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<b>Service Center/Operating Unit: All</b>	<b>Subject: Deficit Reduction Act</b>	
<b>Approval Signatures:</b>		
 		
Donna Pillatsch Director of Compliance		Michele Alfano COO

I. Purpose:  
To provide guidelines for ValueOptions to ensure compliance with the Deficit Reduction Act of 2005.

II. Committee(s) and Department(s) Affected:

- A Corporate Compliance Department
- B. Corporate Compliance Committee
- C. Claims Departments
- D. Service Centers who receive more than \$5 million in annual Medicaid reimbursements



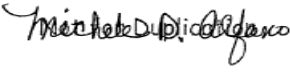
III. Policy:

It is the policy of ValueOptions to be in compliance 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 with any government initiatives to reduce healthcare fraud, waste, and abuse.

IV. Definition:



Claim: any request or demand for money that is submitted to the federal government or its contractors.

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.



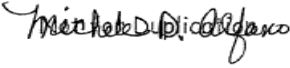
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V. Procedures:



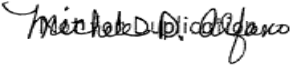
- A. It is the responsibility of service centers and corporate departments Compliance staff to ensure requirements of the Deficit Reduction Act are met if the service center makes or receives more than \$5 million in annual Medicaid payments.
- B. States may also have a variety of laws to facilitate prosecution of Medicaid fraud and abuse and/or 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. ValueOptions has the following requirements for compliance with the Deficit Reduction Act:
  1. Implementation of written policies regarding the Deficit Reduction Act and the False Claims Act. Policies are to be applicable to employees, contractors and agents.
  2. Employee, contractor, and agent education regarding:
    - a) The Deficit Reduction Act;
    - b) The Federal False Claims Act;
    - c) Administrative remedies for false claims and statements;
    - d) State laws pertaining to false claims and statements and related civil or criminal penalties;
    - e) Whistleblower protections under the Federal False Claim Act and under 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 detecting and preventing fraud, waste and abuse including identifying, reporting and investigating potential false claims.
  3. Inclusion of the following in the ValueOptions' Code of Conduct and other employee handbooks as applicable:

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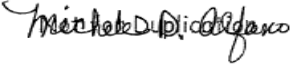
- a) State and federal laws regarding false claims and fraud and abuse;
  - b) Rights of employees for protection as whistleblowers;
  - c) The Company's policies and procedures for detecting fraud, waste, and abuse.
4. Identification and investigation of potential false claims. (Refer to LC309 False Claims). Referrals of fraudulent or abusive billings are handled by the Special Investigations Unit per policies S103 Healthcare Claims Fraud and Abuse Investigations.
  5. Identification and investigation of alleged fraud, waste, or abuse violations.
  6. For those member's dually insured, ensure that claims are paid by other insurance companies prior to payment by Medicaid as Medicaid is the payor of last resort.
  7. Only pay claims for individuals who are a citizen or national of the United States or a qualified alien who meets all other Medicaid program eligibility criteria.
  8. Comply with co-payment limit regulations.
  9. 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. ValueOptions will, upon a state's request, provide eligibility and claims payment data with respect to individuals who are eligible to receive Medicaid.
  - E. ValueOptions will accept an individual's or other entity's assignment of rights to payment from the parties to the state.

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- F. ValueOptions 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. ValueOptions agrees not to deny a claim submitted by a state solely on the basis of the date of submission.
- H. ValueOptions requires all employees to be trained on the Code of Conduct and Investigating Fraud and Abuse within 30 days of hire and annually thereafter.
- I. ValueOptions will ensure that all potential violations of the Deficit Reduction Act will be investigated and actions will be taken to resolve the identified problem.
- J. The Legal Department will review possible violation requiring potential reports to government agencies.
- K. Under the FEDERAL FALSE CLAIMS ACT (31 U.S.C. §§3729-3733), anyone knowingly and willfully submitting or causing a person or entity to submit a false claim for government funds is liable for damages up to three times the amount of the government's damages plus mandatory penalties of \$5,500 to \$11,000 per each false claim.
- L. CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS (42 U.S.C. SEC 1128B, 1320a-7b) states that criminal penalties will result in conviction of a felony and a fine of not more than \$25,000 and/or imprisonment for not more than 5 years for whomever:
  - 1. Knowingly and willfully makes or causes to be made any false statement in applications for any benefit or payment under a Federal health care program;
  - 2. Knowingly and willfully makes or causes to be made any false statement for use in determining rights to such benefit or payment;
  - 3. Has knowledge of the occurrence of any event affecting the initial or continued right to a benefit or payment which is fraudulent;

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4. Has knowledge of the occurrence of any event affecting the initial or continued right to any benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment which is fraudulent;
  5. Knowingly and willfully converts the benefit or payment to a use other than the intended;
  6. Presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the person furnishing the services is not licensed as a physician;
  7. For a fee, knowingly and willfully counsels or assists an individual to dispose of assets in order to become eligible for medical assistance under a state plan;
  8. Knowingly and willfully charges for any service provided to a patient under a Federal health care program in excess of established rates.
- M. THE FALSE CLAIMS ACT 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.
- N. ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS AND STATEMENTS (31 U.S.C. Chapter 8. §3801): 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.
- O. Ethical concerns regarding billing and claims payment may be confidentially reported to the Ethics Hotline at 1-888-293-3027.
- P. No adverse action or retribution of any kind will be taken against an employee because he or she reports a suspected violation of the Deficit Reduction Act or the False Claims Act or other irregularity by another person or entity. If you are



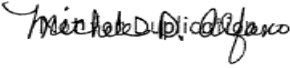
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reporting your own actions, you may still be subject to disciplinary proceedings to the extent of your personal involvement in the reported activity.

- Q. 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.
- R. The Centers for Medicare and Medicare Services (CMS) web page for state fraud statutes can be accessed at <http://www.cms.hhs.gov/apps/mfs/weblist.asp>. By selecting the state in which ValueOptions operates, the search engine pulls all the state's laws related to Medicaid fraud. State specific whistleblower protection laws may also be accessed at this site.
- S. Also refer to:
- LC310 Deficit Reduction Act
  - Fraud and Abuse Training on the ValueOptions website
  - Code of Conduct training on the ValueOptions website
  - State-by-state charts located on the Legal and Finance websites
  - Code of Conduct
  - S001 Anti-Fraud Plan
  - S103 Healthcare Claims Fraud and Abuse Investigations
  - Taxpayers Against Fraud: <http://www.taf.org/statefca.htm>

VI. References:

- A. "Criminal Penalties for Acts Involving Federal Health Care Programs", Compilation of Social Security Laws, 42 U.S.C. SEC 1128B, 1320a-7b.
- B. "The Law: An Overview – False Claims Act Whistleblower Employee Protections", WhistleblowerLaws.com
- C. "Deficit Reduction Act: Implications for Compliance Teams", MediRegs

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- D. Wilson, Joy Johnson, Health Policy Director, “Deficit Reduction Act of 2005: A Summary of Medicaid/Medicare Health Provisions”, National Conference of State Legislators, February 3, 2006.
- E. “Administrative Remedies for False Claims and Statements”, U.S. Code, Title 31, Chapter 38, §3801 – 3806.
- F. “Public Law 109-171”, The Federal Register, February 8, 2006.