

**POLICY STATEMENT:**

The Fraud, Waste, and Abuse Policy outlines the processes and procedures for handling the prevention, detection, and reporting of fraud, waste, and abuse at Gateway Health Plan® (“Gateway”).

This Fraud, Waste, and Abuse Policy covers the following elements:

- Responsibility for Compliance
- Responsibility for Identifying Fraud , Waste, and Abuse
- Actions to be Investigated
- Monitors in place to guard against Fraud , Waste, and Abuse
- Process for Detecting and Reporting Fraud , Waste, and Abuse
- Referral Tracking Process
- Reporting to Oversight Agencies
- Subcontractor Language
- Suspensions/Terminations of Providers
- Fraud and Abuse Sanctions imposed by Regulatory Agencies
- Recovery and/or Adjustment of Identified Fraud and Abuse Payments
- Printed Materials, Violations, & Record Retention
- Training and Education Oversight
- The SIU Audit Plan

**DEFINITIONS:** (source: 42 CFR '455.2)

**Fraud:**

An 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.

**Abuse:**

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 recipient practices that result in unnecessary cost to the Medicaid program.

**ATTACHMENTS:**

<b>ATTACHMENT A:</b>	Provider Prohibited Acts
<b>ATTACHMENT B:</b>	Recipient Prohibited Acts
<b>ATTACHMENT C:</b>	Federal False Claims Act
<b>ATTACHMENT D:</b>	Pennsylvania Fraud and Abuse Control Act - Provider
<b>ATTACHMENT E:</b>	Pennsylvania Fraud and Abuse Control Act - Other
<b>ATTACHMENT F:</b>	Title 18 - Crimes and Criminal Procedure
<b>ATTACHMENT G:</b>	False Claims and Statements: Liability
<b>ATTACHMENT H:</b>	Fraud and Abuse Sanctions
<b>ATTACHMENT I:</b>	Social Security Act Sanctions
<b>ATTACHMENT J:</b>	False Claims Act Sanctions

## **PROCEDURES**

### **A. Responsibility for Compliance:**

- Every individual within each department of Gateway has the responsibility to comply with applicable statutory, regulatory and other requirements including but not limited to the following:
  1. False Claims Act
  2. Anti-Kickback Statute
  3. Prohibition on inducements to beneficiaries
  4. Health Insurance Portability and Accountability Act
    - **RCL-408-ALL-ALL** Definitions of HIPAA Terminology
  5. Criminal statutes
  6. Code of Federal Regulations 42 C.F.R. §400, 203, 411, 417, 423
  7. All sub-regulatory guidance produced by CMS for Part D such as manuals, training materials, and guides
  8. Civil Monetary Penalty Laws
  9. Federal Food, Drug and Cosmetic Act
  10. State laws
  11. Contractual commitments

### **B. Responsibility for Identifying:**

- Every individual within each department of Gateway has the responsibility for identifying irregularities in the business and utilization practices of providers, vendors, members, or employees.

### **C. Actions to be Investigated:**

- It is Gateway's policy to investigate any action by providers, vendors, members or employees that affects the integrity of the Medicaid program. Such actions include suspected fraud/abuse and quality issues. Quality issues are those which on an individual basis affect the member's health or the program's integrity. Examples of fraud/abuse and quality actions include, but are not limited to:
  1. Suspected fraud based on a pattern of billing or encounter form inconsistencies
  2. Suspected abuse based on quality issues of six months or more duration (i.e. poor quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of medically necessary services from enrollees)
  3. Suspected abuse based on the falsification of credentialing/recredentialing information
  4. Suspected violations of any of the following laws:
    - Federal False Claims Act
    - Pennsylvania Fraud and Abuse Control Act
    - Stark Law
    - Anti-Kickback Statutes
  5. Suspected abuse based on consumers being charged cash for covered services
  6. Suspected marketing violations including inducements (refer to Gateway's policy Investigation on Marketing Allegations **MKT-007-MC-ALL**)
  7. Improper relationships between providers, subcontractors, enrollees, or employees

8. Suspected fraudulent consumer actions
9. Any act defined in the 55 PA Code §1101.75(a) and (b) as a “Provider Prohibited Act” - see **ATTACHMENT A** (such as submitting false information to obtain an authorization, referring a member for unnecessary services, submitting a claim for services not rendered, etc.).
10. Any act defined in the 55 PA Code §1101.92 as a “Recipient Prohibited Act” - see **ATTACHMENT B** (such as using someone else’s ID card to obtain benefits, falsifying an application for benefits, misusing or over utilizing benefits, etc.).
11. Any act defined in 31 U.S.C. §3729 of the Federal False Claims Act - see **ATTACHMENT C**.
12. Any act identified in 62 P.S. §1407 and 1408 of the Pennsylvania Fraud and Abuse Control Act - see **ATTACHMENT D** and/or **ATTACHMENT E**.
13. Any act defined in 18 U.S.C Chapter 47, especially sections 1001 and 1035 - see **ATTACHMENT F**.
14. Any act defined in the Prescription Drug Benefit Manual, Chapter 9 Part D Program to Control Fraud, Waste, and Abuse Section 70 (such as inappropriate billing practices, prescription drug shorting, bait and switch pricing, prescription forging or altering, prescription refill errors, illegal remuneration schemes, and Troop manipulation).

**D. Monitoring Fraud and Abuse:**

- The Special Investigations Unit (“SIU”):
  - The SIU will perform the following activities to protect Gateway from Fraud and Abuse Activities to prevent 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:
    1. Performs monthly audits to review the following:
      - a. Duplicate claims
      - b. CPT quantity billing issues
      - c. Date of death reviews
      - d. Disenrollment reviews
      - e. 70.1.3 – Pharmacy Fraud, Waste, and Abuse (Rev.2, 04-25-2006) in the CMS Prescription Drug Manual Chapter 9 – Part D program to Control Fraud, Waste and Abuse
    2. Monthly reviews of state and federal exclusion lists.
    3. Peer review ranking reports to identify outlier providers and members including referral activities.
    4. Periodic audits with an emphasis being placed on audits identified in the yearly Office of Inspector General Work Plan.
    5. Scheduled audit validation, as well as periodic member utilization reviews to confirm services billed to Gateway were received by member.
  - The SIU will also utilize the following subcontractor services to perform external auditing functions:
    1. PharmDur - External Pharmacy Auditor
    2. ACS Heritage - Home Infusion Therapy/DME Auditor

- A representative of the SIU will also attend periodic regional and national conferences and seminars on fraud and abuse detection and prevention. The SIU will also continue their support and membership in the National Health Care Anti-Fraud Association.
- Gateway has established monitors to prevent fraud and abuse in the following areas (additional monitors will be implemented as needed):
  1. Utilization Management:
    - The Utilization Management Department reviews cases for potential fraud/abuse and quality issues when healthcare services are requested. Home health services, which have been widely recognized as a potential area for fraud, require prior authorization for payment. Most services require a PCP referral for payment. If a problem is noted, it must be brought to the attention of the Medical Director and/or the Quality Improvement Department for further review. If fraud or abuse is suspected, the section on Reporting Suspected Fraud and Abuse is to be followed.
  2. Credentialing/Re-credentialing:
    - The Credentialing Department takes the following steps to guard against credentialing/re-credentialing providers with a history of fraud and abuse:
      - Searches the National Practitioner Data Bank (NPDB), and the Healthcare Integrity Protection Data Bank (HIPDB) to review any past sanction history;
      - Reviews Medichex list in PA only and Office of Inspector General (OIG) list to see if the Practitioner has been suspended, terminated or sanctioned from the Medicaid program;
      - Checks the State Licensure Board to ensure the provider does not have any disciplinary actions;
      - Verifies the provider's education, training history and board certification;
      - Verifies that the provider has a non-encumbered DEA license.
  3. Claims Processing:
    - Gateway utilizes GMIS Claim Check, which is a code reviewer that detects unbundling and upcoding of physician claims for the Medicaid program. If unbundling or upcoding is detected, the claim is paid at the appropriate coding. If a pattern of unbundling or upcoding is noted, or any other improprieties or inconsistencies are noted by the claims processors, the Manager of Claims is notified. If, after further review, the Manager suspects fraud or abuse, the section on Reporting Suspected Fraud and Abuse is to be followed.
- Gateway also requires its pharmacy, dental and vision Third Party Vendors to provide safeguards to prevent fraudulent activities. If fraud or abuse is detected, the section on Reporting Suspected Fraud and Abuse is to be followed. The Third Party Vendors are as follows:
  1. Pharmacy:
    - Prior to 12/31/2003

- Medco/PAID Prescriptions, Inc.
- Subsequent to 01/01/2004
  - Argus/Integrated Pharmacy Network System (IPNS)
- 2. Dental:
  - Prior to 10/31/2007
    - Dental Benefit Providers, Inc.
  - Subsequent to 11/01/2007
    - United Concordia Companies, Inc.
- 3. Vision:
  - Prior to 10/31/2004
    - Highmark Blue Cross/Blue Shield/Clarity Vision (Blue Shield)
  - Subsequent to 11/01/2004
    - Davis Vision, Inc.

**E. Detecting Fraud and Abuse:**

- Gateway extracts the raw data from its Power MHC (also known as GATELink) on a monthly basis into a data warehouse, which is accessed by its data analysts via (a) MS Access, (b) MEDSTAT Advantage Suite, or (c) Terminal Control Language (TCL). The data analysts, who represent the areas of Finance, Information Systems, Health Services, Quality Improvement, Pharmacy, Network Development, Provider Relations, and Product Development, run their own reports to analyze health care utilization and costs.
- Such data is often reviewed to get a better understanding of the top procedures, providers, diagnoses, etc. The data can be drilled down to the finest level of detail to enable Gateway to investigate any potential problems.

**F. Detecting Violations of Fraud and Abuse Laws:**

- Gateway will make every effort to identify violations of the following laws and regulations:
  1. The Federal False Claims Act:
    - The Federal False Claims Act (31 U.S.C. §3729) prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. Additionally, it prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents, like a carrier, other claims processor, or state Medicaid program.
    - In addition, Gateway will follow The Federal False Claims Act (31 U.S.C. §3802) in pursuing remedies for false claims and statements, as defined in **ATTACHMENT G**.
    - Whistleblowers are also offered certain protections against retaliation for bringing an action under the Act. Employees who are discharged, demoted, harassed, or otherwise confront discrimination in furtherance of such an action or as a consequence of whistle blowing activity are entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay, and compensation for any special damages including litigation costs and reasonable attorneys' fees.

2. The Pennsylvania Fraud and Abuse Control Act:
  - The Pennsylvania Fraud and Abuse Control Act (62 P.S. §1401 et seq.). The Pennsylvania Fraud and Abuse Control Act imposes liability on persons who and companies that make, or cause to be made, false or fraudulent claims to the government for payment and/or who/that knowingly make, use or cause to be made or used a false record or statement to get a false or fraudulent claim paid by the government. Remedies for 62 P.S. §1407 and §1408 are defined in **ATTACHMENT D** and/or **ATTACHMENT E** Sections (b)(1).
  - In addition, Pennsylvania’s Whistleblower Law (43 P.S. §1421-1428) prohibits state employers from retaliating, discriminating or harassing state employees who report a misuse of state funds and resources or a violation of federal or state laws, rules, or regulations. Even though Pennsylvania’s Whistleblower Law does not contain whistleblower protections for non-governmental employees, Gateway expects employees to adhere to federal law and to Gateway’s policies.
3. The Anti-Kickback Statute:
  - Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicaid program or other Federal health care programs. For the purpose of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
4. Stark Law:
  - The Stark Law prohibits physicians from making referrals for a "designated health service," payable by Medicaid, to any entity with which the physicians have a financial relationship. A financial relationship means either an ownership interest or a compensation arrangement. Penalties for violating the Stark Law include denial of payment for the service, civil monetary penalties, or even the possibility of being excluded from the Medicaid program.

**G. Procedures for Employees to Report Fraud and Abuse:**

- Once fraud and abuse is suspected, employees should refer to the Code of Conduct for the appropriate methods of reporting fraud and abuse. Failure to do so could result in employee disciplinary action.
- Any egregious situation or act will be referred immediately to the appropriate Medicaid regulatory agency for further investigation.
- A dedicated voice mailbox at (412) 255-4340 or 1-800-685-5235 has been set up to report incidents of fraud and abuse. The process is documented at Policy **RCL-302-ALL-ALL** Fraud and Compliance Hotline. This number is published in a provider newsletter annually. All messages will be investigated and, if determined to be fraud and abuse, a referral form will be completed and forwarded as noted above.
- Any employee who makes a report in good faith will not be subject to retaliation or any other form of reprisal. If employees wish to remain anonymous, Gateway

will make every effort to maintain the confidentiality of their identity, within the limits of applicable law(s). Gateway will also make every effort to protect the rights of any individual(s) accused of violating this fraud and abuse policy. However, any employee who deliberately makes a false accusation with the intention of harming or retaliating against another employee or Gateway itself will be subject to disciplinary action up to, and including, discharge from employment.

- It is Gateway's policy to discharge any employee, terminate any provider or recommend any member be withdrawn from the Medicaid program who, upon investigation and referral to the appropriate regulatory agency, has been identified as being involved in fraudulent or abusive activities.

**H. Procedures for External Parties to Report Fraud and Abuse**

- Once the fraud and abuse is suspected, the appropriate Standardized Referral Process Form should be completed.
- The form should then be forwarded to the Vice President and CFO, who will review all instances of potential fraud and abuse and notify the appropriate regulatory agency within 5 days of identification of the issue.
- Any egregious situation or act will be referred immediately to the appropriate Medicaid regulatory agency for further investigation
- A dedicated voice mailbox at (412) 255-4340 or 1-800-685-5235 has been set up to report incidents of fraud and abuse. The process is documented at Policy **RCL-302-ALL-ALL** Fraud and Compliance Hotline. This number is published in a provider newsletter annually. All messages will be investigated and, if determined to be fraud and abuse, a referral form will be completed and forwarded as noted above.
- Gateway has procedures in place to voluntarily self-report potential fraud or abuse as defined in 42 CFR part 423.504 H and to report to the appropriate governmental authorities such as the Office of Inspector General's protocol as well as the Pennsylvania Department of Public Welfare Provider Self Audit Protocol.

**I. Referral Tracking**

- All referrals will be documented in a referral tracking system within seven business days of the referral receipt. Determination will be made within 12 business days as to whether the referral needs reported to an oversight agency. All referrals will be documented according to Policy **FI-041-ALL-ALL** Referral Tracking.

**J. Reporting to Oversight Agencies:**

- The Vice President and CFO will also report fraudulent and abusive activities to the appropriate oversight agencies using the Medicaid standard processes to ensure the appropriate disposition of information. These agencies include but are not limited to Medics, State Bureaus of Program Integrity, Attorney General Offices, The Office of Inspector Generals and various other local, state, and federal law enforcement agencies. Gateway will cooperate fully with these agencies during any investigation, whether the investigation is initiated by an agency or by Gateway.

**K. Subcontractor Requirements:**

- All Gateway subcontracts contain the following language:
  1. The subcontractor shall comply with all policies and procedures that are developed and amended from time to time by Gateway or any appropriate regulatory agency for the detection and prevention of fraud and abuse committed by providers, employees, or Gateway members.
  2. Such compliance may include, but not be limited to, the submission of statistical and narrative reports regarding fraud and abuse detection activities, referral of information regarding suspected or confirmed fraud or abuse to Gateway, and/or immediate notification regarding such suspected or confirmed fraud and abuse activity.
- The subcontractor acknowledges that any payments made to the subcontractor by Gateway are derived from federal and state funds and that the subcontractor shall be held civilly and/or criminally liable, in the event of nonperformance, misrepresentation, fraud, or abuse of services rendered to Gateway members.

**L. Suspensions/Terminations of Providers:**

- Gateway will immediately act to terminate a provider upon notification from any regulatory agency that a provider with whom it has entered into an agreement is suspended or terminated from participation in the Medicaid program. Gateway will review the LEIE list generated by the Social Security Act §1128 as well as the Medichex list generated by the State of Pennsylvania to identify individuals rendering services on behalf of Gateway members that are excluded from the Medicaid program.
- Terminations for loss of licensure and/or criminal convictions will be effective as of the date of action.
- In addition, the Vice President and CFO will immediately notify the appropriate regulatory agency, in writing, if a provider or subcontractor with whom it has entered into an agreement is subsequently suspended, terminated or voluntarily withdraws from participation in the program after commencement of an action by Gateway to suspend or terminate the provider.

**M. Fraud and Abuse Sanctions:**

- The appropriate regulatory agency will impose sanctions as deemed appropriate where there is evidence of violations involving fraud and abuse issues. Refer to **ATTACHMENT H** for a list of the issues, which may result in sanctions, and for a list of the range of sanctions. Refer to **ATTACHMENT I** for a list of sanctions as defined by the Social Security Act §1128. Refer to **ATTACHMENT J** for sanctions as defined by The False Claims Act (31 U.S.C. 3729). Refer to **ATTACHMENT D** and **ATTACHMENT E** for sanctions as defined by the Pennsylvania Fraud and Abuse Control Act (62 P.S. 1407 and 1408).

**N. Recovery and/or Adjustment of Identified Fraud and Abuse Payments:**

- The SIU will aggressively pursue recoveries of any amounts paid by Gateway that relate to identified fraud and abuse activities. These recoveries and/or adjustments will be made in regards to all federal and state laws and the requirements for penalties that apply to each law or regulation.

**O. Printed Materials:**

- The Toll-Free Fraud and Abuse Hotline number accompanied by the proper explanatory statements will be included on all future printings of Gateway member and provider handbooks.

**P. Violations:**

- Knowledge of a violation or potential violation of this policy must be reported promptly to mitigate the effects on Gateway. In some instances, there is an obligation to report violations of law and policy to various state and federal agencies, its responsible designee and/or to law enforcement. Disciplinary actions can be imposed for non-compliance, including oral or written warnings or reprimands, suspensions, terminations, loss of contract, and financial penalties.
- Human Resources, in consultation with the SIU, as appropriate, shall help ensure that appropriate and consistent disciplinary action is taken against any employee responsible for any misconduct or non-compliance, as well as any employee responsible for the failure to prevent, detect, or report any violation.
- Disciplinary action will take into consideration, among other things, the nature of any violation, the impact or potential impact on the company, whether the violation was knowing or willful, whether the employee voluntarily reported his or her own violation, whether the employee attempted to hide or cover-up the violation, and the extent to which the employee cooperated fully in the investigation and correction of the violation.
- Violations of this policy may result in disciplinary actions up to, and including, termination of employment as determined by the Human Resources department in conjunction with the SIU.

**Q. Record Retention:**

- All violations, investigations, referrals, and reports will be maintained in accordance with **RCL-305-ALL-ALL** Records Management and Retention.

**R. Employee Training**

- Gateway conducts Fraud, Waste, and Abuse (FWA) training and education for all internal employees that includes, but is not limited to the following:
  1. New Hire
    - New hire FWA training is conducted on a quarterly basis by a representative of the Special Investigations Unit (SIU). Sign in sheets are distributed and maintained within the SIU upon completion (See Policy **MA-027-MC-ALL**).
    - The definitions of Fraud and Abuse, the key responsibilities of the Special Investigations Unit (SIU), and the Fraud and Compliance hotline number are included in the new hire Corporate Orientation located within the Employee Resource Center on Gatenet.
    - Information on FWA is distributed by Corporate Compliance at new hire orientation with the circulation of an educational flyer on key FWA laws.
  2. Existing Employees
    - Training and Education on FWA is conducted annually as part of Employee Education Day. Training consists of the following:

- Laws and regulations related to FWA (i.e. False Claims Act, Anti-Kickback Statue, Stark Law, FERA, HIPAA, Whistleblowers, etc.).
- Process / Methods for reporting suspected FWA.
- Protections for employees who report suspected FWA.
- Types of FWA that can occur.

**S. First Tier, Downstream and Related Entity Training**

- Gateway conducts training and education for first tier, downstream and related (FDR) entities that includes, but is not limited to the following:
  1. Gateway's FWA training program and policy is posted on Gateway's internet site by the Manager of Gateway's SIU / Internal Audit, or designee.
  2. Gateway's FDR entities can utilize their own training as long as it meets the following requirements:
    - Laws and regulations related to the Medicaid program FWA (i.e. False Claims Act, Anti-Kickback Statue, Stark Law, FERA, HIPAA, Whistleblowers, etc.).
    - Obligations of the first tier, downstream, and related entities to have appropriate policies and procedures to address FWA.
    - Process for reporting to the MAO or PDP sponsor suspected FWA in first tier, downstream, and related entities.
    - Protections for employees of first tier, downstream, and related entities who report suspected FWA.
    - Types of FWA that can occur in first tier, downstream, and related entities.
  3. Gateway's SIU notifies FDR entities that training is available and follow-up, if necessary, through, but not limited to, the following means:
    - Provider newsletters
    - E-mails via the delegated entity's assigned Gateway business owner

**T. Governing Body Training**

- The SIU seeks to assure Gateway's governing body is educated on Gateway's FWA program through the following mechanisms:
  - Annual distribution of Gateway's FWA Education Day program which includes key FWA laws, the Fraud and Compliance hotline information, and the location of the FWA Policy.
  - Distribution of the FWA training will be evidenced by meeting agenda and/or meeting notes.

**U. Training and Education Oversight**

- Gateway's SIU develops the materials for FWA training and seeks to assure compliance with all CMS FWA training requirements through the following (See Policy MA-027-MC-ALL):
  1. Employee Oversight
    - Compliance with training requirements is evident by any of the following:
      - New hire training sign in sheets maintained by the SIU.

- The annual training and education sign-in sheets are maintained by the Human Resources Department.
- The completed annual training and Education Day quizzes maintained by Corporate Compliance.
- 2. First Tier, Downstream and Related Entity Oversight
  - Delegated Entities **Without** Networks
    - Compliance with training requirements is evident by any of the following:
      - Completion of Gateway’s annual CMS Delegated Entity Survey which includes a FWA section.
      - Completed FWA surveys are returned to the SIU for tracking and maintenance.
  - Delegated Entities **With** Networks
    - Compliance with training requirements is evident by any of the following:
      - Completion of Gateway’s annual CMS Delegated Entity Survey which includes a FWA section.
      - Completed FWA surveys are returned to the SIU for tracking and maintenance.
    - Delegated entity maintains record of their networks who have completed FWA training and education. Gateway will audit the delegate to assure compliance.

V. **The SIU Audit Plan**

- The SIU conducts audits according to the following schedule:
  1. Hospital/Facility Audits:
    - The SIU will review participating hospitals/facilities on a three year rotating basis, unless there is a one year recovery provision in the contract. Hospital/facility contracts containing this provision will be reviewed annually.
  2. Physician Specialty Audits:
    - The SIU will annually review physician specialties to identify those that may have aberrant billing patterns. In addition, the fraud and abuse detection software assigns a Composite Lead Indicator (CLI) to each provider. The SIU will review specialties with a CLI of 85 or higher.
  3. Pharmacy Audits:
    - The SIU will annually review pharmacies according to the CMS Prescription Drug Benefit Manual Chapter 9 – Part D program to Control Fraud, Waste, and Abuse. The SIU will review pharmacies with a CLI of 85 or higher.
  4. Ancillary Audits:
    - The SIU will annually review ancillary providers to identify those that may have aberrant billing patterns. The SIU will review ancillary providers with a CLI of 85 or higher.
  5. OIG Audits:
    - The SIU will review the current year OIG work plan and determine which audits apply to Gateway.

**ATTACHMENT A:**

**Provider Prohibited Acts**

**55 PA Code §1101.75 (a) and (b) - Provider Prohibited Acts.**

(a) An enrolled provider may not, either directly or indirectly, do any of the following acts:

(1) Knowingly or intentionally present for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA, knowingly present for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA, or knowingly submit false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled for furnishing services or merchandise under MA.

(2) Knowingly submit false information to obtain authorization to furnish services or items under MA.

(3) Solicit, receive, offer or pay a remuneration, including a kickback, bribe or rebate, directly or indirectly, in cash or in kind, from or to a person in connection with furnishing of services or items or referral of a recipient for services and items.

(4) Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.

(5) Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.

(6) Submit a claim for services or items which includes costs or charges which are not related to the cost of the services or items.

(7) Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary.

(8) Submit a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.

(9) Submit a claim for a service or item at a fee that is greater than the provider's charge to the general public.

(10) Except in emergency situations, dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient.

(11) Except in emergency situations, dispense, render or provide a service or item to a patient claiming to be a recipient without first making a reasonable effort to verify by a current Medical Services Eligibility card that the patient is an eligible recipient with no other medical resources.

(12) Enter into an agreement, combination or conspiracy to obtain or aid another in obtaining payment from the Department for which the provider or other person is not entitled, that is, eligible.

(13) Make a false statement in the application for enrollment or reenrollment in the program.

(14) Commit a prohibited act specified in § 1102.81(a) (relating to prohibited acts of a shared health facility and providers practicing in the shared health facility).

(b) A provider or person who commits a prohibited act specified in subsection (a), except paragraph (11), is subject to the penalties specified in § § 1101.76, 1101.77 and 1101.83 (relating to criminal penalties; enforcement actions by the Department; and restitution and repayment).

**ATTACHMENT B:**

**Recipient Prohibited Acts**

**55 PA Code §1101.92 Recipient Prohibited Acts, criminal penalties & civil penalties**

(a) It shall be unlawful for a person to commit any of the following acts:

(1) Knowingly or intentionally make or cause to be made a false statement or representation of a material fact in an application for a benefit or payment.

(2) Having knowledge of the occurrence of an event affecting his initial or continued right to a benefit or payment or the initial or continued right to a benefit or payment of another individual in whose behalf he has applied for or is receiving the benefit or payment, conceal or fail to disclose the event with an intent fraudulently to secure the benefit or payment either in a greater amount or quantity than is due or when no the benefit or payment is authorized.

(3) Having made application to receive a benefit or payment for the use and benefit of himself or another and having received it, knowingly or intentionally convert the benefit or a part of it to a use other than for the use and benefit of himself or the other person.

(4) Knowingly or intentionally visit more than three practitioners or providers, who specialize in the same field, in the course of 1 month for the purpose of obtaining excessive services or benefits beyond what is reasonably needed (as determined by medical professionals engaged by the Department) for the treatment of a diagnosed condition of the recipient.

(5) Borrow or use a MA identification card for which he is not entitled or otherwise gain or attempt to gain medical services covered under the MA Program if he has not been determined eligible for the Program.

**ATTACHMENT C:**

**Federal False Claims Act**

**31 U.S.C. §3729 of the Federal False Claims Act**

(a) Liability for certain acts. Any person who--

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States 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 Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

(4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

(5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

(7) 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 Government, is liable to the United States Government for a civil penalty of not less than \$ 5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person, except that if the court finds that

**ATTACHMENT D:** Pennsylvania Fraud and Abuse Control Act - Provider

**62 P.S. §1407 Provider prohibited acts, criminal penalties and civil remedies.**

- (a) It shall be unlawful for any person to:
- (1) Knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, or to knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance, or to knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance.
  - (2) Solicit or receive or to offer or pay any remuneration, including any kickback, bribe or rebate, directly or indirectly, in cash or in kind from or to any person in connection with the furnishing of services or merchandise for which payment may be in whole or in part under the medical assistance program or in connection with referring an individual to a person for the furnishing or arranging for the furnishing of any service or merchandise for which payment may be made in whole or in part under the medical assistance program.
  - (3) Submit a duplicate claim for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source.
  - (4) Submit a claim for services, supplies, or equipment which were not rendered to a recipient.
  - (5) Submit a claim for services, supplies or equipment which includes costs or charges not related to such services, supplies or equipment rendered to a recipient.
  - (6) Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the recipient.
  - (7) Submit a claim which misrepresents the description of services, supplies or equipment dispensed or provided; the dates of services; the identity of the recipient, the identity of the attending, prescribing or referring practitioner; or the identity of the actual provider.
  - (8) Submit a claim for reimbursement for a service, charge or item at a fee or charge which is higher than the provider's usual and customary charge to the general public for the same service or item.
  - (9) Submit a claim for a service or item which was not rendered by the provider.
  - (10) Dispense, render or provide a service or item without practitioner written order and the consent of the recipient, except in emergency situations, or submit a claim for a service or item which was dispensed, or provided without the consent of the recipient except in emergency situations.
  - (11) Except in emergency situations, dispense, render or provide a service or item to a patient claiming to be a recipient without making a reasonable effort to ascertain verification through a current medical assistance identification card, that the person or patient is, in fact, a recipient who is eligible on the date of service and without another available medical resource.
  - (12) Enter into an agreement, combination or conspiracy to obtain or aid another to obtain reimbursement or payments for which there is not entitlement.
  - (13) Make a false statement in the application for enrollment as a provider.

(b)(1) A person who violates any provision of subsection (a) excepting subsection (a)(11), is guilty of a felony of the third degree for each such violation with a maximum penalty of fifteen thousand dollars (\$15,000) and seven years imprisonment. A violation of subsection (a) shall be deemed to continue so long as the course of conduct of the defendant's complicity therein continues; the offense is committed when the course of conduct or complicity of the defendant therein is terminated in accordance with the provisions of 42 Pa.C.S. 5552(d) (relating to other offenses). Whenever any person has been previously convicted in any state or Federal court of conduct that would constitute a violation of subsection (a), a subsequent allegation, indictment or information under subsection (a) shall be classified as a felony of the second degree with a maximum penalty of twenty-five thousand dollars (\$25,000) and ten years imprisonment.

(2) In addition to the penalties provided under subsection (b), the trial court shall order any person convicted under subsection (a)

(i) to repay the amount of the excess benefits or payments plus interest on that amount at the maximum legal rate from the date payment was made by the Commonwealth to the date repayment is made to the Commonwealth;

(ii) to pay an amount not to exceed threefold the amount in excess benefits or payments.

(3) Any person convicted under subsection(a) shall be ineligible to participate in the medical assistance program for a period of five years from the date of conviction. The department shall notify any provider so convicted that the provider agreement is terminated for five years, and the provider is entitled to a hearing on the sole issue of identity. If the conviction is set aside on appeal, the termination shall be lifted.

(4) The Attorney General and the district attorneys of the several counties shall have concurrent authority to institute criminal proceedings under the provisions of this section.

(5) As used in this section the following words and phrases shall have the following meanings:

“Conviction” means a verdict of guilty, a guilty plea, or a plea of nolo contendere in the trial court.

“Medically unnecessary or inadequate services or merchandise” means services or merchandise which are unnecessary or inadequate as determined by medical professionals engaged by the department who are competent in the same or similar field within the practice of medicine.

(c)(1) If the department determines that a provider has committed any prohibited act or has failed to satisfy any requirement under section 1407(a), it shall have the authority to immediately terminate, upon notice to the provider, in the court of common pleas for twice the amount of excess benefits or payments plus legal interest from the date the violation or violations occurred. The department shall have the authority to use statistical sampling methods to determine the appropriate amount of restitution due from the provider.

(2) Providers who are terminated from participation in the medical assistance program for any reason shall be prohibited from owning, arranging for, rendering or ordering any service for medical assistance recipients during the period of termination. In addition, such provider may not receive, during the period of termination, reimbursement in the form of direct payments from the department or indirect payments of medical assistance funds in the form of salary, shared fees, contracts, kickbacks or rebates from or through any participating provider.

(3) Notice of any action taken by the department against a provider pursuant to clauses (1) and (2) will be forwarded by the department to the Medicaid Fraud Control Unit of the Department of Justice and to the appropriate licensing board of the Department of State for appropriate

action, if any. In addition, the department will forward to the Medicaid Fraud Control Unit of the Department of Justice and the appropriate Pennsylvania licensing board of the Department of State any cases of suspected provider fraud.

**ATTACHMENT E:** Pennsylvania Fraud and Abuse Control Act - Other

**62 P.S. §1408 Other prohibited acts, criminal penalties and civil remedies.**

- (a) It shall be unlawful for any person to:
  - (1) knowingly or intentionally make or cause to be made false statement or misrepresentation or to willfully fail to disclose a material fact regarding eligibility, including, but not limited to, facts regarding income, resources or potential third part liability , for either themselves or any other individual, either prior to or at the time of or subsequent to the application for any medical assistance benefits or payments;
  - (2) having knowledge of the occurrence of any event affecting his initial or continued right to any such benefit or payment or the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceal or fail to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized;
  - (3) having made application to receive any such benefit or payment for the use and benefit of himself or another and having received it, knowingly or intentionally converts such benefit or any part thereof to use other than for the use and benefit of himself or such other person; or
  - (4) knowingly or intentionally visit more than three practitioners or providers, who specialize in the same field, in the course of one month for the purpose of obtaining excessive services or benefits beyond what is reasonably needed (as determined by medical professionals engaged by the department) for the treatment of a diagnosed condition of the recipient,
  - (5) borrow or use a medical assistance identification card for which he is not entitled or otherwise gain or attempt to gain medical services covered under the medical assistance program if he has not been determined eligible for the program.
- (b)(1) Any person violating subsection (a)(1), (2) or (3) commits the grade of crime determined from the following schedule:

Amount of Benefit	Degree of Crime
\$3,000 or more	Felony of the third degree
\$1,500 to \$2,999	Misdemeanor of the first degree.
\$1,000 to \$1,499	Misdemeanor of the second degree.
\$999 and under or an attempt to commit	Misdemeanor of the third degree

any act prohibited in subsection (a)(1), (2) or (3)

- (1.1) Pursuant to 42 Pa.C.S. 1515(a)(7) (relating to jurisdiction and venue), jurisdiction over cases graded as a misdemeanor of the third degree under this section shall be vested in district justices.
- (1.2) Any person committing a crime enumerated in subsection (a)(1), (2), (3), (4) or (5) shall be ordered to pay restitution of any medical assistance benefits or payments made on behalf of either themselves or another individual. A restitution order under this subsection may be paid in a lump sum or by monthly installments or according to such other schedule as is deemed just by the sentencing court. Notwithstanding the

provisions of 18 Pa.C.S. 1106(c)(2) (relating to restitution for injuries to persons or property) to the contrary, the period of time during which the offender is ordered to make restitution may exceed the maximum term of imprisonment to which the offender could have been sentenced for the crime of which he was convicted if the sentencing court determines such period to be reasonable and in the interest of justice.

- (1.3) There shall be a five year statute of limitations on all crimes remunerated in subsection (a).
- (2) A person who commits a violation of subsection (a)(4) or (5) is guilty of a misdemeanor of the first degree for each violation thereof with a maximum penalty thereof of ten thousand dollars (\$10,000) and five years imprisonment.

**ATTACHMENT F:**

**Title 18 - Crimes and Criminal Procedure**

**TITLE 18--CRIMES AND CRIMINAL PROCEDURE**

**PART I--CRIMES**

**CHAPTER 47--FRAUD AND FALSE STATEMENTS**

**Sec. 1001. Statements or entries generally**

(a) Except as otherwise provided in this section, whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully--

(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact;  
(2) makes any materially false, fictitious, or fraudulent statement or representation; or (3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title, imprisoned not more than 5 years or, if the offense involves international or domestic terrorism (as defined in section 2331), imprisoned not more than 8 years, or both.

(b) Subsection (a) does not apply to a party to a judicial proceeding, or that party's counsel, for statements, representations, writings or documents submitted by such party or counsel to a judge or magistrate in that proceeding.

(c) With respect to any matter within the jurisdiction of the legislative branch, subsection (a) shall apply only to--

(1) administrative matters, including a claim for payment, a matter related to the procurement of property or services, personnel or employment practices, or support services, or a document required by law, rule, or regulation to be submitted to the Congress or any office or officer within the legislative branch; or

(2) any investigation or review, conducted pursuant to the authority of any committee, subcommittee, commission or office of the Congress, consistent with applicable rules of the House or Senate.

**Sec. 1035. False statements relating to health care matters**

(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully--

(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

(b) As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

**ATTACHMENT G:**

**False Claims and Statements: Liability**

**31 U.S.C. §3802 - False Claims and Statements, Liability**

a)(1) Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a claim that the person knows or has reason to know -

(A) is false, fictitious, or fraudulent;

(B) includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

(C) includes or is supported by any written statement that -

(i) omits a material fact;

(ii) is false, fictitious, or fraudulent as a result of such omission; and

(iii) is a statement in which the person making, presenting, or submitting such

statement has a duty to include such material fact; or

(D) is for payment for the provision of property or services which the person has not provided as claimed, shall be subject to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than \$5,000 for each such claim. Except as provided in paragraph (3) of this subsection, such person shall also be subject to an assessment, in lieu of damages sustained by the United States because of such claim, of not more than twice the amount of such claim, or the portion of such claim, which is determined under this chapter to be in violation of the preceding sentence.

(2) Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a written statement that -

(A) the person knows or has reason to know -

(i) asserts a material fact which is false, fictitious, or fraudulent; or

(ii)(I) omits a material fact; and

(II) is false, fictitious, or fraudulent as a result of such omission;

(B) in the case of a statement described in clause (ii) of subparagraph (A), is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; and

(C) contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement, shall be subject to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than \$5,000 for each such statement.

(3) An assessment shall not be made under the second sentence of paragraph (1) with respect to a claim if payment by the Government has not been made on such claim.

(b)(1) Except as provided in paragraphs (2) and (3) of this subsection -

(A) a determination under section 3803(a)(2) of this title that there is adequate evidence to believe that a person is liable under subsection (a) of this section; or

(B) a determination under section 3803 of this title that a person is liable under subsection (a) of this section, may provide the authority with grounds for commencing any administrative or contractual action against such person which is authorized by law and which is in addition to any action against such person under this chapter.

(2) A determination referred to in paragraph (1) of this subsection may be used by the authority, but shall not require such authority, to commence any administrative or contractual action which is authorized by law.

(3) In the case of an administrative or contractual action to suspend or debar any person who is eligible to enter into contracts with the Federal Government, a determination referred to in

paragraph (1) of this subsection shall not be considered as conclusive determination of such person's responsibility pursuant to Federal procurement laws and regulations.

**ATTACHMENT H:**

Fraud and Abuse Sanctions

**Fraud and Abuse Sanctions 55 Pa Code  
§ 1101.77. Enforcement actions by the Department**

*(a) Departmental determination of violation.*

The Department may terminate a provider's enrollment and direct and indirect participation in the MA Program and seek restitution as specified in §1101.83 (relating to restitution and repayment) if it determines that a provider, an employee of the provider or an agent of the provider has:

- (1) Failed to comply with this chapter or the appropriate separate chapters relating to each provider type.
- (2) Committed a prohibited act as specified in this chapter or the appropriate separate chapter relating to each provider type or under Article XIV of the Public Welfare Code (62 P. S. § § 1401—1411).
- (3) Failed to comply with the conditions of participation listed in Articles IV or XIV of the Public Welfare Code (62 P. S. § § 401—493 and 1401—1411).
- (4) Not complied with the terms of the provider agreement.
- (5) Been suspended or terminated from Medicare.
- (6) Been convicted of a Medicare or Medicaid related criminal offense as certified by a Federal, State or local court.
- (7) Been convicted of a criminal offense under State or Federal laws relating to the practice of the provider's profession as certified by a court.
- (8) Been subject to a disciplinary action taken or entered against the provider in the records of the State licensing or certifying agency.
- (9) Had a controlled drug license withdrawn or failed to report to the Department changes in the Provider's Drug Enforcement Agency Number.
- (10) Rendered or ordered services or items which the Department's medical professionals have determined to be harmful to the recipient, of inferior quality or medically unnecessary.
- (11) Ordered services for recipients or billed the Department for rendering services to recipients at an unregistered shared health facility after the shared health facility and provider are notified by the Department that the shared health facility is not registered.
- (12) Refused to permit duly authorized State or Federal officials or their agents to examine the provider's medical, fiscal or other records as necessary to verify services or claims for payment under the program.

*(b) Departmental termination of the provider's enrollment and participation.*

(1) The Department may terminate the enrollment and direct and indirect participation of, and suspend payments to, any provider upon 30 days advance notice for the convenience or best interest of the Department.

(2) If the Department terminates the enrollment and participation of a provider for reasons specified in subsections (a)(3), (5), (6), (7) or (8), the effective date of the termination will be the date of the action specified in the appropriate paragraph of subsection (a).

(3) Termination for criminal conviction or disciplinary action shall be as follows:

(i) The Department will terminate a provider's enrollment and participation for 5 years if the provider is convicted of a criminal act listed in Article XIV of the Public Welfare Code (62 P. S. §§ 1401—1411), a Medicare/Medicaid related crime or a criminal offense under State or Federal law relating to the practice of the provider's profession. If the Department has an additional basis for termination which is unrelated to, and in addition to, the criminal conviction, it may terminate the provider for a period in excess of 5 years.

(ii) If the additional basis for the termination is a disciplinary action taken against the provider or entered in the records of the State licensing or certifying agency, the period of termination will be the duration of the disciplinary action plus 5 years for the criminal conviction.

(iii) If the Department has a basis for termination which is related to the criminal conviction (with the exception of exclusions from Medicare) the minimum period of the termination will be the longer of 5 years or the period related to the other action.

*(c) Effects of termination of providers.*

(1) The Department does not pay for services or items rendered, prescribed or ordered on and after the effective date of a provider's termination from the Medical Assistance Program.

(i) A provider is not paid for services or items rendered on and after the effective date of his termination from the program.

(ii) A participating provider is not paid for services, including inpatient hospital care and nursing home care, or items prescribed or ordered by a provider who has been terminated from the program.

(iii) A participating provider is paid for services or items prescribed or ordered by a provider who voluntarily withdraws from the program.

(2) A provider whose enrollment in the program has been terminated may not, during the period of termination:

(i) Own, render, order or arrange for a service for a recipient.

(ii) Receive direct or indirect payments from the Department in the form of salary, equity, dividends, shared fees, contracts, kickbacks or rebates from or through a participating provider or related entity.

(3) If a provider appeals the Department's action of terminating the enrollment and participation of or suspending payments to the provider:

(i) The Department will pay the provider for compensable service rendered on and after the effective date specified in the notice if the appeal of the provider is upheld.

(ii) The Department will not pay the provider for services rendered on or after the effective date specified in the notice if the appeal of the provider is denied.

(d) *Provider notification.*

(1) The Department will issue a Notice of Termination to a provider whose enrollment and participation is being terminated with cause or as a result of a criminal conviction. The notice will state the basis for the action, the effective date, whether the Department will consider re-enrollment and, if so, the date when re-enrollment will be considered.

(2) If the Department is terminating the enrollment and participation of all providers or all providers of a specific type under a statute of the General Assembly of the Commonwealth or of the Congress of the United States, notification will be by publication in the *Pennsylvania Bulletin*.

(3) A provider's participation is automatically terminated as of the effective date of the provider's termination or suspension from Medicare. A notice confirming the termination will be sent to the provider.

(e) *Dissemination of information.*

(1) When the Department takes an action against a provider, including termination and initiation of a civil suit, it will also notify and give the reason for the termination to all of the following:

(i) The Medicaid Fraud Control Unit, Office of the Attorney General.

(ii) The Health Care Financing Administration.

(iii) Other State and local agencies involved in providing health care.

(iv) The applicable professional licensing board.

(2) After final adjudication, a copy of the Notice of Termination and the reasons for termination may be made available to Medicaid agencies of other states, the appropriate professional associations and the news media. Detailed case material and findings will be made available to the agencies specified in paragraph (1).

(3) The Department will issue a medicheck list containing the names of all providers who have been terminated from the Program.

(f) *Violations by nonparticipating former providers.*

(1) The Department may take an enforcement action against a nonparticipating former provider that it may impose upon a participating provider for an act committed while a provider.

(2) If the Department takes action, it will issue a Notice of Exclusion to the nonparticipating former provider stating the basis for the action, the effective date, whether the Department will consider re-enrollment, and, if so, the date when the request for re-enrollment will be considered.

**ATTACHMENT I:**

**Social Security Act Sanctions**

**SEC. 1128. [42 U.S.C. 1320a-7]**

(a) **MANDATORY EXCLUSION.**—The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):

- (1) **Conviction of program-related crimes.**—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program.
- (2) **Conviction relating to patient abuse.**—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.
- (3) **FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.**—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996<sup>[43]</sup>, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
- (4) **FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.**—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(b) **PERMISSIVE EXCLUSION.**—The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):

- (1) **CONVICTION RELATING TO FRAUD.**—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law—
  - (A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—
    - (i) in connection with the delivery of a health care item or service, or
    - (ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or
  - (B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.
- (2) **Conviction relating to obstruction of an investigation.**—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with

or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a).

(3) Misdemeanor conviction relating to controlled substance.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(4) LICENSE REVOCATION OR SUSPENSION.—ANY INDIVIDUAL OR ENTITY—

(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or

(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.

(5) EXCLUSION OR SUSPENSION UNDER FEDERAL OR STATE HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under—

(A) any Federal program, including programs of the Department of Defense or the Department of Veterans

Affairs, involving the provision of health care, or

(B) a State health care program, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

(6) CLAIMS FOR EXCESSIVE CHARGES OR UNNECESSARY SERVICES AND FAILURE OF CERTAIN ORGANIZATIONS TO FURNISH MEDICALLY NECESSARY SERVICES.—Any individual or entity that the Secretary determines—

(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

(B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under title XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(C) is—

(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

(ii) an entity furnishing services under a waiver approved under section 1915(b)(1), and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

(7) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines has committed an act which is described in section 1128A, 1128B, or 1129.

(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

(A)(i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1124(a)(3)) in that entity,

(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity; or

(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—

is a person—

(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1128A or 1129; or

(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

(9) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required by section 1124, section 1124A, or section 1126.

(10) FAILURE TO SUPPLY REQUESTED INFORMATION ON SUBCONTRACTORS AND SUPPLIERS.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of \$25,000, or

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were

due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

(12) FAILURE TO GRANT IMMEDIATE ACCESS.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

(D) To a State Medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

(13) FAILURE TO TAKE CORRECTIVE ACTION.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

(14) DEFAULT ON HEALTH EDUCATION LOAN OR SCHOLARSHIP OBLIGATIONS.—Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that (A) the Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be excluded, and (B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of beneficiaries to physician services for which payment may be made under title XVIII or XIX.

(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—

(A) Any individual—

(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

(B) For purposes of subparagraph (A), the term “sanctioned entity” means an entity—

(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—

(1) An exclusion under this section or under section 1128A shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under title XVIII or under a State health care program for—

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion, until the passage of 30 days after the effective date of the exclusion.

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12) or in the case described in subparagraph (G), the period) of the exclusion.

(B) Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

(i) the length of the period in which the individual failed to grant the immediate access described in that subsection, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(D) Subject to subparagraph (G), in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.

