BEACON HEALTH OPTIONS		POLICIES AND PROCEDURES
Policy Number: CO 310.2 (Legacy LC310)	Category: A	Page 1 of 5
Title: Compliance with Fraud, Waste and Abuse Laws and Regulations	Original Date of Issue: 4/30/15	
Keyword Search: Deficit Reduction Act, False Claim, FCA, FERA, Healthcare Crime, Civil Penalties	Date Approved: 7/14/17	

Beacon Health Options Policies and Procedure cover the operations of all entities within the BVO Holdings, LLC corporate structure, including but not limited to Beacon Health Strategies LLC, Beacon CBHM LLC and Beacon Health Options, Inc.

Reviewed ☑	Revised ☑	New ☐	Approval Signatures:
Functional Area(s) Involved in Review: Corporate Compliance Management			Daniel Risku, EVP and General Counsel; Rebecca White, SVP and Chief Compliance Officer
Service Center/Engagement Center: All			
Previous Approval Date: 5/13/17			Next Annual Review Due: 7/31/18

*This policy is based on VO legacy policy LC310 issued 12/4/06 and last approved 3/14/14

I. Policy:

It is the policy of Beacon Health Options (Beacon) to comply with federal and state laws and regulations related to the Deficit Reduction Act, False Claims Act, Criminal Penalties for Acts Involving Federal Health Care Programs Act, and support government initiatives to reduce healthcare fraud, waste, and abuse.

II. Definition(s):

Claim: means any request or demand for money or property that

- Is presented to the federal government or a contractor performing services for the federal government; and
- The federal government will (or has) provided any portion of the money or property requested or demanded.

Obligation: means an established duty arising from an express or implied contractual or licensure relationship, a statute or regulation, or from the retention of any overpayment.

For purposes of the Deficit Reduction Act, a contractor or agent: includes any contractor, subcontractor, or agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

III. Purpose:

To provide guidelines for Beacon employees to comply with Federal and State laws and regulations related to the avoidance, prevention, detection and response to healthcare fraud, waste and abuse.

IV. Procedures:

A. It is the responsibility of all employees to comply with applicable federal and state laws related to healthcare fraud, waste and abuse. This includes compliance with the Federal

False Claims Act, and, for employees performing services pursuant to a Medicare/Medicaid program, the Deficit Reduction Act.

B. States may also have a variety of laws to facilitate prosecution of healthcare fraud and abuse and/or state Medicaid false claims regulations. State specific laws and regulations must also be followed to ensure full compliance with the Deficit Reduction Act. State-by-State charts on False Claims regulations and on Fraud and Abuse regulations may be found on the Legal website under references.

C. The Deficit Reduction Act requires Beacon address the following activities:

1. Implement written policies regarding the Deficit Reduction Act and the False Claims Act, which are applicable to employees, contractors and agents, including:
   a. CO 101.2 – Compliance Program Activities (LC101)
   b. CO 119.2 – Program Integrity Activities and Action Plan (LC101A)
2. Provide education to employees, contractors, and agents regarding:
   a. The Deficit Reduction Act;
   b. The Federal False Claims Act;
   c. Administrative remedies for false claims and statements;
   d. Applicable state laws pertaining to false claims and statements and related civil or criminal penalties;
   e. Whistleblower protections under the Federal False Claim Act and applicable state laws;
   f. The role of laws in preventing and detecting fraud, waste, and abuse in Federal health care programs;
   g. The company's policies and procedures for preventing, identifying, reporting and investigating fraud, waste and abuse within Medicaid programs.
3. Address the below topics in the Code of Conduct and Ethics, and other employee handbooks if available:
   a. State and federal laws regarding false claims and fraud and abuse;
   b. Rights and protections of employee whistleblowers;
   c. Policies and procedures for detecting fraud, waste, and abuse.
4. Medicaid Claims Payment:
   a. Medicaid is generally a payor of last resort, and appropriate processes should be followed to ensure appropriate coordination of benefits occur.
   b. Medicaid claims should only be paid for individuals who are a citizen or national of the United States or a qualified alien meeting all other Medicaid program eligibility criteria.

c. Payments need to comply with co-payment limit regulations

d. Require electronic claims from providers unless it is a small provider with fewer than 25 full time equivalent employees; or physicians, practitioners, or suppliers with fewer than 10 full time equivalent employee; or other providers specified by CMS.

D. Beacon will, upon a state's request, provide eligibility and claims payment data with respect to individuals who are eligible to receive Medicaid.

E. Beacon will accept an individual's or other entity's assignment of rights to payment from the parties to the state.

F. Beacon will respond to any inquiry from a state regarding a claim for payment for any health care item or service submitted not later than 3 years after the date the item or service was provided.

G. Beacon agrees not to deny a claim submitted by a state solely on the basis of the date of submission.

H. Beacon will ensure that all potential violations of the Deficit Reduction Act will be investigated and actions will be taken to resolve the identified problem.

I. The Legal Department will review violations requiring potential reporting to government agencies.

J. Federal laws provide a variety of criminal and civil penalties that may be brought against individuals and entities who engage in fraudulent activities. False Claims Act (31 U.S.C.§§3729-3733). The federal False Claims Act defines false or fraudulent activities very broadly. Examples include:

1. Submitting false or fraudulent claims for payment with federal funds.
2. Making a false record or statement to get a false or fraudulent claim paid by the government.
3. Conspiring to have a false or fraudulent claim paid by the government.
4. Withholding property of the government with the intention of defrauding the government or of willfully concealing it from the government.
5. Making or delivering a receipt for government property which is false or fraudulent.
6. Buying property belonging to the government from someone who is not authorized to sell the property.
7. Making a false statement to avoid or deceive an obligation to pay money or property to the government.
8. Causing someone else to submit a false claim to the government.
9. Knowingly using or causing to be used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
10. Omitting a material fact to get a false or fraudulent claim paid by the government.

K. False Claims Act: Under the False Claims Act (31 U.S.C.§§3729-3733), those who knowingly submit or cause another person or entity to submit false claims for government funds are liable for damages up to three times the amount of the government's damages plus mandatory penalties. A person or entity who violates the False Claims Act may receive a felony conviction as well as criminal and civil penalties with civil penalties being not more than $10,957 to $21,916 for each claim.

L. Administrative Remedies for False Claims and Statements (31 U.S.C. Chapter 38 §3802): Under this Act, any person who makes, presents, or submits a claim that is false or fraudulent is subject to a civil penalty of not more than $5,000 for each claim and also an assessment of not more than twice the amount of the claim.

M. Criminal Penalties for Acts Involving Federal Health Care Programs (42 U.S.C. Chapter 7, § 1320a–7b): Under the Criminal Penalties for Acts Involving Federal Health Care Programs, those who knowingly and willfully cause false statements or representations of material facts in any benefit or payment under a Federal health care program are subject to a felony conviction with a fine of up to $25,000 and/or 5 years imprisonment.

N. Whistleblower Employee Protection Act (31 U.S.C. Sec 3730(h)) prohibits a company from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee because of lawful acts done by the employee on behalf of the employer or because the employee testifies or assists in an investigation of the employer.

O. Reporting and Investigation of Potential Fraud, Waste or Abuse:

1. Employees are required to promptly report suspected fraud, waste or abuse to the Compliance and Ethics Hotline at 1-888-293-3027.
2. Ethics Hotline reports may be made anonymously and no adverse action or retribution of any kind will be taken against an employee because he or she reports a suspected violation.
   Employees self-reporting their own violations may still be subject to disciplinary proceedings to the extent of their personal involvement in the reported activity.
3. Employees not in compliance with the Deficit Reduction Act and the False Claims Act and the company's related policies may receive disciplinary action up to and including termination.

V. DEPARTMENTS AFFECTED:

A. Executive Management
B. Legal and Compliance Department
C. Operational Management
D. All employees

VI. ATTACHMENT(S):

None

VII. REFERENCED POLICIES:

CO 101.2 – Compliance Program Activities (LC101)

CO 119.2 – Program Integrity Activities and Action Plan (LC101A)

VIII. HOW OFTEN IS POLICY/PROCEDURE FOLLOWED:

At all times

IX. WHO IS RESPONSIBLE FOR IMPLEMENTING THE POLICY/PROCEDURE:

All employees

X. WHO MONITORS COMPLIANCE WITH THE POLICY/PROCEDURE:

Chief Compliance Officer