

16: Compliance

16.1 Background

Unison operates a compliance program that applies to all Unison Health Plan companies. This organization-wide compliance program is administered by the Unison Compliance Officer. The program is documented in written policies and procedures and a formal compliance plan, which includes an employee Code of Ethics. Introductory compliance training is provided to all new hires in conjunction with updated training provided, as needed, on an annual basis.

The compliance program is publicized through periodic company-wide e-mails, posters posted in employee common areas, and live compliance training. Employees are advised regarding the obligations and methods to report compliance issues, including anonymous reporting methods and the disciplinary guidelines used for compliance violations. The Compliance Officer is available to receive compliance reports or inquiries in person, by telephone, mail or e-mail. Reports or inquiries can also be received anonymously via an Anonymous Compliance Hotline or an Anonymous On-Line Reporting Tool. The Unison Compliance Officer reports directly to a member of the Unison Health Plan Board of Directors on a regular basis and also compiles an annual report of compliance activities for the Unison Board of Directors.

The Compliance Officer works in conjunction with all Unison Health Plan senior management to ensure that Unison and its employees comply with all laws, regulations and agency standards governing the various government-funded managed care programs in which we participate. The Compliance Officer responds to inquiries as to governing law or regulations and investigates compliance reports about Unison's operations.

16.2 Fraud and Abuse Controls

Unison Health Plan employs a multi-faceted approach to identify, detect and prevent fraud and abuse in the government-funded programs that are our market focus. These actions include, but are not limited to claims edits, post-processing review of claims, provider profiling and credentialing, quality control and utilization management.

All network providers undergo a government program sanctions review as part of the credentialing process. The standard network participation agreement requires that providers immediately notify Unison if they are terminated, suspended or otherwise excluded from the Medicaid program. Additionally, if we discover that a participating provider has been so excluded, Unison will immediately terminate the provider's participation agreement. We also act to detect fraud and abuse through provider profiling, claims adjudication and audits and medical records review. Providers are reminded that, because Unison Health Plan focuses solely on the government-funded managed care market, payments from Unison are derived from government funds and that civil or criminal penalties may apply for fraud, program abuse or other misrepresentations. Access to records and cooperation with audits, both by Unison Health Plan and other government oversight agencies, is a mandatory element of network participation.

Unison also recognizes that fraud and abuse can be an internal problem. All our employees undergo a thorough background check before commencing work. Our Audit Department regularly conducts inquiries as to payroll records, expense reports, adjudicated claims and enrollment verifications to closely monitor and detect potential employee fraud and abuse.

Member waste or abuse is detected through the monitoring of special claims audits, member profiling/claims histories, physician or pharmacy complaints and enrollment verifications. Where permitted, Unison Health Plan will either disenroll or employ a lock-in program to help control members whose conduct demonstrates a pattern of fraud and abuse.

16.3 HIPAA

Unison Health Plan is proud of its success in implementing the required HIPAA standards. Unison is CLAREDI certified as to the administrative simplification standards for transactions and code sets. We are capable of interacting directly with providers through HIPAA-compliant EDI transactions. Unison also contracts with a clearinghouse which providers can use to submit and receive non-compliant EDI transactions. If you are interested in communicating with us via EDI, please contact the Provider Services Department.

The Unison Health Plan companies adopted 'affiliated entity' status for purposes of the HIPAA privacy standards. We use and disclose our members' protected health information (PHI) only for purposes of treatment, payment and health care operations. Copies of the notices that describe our privacy practices for each Unison managed care product can be accessed at www.unisonhealthplan.com or can be provided as a hard-copy upon request. The Unison ID card reminds our members that, by enrolling in Unison's managed care product, they agreed to our limited use of their PHI for appropriate purposes. Unison reminds providers that they are obligated, both by applicable law and the standard provider participation agreement, to obtain the consent of our member, who is their patient, as it relates to the use of PHI for any purposes other than those permitted by law. Providers are also required to timely inform Unison about any breach of the HIPAA privacy rules and cooperate with reasonable actions designed to remediate the adverse effects of such a breach.

Like all members of the health care industry, Unison Health Plan is aware of the significant HIPAA security challenges we all face. Unison is committed to adopting and updating its physical, electronic and administrative safeguards to protect our member's PHI. We encourage our network participating providers to adopt similar safeguards that are suitable to the associated risks and their individual environments to further secure PHI.

16.4 False Claims Acts

Unison Complies with Federal and State Law to Prevent and Detect Fraud, Waste, and Abuse in Government Health Care Programs

Unison Complies with Section 6032 of the federal Deficit Reduction Act of 2005 (DRA)

Unison is required to comply with Section 6032 of the DRA. Unison provides the following information in accordance with the DRA.

Federal False Claims Act

The False Claims Act (31 USC § 3279-33) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The Act establishes liability for any person who knowingly presents or causes to be presented a false claim to the U.S. government for payment.

The term “knowingly” is defined to mean that a person, with respect to information: has actual knowledge of the falsity of information in the claim; acts in deliberate ignorance of the truth or falsity of the information in a claim; or acts in reckless disregard of the truth or falsity of the information in a claim.

The Act does not require proof of a specific intent to defraud. Instead, people can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished, or otherwise causing a false claim to be submitted.

Penalties can be up to three times the value of the false claim, plus from \$5,500 to \$11,000 in fines, per claim.

Qui Tam “Whistle-blower” Provisions

To encourage individuals to come forward and report misconduct involving false claims, the Act includes a “qui tam” or whistle-blower provision. This provision essentially allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government. Individuals seeking whistle-blower status must meet several criteria to prevail as outlined below.

Original Source

The whistle-blower must be the “original source” of the information reported to the U.S. government. Specifically, the whistle-blower must have direct and independent knowledge of the false claims activities, must voluntarily provide this information to the government, and the matter disclosed cannot already be the subject of a federal investigation.

Rights of Parties to Qui Tam Actions

If the government determines that the lawsuit has merit and decides to join, the lawsuit will be directed by the U.S. Department of Justice. At this point, the government will be the “plaintiff,” or party suing. If the government decides not to intervene, the whistle-blower can continue with the lawsuit on his or her own.

Award to Qui Tam Whistle-blowers

If the lawsuit is successful (after being prosecuted by the government), the whistle-blower may receive an award ranging from 15 to 30 percent of the amount recovered by the government. The whistle-blower may also be entitled to reasonable expenses, including attorneys’ fees and costs for bringing the lawsuit.

No Retaliation Protection for Whistle-blowers

In addition to a financial award, the Act entitles whistle-blowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against a whistle-blower for filing an action under the Act or committing other acts, such as providing testimony of assisting in a False Claims Act action. Unison’s Team Members are protected from retaliation (i.e. discharge, demotion, suspension, threat, harassment, discrimination, or anything similar thereto), in the event any Team Member files a claim pursuant to the Act or otherwise makes a good faith report alleging fraud, waste or abuse in a federal health care program, including the Medicare and Medicaid programs, to Unison or the proper authorities, subject to the terms and conditions of Unison’s Compliance Plan.

State Laws

States where Unison does business have laws that contain civil or criminal penalties for false claims and statements that are in addition to the penalties provided in the Act. Certain states also have whistleblower protections similar to the Act. In Ohio the applicable laws are ORC Sections 5111.03, 5111.101, 2913.40, 124.34.1, 4113.52, and 3901.44. For more information on a specific state law, please contact the Unison Compliance Officer or Legal Department.

Applicability of Compliance Plan and Policies and Procedures to Team Members and Contracted Third Parties

Unison's Compliance Plan, and various departmental policies and procedures, help ensure Unison's compliance with the Act and the various state false claims laws, as well as to detect and prevent fraud, waste and abuse in federal health care programs. Team Members and the third parties that contract with Unison, including but not limited to health care providers and other entities to whom Unison has delegated obligations, must abide by Unison's Compliance Plan and the relevant policies and procedures in this regard. Please see the Compliance page link on the Unison internet website at www.unisonhealthplan.com for the most up to date version of the Unison Compliance Plan. For more information on this topic, please contact the Unison Compliance Officer or Legal Department.

Providers can learn more about Unison's compliance program or its HIPAA privacy and security practices by contacting the Provider Services Department at 1.800.600.9007.