Medicare Fraud, Waste and Abuse

2021

Please review the notes section of each slide for additional information and details.

As a trusted Tivity Health colleague or contractor, you play an important role in upholding our reputation and the trust that our stakeholders place in us. Learning about Medicare Fraud, Waste and Abuse and your responsibilities to prevent and report it helps us preserve that trust.

Compliance at Tivity Health

- Tivity Health follows the Centers for Medicare & Medicaid Services (CMS) training requirements for Fraud, Waste and Abuse in support of our relationships with Health Plan clients.
- CMS requires Health Plans to have a compliance program in place.
- Health Plans, in turn, must require certain service providers to have similar programs and provide similar training.

Tivity Health follows the CMS training requirements for Fraud, Waste and Abuse in support of our relationships with our Health Plan clients.

Many Health Plans provide services paid for by Medicare dollars and have contracts for such services directly with CMS. CMS requires that these Health Plans have a compliance program in place that includes training on measures to mitigate Fraud, Waste and Abuse. CMS also requires that these Health Plans require certain service providers provide similar training.

Therefore, because we deliver services to certain Medicare beneficiaries through our programs, we are requested by our Health Plans to provide our colleagues with Fraud, Waste and Abuse training.

Medicare is…

- Federal health insurance program for:
  - People who are age 65 and over
  - Disabled Americans
- Medicare includes:
  - Part A - Hospital insurance
  - Part B - Medical insurance
  - Part D - Prescription drug coverage

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Medicare is a federal health insurance program for Americans age 65 and over and for those who are disabled.

The program is administered by the Centers for Medicare and Medicaid Services ("CMS"). CMS contracts with private health insurance companies to manage benefits payments and the flow of money between the government and providers.

The different parts of Medicare help cover specific services: Hospital Insurance, Medical Insurance, and Prescription Drug Coverage.

Fraud, Waste and Abuse Defined

- Fraud
  - Making false statements or representations to obtain some benefit
  - Requires intent and knowledge that actions are wrong
- Waste and Abuse
  - Practices by providers, physicians or suppliers that are inconsistent with the accepted sound medical, business or fiscal standards
  - May occur without the same level of knowledge as fraud

There is a distinction between Medicare *Fraud* and Medicare *Waste* and *Abuse*.

Medicare *Fraud* means making false statements or false representations to obtain some benefit, money or property owned by, or under the custody and control of, the Medicare program. *Fraud* requires the person to have intent to obtain the money or property improperly, and to have knowledge that his or her actions are wrong.

Waste and A*buse* describe practices by providers, physicians or suppliers that are inconsistent with accepted sound medical, business or fiscal standards and that result in unnecessary costs to the Medicare program. *Waste* and *Abuse* may occur without the same level of knowledge that is required for *Fraud*.

Regardless of the differences between Fraud, Waste and Abuse, any of these actions can expose entities to criminal and civil liability. Therefore, any concerns regarding Fraud, Waste and Abuse should be reported to the Compliance or Legal Departments.

Provider Fraud

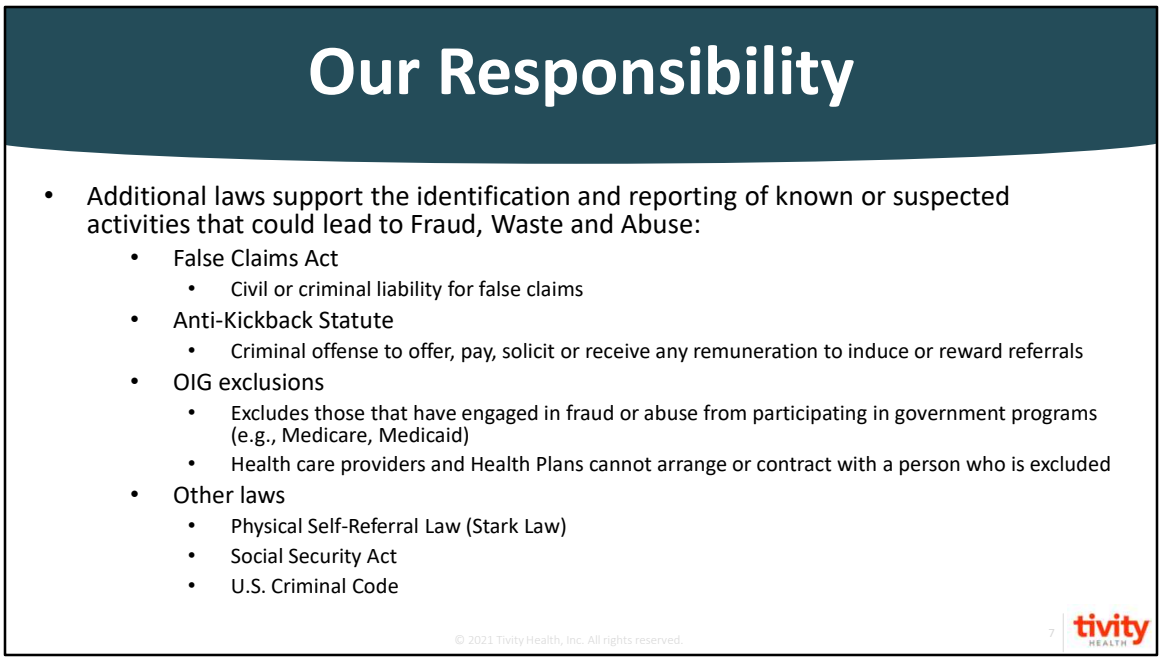
- Knowingly billing for services not furnished and/or billing for supplies not provided
- Knowingly altering claims forms and/or receipts
- Accepting kickbacks for program referrals
- Upcoding or billing for a service not rendered

Fraud can be perpetrated by providers, suppliers or beneficiaries.

- Provider fraud may include:
  - Knowingly billing for services that were not furnished and/or billing for supplies not provided;
  - Knowingly altering claims forms and/or receipts to receive a higher payment amount;
  - Accepting kickbacks for program referrals; and
  - Upcoding or billing for a service that was not rendered because it generates more income.

Beneficiary Fraud

- Examples of fraud may include:
  - Selling a medical identity so an ineligible individual can receive coverage
  - Falsifying information to receive coverage



Now that you know more about Fraud, Waste and Abuse and our practice as a company, let's talk about our responsibility. Our role is to report any known or suspected incidents of Fraud, Waste and Abuse.

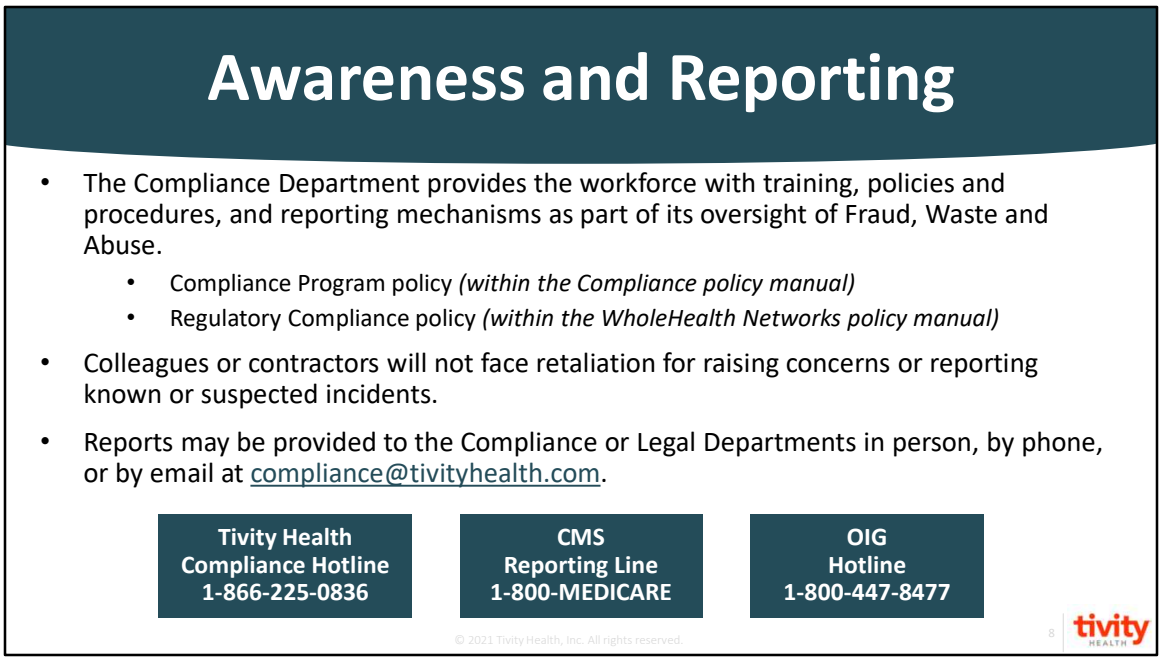
Let's first talk about what's covered…the False Claims Act imposes civil or criminal liability on any person or organization that submits a claim to the federal government or causes a claim to be submitted to the government that is known (or should be known) to be false.

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.

The Office of Inspector General of the Department of Health and Human Services ("OIG") has the authority to exclude individuals and entities that have engaged in fraud or abuse from participation in Medicare, Medicaid, and other federal healthcare programs. No Medicare or Medicaid payment may be made for any item or service furnished, ordered or prescribed by an individual or entity excluded by the OIG. Further, a health care provider or Health Plan that arranges or contracts with a person

that the provider or plan knows or should know is excluded by the OIG may be subject to penalties if the excluded person provides items or services paid by Medicare, Medicaid or other federal healthcare programs.

Other laws related to preventing fraud and abuse include Physician Self-Referral Law (also known as the Stark Law), the Social Security Act, and the U.S. Criminal Code.



Tivity Health's Compliance Department provides the workforce with training, policies and procedures, and reporting mechanisms as part of its oversight of Fraud, Waste and Abuse.

As a Tivity Health colleague or contractor, you are required to report known or suspected Medicare Fraud, Waste, and Abuse to the Compliance or Legal Departments or through Tivity Health's Compliance Hotline AND to cooperate with any fraud-related investigations. Colleagues or contractors will not face retaliation for reporting suspected fraud or providing information for an investigation.

You also have the option to report to the CMS Reporting Line or the OIG Hotline.

Thank You

Attestation

NOTE: This will be in Impact, not in the training module itself.

I acknowledge that:

- I am aware of my responsibility to promptly report any known or suspected Fraud, Waste or Abuse to the Compliance or Legal Departments.
- I will contact the Compliance Department (compliance@tivityhealth.com) with any questions associated with this training module.
- I agree to abide by Tivity Health's policies and procedures and all topics discussed within this training.

Yes

No