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ANTI-FRAUD PLAN

INTRODUCTION

We recognize the importance of preventing, detecting and investigating fraud, abuse and waste, and are committed to protecting and preserving the integrity and availability of health care resources for our recipients, clients and business partners by maintaining a comprehensive program to combat fraud in the health care industry.

These responsibilities are delegated to our fraud and abuse department, whose mission is to combat fraud, abuse and misrepresentation against our various commercial plans and to seek to ensure the integrity of publicly funded programs.

OBJECTIVES

Anti-Fraud Program Goals

- Effectively implement written policies and procedures
- Provide appropriate training to improve the knowledge and effectiveness of the Anti-Fraud Program personnel
- Ensure an effective Fraud Awareness Program for all associates
- Maintain HIPAA compliance
- Track and report investigation activities and outcomes
- Cooperate with local, state, federal, administrative and law enforcement agencies
- Support our company's ethics and compliance

The Anti-Fraud Program consists of:

1. Reporting structure
2. Reporting fraud, abuse and waste
3. Methods of detection
4. Investigation procedures
5. Written policies and procedures
6. Fraud and abuse training
7. Ethics
8. False claims act
9. HIPAA (Health Insurance Portability and Accountability Act)
10. Record retention

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REPORTING STRUCTURE

The fraud and abuse department is under the direction of the staff vice president of Financial Operations, who has the authority to carry out the provisions of the Anti-Fraud Plan.

Responsible Individuals for Investigating and Reporting Possible Acts of Fraud, Abuse and Waste

The Fraud and Abuse department (the "F&A department") is staffed with employees dedicated to preventing, detecting and investigating fraud, waste and abuse. The professional experiences among the F&A department associates vary and are diverse, including claims, provider network, nursing, pharmacy and fraud investigations. The F&A department consists of three distinct units: (1) the Special Investigations Unit ("SIU"), which comprises investigators, many of whom have law enforcement experience or significant experience in the health care industry; (2) the Clinical Investigations Unit ("CIU"), which comprises medical professionals, including doctors and nurses who have clinical and coding expertise; and (3) the Data Analysis Team, which comprises individuals with information technology or other computer-related backgrounds.

An SIU director manages each region (West, Central, and East). The company's CIU is located primarily in Camarillo, Calif., and is managed by the director over the West region. A director of analytics manages the data analyst team.

The manager of the SIU is accountable for developing, overseeing and implementing the Anti-Fraud Plan. The manager is responsible for providing the overall strategic direction for the unit and leading the team of investigators and auditors. The manager assists in identifying new fraud schemes and directs activities of all investigators.

Investigators are responsible for investigating assigned cases to detect fraudulent, abusive or wasteful activities/practices and recover funds paid on fraudulent claims. They act as members on investigative teams, perform tasks assigned to contribute to the overall case development and effectively collaborate with law enforcement resources.

REPORTING FRAUD, ABUSE & WASTE

To maintain the effectiveness of the Anti-Fraud Plan, we use a comprehensive approach to report all fraud, abuse and waste allegations.

Referrals to SIU

Company personnel, recipients, health care providers, vendors, subcontractors and other external entities refer allegations to the SIU.

Methods:

- Our fraud hot line is available for confidential and/or anonymous reporting of allegations of fraud, abuse and waste.

- The Fraud Referral Form is made available to company personnel and providers.

- Recipients and providers may also use the Customer Service Center to report fraud involving the state-sponsored business programs.

Referral Requirements

- Name of person reporting fraud (optional)
- Name, address, license or insurance ID of subject
- Nature of complaint
- Date of incident(s)
- Supporting documentation (optional)

Regulatory Reporting

The SIU will report as appropriate to regulatory, state and federal law enforcement and prosecution agencies, and appropriate medical boards on fraudulent activities as identified through the unit's investigations.

The report and referral shall include:

- Allegation
- Statutes or regulations violated
- Results of the investigation
- Copies of program rules and regulations violated for the time period in question
- Estimated overpayment identified
- Summary of interviews conducted
- Encounter data submitted by the provider for the time period in question
- All supporting documentation obtained as the result of the investigation.

The SIU will submit monthly report investigative activities summaries and reports as company management.

The report shall include:

- Internal monitoring and auditing activities
- Review of fraud and abuse activities
- Corrective action plans
- Outcomes

DETECTION OF FRAUD, ABUSE & WASTE

Data Analysis

Data analysis is essential in determining the existence of aberrancies or pattern in claims. Data analysis is a tool to compare various claims and other related information to identify potential errors, identify areas of risk and establish a baseline to recognize trends.

The SIU uses monitoring tools and controls to detect fraud, abuse and waste such as:

- Random payment reviews

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- Compliance audits
- Monitoring of new fraud schemes
- Detailed claims reports
- Trending and analysis reports to identify outliers and under- or overutilization patterns
- Facility site review information
- Credentialing information
- Membership information
- Licensing information
- Medical record review
- On-site reviews
- Field staff information – community resource center
- Information from our Utilization, Quality and Care Management departments
- Public information databases (for example, Accurint or the Internet)
- System edits

The SIU monitors issues such as:

- Billing for services or goods not rendered
- Billing of services under another subscriber ID
- Billing under another provider's license number
- Billing for medically unnecessary tests
- Unbundling
- Misrepresentation of diagnoses or services
- Upcoding
- Double billing
- Soliciting, offering or receiving kickbacks or bribes
- "Ping-ponging" of patients (referral of patients to other providers within the same medical group so the providers may benefit financially)
- Billing professional services performed by untrained personnel
- Billing for more complex surgical procedures than performed
- Split billing over a period of days (separate billings for services rendered on the same day, billed on different days, with some charges being duplicated on each billing)
- Altered claim forms
- Treatment(s) and/or medication(s) prescribed by more than one provider that appears to be duplicative, excessive or contraindicated
- Recipients using more than one physician to obtain similar treatments and /or medications
- High volume of emergency room visits with a non-emergent diagnosis
- Using multiple pharmacies to obtain drugs from the same therapeutic class
- Report of recipient forging prescription
- Report of recipient loaning a card to another individual to obtain Medicaid reimbursed services

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The Fraud and Abuse department uses several computer-based applications to help detect and prevent potential fraud. The primary application is an on-line query application that maintains multiple combinations of professional, institutional, dental and pharmacy claims. This application allows investigators to work with 36 months of paid claims data at their desktops, running various queries to uncover aberrant billing or treatment patterns. The system creates an electronic environment in which information is readily available and shared by all authorized users from the convenience of their desktops, without the need for programming support and special computer runs. The department also uses public records databases and industrywide data accesses.

The data analysis team is expert at obtaining data across the entire company. It is responsible for data analysis to find outliers and potential patterns of abuse, as well as to investigate exposure to alleged conduct across the company. It works closely with the SIU and CIU.

INVESTIGATING FRAUD, ABUSE & WASTE

The SIU investigator is responsible for conducting a thorough investigation of suspected fraud, abuse and waste. Procedures and job aides are used to provide guidance in conducting an investigation and ensure accurate reporting.

Data Management

The F&A department uses both provider and member fraud and abuse databases to track the investigation, house documentation and maintain regulatory notification The databases are also used maintain a log of all incidences of suspected fraud, abuse and waste. The log shall contain as appropriate:

- Subject of the complaint
- Referral source
- Allegation
- Allegation/referral date
- Recipient or provider's unique identifying number
- Status of the investigation

Investigation

An investigation may consist of:

- Review to determine any previous allegations
- Determining if the provider has received any educational training pertaining to the allegation
- Comparing allegations to program policies and procedures
- Review of licensing and credentialing information
- Review of grievance and appeals information
- Random sampling*
- Review of medical records
- Review of up to three years of medical claims detail reports
- Review of up to three years of pharmacy claims detail reports
- Review by medical director
- Review by legal advisor
- Documentation
- Determining type/s of corrective actions required

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Three years of pharmacy claim data is reviewed for suspected recipients to determine possible abuse of controlled or non-controlled medications by either the member or the provider.

Three years of medical claims are reviewed to determine if there are any suspicious indicators and to determine if the diagnosis is appropriate for any medications prescribed.

Corrective Actions include:
The method and/or resources used for corrective action depend on the scope and severity of the identified issue.

Provider Letter
Upon review by the director of the SIU (and, in cases seeking reimbursement of greater than $75,000, the staff vice president), certified letters sent to providers document the findings and the need for improvement with response requested. The letter may include education and/or request for recoveries, in accordance with state statutes and regulations. Further action is based on the provider's response or lack thereof.

Medical Record Audit
Medical records may be reviewed to substantiate allegations or validate claims submission.

Special Claims Review
When billing issues are egregious or the provider fails to comply despite intervention, the provider may be placed on special claims review (SCR) for further monitoring and evaluation. SCR uses system edits to prevent automatic payment of claims and requires a medical reviewer evaluation.

Recoveries
Recoveries are sought through either direct reimbursement by the provider to the SIU, or, if in accord with a contractual relationship between us and the provider, through a recovery process as described in the contract.

Termination
Failure to comply with program policy and procedures or any violation of the contract could result in termination.

ADVISERS

The SIU is supported by medical and legal professionals who provide guidance on investigations or audits.

- The medical directors provide medical oversight, clinical guidance and expertise, and review of medical records.
- The Legal department provides legal oversight, responses to legal questions and interpretation of legislation

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REQUEST FOR INVESTIGATIONS ASSISTANCE

Federal, state and local law enforcement agencies may seek information to further their investigations or prosecutions of those alleged to have committed health care fraud. The SIU cooperates with and promptly responds to all fraud and abuse investigation efforts by regulatory, state and federal agencies, and prosecution and law enforcement agencies.

Agencies tasked by the federal and state government to investigate all acts of provider fraud are considered HIPA.A exempt Health Care Oversight Agencies, as defined in 45 CFR 164.501.

TRAINING

Annually, SIU provides training to company personnel on fraud, abuse and waste. New associates receive training within 90 days of employment.

An online training program educates claims processors, customer service representatives, medical review personnel and other company associates to identify patterns and trends indicating potential fraud and abuse. *The training is specific to the area of responsibility or staff receiving the training, and provides examples of fraud and abuse.*

The term "red flags" is used to identify actions that may indicate the potential for fraud.

"Red flags" may include the following:

- Pressure to adjudicate or process claims quickly or demanding same-day payment
- Threats of legal action for delay in making payments
- Frequent telephone inquiries on claims status
- Consecutive invoice numbers
- Altered or hand written claim forms
- Charges submitted for payment with no supporting documentation, such as X-rays or lab results
- An individual provider using a post office box as a return address
- Unusual charges for a service
- Unassigned bills that are normally assigned, such as large hospital or surgical bills
- Services not consistent with diagnosis
- Services provided outside the scope of the provider's practice
- Family members getting the same surgery
- High volume of foreign claims
- Incorrectly spelled medical terms

- Excessive number of services per day
- Routine services billed for a Sunday or holiday
- Delayed claim submission
- Excessive drug purchases or use of multiple pharmacies

The online training program also provides education on how to report fraud, abuse and waste, and the False Claims Act.

SIU Associates

The F&A department staff undergoes additional formal training provided by professional organizations such as those sponsored by:

- National Health Care Anti-Fraud Association
- Association of Certified Fraud Examiner
- Blue Cross and Blue Shield Association

The SIU is part of a corporate membership of the National Health Care Anti-Fraud Association (NHCAA) and has access to the NHCAA Special Investigations Resource and Information System as a resource for referrals and investigations.

Providers & Recipients

Public awareness is a vital part of any effective fraud prevention program. Education is provided to recipients and providers, outlining their responsibilities, the definition and common examples of fraud and abuse, and how to report it.

Methods of educating include:

- Newsletters
- Pamphlets
- Bulletins
- Provider operations manuals
- Provider training

FALSE CLAIMS ACT

SIU is committed to complying with all applicable federal and state laws including the Federal False Claim Act (FCA).

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The FCA is a federal law that provides the federal government with the means to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages, or loss, to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam or "whistleblower" provisions. A "whistleblower" is an individual who reports in good faith an act of fraud, waste and abuse to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

COMPLIANCE AND ETHICS

Pursuant to corporate policy, associates have an obligation to report any known or suspected violations of the Standards of Ethical Business Conduct, policies and procedures or laws and regulations. The Ethics and Compliance Department provides various channels to report plan violations. SIU is committed to providing its associates a work environment that is free from retaliation and retribution for reporting actual or suspected ethical or compliance concerns. SIU is committed to comply with all applicable federal and state standards and regulations.

HIPAA

SIU associates have a responsibility to keep protected health information confidential in accordance with applicable federal and state laws. The SIU will maintain the confidentiality of any recipient information relevant to an investigation pursuant to our HIPAA privacy guidelines and policies. All files are maintained in locked filing cabinets within the department. All documents with protected health information, or case related documentation, are placed in a locked container before disposal. Additionally, the SIU protects the confidentiality of all investigations to prevent unauthorized access to and inadvertent observation of sensitive information.