POLICY INFORMATION

Policy Title: Detection and Prevention of Fraud, Waste, and Abuse (Pursuant to the Federal Deficit Reduction Act of 2005) Policy and Procedure

Departmental Owner: Chief Compliance, Audit, and Privacy Officer

Version Effective Date: 11/30/2023

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SCOPE

This policy applies to the following individuals and/or groups:

☒All of the below categories

☐All Employees ☐CT Employees ☐NY Employees ☐Remote Employees ☐Contractors☐Volunteers ☐Students/Interns ☐Vendors

This policy applies to all above listed Nuvance Health Workforce Members including but not limited to the following locations:

☒All of the below entities

☐Nuvance Health Systems

☐ Danbury Hospital (including New Milford Hospital Campus)	☐ Health Quest Systems, Inc. "(HQSI)"	☐ Western Connecticut Home Care, Inc ("WCHN")
☐Northern Dutchess Hospital	☐ Health Quest Home Care, Inc	☐ Western Connecticut Health Network Physician Hospital Organization ACO, Inc.
☐Norwalk Hospital	☐ Hudson Valley Cardiovascular Practice, P.C. (aka The Heart Center) ("HVCP")	☐Western Connecticut Home Care, Inc
☐ Putnam Hospital	☐ Other HQSI-affiliated Entities Not Listed	☐ Other WCHN-affiliated Entities Not Listed
☐Sharon Hospital		☐Nuvance Health Medical Practices (NHMP PC, NHMP CT, ENYMS & HVCP)
☐Vassar Brothers Medical Center		

POLICY STATEMENT/PURPOSE

To prevent and detect Fraud, Waste and Abuse ("FWA") by providing Covered Individuals detailed information regarding: (1) the Federal False Claims Act ("FCA"); (2) federal laws and penalties pertaining to reporting and returning overpayments; (3) state laws and penalties pertaining to false claims; and (4) whistleblower protections under certain laws.

POLICY

Nuvance Health and its affiliates ("Nuvance") has adopted an extensive set of programs for detecting and preventing FWA. The Compliance Office oversees these programs. Depending on the nature of the allegations, the Compliance Office works collaboratively with the Office of the General Counsel to conduct investigations in these areas.

Nuvance devotes substantial resources to investigate allegations of fraud, waste, and abuse and therefore, believes that all Covered Individuals should bring their concerns to Nuvance first, in accordance with the Compliance Disclosure Program Policy/Procedure so it can redress and correct any fraudulent activity, and implement corrective action plans when appropriate. Any employee of Nuvance who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under Nuvance

Health's Whistleblower Protection Policy and Federal and State law. However, Nuvance retains the right to take appropriate action against an employee who has participated in a violation of Federal or State law or Nuvance policy.

While Nuvance requires that its employees bring their concerns to Nuvance, certain State and Federal laws discussed more fully below provide that any private citizen may bring concerns of fraud and abuse directly to the government. Please note, however, that if an employee never reports his/her concerns through Nuvance's internal compliance processes so that Nuvance can address these concerns, they will be in breach of their duty of loyalty to Nuvance.

If you would like more information on the Corporate Compliance Program and specific compliance policies, or on how to report any concerns, please contact the Compliance Office at (203) 739-7110 or go to the Compliance section of *Ellucid*.

FEDERAL LAWS

Federal False Claims Act

The Federal False Claims Act ("FCA") makes it a crime for any person or organization to knowingly make a false record or file a false record or file a false claim with the government for payment. "Knowingly" means that the person or organization:

- Knows the record or claims is false, or
- Seeks payment with ignoring whether or not the record or claim is false, or
- Seeks payment recklessly without caring whether or not the record or claim is false.

The FCA imposes civil penalties on individuals and organizations who knowingly submit a false claim or statement to a federally funded program, or otherwise conspire to defraud the government, in order to receive payment.

The FCA is not confined to health care claims but extends to any payment requested of the federal government. The FCA applies to billing and claims sent from hospitals to any government payor program, including Medicare and Medicaid.

It is the policy of Nuvance that an employee, contractor, or agent of Nuvance who knowingly and intentionally submits a false claim will be reported to the necessary authorities. Anyone, or any company, that submits a false claim or statement to the government may be fined under the FCA regardless of the size of the false claim, and the person or company could be required to pay an additional fine of three (3) times the value of any charges.

The FCA also protects people who report suspected fraud. A person who knows a Claim was filed for payment in violation of the False Claims Act can file a lawsuit in Federal Court on behalf of the government. It is Nuvance's policy to fully support the FCA's protections. Any person who lawfully reports information about false claims or suspected false claims that are submitted by others, may not be retaliated against, demoted, suspended, threatened, or harassed by Nuvance for making such a report. The FCA also protects individuals who assist in an investigation, provide testimony, or participate in the government's handling of a false claim.

The FCA provisions are generally enforced by the U.S. Department of Justice. The FCA provides that a person may initiate a formal claim if he or she is the "original source" of the information. This means that the person bringing the claim must have direct and independent knowledge of the alleged fraud. If any funds are recovered, a portion of the funds may be paid to the person who initiated the formal claim, at the discretion of a federal court.

If a person wishes to file a claim regarding fraud or suspected fraud related to a health care payment directly with the government, he or she must first present a formal complaint, along with all material evidence relating to the alleged fraud, to the authorities at the U.S. Department of Justice.

A private legal action under the FCA must be brought within six (6) years from the date that the false claim was submitted to the government. (A government-initiated claim may be brought up to 10 years after the false claim, depending on the circumstances.)

Patient Protection and Affordable Care Act ("PPACA")

Under Section 6402, Enhanced Medicare and Medicaid Program Integrity Provisions, Part (d) reporting and returning of overpayments:

1. In general, if a person has received an overpayment, the person shall
    a. report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
    b. notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.
2. Deadline for Reporting and Returning Overpayments – An overpayment must be reported and returned under paragraph (1) by the later of
    a. the date that is 60 days after the date on which the overpayment was identified; or
    b. the date any corresponding cost report is due, if applicable.
3. Enforcement - Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.
4. Definitions – In this subsection:
    a. Knowing and Knowingly – The terms "knowing" and "knowingly" have the meaning given those terms in section 3729(b) of title 31, United States Code.
    b. Overpayment – The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.
    c. Person – (i) In General – The term "person" means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D-41(a)(13)).

Federal Program Fraud Civil Remedies Act

Persons or companies that commit fraud on the federal government, by false claim or statement, can be assessed money penalties in addition to the penalties of the False Claims Act because of a law called the Program Fraud Civil Remedies Act (referenced in this policy as "PFCRA"). Specifically, there are penalties per false claim or statement that apply if a person or company submits a claim to the federal government that: the person or company knows or has reason to know is false, fictitious, or fraudulent; includes or is supported by written statements containing false, fictitious, or fraudulent information; includes or is supported by written statements that omit a material fact, which causes the statements to be false, fictitious, or fraudulent, and the person submitting the statement has a duty to include the omitted fact; or is for payment of property or services that are not provided as claimed.

The penalty also applies if a person or company provides written back-up or materials relating to the claim in which the person or company asserts a material fact that is false, fictitious, or fraudulent; or omits a fact that the individual had a duty to include, the omission causes the statement to be false, fictitious, or fraudulent, and the statement contains a certification of accuracy.

NEW YORK STATE LAWS

The New York False Claims Act ("NYFCA") provides, in pertinent part, that:

Any person who:

1. Knowingly presents, or causes to be presented, to any employee, officer, or agent of the State or a local government 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 State or a local government; conspires to defraud the State or a local government by getting a false or fraudulent claim allowed or paid; or
3. 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 State or a local government;

is liable (a) to the State of New York for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, plus three times the amount of damages that the State sustains because of the act of that person; and (b) to any local government for three times the amount of damages sustained by such local government because of the act of that person.

For purposes of this section, the terms "knowing" and knowingly" mean that with respect to a claim, or information relating to a claim, a person:

1. Has actual knowledge of such claim or information;
2. Acts in deliberate ignorance of the truth or falsity of such claim or information; or
3. Acts in reckless disregard of the truth or falsity of such a claim or information.

Proof of specific intent to defraud is not required, but acts occurring by mistake or due to mere negligence are not covered by this law.

Under the NYFCA, "claim" means any request or demand for money or property that is made to any employee, officer, or agent of the State or a local government. This includes requests or demands submitted to a contractor of the government and includes Medicaid claims, among other items.

The NYFCA also provides that private parties may bring an action on behalf of the State or a local government. These private parties, known as "qui tam relators," may share in a percentage of the proceeds from a NYFCA action or settlement.

The NYFCA provides protection to an employee of any private or public employer who is discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by his or her employer because of lawful acts taken by the employee in furtherance of an action under the NYFCA. Remedies for such discrimination include reinstatement, two times back pay, and compensation for any special damages sustained as a result of the discrimination.

Certain relevant portions of other New York State Codes are summarized below:

New York Social Services Law §145-b, it is unlawful to knowingly make a false statement or representation, or to deliberately conceal any material fact, or engage in any other fraudulent scheme or device, to obtain or attempt to obtain payments under the New York State Medicaid program. For a violation of this law, the local Social Services district or the State has a right to recover civil damages equal to three times the amount by which any figure is falsely overstated. In the case of non-monetary false statements, the local Social Service district or State may recover three times the damages (or $5,000, whichever is greater) sustained by the government due to the violation.

The law also empowers the New York State Department of Health to impose a monetary penalty on any person who, among other actions, causes Medicaid payments to be made if the person knew or had reason to know that:

- the payment involved care, services, or supplies that were medically improper, unnecessary, or excessive;
- the care, services or supplies were not provided as claimed;
- the person who ordered or prescribed the improper, unnecessary, or excessive care, services, or supplies was suspended or excluded from the Medicaid program at the time the care, services, or supplies were furnished; or
- the services or supplies were not in fact provided.

The monetary penalty shall not exceed $10,000 for each item or service in question, unless a penalty under the section has been imposed within the previous five years, in which case the penalty shall not exceed $30,000 per item or service.

New York Social Services Law §366-b (2), any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining compensation greater than that to which s/he is legally entitled for furnishing services or merchandise shall be guilty of a Class A misdemeanor. If such an act constitutes a violation of a provision of the penal law of the state of New York, the person committing the act shall be punished in accordance with the penalties fixed by such law.

New York Penal Law §177 establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including nongovernmental plans), s/he knowingly and willfully provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which s/he is not entitled. Health Care Fraud is punished with fines and jail-time based on the amount of payment inappropriately received due to the commission of the crime; the higher the payments in a one-year period, the more severe the punishments, which currently range up to 25 years if more than $1 million in improper payments are involved.

New York law also affords protections to employees who may notice and report inappropriate activities. Under **New York Labor Law §740**, an employer shall not take any retaliatory personnel action against an employee because the employee:

- discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud; provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or

- objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

To bring an action under this provision, the employee must first bring the alleged violation to the attention of the employer and give the employer a reasonable opportunity to correct the allegedly unlawful practice. The law allows employees who are the subject of a retaliatory action to bring a civil action in court and seek relief such as injunctive relief to restrain continued retaliation, reinstatement, back-pay and compensation of reasonable costs. The law also provides that employees who bring an action without basis in law or fact may be held liable to the employer for its attorneys' fees and costs.

CONNECTICUT STATE LAWS

The Connecticut False Claims Act: provides, in pertinent part, that:

No person shall:

1. Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval under a state-administered health or human services program;
2. Knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim under a state-administered health or human services program;
3. Conspire to commit a violation of this section;
4. Having possession, custody or control of property or money used, or to be used, by the state relative to a state-administered health or human services program, knowingly deliver, or cause to be delivered, less property than the amount for which the person receives a certificate or receipt;
5. Being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state relative to a state-administered health or human services program and intending to defraud the state, make or deliver such document without completely knowing that the information on the document is true;

6. Knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the state relative to a state-administered health or human services program, who lawfully may not sell or pledge the property;
7. Knowingly make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state under a state-administered health or human services program; or
8. Knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the state under a state-administered health or human services program.

(b) Any person who violates the provisions of subsection (a) of this section shall be liable to the state for: (1) A civil penalty of not less than five thousand five hundred dollars or more than eleven thousand dollars, or as adjusted from time to time by the federal Civil Penalties Inflation Adjustment Act of 1990, 28 USC 2461, (2) three times the amount of damages that the state sustains because of the act of that person, and (3) the costs of investigation and prosecution of such violation. Liability under this section shall be joint and several for any violation of this section committed by two or more persons.

(c) Notwithstanding the provisions of subsection (b) of this section concerning treble damages, if the court finds that: (1) A person committing a violation of subsection (a) of this section furnished officials of the state responsible for investigating false claims violations with all information known to such person about the violation not later than thirty days after the date on which the person first obtained the information; (2) such person fully cooperated with an investigation by the state of such violation; and (3) at the time such person furnished the state with the information about the violation, no criminal prosecution, civil action or administrative action had commenced under sections 4-276 to 4-280, inclusive, with respect to such violation, and such person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than two times the amount of damages which the state sustains because of the act of such person. Any information furnished pursuant to this subsection shall be exempt from disclosure under section 1-210.

It is a crime in Connecticut to bill Medicaid or the general assistance program fraudulently. All employees, contractors and agents of DCF shall immediately report suspicion of any criminal activity occurring at DCF, including criminal fraud, to the DCF Compliance Officer. Anyone who provides services to a state Medicaid beneficiary and seeks or accepts payment for unnecessary or improper services is subject to possible imprisonment and criminal fines under state law. Depending upon the amount of the fraudulent services involved, such offenses carry penalties of up to 20 years in prison and a maximum fine of $15,000.

PROCEDURE

Nuvance will train and educate its Covered Individuals as necessary to comply with the legal and regulatory requirements related to Fraud, Waste and Abuse and other improper conduct as outlined below. Additionally, Nuvance will work cooperatively with Covered Individuals when problems are identified to resolve those problems as quickly as possible.

1. Nuvance will follow Federal, and State False Claims Acts when educating new and existing Covered Individuals to the policies and procedures intended to meet those requirements. Nuvance will monitor education given to employees to verify the Detection of Fraud, Waste and Abuse Policy has been effectively implemented.

2. Covered Individuals who are involved with creating and filing claims for payment shall only use true, complete, and accurate information to make the claim and shall receive specific training regarding their responsibilities.
3. Nuvance shall monitor and audit compliance with billing and coding requirements (through the Revenue Cycle department and other appropriate departments) in order to detect errors and inaccuracies and will take appropriate actions to correct any issues causing billing inaccuracies.
4. Nuvance shall exercise reasonable diligence to investigate any instances in which an Overpayment may have been received.
5. In all situations where Overpayments are identified, Nuvance shall report and return Overpayments identified timely and in accordance with applicable Federal and/or State requirements and the Nuvance Identification, Quantification and Repayment of Overpayments Policy/Procedure.
6. Covered Individuals are required to bring immediately to the attention of their supervisor, director, the Chief Compliance, Audit, and Privacy Officer, the Compliance Office or the Legal Department, information regarding suspected fraud, waste, or abuse and/or other improper conduct.

   Examples of potential fraud, waste and abuse and other improper conduct include, but are not limited to:

   - Falsifying Claims
   - Improper Alteration of Claim
   - Incorrect coding
   - Double Billing
   - Billing for services not provided
   - Misrepresentation of services/supplies
   - Improper substitution of services
   - Inaccurate cost reports
   - Kickback/Stark violations
   - Fraudulent credentials
   - Embezzlement
   - Over-utilization
   - Known retention of an Overpayment
   - Eligibility determination issues
   - Misrepresentation of medical condition
   - Failure to report third party liability
   - Providing substandard care
   - Providing medically unnecessary services
   - Financial exploitation
   - Fraudulent recoupment practices
   - Failure to refer for needed services
   - Violations of Medicare's Conditions of Participation

7. Covered Individuals may also call the Compliance Helpline and report anonymously at 844-YES-WeComply (844) 937-9326 or 1-844-395-9331 to discuss concerns about possible compliance violations, including, violations of law, regulations or Nuvance policies.
8. Nuvance is committed to investigating any such allegation of FWA swiftly, thoroughly and will do so through its internal compliance programs and processes. To ensure that the allegations are fully and fairly investigated, Nuvance requires that all Covered Individuals fully cooperate in the investigation. Any Covered Individual of Nuvance who reports such information will be protected against retaliation for coming forward with such information both under the Nuvance Health Whistleblower Protection Policy, and Federal and State Law.

If you would like more information on the Corporate Compliance Program and specific compliance policies, or on how to report any concerns, please contact the Compliance Office at (203) 739-7110, compliance@nuvancehealth.org, or go to the Compliance/Privacy section of Ellucid.

ENFORCEMENT

All individuals whose responsibilities are affected by this process are expected to be familiar with the basic procedures and responsibilities created by this process. Failure to comply with this process will be subject to appropriate remedial and/or disciplinary action, up to and including termination of any employment or other relationship, in accordance with this process.

REFERENCES

External References and Related Policies

- New York False Claims Act
- Connecticut False Claims Act
- Section 6032 of the Deficit Reduction Act of 2005
- 1902(a)(68)(A) Social Security Act
- 31 U.S.C. §§ 3729-3733
- 31 U.S.C. §§ 3801-3812
- NYS Social Services Law § 363-d
- NYS Social Services Law § 366-b (2)
- NYS Social Services Law§ 145-b
- NYS Penal Law § 177
- NYS Labor Law § 740

Internal References and Related Policies

- Identification, Quantification and Repayment of Overpayments Policy and Procedure
- Compliance Disclosure Program Policy and Procedure
- Annual Nuvance Health Deficit Reduction Act Memorandum from the Chief Compliance Officer
- Nuvance Health Compliance and Ethics Program Charter
- Nuvance Health Whistleblower Protection Policy

APPROVAL

DocuSigned by:
Jared B Gaynor
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Signature

11/30/2023

Date

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