters any record or other written instrument filed with, deposited in, or otherwise constituting a record of a public office or public servant, when he or she knows he or she does not have the authority to do so.

- **Offering a False Instrument for Filing (New York Penal Law §§ 175.30-175.35)**
  A person may be found guilty of offering a false statement for filing if he or she, knowing that a written instrument contains false information, offers or presents it to a public office with the knowledge or belief that is will be filed with, registered or recorded in or otherwise become a part of the records of such public office.

- **Insurance Fraud (New York Penal Law Article 176)**
  It is a crime to file a health insurance claim, knowing that it is false. Insurance fraud may be a Class A misdemeanor or a Class B, C, D or E felony, depending upon the amount involved. It is also a Class D felony to commit insurance fraud more than once.

- **Health Care Fraud (New York Penal Law Article 177)**
  Health care fraud includes knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. Health care fraud may be a Class A misdemeanor or a Class B, C, D or E felony, depending upon the amount involved.

  Under New York state law, any person or entity that obtains or attempts to obtain false payment may be ordered to pay damages of three times the amount that was overstated. If the false statement was non-monetary, the damages may be three times the amount of loss that the state or other governmental entity incurred. In addition to requiring repayment of improperly claimed funds, the Department of Health may impose additional penalties per item or service.

- **Criminal Impersonation (New York Penal Law Article 190)**
  A person may be found guilty of criminal impersonation if he or she assumes another person's identity with the intent to defraud, deceive, or injure another. This crime can be classified as a misdemeanor or a felony, depending on the circumstances and the harm caused.

C. Whistleblower Protections

An individual who brings action under the False Claims Act is called a qui tam relator or whistleblower. Federal law prohibits employers from retaliating against employees who file suits on behalf of the government under the False Claims Act. New York law prohibits employers from retaliating against an employee for disclosing or threatening to disclose practices which violate a law and create a danger to public health or safety or which constitutes health care fraud.

All employees are encouraged to report any potential fraudulent activity by using any of the established reporting paths including the Ethics and Integrity hotline that allows employees to report anonymously at 1-888-357-2687 or online at www.EthicsPoint.com. Calls made to the Ethics and Integrity hotline are received by EthicsPoint/NavexGlobal, an independent vendor that manages MVP's confidential reporting system.

E. Role of False Claims Laws

The false claims laws described in this policy create a system for preventing and detecting fraud, waste and abuse in federal and state health care programs by providing governmental agencies with the appropriate authority and mechanisms to investigate and punish fraudulent activity.