Samaritan Health Plans	Samaritan Health Plans Policies & Procedures

SHP Compliance Department	SAHP	IHP	SGC	LGC	SC	ADMIN
	X	X	X	X	X	X

CP-03 Fraud Waste and Abuse Program	**Effective Date:** 1/14/2016
	Last Revision Date: 1/4/2019
	Dissemination Date: 1/4/2019
	Required Review Date: 11/1/2019

PURPOSE

This policy describes the Samaritan Health Plans (SHP) comprehensive Fraud, Waste, and Abuse (FWA) program. It includes an overview of the minimum activities conducted yearly for prevention and detection of FWA. This policy serves as a guide to SHP staff on understanding the process for reporting, investigating suspected or confirmed FWA, and reporting internally and externally as needed to oversight agencies.

APPLICATION / SCOPE

All Samaritan Health Plans (SHP) employees, Delegated Entities (DE), any provider or supplier billing SHP, and SHP's Pharmacy Benefits Manager (PBM).

DEFINITIONS

I. ***Abuse*:** Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

II. ***Audit:*** Is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

III. ***CMS*:** Centers for Medicare & Medicaid Services

IV. ***Delegated Entity (DE):*** Any First-Tier, Downstream or Related Entity, Sub-Contractor: any party that has entered into a written arrangement with SHP to provide administrative or healthcare services for a SHP member.

V. ***Downstream Entity:*** Is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage (MA) benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization (MAO) or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

VI. ***FDR*:** First-Tier, Downstream, and Related Entity

VII. ***First-Tier Entity:*** Is any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program (See, 42 CFR 423.501).

VIII. ***Fraud*****:** Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

IX. ***FWA*****:** Fraud, Waste, and Abuse monitoring regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

X. ***Medicaid Fraud Control Unit (MFCU):*** Investigate and prosecute Medicaid provider fraud as well as patient abuse or neglect in health care facilities and board and care facilities.

XI. ***National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC):*** Investigate and respond to allegations of Fraud, Waste, and Abuse in Medicare Parts C and D.

XII. ***Related Entity*****:** Means any entity that is related to an MAO or Part D sponsor by common ownership or control and (1) Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an or written agreement; or (3) Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period. (see, 42 CFR 423.501)

XIII. ***Waste:*** Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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POLICY

Samaritan Health Plans (SHP) staff and DE's are responsible for reporting any suspected or known Fraud, Waste, and Abuse (FWA) to the SHP Special Investigations Unit (SIU) or appropriate government organization (Appendix A). SHP is proactive in detecting, correcting and preventing potential offenses of FWA through its comprehensive FWA program. SHP thoroughly investigates any suspected cases of FWA and takes steps to report and resolve in a timely matter. All instances of FWA or potential FWA are reported directly to the Compliance Officer, who then reports any offenses and outcomes to the SHP Compliance Committee.

PROCEDURES

I. The SIU develops claim queries based on Center for Medicare & Medicaid Services (CMS) list of high risk areas for potential cases of FWA, which are posted by the Recovery Audit Contractor (RAC) for our region, Health Data Insights at the following website: https://racinfo.hms.com/home.aspx

II. The SIU develops queries based on industry discoveries for high risk areas for potential cases of FWA, which can be found in the process documentation. The SIU also develops and pulls queries based off of staff reports.

III. SHP and it's DEs cooperate with, and require its subcontractors to cooperate with, any investigator during an investigation of FWA.

IV. No retaliation will be made against any employee who in good faith has filed a report of alleged FWA or who participated in an investigation.

V. An employee of SHP or an DE shall not destroy, or allow to be destroyed any documents or record of any kind that the employee knows may be relevant to a past, present, or future investigation of FWA.

VI. Any suspected offense of FWA is reported to the SIU. Within two weeks of the submission of possible FWA, the SIU team initiates an investigation.

VII. The SIU documents the entire audit, organizes their findings, updates the Audit Report and OMT with recommendations, if any, and submits the findings to the Compliance Officer.

VIII. If SIU determines that there are any changes required in the system of record, the operational area Director and/or Manager will be notified. The operational area will have 30 calendar days to complete the required updates from the notification date.

IX. The Compliance Officer and Assistant General Councel when necessary, determines the appropriate corrective action(s) based off of the recommendations. These may include, but are not limited to, any of the following actions:

A. Provider office education
B. SIU submits a request to the Claims department for claims hold on Provider.
C. Conduct a targeted audit of the Provider
D. Report the Provider offense to outside oversight agencies
E. Non-Renewal of credentialing and/or termination of contract

X. SHP self-discloses all cases of egregious FWA conducted by a SHP provider or pharmacy to the appropriate authority once an investigation has been conducted and determined to be fraudulent.

REFERENCES

I. 42 CFR 423.504(b)(4)(vi)

II. 42 CFR 422.503(b)(4)(vi)

III. DHHS Office of Inspector General Compliance

IV. Program Guidance for Certain Medicare + Choice Organization
http://oig.hhs.gov/authorities/docs/cpgm_c.pdf

V. Medicare Managed Care Manual and Prescription Drug Benefit Manual, Chapters 9 and 21

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RESPONSIBLE PARTY

SHP Compliance Officer

RELATED DOCUMENTS

I. CP-01 Commitment to Statutory Regulatory and other Requirements

II. CP-04 Compliance Enforcement Policy

III. SHS Corporate Integrity Program

IV. SHP Compliance Program

Required Review Date: 12/15/2016			
Revision #	Approved By / Date	Policy Owner	Revision Description
11	1/4/2018	Denise Severson	Formatting
10	7/12/2018	Denise Severson	Added Contact Information for external entities and website links
9	3/15/2018	Denise Severson	Updated system of record
8	01/15/2018	Denise Severson	No additional edits needed
7	11/20/17 / BC	Denise Severson	Add timeframe for starting investigation.
6	3/7/2017 / SK	Denise Severson	Updated Verbiage and Content
5	2/7/2017 / SK	Denise Severson	Verfied Content and Formatting
4	9/15/2016 / SK	Denise Severson	Updated formatting/ verified content
3	06/13/2016/JW	Denise Severson	Updated definitions and Policy Language
2	1/14/2016 / DS	Denise Severson	

Appendix A
Reporting Requirements Per Line of Business

LOB	REPORTING EXTERNAL ENTITY #1	REPORTING EXTERNAL ENTITY #2	REPORTING EXTERNAL ENTITY #3	REPORTING EXTERNAL ENTITY #4
SAHP	Medicare NBI MEDIC 1-877-772-3379 (1-877-7SafeRX) http://www.qlarant.com/wp-content/uploads/2018/03/NBI_Contract_Qlarant_MEDIC_ComplaintForm_2018.pdf	Oregon Department of Consumer and Business Services (DCBS) 350 Winter Street NE Salem, OR 97309 Phone: 503-378-4100	The DHS Office of the Inspector General (OIG) 1-800-323-8603 1-844-889-4357 – TTY https://www.oig.dhs.gov/about/contact	Local Law Enforcement
IHN	Medicaid Fraud Control Unit (MFCU) Oregon Department of Justice 100 SW Market Street Portland, OR 97201 Phone: 971-673-1880 Fax: 971-673-1890 **or** Department of Fraud Investigations Unit (FIU)	**OHA Program Integrity Audit Unit** 3406 Cherry Ave. NE Salem, OR 97303-4924 Phone: 503-378-8113 Fax: 503-378-2577 Hotline: 1-888-FRAUD01 (888-372-8301)	The DHS Office of the Inspector General (OIG) 1-800-323-8603 1-844-889-4357 – TTY https://www.oig.dhs.gov/about/contact	Local Law Enforcement
OTHER ISSUES	The Oregon Health Authority (OHA) 500 Summer Street, NE, E-20 Salem, OR 97301-1097 **Phone:** 503-947-2340 **Toll Free:** 800-375-2863 **Fax:** 503-947-5461	U.S Department of Justice (DOJ) 1036 SE Douglas Ave Roseburg, OR 97470 Phone: 541-440-4518	The Oregon Office of Private Health Partnerships (OPHP)	Local Law Enforcement

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