DELTA DENTAL OF IOWA ("Delta Dental")
GOVERNMENT PROGRAMS
FRAUD, WASTE, AND ABUSE VENDOR POLICY

Purpose

The purpose of this policy is to provide detailed information to all applicable vendors about the Federal and State False Claims Acts, Iowa Insurance Fraud Act, including the Federal Deficit Reduction Act of 2005, consequences of non-compliance, whistleblower protections, the role of such laws in preventing and detecting fraud, waste, and abuse in Federal and State healthcare programs, and to establish Delta Dental of Iowa's commitment to practices that do not violate Federal and State False Claims related laws.

Applicability

This Policy applies to Delta Dental, as well as its subsidiary and affiliate companies. It applies to any entity or individual including First Tier, Downstream Entity, and Related Entities (FDRs) that enter into a written arrangement with Delta Dental to provide services, Delta Dental is obligated to provide as part of its required performance under its Government Programs contracts, whereby the entity or individual is delegated the performance of a core function of Delta Dental's performance of its Government Programs contracts as determined by various factors. Hereinafter, referred to as ("Vendors").

Compliance with State and Federal Requirements

Vendors must operate in accordance with all applicable state and federal laws, regulations, Medicare and Medicaid program requirements and CMS guidance, including:

Federal False Claims Act

The False Claims Act (the "FCA") (31 U.S.C. Sections 3729 through 3733) is a Federal statute that covers fraud involving any federally funded contract or program, including the Medicaid program.

Among other matters, the FCA establishes liability for any person who:

a. Knowingly submits a false or fraudulent claim for payment to the U.S. government;
b. Knowingly makes a false record or statement to get a false or fraudulent claim paid or approved by the U.S. government;
c. Conspires to defraud the U.S. government by getting a false or fraudulent claim paid or approved by the U.S. government; or
d. Knowingly makes a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the U.S. government.

The terms "knowing" and "knowingly" are defined to mean that a person, with respect to information:

- Has actual knowledge of falsity of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information.

The FCA does not require proof of a specific intent to defraud the U.S. government.

Civil penalties for violating the FCA may include recovery of up to three times the dollar amount of damages ("treble damages") sustained by the U.S. government as a result of the false claims.

An additional civil penalty per false claim filed may also be imposed, and the U.S. government, or an agency thereof, may take contractual or administrative action against the person who has violated the FCA. See 31 U.S.C. Section 3802.

The FCA allows private citizens (called "qui tam plaintiffs") to bring an action for violation of the FCA in the name of the U.S. government. To reward individuals for identifying fraud and assisting the U.S. government in such actions, qui tam plaintiffs are entitled to a percentage of the proceeds collected in any such action, typically between 15 and 25 percent (not more than 30 percent).

Federal Anti-Kickback Statute

The Anti-Kickback Statute (AKS) (42 U.S.C. Section 1320a-7b(b)) protects health care beneficiaries from the influence of money over medical and health decision making. The AKS makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program.

Remuneration includes anything of value such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultations.

A violation of the AKS is a felony. If convicted, the AKS authorizes <u>both</u>:

- A fine of not more than $100,000 per count.
- Imprisonment for not more than ten (10) years.

A conviction under the AKS is an automatic exclusion from Medicare, Medicaid, and other Federal health care programs (42 U.S.C. Section 1320a-7(a)).

State False Claims Act

Similar to the FCA, Iowa Code Chapter 685 provides that a person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval where the State of Iowa will ultimately pay for such claim, is liable to the State of Iowa for a civil penalty of not less than and not more than the civil penalty allowed under the FCA, plus three times the amount of damages which the State of Iowa sustains. Like the FCA, a person (qui tam plaintiff) may bring a civil action for a violation of Chapter 685 for the person and for the State of Iowa, in the name of the State of Iowa.

Whistleblower Protection

Both the FCA and the Iowa False Claims Act provide certain protections for vendors who report a violation of such statutes. Such vendors would commonly be referred to as a "whistleblower." Whistleblower protections are necessary to ensure that fraud, waste, and abuse are properly reported without fear of retribution.

The FCA and Iowa False Claims Act provide that any vendor shall be entitled to all relief necessary to make that vendor whole, if that vendor is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of contracting because of lawful acts done by the vendor or associated others in furtherance of an action under the FCA or the Iowa False Claims Act.

Relief under the foregoing statutes includes reinstatement with the same seniority status that the vendor would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees.

Iowa Insurance Fraud Act

In addition to the foregoing, Iowa Code Chapter 507E, also known as the Iowa Insurance Fraud Act, provides that a person commits a class "D" felony if the person, with the intent to defraud an insurer, does any of the following:

a. Presents or causes to be presented to an insurer, any written document or oral statement, including a computer-generated document, as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, knowing that such document or statement contains any false information concerning a material fact;

b. Assists, abets, solicits, or conspires with another to present or cause to be presented to an insurer, any written document or oral statement, including a computer-generated document, that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, knowing that such document or statement contains any false information concerning a material fact; or

c. Presents or causes to be presented to an insurer, any written document or oral statement, including a computer-generated document, as part of, or in, an application for insurance coverage, knowing that such document or statement contains false information concerning a material fact.

The Iowa Insurance Fraud Act provides immunity to a person acting without malice, fraudulent intent, or bad faith in filing a report or furnishing, orally or in writing, other information concerning alleged acts in violation of the Iowa Insurance Fraud Act, if the report or information is provided to or received from (a) law enforcement officials, their agents and employees, (b) the National Association of Insurance Commissioners, the Insurance Division, a Federal or state governmental agency or bureau established to detect and prevent fraudulent insurance acts, or any other organization established for such purpose, and their agents, employees, or designees, or (c) an authorized representative of an insurer.

Health Insurance Portability and Accountability Act (HIPAA)/Health Information Technology for Economic and Clinical Health (HITECH) Act

HIPAA created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry. Health Information Technology for Economic and Clinical Health (HITECH) Act later strengthened HIPAA's Privacy and Security protections including expanding the applicability of certain provisions for business associates of covered entities.

HIPAA safeguards help prevent unauthorized access to protected health care information (PHI). Everyone with access to PHI must comply with HIPAA including but not limited to maintaining confidentiality of PHI.

Violations of HIPAA may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

Other Federal Laws/Regulations

The following are other Federal laws and regulations that help protect government programs against fraud, waste, and abuse:

- Title XVIII of the Social Security Act – Medicare Program Act administered by CMS
- Medicare regulations governing Parts C (Medicare Advantage) (42 C.F.R. §§ 422)
- Patient Protection and Affordable Care Act (ACA)
- Federal Criminal False Claims Statutes (18 U.S.C. §§ 287,1001) – establishes criminal liability against any person (or entity) who knowingly submits, or causes, a false or fraudulent claim with intent to receive payment or approval.
- The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5)) – created as part of HIPAA, making it illegal to offer money or services likely to influence a member to select a particular health care provider, practitioner or supplier.
- Civil monetary penalties of the Social Security Act (42 U.S.C. § 1395w-27(g))
- Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn) – prohibits a physician from making referrals to an entity for healthcare services if the physician has a financial relationship with that entity
- Health Care Fraud Statute (18 U.S.C. § 1347) – establishes criminal liability for defrauding a health care benefit program or obtaining by false pretenses any money or property owned by a health care benefit program
- Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the Federal Government (42 U.S.C. §1395w-27(g)(1)(G)
- Fraud Enforcement and Recovery Act of 2009 – imposes liability and penalties for false statements or claims made directly to the government or made for the purpose of inducing the government to pay a false claim
- Sub-regulatory guidance by CMS and The Department of Health and Human Services (HHS) such as manuals, training materials, Health Plan Management System (HPMS) memos, and guides
- Other Criminal Fraud statutes under Title 18 and other parts of the US Code

Methods of preventing and detecting fraud, waste, and abuse

Key Definitions

<u>Fraud</u>:

- Medicare Advantage – knowingly and willfully executing, or attempting to execute, a scheme or intentional deception or misrepresentation to defraud any health care benefit program or to obtain unauthorized benefit from any health care benefit program.

- Medicaid (42 CFR 455.2) – intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste:

- Medicare Advantage – overutilization/misuse of services, or other practices that, directly or indirectly, result in unnecessary costs to the plan/program.
- Medicaid – health care spending that can be eliminated without reducing the quality of care. "Quality Waste" includes overuse, underuse, and ineffective use. "Inefficiency Waste" includes redundancy, delays, and unnecessary process complexity.

Abuse:

- Medicare Advantage – actions that may, directly or indirectly, result in unnecessary costs to the plan/program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are dentally unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.
- Medicaid (42 CFR 455.2) - provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of Fraud, Waste, and Abuse

- Falsifying information on contract proposals or falsifying data
- Assisting another person or entity to obtain improper payments from Delta Dental or the federal government for personal benefit
- Misrepresentation of a project's status to continue to receive funds
- Charging higher rates than those stated or negotiated for in the contract
- Billing for services not rendered
- Billing for higher service levels than performed
- Kickbacks/bribes & Illegal solicitations
- The misuse of a member's or provider's unique identification information to obtain or bill for fraudulent dental services

Differences Between Fraud, Waste, and Abuse

One of the primary differences between Fraud, Waste, and Abuse is intent and knowledge. Fraud requires intent to obtain payment and the knowledge that the actions are wrong. Waste and Abuse may involve obtaining an improper payment or creating an unnecessary cost to Government-Sponsored Health Care Programs but does not require the same intent and knowledge.

Prevention and Detection Measures

Strategic fraud prevention and detection programs and processes form the front line of fraud defense by identifying and filling gaps before losses happen. Delta Dental is committed to complying with applicable laws and operating under the highest ethical standards. Our customers expect this commitment from us. We expect the same commitment from our vendors. You have a process for reporting all compliance and FWA issues that impact Delta Dental. There can be no retaliation against or coercion of anyone reporting suspected misconduct.

Reporting Fraud, Waste, and Abuse and Compliance Concerns

Delta Dental requires its Vendors to promptly, and no later than within 72 hours of discovery, unless otherwise defined in your agreement, report any suspected or confirmed non-compliance or FWA, including criminal activity, immediately. It is the duty of every person who has knowledge of a potential compliance issue or potential FWA instance to promptly report such issues. This reporting obligation applies even if the individual with the information is not able to mitigate or resolve the issue. There will be no retaliation against or coercion of anyone reporting suspected misconduct.

Vendors shall contact Delta Dental's Compliance Director and Director of Legal Services & General Counsel by emailing compliance@deltadentalia.com. You also may contact attorney Michael Dayton at the law firm of Nyemaster Goode at (515) 283-3111.

At that time, you will receive instructions on how to further report such information. Reporting the activity will not subject the individual to discipline absent making a knowingly false report. All reports will be treated as confidentially as possible under the circumstances. Remember to include the following information when reporting:

- Nature of concern
- Names of individuals and/or entity involved including address, phone number, enrollee/member ID number and any other identifying information
- Reporter's contact information

Delta Dental's actions in response will depend on the severity of the compliance issue. An investigation of identified or reported activities will be completed. Cases will be referred to the appropriate government agencies, where applicable and/or required. Violations will be investigated and may result in disciplinary action up to and including termination of contracts.

Your vendors, subcontractors or downstream entities also must have policies and procedures in place to report issues of non-compliance and suspected/potential FWA concerns. The system must maintain confidentiality and anonymity, if desired. Such reporting must also be subject to non-retaliation and non-intimidation when done in good faith.

Delta Dental Reporting/Inquiry Resources:

- HIPAA Security Incidents/Breaches – DDIAIRT@deltandentalia.com
- Government Programs Vendor Compliance Requirements Guide Requests and HIPAA Privacy Concerns – Compliance@deltadentalia.com
- Special Investigations (FWA) - Programintegrity@deltadentalia.com
- Vendor Management - vendormanagement@deltadentalia.com or your Delta Dental contract contact

- CMS: https://www.cms.gov
- Iowa Medicaid: https://hhs.iowa.gov/report-abuse-fraud/report

Mailing address for legal notices:
Delta Dental of Iowa
ATTN: CEO
9000 Northpark Drive
Johnston, Iowa 50131