VNS HEALTH HEALTH PLANS POLICY AND PROCEDURE MANUAL	SUPERCEDES: Fraud, Waste and Abuse Compliance Program
SUBJECT: Special Investigations Unit (SIU) and Fraud Waste and Abuse (FWA)	
APPLIES TO: Compliance & the Special Investigations Unit (SIU)	**Applies to Lines of Business:** ☒ Medicare ☒MLTC ☒ SelectHealth

1. PURPOSE

A. To establish the VNS Health Health Plans SIU to oversee a comprehensive anti-fraud program designed to detect, investigate, resolve, correct and report incidents of suspected FWA in compliance with all applicable state and federal laws and regulations.

B. To ensure appropriate investigation, resolution and corrective action of all potential FWA by VNS Health Health Plans's Directors, Officers, Employees, Contractors, Agents and others associated with VNSNY and VNS Health Health Plans's FDRs (defined below) and providers.

C. To assist in supporting and enforcing VNS Health Health Plans's compliance standards, which are clearly communicated through well-publicized disciplinary guidelines.

D. To ensure the appropriate referral, notification, and/or reporting of suspected and confirmed incidents of FWA to federal and state agencies, as appropriate, and to assist state and federal investigative agencies on FWA investigations upon request.

2. SCOPE

This policy applies to all VNS Health Health Plans Directors, Officers**,** Employees, Contractors, Agents and FDRs, who each have obligations to detect and prevent FWA. The SIU and Compliance Department are primarily responsible for implementing this policy.

3. DEFINITIONS

A. **Abuse** is a practice that is inconsistent with accepted business, financial or medical practices or standards and that results in unnecessary cost or in reimbursement.

B. **Compliance Officer** means the VNS Health Chief Compliance and Privacy Officer.

C. **FDRs** mean First Tier, Downstream and Related Entities, as defined by the Centers for Medicare & Medicaid Services (CMS) in the Medicare Managed Care Manual, which includes business partners, downstream entities and entities that perform delegated operations under state-approved management agreements.

D. **Fraud** is an intentional deception, concealment or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.

E. **FWA** means Fraud, Waste and Abuse.

F. **SIU** means the Special Investigations Unit.

G. **VNS Health** means VNS Health and all its related entities.

H. **Waste** includes any practice that results in an unnecessary use or consumption of financial or medical resources. Waste does not necessarily involve personal gain, but often signifies poor management decisions, practices or controls.

4. BACKGROUND

A. As a licensed managed care organization that offers Medicare Advantage (MA), Managed Long-Term Care (MLTC) and Special Needs Plans, VNS Health Health Plans is required by law, regulations and contract to detect, investigate, report and prevent FWA and to have a SIU that is responsible for investigating cases of suspected fraudulent or abusive activity and for implementing the VNS Health Health Plans Fraud, Waste and Abuse Prevention Plan that has been submitted to the New York State Department of Health (DOH).

B. Although the SIU is VNS Health Health Plans's primary investigative unit for FWA, VNS Health Health Plans's anti-fraud efforts are not limited to those designated personnel, and it will afford and make available all necessary resources that may be required to complete any investigation. The SIU assists Management in meeting compliance standards regarding FWA and serves as a liaison between VNS Health Health Plans, Providers, Contractors, FDRs, Federal and State agencies, and other constituents in the prevention, detection, and reporting of suspected FWA.

C. The objective of the SIU is to reduce the incidence of FWA through a program that includes education and training, prevention, detection, investigation and reporting, subject to the VNS Health Code of Conduct and the VNS Health Compliance Program Structures and Guidelines, as well as state and federal regulation. The SIU has authority for conducting inquiries and investigations of suspected FWA and will coordinate with any and all resources deemed necessary to thoroughly conduct an investigation.

5. POLICIES

A. VNS Health Health Plans maintains a strict policy of zero tolerance toward FWA and is committed to complying with all applicable federal and state standards on FWA.

B. All VNS Health Health Plans Directors, Officers, Employees, Contractors, Agents, Providers, FDRs and others associated with VNSNY have a responsibility to detect, report and prevent FWA. All such persons report all incidents of suspected FWA, as per the VNS Health Corporate Policy: Reporting Non-Compliance and Fraud, Waste and Abuse.

C. VNS Health Health Plans has created the SIU to detect, prevent, document, investigate, report, correct and deter FWA. The SIU also recommends corrective and/or disciplinary actions in cases of FWA.

D. The SIU reports, as required by state and federal guidelines, all suspected or confirmed incidents of FWA and, upon request, assists state and federal investigative agencies in investigating FWA.

E. VNS Health Health Plans's Compliance Department and other CHOICE Departments refer all complaints involving suspected FWA to the SIU.

F. The SIU promotes the immediate reporting of suspected incidents of FWA by establishing clear lines of communications with Directors, Officers, Employees, Contractors, Agents, Providers and FDRs.

G. The SIU maintains written policies and procedures and adheres to standards of conduct that articulate VNS Health Health Plans's commitment to comply with all applicable federal and state standards.

H. VNS Health Health Plans is committed to detecting and deterring FWA to ensure that inappropriate payments are identified and recouped, and that appropriate action is taken against perpetrators of FWA, which may include prosecution and the initiation of civil actions.

I. The SIU, assisted by other individuals, entities, and departments as appropriate, is responsible for the timely investigation of suspected FWA and for implementing VNS Health Health Plans's FWA prevention and reduction activities within VNS Health Health Plans and as to all VNS Health Health Plans contracted providers with the oversight of the Compliance Officer.

J. The SIU uses a multi-faceted approach to prevent and detect suspected or potential FWA, including a combination of analytical tools, clinical expertise, investigative knowledge, internal and external referrals and education and awareness training program to maximize referrals from Employees, Directors, Officers, Contractors, Agents, Providers, Members and FDRs.

K. The SIU is responsible for the timely investigation of allegations related to Medicare sales agent practices.

L. The SIU is responsible for the timely investigation of allegations of improper practices by VNS Health Health Plans MLTC and MAP marketing and enrollment representatives.

M. The SIU maintains training and education materials specific to FWA, in support of VNS Health Health Plans's overall Compliance Program, and assists in providing training to Employees, Directors, Officers, Contractors, Agents, Providers and FDRs.

6. RESPONSIBILITIES

A. SIU Director:

i. Ensures that the SIU performs all responsibilities in compliance with applicable federal and state laws, regulations and guidelines and responds timely, thoroughly and appropriately to all allegations of FWA;

ii. Assists with the development, implementation, and oversight of the compliance awareness, training, and education program, including continuously creating methods for communicating the compliance message throughout the organization and the appropriate and timely training of internal and external parties. Ensures appropriate tracking of compliance training as assigned;

iii. Develops, implements, tracks progress, and reports on SIU portions of the annual Compliance Work Plan across product lines, which outlines the objectives, projects, training, timelines, and deliverables for the Compliance Program. Assists in the development and maintenance of policies and procedures. Manages day-to-day operation of the Program;

iv. Communicates with the Claims, Network Development and Contracting and Finance Departments and/or other VNS Health Health Plans departments as necessary to ensure that corrective actions required to be taken against network or non-network providers as the result of substantiated allegations of FWA, including recoupment, is taken consistently and timely.

v. Develops, assesses and improves compliance investigation processes and procedures. Ensures processes are in place to investigate and take action on compliance concerns and issues that are reported to the Compliance Committee and Board of Directors through various reporting channels. Provides guidance on the direction of investigations, identification of appropriate interviewees, interpretation of witness statements, and interpretation of evidence;

vi. Oversees the maintenance of the Compliance Hotline and SIU case management database (the "SIU Database") containing reported compliance issues, allegations, and concerns; reviews findings as needed;

vii. The Interim SVP & Chief Compliance &Privacy Officer reports directly to the Compliance Committee on SIU compliance matters and assists in establishing methods to reduce the VNS Health Health Planss vulnerability to violations of the Compliance Program; and

viii. Participates in special projects and performs other duties as assigned.

ix. Handles all investigations:

x. Develops investigations that involve monetary losses and sensitive issues that may meet criteria for referral to law enforcement or the imposition of administrative actions;

xi. Utilizes data analysis techniques to detect discrepancies in claims/billing data, and proactively seeks out and develops leads received from a variety of source;

xii. Conducts independent investigations resulting from the discovery of situations that potentially involve FWA;

xiii. Reviews information contained in standard claims processing system files to determine provider billing patterns and to detect potential fraudulent or abusive billing practices or vulnerabilities in policies;

xiv. Completes written referrals to law enforcement and collaborates with various operational areas to recoup overpaid monies;

xv. Identifies overpayments, initiating repayments, suspensions and pre- and post-payment edits; and

B. Support Staff and Physical Resources:

i. The SIU Director has access to sufficient staff and resources to effectively support the detection and prevention of FWA. These resources include:

- an internal team of SIU Managers and/or Specialists that serve as investigators and support day to day SIU activities, including conducting FWA investigations, making FWA referrals, investigating and remediating conflicts of interest, identifying and recovering overpayments, conducting provider terminations, education or re-education, and other related actions; implementing the FWA prevention program required by applicable regulations; and participating in any meetings required by OMIG and/or MFCU, and; access to third party resources, including vendors to support lead identification and investigative functions such as data mining and review of medical documentation for the purposes of FWA detection.

Through both the internal and external resources described above, the SIU shall engage at least one (1) full-time investigator per sixty thousand (60,000) Medicaid members, except in the case of an MLTC, where it shall engage at least one (1) full-time investigator per six thousand (6,000) members. Any alternative minimum staffing levels will be proposed to OMIG for approval, in accordance with applicable regulations.

7. SIU Staff Qualifications

i. Individuals serving as SIU investigators, whether directly employed by VNS Health Health Plans or vendors engaged by the SIU, shall meet the following minimum qualifications:

i. A minimum of five (5) years in the healthcare field working in FWA investigations and audits, of five (5) years of insurance claims investigation experience or professional investigation experience with law enforcement

agencies, or seven years of professional investigation experience involving economic or insurance related matters; or

ii. An associate or bachelor's degree in criminal justice or a related field.

8. Detection, Reporting and Referral of Potential FWA to the SIU

A. Potential FWA cases can be identified or received by the SIU through a variety of mechanisms, including, but not limited to:

i. Employees, Directors, Officers, Providers, Vendors, Consultants, Members, Caregivers, FDRs, and the Public;

ii. via the anonymous VNS Health Health Plans Compliance Hotline: 1-888-634-1558, vnshealthcompliance@vnshealth.org;

iii. the EthicsPoint web portal;

iv. Law enforcement or regulatory agencies;

v. Referrals from other VNS Health Health Plans departments as well as third parties contracted by VNS Health Health Plans including:

- Medical Management
- Quality Management
- Cost Containment
- Provider Credentialing
- Provider and Member Services
- Grievances and Appeals
- Pharmacy

B. The SIU coordinates with other VNS Health Health Plans departments, as appropriate, to obtain additional information, data and reports that will assist in identifying, investigating and preventing FWA.

i. If any VNS Health Health Plans Employee, Director, Officer, Contractor, Agent, FDR or other person associated with VNS Health Health Plans receives or uncovers information that suspects FWA, such person must notify the SIU by one of the previously noted approaches. Upon receipt of this information, the SIU will log the information internally in the SIU Database, review the facts presented and open an investigation as appropriate.

ii. Reports of potential FWA can be made anonymously via the VNS Health Health Plans Compliance Hotline (1-888-634-1558) or the EthicsPoint web portal. All possible measures are to be taken to protect the anonymity and confidentiality of the reporting individual or entity, in accordance with VNS Health Health Plans's confidentiality policies. VNS Health Health Plans will not retaliate against or intimidate any individual who reports suspected FWA, in accordance with the VNS Health Health Plans Non-Retaliation and Non-Intimidation Policy.

iii. Examples of FWA and specific areas of risk and vulnerability include, but are not limited to, the following:

a. Providers

- Billing for services not rendered;
- Deliberately filing incorrect diagnosis or procedure codes to maximize payment;
- Quality of care issues;
- Failure to maintain adequate medical records;
- Cover-ups in coordination of benefits;
- Misrepresenting services or dates of service;
- Billing non-covered services as covered services;
- An eligible provider billing for services provided by a non-eligible provider or individual;
- Providing and billing for unnecessary services; and
- Accepting or offering kickbacks and bribery.

b. Members

- Loaning a VNS Health Health Plans identification card for use by another person;
- Altering the amount or date of service on a claim form or prescription receipt;
- Fabricating claims;
- "Doctor shopping" (seeing several providers to obtain frequent drug prescriptions) and excessive trips to the emergency room for narcotics; and

- Collusion with fraudulent providers.

c. Non-members

- Using a stolen VNS Health Health Plans card to obtain medical services or prescriptions; and
- Engaging in impermissible sales and marketing practices to steer potential members to or from VNS Health Health Plans.

d. VNS Health Health Plans Employees

- Creating claims;
- Delaying assignment of a provider to reduce costs;
- Failing to provide covered services to reduce costs;
- Engaging in impermissible sales and marketing practices, such as using unapproved promotional materials, falsifying eligibility information, enrolling individuals without their knowledge or offering inducements to members and providers to join; and
- Changing member or provider addresses to intercept payments.

9. Investigation Guidelines

A. The SIU conducts all FWA investigations in accordance with the Policies and Procedures set forth herein and the VNS Health Corporate Policy: Investigating Compliance Issues and Corrective Action Plans.

B. The SIU Director logs the investigation in the SIU Database, noting the date the report was received and establishes a case file.

C. In the case of FWA referrals from Grievance & Appeals (G&A), the G&A Department provides acknowledgment of receipt, and notice of referral to the SIU to the member or member representative.

D. The SIU researches the validity of the report and obtains all necessary supporting documentation for the case file. The research and document collection may include, but is not limited to:

- reviews of provider and member claims history,
- reviews of billing and/or payment history or patterns,
- reviews of prescribing/ordering history,
- reviews of medical records,
- on-site review or monitoring of a provider office,

- interviews with providers and/or members and
- review of provider and/or member contacts with VNS Health Health Plans.

E. At any point in an investigation, the SIU may seek assistance from internal and external experts such as Physicians, Pharmacists, Certified Coders and/or Attorneys. Before engaging an external expert to assist with the investigation, the Investigator will obtain approval from the Compliance Officer in accordance with VNS Health procurement standards.

F. The SIU will investigate all instances of FWA, unless the SIU believes that law enforcement or another regulatory agency should be engaged to handle the investigation (for example, when the FWA conduct involves bribery or stolen identity) in which case the appropriate referral is made upon the Chief Compliance Officer or VNS Health Health Plans Counsel consent.

G. Investigations will be commenced within three (3) business days following the assignment of a case to the Special Investigator due to receipt of a report of potential FWA.

H. The SIU promptly reviews identified issues to determine the validity and severity of every potential case. Such Investigations are commenced and prioritized based on the nature and potential severity of the issue, rather than by the order in which reports are received and issues are identified.

I. The SIU Director will make best efforts to update any investigation, if possible, every thirty (30) days of the receipt date. The SIU Director must close all employee and sales investigations according to Compliance standards. VNS Health Health Plans operational areas must refer investigations to SIU promptly and within reasonable time.

J. The SIU Director will request medical / hospital / pharmacy records (or other patient data) for three to six patients with claims from the previous year for review. The SIU Director will send one monthly follow-up request if the provider does not respond.

K. If the provider of the FWA claim does not forward the requested documentation, the SIU Director will request a refund for the undocumented claims. There will be one follow-up refund request with the final letter advising of a claim offset from future claims if the request is unanswered.

10. Medicare Reporting and Cooperation

A. If the SIU determines that potential fraud or misconduct related to the Medicare program has occurred, the SIU will forward the referral to the VNS Health Health Plans Counsel. Once approved by VNS Health Health Plans Counsel, the SIU will report the conduct to the Qlarant National Benefit Integrity Medicare Drug Integrity Contractor ("MEDIC") promptly, within seven days after the determination that a violation may have occurred.

B. The SIU Director reviews all allegations and determines within two weeks (14 calendar days) of receipt by the SIU, whether a case is initiated. If the allegation cannot be addressed by the SIU (e.g., provider/member collusion cases that require undercover and/or surveillance or allegations of kickbacks or bribery) then the case file will be sent to the VNS Health Health Plans Counsel for review. VNS Health Health Plans Counsel

will determine whether the allegations and supporting evidence support a referral to the appropriate outside regulatory agency. A case is opened in the SIU Database documenting the referral. The case is closed but any assistance required by MEDIC is quickly responded to by the SIU and is logged into the file. If MEDIC or OMIG returns the investigation the case will be reopened and handled accordingly.

11. MLTC and SelectHealth (HIV Special Needs Plan) FWA Reporting Requirements

A. VNS Health Health Plans has developed and submitted to DOH a Fraud, Waste and Abuse Prevention Plan as well as a designation of a SIU Director, reporting up to the Compliance Officer, as the officer with responsibility for carrying out the provisions of the Fraud, Waste and Abuse Prevention Plan.

B. The VNS Health Health Plans Compliance Department shall file an annual report with DOH no later the January 15 of each year, which shall describe VNS Health Health Plans's experience, performance and efficiency in implementing the Fraud, Waste and Abuse Prevention Plan and proposals for improving the Fraud, Waste and Abuse Prevention Plan. VNS Health Health Plans shall also report at least annually the number of FWA complaints made to VNS Health Health Plans each year, and shall include the following information regarding confirmed cases of FWA:

   i. The name of the individual or entity;

   ii. The source that identified the fraud or abuse;

   iii. The type of provider, entity or organization that allegedly committed the fraud or abuse;

   iv. A description of the fraud or abuse;

   v. The approximate range of dollars involved;

   vi. The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and

   vii. Other data/information as prescribed by DOH.

C. The VNS Health Health Plans Compliance Department will also file a quarterly report with DOH no later than fifteen (15) business days after the close of each quarter that includes information about FWA complaints that warranted investigation by VNS Health Health Plans. VNS Health Health Plans will use the DOH "Quarterly Reporting Template," or such other form as directed by DOH. The quarterly reports will include the following FWA information:

   i. Number of FWA complaints received during the quarter that warranted preliminary investigation;

   ii. A summary of the FWA issues raised during the quarter;

   iii. For each confirmed case of FWA identified through any source:

      a) The name of the individual or entity that committed the FWA;

b) The source that identified the FWA; and

c) The actions taken by the plan to address the FWA.

D. In addition, for each case of FWA confirmed by the SIU or law enforcement or other government regulatory agency, the VNS Health Health Plans Compliance Department shall report to the DOH on an ongoing basis.

E. The VNS Health Health Plans Compliance Department shall also, notify the New York State Office of the Medicaid Inspector General ("OMIG"), of any suspected misconduct committed by a member, provider or a contractor's employee. If the during the investigation the SIU determines that potential fraud or misconduct has occurred, the SIU forwards the referral to VNS Health Health Plans Counsel. If approved, the SIU reports the misconduct to the appropriate agency (MEDIC, DFS, OMIG, OIG or MFCU) within seven days after the determination that a violation may have occurred. The SIU will continue to work the active investigation unless instructed otherwise.

F. The SIU Director reviews all allegations and determines within two weeks (14 calendar days) of receipt by the SIU, whether a case is initiated. If the allegation cannot be addressed by the SIU (e.g., provider/member collusion cases that require undercover and/or surveillance or allegations of kickbacks or bribery) then OMIG or another Law Enforcement Agency will be notified, and the case referred. A case is opened in the SIU Database documenting the referral. The case is closed but any assistance required by OMIG is quickly responded to by the SIU and is logged into the file. If OMIG returns the investigation the case will be reopened and handled accordingly.

G. The annual reports submitted to DOH signed by the Compliance Officer.

H. The VNS Health Health Plans Compliance Department shall file an annual Managed Care Provider Investigative report no later the January 30 of each year, to the OMIG.

12. Cooperation with New York State and Other Government Investigations

A. In connection with investigations or inquiries from DOH, DFS, CMS, OIG, OMIG and/or the New York State Office of the Attorney General (including the New York Medicaid Fraud Control Unit (MFCU)) or other agency, VNS Health Health Plans will provide access to its personnel, subcontractors and their personnel, witnesses, and enrollees and permit the above-mentioned agencies to conduct private interviews of such persons.

B. VNS Health Health Plans will cooperate fully in making its personnel, subcontractors and their personnel available to the agencies for in person interviews, consultations, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

i. VNS Health Health Plans will provide to the agencies originals and/or copies of all records and information requested, in the form requested, and allow access to the VNS Health Health Plans's premises. All copies of records will be provided free of charge.

ii. VNS Health Health Plans will conduct case development and support activities for the NBI MEDIC and law enforcement relating to suspected, detected or reported cases of illegal drug activity.

13. Corrective Action

A. Corrective action will be taken as necessary to address the findings of any investigation, to ensure compliance with regulatory requirements going forward and/or to ensure that FWA does not recur. Corrective action may include:

i. The development and completion of a Corrective Action Plan in accordance with the VNS Health Corporate Policy: Investigating Compliance Issues and Corrective Action Plans and the VNS Health Health Plans Policy: Corrective Action Plans;

ii. A referral to criminal and/or civil law enforcement authorities having jurisdiction over such matter, or a report to state or federal agencies (see below);

iii. Recoupment and/or submission of any overpayments;

iv. Appropriate education or training, including education of FDRs and providers; and/or

v. Appropriate disciplinary action, including termination of FDR contract.

B. Overpayments to Providers:

i. VNS Health Health Plans complies with the requirements of New York Ins. Law § 3224-b in recovering overpayments made to its physician network.

ii. VNS Health Health Plans shall not attempt to recover payments more than twenty-four months after the original payment date, unless the recovery efforts are:

a) Based on a reasonable relief of fraud or other intentional misconduct;

b) Required by, or initiated at the request of, a self-insured plan; or

c) Required by a state or federal government program.

14. Training and Documentation

A. VNS Health Health Plans and its delegated FDRs, providers, vendor and others associated with VNS Health and VNS Health Health Plans's FDRs, where applicable, conduct annual compliance training programs for all personnel, which includes training in identifying and evaluating instances of suspected fraud, and abuse.

B. The SIU provides additional FWA training to VNS Health Health Plans employees, on an as needed basis, specific to job functions and departments.

C. VNS Health Health Plans maintains all documents relating to the activities of the SIU for at least ten years.

15. Responding to Compliance Issues

A. Prior to closure, the SIU Director alerts the Compliance Officer.

16. Self-reporting and Referrals

A. VNS Health Health Plans will voluntarily disclose matters that, in reasonable assessment, potentially violate federal or state criminal, civil, or administrative laws. The self-disclosure will follow CMS, NBI MEDIC, and OIG/OMIG Provider Self-Disclosure Protocol requirements.

B. The SIU refers suspected, detected or reported cases of illegal drug activity, or other illegal activity, to the NBI MEDIC and/or local law enforcement.

C. The SIU will otherwise self-report and disclose in accordance with the VNS Health Self-Reporting and Self-Disclosure Policy to Governmental Agencies.

REFERENCES:

VNS Health Code of Conduct;

VNS Health Compliance Program Structure and Guidelines;

VNS Health Corporate Policy: Investigating Compliance Issues;

VNS Health Corporate Policy: The Detection & Prevention of Fraud, Waste and Abuse and Applicable Federal and State Laws;

VNS Health Corporate Policy: Self-Reporting and Self-Disclosure Policy to Governmental Agencies;

VNS Health Corporate Policy: Reporting Non-Compliance and Fraud, Waste and Abuse;

VNS Health Corporate Policy: Non-Retaliation and Non-Intimidation;

VNS Health Corporate Policy: Compliance Hotline;

VNS Health Health Plans Fraud, Waste and Abuse Prevention Plan;

VNS Health Health Plans Policy: Corrective Action Plans;

N.Y. Comp. Codes R. & Regs. title. 10, § 98-1.21;

Centers for Medicare & Medicaid Services, Medicare Managed Care Manual, Chapter. 21; Medicare Prescription Drug Benefit Manual, Chapter 9;

New York State Department of Health, Managed Long Term Care Partial Capitation Contract.

APPROVAL/REVISION HISTORY

Reviewed:	08/2025
Revised:	08/2025
Approved:	09/2025
Originally Approved:	2010