



SECTION 6



FRAUD WASTE AND ABUSE

ETERNALHEALTH'S FRAUD, WASTE, AND ABUSE OBLIGATIONS



As a partner of the Centers for Medicare & Medicaid Services (CMS), eternalHealth is obligated to monitor for signs of fraud, waste, and abuse; and to ensure well-managed care through a payment integrity review both before and after payment is issued. eternalHealth uses software tools to identify providers and facilities whose billing practices match patterns associated with suspicious conduct.

The eternalHealth Fraud Waste and Abuse (FWA) Program is designed and administered consistent with applicable federal laws, regulations, CMS requirements, and authoritative compliance guidance, including 42 C.F.R. Parts 422 and 423 as applicable, CMS Medicare Advantage and Part D compliance program requirements, the Federal False Claims Act, Anti-Kickback Statute, Civil Monetary Penalties Law, criminal health care fraud statutes, exclusion authorities, HIPAA, CMS Center for Program Integrity guidance, HHS-OIG compliance guidance, applicable MEDIC requirements, and applicable federal and state insurance and fraud reporting requirements.

eternalHealth FWA program requirements apply to Medicare-related activities conducted by or on behalf of the Plan, including employees, officers, governing body members, providers and suppliers, pharmacies where applicable, members and beneficiaries, brokers and agents, FDRs, delegated entities, subcontractors, vendors, consultants, and other individuals or entities involved in the administration or delivery of Medicare benefits.

The eternalHealth FWA Program is an integral component of its Medicare Compliance Program and is designed to protect Medicare beneficiaries, the Medicare Trust Funds, the Plan, providers, and other stakeholders from inappropriate, fraudulent, abusive, wasteful, or otherwise improper activities.

eternalHealth maintains controls reasonably designed to:

- Prevent FWA before it occurs;
- Detect suspected FWA and improper payments;
- Provide accessible mechanisms for reporting concerns;
- Conduct timely and objective investigations;
- Coordinate Payment Integrity and investigation activities;
- Identify and recover inappropriate payments;
- Take appropriate corrective and disciplinary action;
- Refer potential FWA to governmental authorities when appropriate;
- Monitor FDRs;
- Identify systemic vulnerabilities and emerging schemes;
- Protect Medicare beneficiaries from harm;
- Monitor the effectiveness of FWA controls;
- Maintain documentation demonstrating operation of an effective FWA Program.

FWA Risk Assessment

eternalHealth conducts a periodic FWA risk assessment to identify areas presenting heightened exposure to fraud, waste, abuse, improper payment, beneficiary harm, or Medicare

program noncompliance including:

- Financial exposure;
- Claims volume;
- Prior investigations;
- Provider billing anomalies;
- Regulatory changes;
- CMS audit findings;
- OIG reports;
- Government enforcement activity;
- Complaints;
- Payment Integrity findings;
- FDR performance;
- New benefits/vendors/markets;
- Changes in reimbursement or utilization;
- Emerging fraud schemes;
- Internal audit or monitoring findings.

Training & Education

eternalHealth maintains and has available upon request FWA education and training consistent with applicable CMS requirements including:

- Definitions and examples of FWA;
- Reporting mechanisms and non-retaliation;
- False Claims Act and Anti-Kickback requirements;
- Conflicts of interest and exclusions;
- Medicare-specific risk areas;
- Responsibilities of employees and FDRs;
- Potential consequences of misconduct;
- How to identify and report suspected FWA.

Exclusion and Sanction Screening & Monitoring

eternalHealth has processes to ensure we do not employ or contract with individuals or entities that are excluded or otherwise prohibited from participating in federal health care programs. Screening occurs at regular intervals, and potential matches are promptly investigated. Any confirmed excluded parties are addressed.

PAYMENT INTEGRITY PROGRAM



The eternalHealth Payment Integrity Program is designed to prevent, detect, investigate, correct, and recover inappropriate, inaccurate, unsupported, duplicative, abusive, fraudulent, or otherwise improper payments while promoting accurate reimbursement of medically necessary and covered services furnished to eternalHealth members.

Payment Integrity activities are conducted using a risk-based approach and are coordinated with Compliance, Payment Integrity, Claims Operations, Utilization Management, Network, and applicable First Tier, Downstream, and Related Entities (FDRs).

The Payment Integrity Program seeks to:

- Prevent improper payments before claims are paid;
- Detect potential overpayments and underpayments;
- Identify billing patterns indicative of potential fraud, waste, abuse, error, or systemic payment vulnerabilities;
- Validate that services billed were rendered, medically necessary when applicable, appropriately documented, correctly coded, and reimbursed in accordance with applicable requirements;
- Recover identified overpayments;
- Identify and remediate systemic payment vulnerabilities;
- Refer suspected FWA to the Compliance Department for investigation;
- Support required reporting and referrals to CMS, law enforcement, or other governmental entities, as appropriate;
- Measure and report the effectiveness of Payment Integrity activities.

eternalHealth employs prospective, concurrent, pre-payment, and post-payment controls, as appropriate, based on identified risks. Payment integrity activities may include, but are not limited to the following:

Pre-Payment Controls

eternalHealth pre-payment claim payment controls may include:

- Claims edited and coding validation;
- Duplicate claim detection;
- National Correct Coding Initiative (NCCI) and other applicable coding edits;
- Procedure-to-procedure and medically unlikely edit review, as applicable;
- Modifier validation;
- Diagnosis and procedure code validation;
- Place-of-service validation;
- Provider eligibility and enrollment validation;
- Member eligibility and benefit validation;
- Prior authorization and referral validation, where applicable;
- Bundling and unbundling review;
- Global surgery and incidental procedure review;
- Evaluation and management coding review;
- Inpatient and outpatient coding validation;
- Diagnosis Related Group (DRG) validation;
- Coordination of Benefits (COB) and Medicare Secondary Payer (MSP) controls;
- Frequency and until limitations;
- Medical necessity review when permitted and applicable;
- Detection of billing for excluded, non-covered, or otherwise non-payable services;
- Identification of claims exhibiting characteristics associated with known or emerging FWA schemes.

Claims identified through pre-payment controls may be suspended, or pended for additional review with applicable law, regulation, contract requirements and eternalHealth policies.

Post Payment Review

eternalHealth Post payment review activities may include:

- Retrospective data analysis;
- Provider-specific and service-specific audits;
- Medical record reviews;
- Coding and documentation validation;
- DRG and inpatient coding audits;
- High dollar claims reviews;
- Duplicate payment analysis;
- Modifier and procedure-code audits;
- Place-of-service reviews;
- Provider billing pattern analysis;
- Overutilization and aberrant utilization analysis;
- COB/MSP reviews;
- Contract configuration and reimbursement audits;
- Trend analysis;
- Targeted audits based on identified vulnerabilities;
- Validation of services associated with emerging fraud schemes or CMS program integrity concerns.

eternalHealth may request medical records, itemized bills, invoices, orders, treatment records, proof of service, or other documentation necessary to substantiate payment, subject to applicable requirements.

Supplemental Benefits and SSBCI

eternalHealth supplemental benefit review activities may include:

- Phantom services;
- Duplicate billing;
- Ineligible utilization;
- Vendor manipulation;
- Member identity misuse;
- Unsupported services;
- Improper inducements;
- Benefit card misuse.

Part D FWA

eternalHealth Part D benefit review activities may include:

- Prescription forgery;
- Drug diversion;
- Pharmacy billing for prescriptions not dispensed;
- Short fills billed as full fills;
- Inappropriate refill practices;
- Prescriber identity misuse;
- Pharmacy/member collusion;
- Kickbacks;
- Controlled-substance or compound-drug schemes

First Tier, Downstream and Related Entity (FDR) FWA Oversight

eternalHealth FDR FWA Program oversight activities may include:

- Contractual FWA requirements;
- Compliance attestations;
- Training oversight;
- Exclusion screening;
- Monitoring and auditing;
- Investigation referral /reporting requirements;
- Data validation;
- Corrective action plans;
- Subcontractor oversight;
- Contractual remedies where appropriate.

Data Analytics and Surveillance

eternalHealth utilizes data analytics as a core component of its Payment Integrity and FWA detection strategy. Data sources including claims, encounters, authorizations, provider, member, financial, and other available sources are analyzed to identify anomalous or potentially inappropriate billing activity including:

Analytical findings are treated as indicators requiring appropriate validation and are not, standing alone, considered proof that fraud or abuse has occurred.

Identification of Overpayments

Once a claim has been identified as overpaid, eternalHealth may send a written notice of overpayment within the applicable time frame. eternalHealth follows state regulations, provider contract requirements and CMS provisions when processing overpayments and recoupments.

Escalation Processes

Payment Integrity matters are referred for investigation when information obtained during claims review, auditing, data analysis, provider review, or recovery activity presents a reasonable indication of potential fraud, waste, abuse, intentional misrepresentation, or other suspicious conduct. Examples include:

- Billing for services not rendered;
- Falsification or alteration of medical records;
- Billing for medically unnecessary services as part of a potentially abusive or fraudulent pattern;
- Upcoding or unbundling demonstrating potentially intentional or systematic conduct;
- Identity theft or beneficiary identification misuse;
- Phantom billing;
- Kickback or referral concerns;
- Provider credential or enrollment misrepresentation;
- Repeated billing after education or corrective intervention;
- Suspected member-provider collusion;
- Other patterns suggesting intentional or reckless misconduct.

EternalHealth preserves relevant documentation to avoid compromising an investigation. When appropriate, the eternalHealth Chief Compliance Officer will determine whether external reporting or referral is required or appropriate in accordance with eternalHealth's FWA investigation and reporting procedures.

Corrective Action and Root Cause Analysis

Payment Integrity findings are evaluated not only for individual claim recovery but also for underlying systemic causes including:

- Claims system configuration;
- Incorrect fee schedules;
- Contract configuration;
- Inadequate claims edits;
- Provider misunderstanding;
- Internal processing errors;
- Delegated entity performance;
- Inadequate authorization controls;
- Coding vulnerabilities;
- Policy or procedure deficiencies;
- Intentional or potentially fraudulent conduct.

Corrective actions may include claims edit changes, provider education, system configuration changes, process redesign, staff training, contract clarification, increased monitoring, targeted audits, FDR corrective action plans, provider payment restrictions or other contractual remedies, SIU referral, or disciplinary/contractual action. Corrective actions are tracked through completion and, where warranted, tested for effectiveness.

Provider Education

Where inappropriate billing appears to result from error, misunderstanding, or inadequate knowledge rather than suspected fraud or abuse, eternalHealth Network may provide targeted provider education addressing coding, documentation, billing, modifier use, medical necessity documentation, claims submission, authorization, and reimbursement policies. Repeated noncompliance following education may result in additional monitoring, pre-payment review, post-payment audit, corrective action, contractual remedies, or investigation referral.

Coordination with Compliance and Enterprise Risk Management

Payment Integrity findings are incorporated into eternalHealth's broader compliance risk assessment, FWA risk assessment, monitoring and auditing strategy, and Enterprise Risk Management activities, as appropriate, including:

- Modification of the annual FWA or compliance risk assessment;
- Addition of monitoring or auditing activities;
- Implementation of new pre-payment controls;
- Expansion of post-payment review;
- Provider or FDR corrective action;
- FWA investigation;
- Compliance Committee escalation;
- Governing body reporting.

This feedback loop is intended to ensure that Payment Integrity activities function as both a financial control and a proactive component of eternalHealth's overall Medicare program integrity framework.

Record Retention and Audit Readiness

eternalHealth maintains records sufficient to demonstrate its Payment Integrity activities and outcomes in accordance with applicable Medicare record-retention requirements and plan policies including, but not limited to:

- Audit workpapers;
- Claims reviewed;
- Medical records;
- Data analytics;
- Provider correspondence;
- Overpayment calculations;
- Recovery documentation;
- FWA investigation referrals;
- Corrective action plans;
- Claims-edit implementation records;
- Committee reporting;
- Vendor oversight documentation;
- Evidence that demonstrates corrective-action effectiveness.

Documentation is maintained in a manner that permits eternalHealth to demonstrate the operation and effectiveness of its Payment Integrity and FWA controls during CMS audits, regulatory examinations, internal audits, and other oversight activities.

Regulatory and Program Integrity Framework

- 42 C.F.R. § 422.503(b)(4)(vi), Medicare Advantage compliance program requirements;
- 42 C.F.R. Part 422 and other applicable Medicare Advantage requirements;
- CMS Medicare Advantage and Part D Compliance Program Policy and Guidance;
- CMS Center for Program Integrity guidance and program integrity initiatives;
- CMS program audit protocols and related HPMS guidance;
- HHS-OIG compliance and program integrity guidance;
- Applicable federal health care fraud and abuse laws;
- Applicable federal and state overpayment, claims payment, provider notice, recovery, and record-retention requirements.

eternalHealth periodically reviews regulatory guidance, CMS program integrity priorities, government enforcement activity, audit findings, and emerging FWA schemes and updates Payment Integrity activities as necessary to maintain an effective, risk-responsive program.

GOVERNANCE AND OVERSIGHT



Compliance Program and Payment Integrity activities are subject to oversight through eternalHealth's Compliance and FWA governance Structure. eternalHealth ensures that payment-related findings presenting potential FWA concerns are appropriately evaluated, investigated, documented, escalated, and resolved.

Material Payment Integrity risks, trends, investigations, recoveries, corrective actions, and systemic vulnerabilities may be reported to the Compliance Committee and Governing Body.

REPORTING SUSPECTED FRAUD, WASTE, AND ABUSE



Compliance concerns can be reported without fear of retribution or retaliation. Reports may be made orally, by telephone, in person, in writing, or by email. Reports may be made anonymously and will be held in the strictest of confidence except as may be necessary to complete an investigation or required enforcement action. eternalHealth investigates all reports and takes such remedial and/or disciplinary action deemed appropriate upon completion of an investigation.

eternalHealth's confidential compliance & ethics hotline is accessible 24/7 by calling 1-833-823-8603 or eternalhealth.navexone.com. The eternalHealth reporting hotline is administered by an independent third-party vendor. All allegations received are thoroughly investigated by eternalHealth.

Non-Retaliation

eternalHealth does not tolerate retaliation for reports of possible violations made in good faith, using any of the procedures described. Any reports of such retaliation or retribution will be investigated thoroughly and appropriate discipline will be imposed.

Abuse	Abuse includes practices inconsistent with sound fiscal, business, or medical practices that may result in unnecessary Medicare costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or medically unnecessary services.
FDR	First Tier, Downstream and Related entities.
Fraud	Fraud generally involves knowingly and willfully executing, or attempting to execute, a scheme to defraud a health care benefit program or obtaining money or property through false or fraudulent pretenses, representations, or promises. For Plan purposes, potential fraud generally involves intentional deception, misrepresentation, concealment, or other conduct undertaken for an unauthorized benefit.
Payment Integrity	Payment Integrity is the collection of prospective, pre-payment, post-payment, analytical, auditing, and recovery activities designed to ensure claims are paid accurately and appropriately.
Potential FWA	Potential FWA means facts, circumstances, allegations, data patterns, or other information reasonably suggesting that fraud, waste, or abuse may have occurred and warrant additional review. An allegation or data anomaly does not constitute a finding of fraud.
Special Investigation Unit (SIU) Function	The SIU is the function responsible for investigating allegations and indicators of potential FWA and coordinating investigative activities and referrals.
Waste	Waste generally involves overutilization of services or other practices that directly or indirectly result in unnecessary Medicare costs. Waste may result from inefficient practices, poor controls, inappropriate utilization, or errors and does not necessarily involve criminal intent.