

**COMMUNITY FIRST HEALTH PLANS
PLAN TO PREVENT
WASTE, ABUSE AND FRAUD**

September 1, 2009 through August 31, 2010

CONTENTS

| Title | Description | Page |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------|
| Introduction | Scope of document | 4 |
| Corporate Statement | Definition of mission | 5 |
| Section (1) | Procedures for detecting possible acts of waste, abuse or fraud by providers. | 5 |
| Section (2) | Procedures for investigating possible acts of waste, abuse and fraud by providers | 8 |
| Section (3) | Procedures for detecting possible acts of waste, abuse or fraud by recipients | 9 |
| Section (4) | Procedures for investigating possible acts of waste, abuse and fraud by recipients | 10 |
| Section (5) | Internal procedures for referring and reporting possible acts of waste, abuse or fraud | 11 |
| Section (6) | Procedures for determining general overpayments | 17 |
| Section (7) | Procedures for processing general overpayments | 18 |
| Section (8) | Procedures for educating recipients and Providers and training personnel to prevent waste, abuse and fraud | 20 |
| Section (9) | Notice to Recipients, Providers, Employees, Contractors and Agents Regarding the Deficit Reduction Act of 2005 Section 6032 | 26 |

CONTENTS

| Title | Description | Page |
|--------------|----------------------------------------------------------------------------------------------|-------------|
| Section (10) | Identification of assigned plan officer | 31 |
| Section (11) | Personnel responsible for investigating and reporting possible acts of waste, abuse or fraud | 32 |
| Section (12) | Advertising and marketing materials | 32 |
| Section (13) | Other provisions | 33 |

Introduction

This document summarizes the plan developed by Community First Health Plans (CFHP) in response to rules enacted on May 13, 2004, by the State of Texas under Title 1, Chapter 353, regarding the establishment and operation of a Special Investigation Unit (SIU) by Managed Care Organizations.

Items covered in this document include procedures for detecting, investigating and preventing possible acts of waste, abuse or fraud by providers and recipients; procedures for referring possible acts of waste, abuse or fraud for investigation by CFHP Special Investigation Unit (SIU); reporting waste, fraud and abuse to State of Texas and federal agencies; training company personnel and educating recipients and providers to prevent waste, abuse and fraud; identification of designated personnel responsible for compliance with the rules; and advertising and marketing and other provisions of the plan.

CFHP recognizes that the detection, investigation and prevention of waste, abuse and fraud are vital to maintaining an affordable health care system in this state and country. CFHP has mounted a sincere effort to limit waste, fraud and abuse through the efforts summarized in this document.

CORPORATE STATEMENT:

SPECIAL INVESTIGATION UNIT

CFHP is committed to protect and preserve the integrity and availability of health care resources to our recipients, our healthcare partners and the general community. CFHP performs these activities through its Special Investigation Unit to detect, prevent and eliminate waste; abuse and fraud at the provider, recipient and health plan level. CFHP utilizes electronic systems and training of our employees, contractors and agents to identify and report possible acts of waste, abuse and fraud. When such acts are identified, CFHP seeks effective remedies to identify overpaid amounts; prevent future occurrences of waste, abuse and fraud; and report offenses to the appropriate agencies.

| |
|--------------------------------------------------------------------------------------------------|
| (Section 1) Procedures for detecting possible acts of waste, abuse or fraud by providers. |
|--------------------------------------------------------------------------------------------------|

The SIU's procedures for detecting possible acts of waste, abuse or fraud by CFHP providers include:

Audits

The SIU performs audits to monitor compliance and assist in detecting and identifying possible Medicaid/CHIP program violations and possible waste, abuse, and fraud overpayments through:

- Data matching – procedures, treatments, supplies, tests, and other services as well as diagnosis billed are compared for reasonableness using available sources including the American Medical Association (AMA), Centers for Medicare/Medicaid Services. Comparisons include age, gender, and specialty when applicable.
- Analysis – inappropriate submissions of claims are evaluated using software-automated analysis. A comparison of providers' activities lists outliers based on particular specialty and across all specialties and includes procedures, modifiers, and diagnosis. Pharmacy data may be reviewed if provided in usable format by

HHSC.

- Trending and Statistical Activities – The SIU uses software to build provider profiles that show trends and patterns of submissions based on key claim elements and includes providers’ patient activities. Statistical analysis shows provider utilization and identifies unusual trends in weekly, monthly, and yearly patterns.

Monitoring

The SIU monitors patterns for providers, subcontractors and facilities submitting claims. The monitor lists outliers based on claims submissions and utilization. Any provider is flagged for certain payment patterns is also examined for other flags to paint an overall profile. Recipients with flags will be examined for other flags as well and to evaluate patient-provider relationships.

Hotline

CFHP maintains an anti-fraud hotline, at (210)-358-6332 to allow reporting of potential or suspected violations of waste, abuse and fraud by members, providers and employees. Messages left on the hotline are answered by SIU personnel within two business days. The hotline number is printed on appropriate member and provider communications and published on the CFHP web site. The hotline number is also included in CFHP provider and member handbooks.

The SIU maintains a log to record calls, the nature of the investigation, and the disposition of the referral.

Random Payment Review

The profiling and statistical analysis is performed on random selection of claims submitted by providers for reimbursement by varying criteria to detect potential overpayment. The queries include a random function to create the reports on different blocks of data and apply them toward flagged claims.

Edits

Community First Health Plans utilizes claim-editing software to prevent payment for fraudulent or abusive claims. It is an established and widely used clinically based auditing software system that verifies the coding accuracy of professional service claims. These edits include specific elements of a claim such as procedure, modifier, diagnosis, age, gender, or dosage. CFHP applies the edits through AMISYS, CFHP's claims adjudication system. The edits are commonly accepted and verifiable filters including the national guidelines published by CMS, CCI, OIG and AMA.

Routine Validation

CFHP provides our vendor with three years of claims data. The vendor processes the electronic claims data on a quarterly basis and supplies a data load to the SIU, which applies edits, flags, fraud rules, and build routine activity profiles. These routine validations produce:

- Summary Of Findings – A high level of flags and potential overpayment across all claims to identify major areas of concern.
- Triage Reports – List of providers that are in the high percentile of flags and/or utilizations on which CFHP can focus.
- Detail Reports – Provide details supporting the profile activities of a provider or member.

Section (2) Procedures for investigating possible acts of waste, abuse and fraud by providers

The SIU conducts preliminary investigations related to possible acts of waste, abuse and fraud by providers within 15 working days of identification or report of the suspicion or allegation. Information and evidence is gathered from relevant internal and external sources.

The preliminary investigation includes the following activities:

- Determine if CFHP has received any previous reports of incidences of suspected waste, abuse, or fraud or conducted any previous investigations of the provider in question. If so, the investigation includes a review of all materials related to the previous investigations, the outcome of the previous investigations, and a determination of whether the new allegations are the same or relate to the previous investigation.
- Determine if the service provider has received any educational training from CFHP in regard to the allegation;
- Conduct a review of the provider's billing pattern to determine if there are any suspicious indicators;
- Review the provider's payment history for the past three years to determine if there are any suspicious indicators; and
- Review the policies and procedures for the program type in question to determine if what has been alleged is a violation.

If the preliminary investigation determines that suspicious indicators of possible waste, abuse, or fraud exist, within 15 working days from the conclusion of the preliminary investigation, the SIU selects a sample for further review. The sample consists of a minimum of 50 recipients that allegedly received services from the provider or 15% of a provider's claims related to the suspected waste, abuse, and fraud.

Within 15 working days of the selection of the sample, the SIU requests medical records and encounter data for the sample recipients.

Within 45 working days of receipt of the requested medical records, the SIU reviews the medical records and encounter data in order to:

- validate the sufficiency of service delivery data and to assess utilization and quality of care;
- ensure that the encounter data submitted by the provider is accurate;
- evaluate if a review of other pertinent records is necessary to determine if waste, abuse, or fraud has occurred. If the review of additional records is necessary the SIU conducts such review.

Industry/Public databases

The SIU is authorized to query industry/public databases and other commercial/public information sources when directly related to an investigation or when conducting necessary SIU research.

| |
|-----------------------------------------------------------------------------------------------------------|
| <h3>Section (3) Procedures for detecting possible acts of waste, abuse or fraud by recipients</h3> |
|-----------------------------------------------------------------------------------------------------------|

The SIU utilizes software flags for detecting possible acts of waste, abuse or fraud by CFHP recipients. Flags include:

- Treatments and procedures that appear to be duplicative, excessive or contraindicated by more than one provider, i.e., same patient, same date-of-service, same procedure code.
- Medications that appear to be prescribed by more than one provider, i.e., same patient, same date-of-service, and same NDC code.
- Recipients that appear to receive excessive medications higher than average dosage for the medication.
- Compare the Primary Care Provider (PCP) relationship code to the recipient to evaluate if other providers and not the PCP are treating the recipient for the same diagnosis.
- Identify recipients with higher than average emergency room visits with a non-emergent diagnosis.

The SIU utilizes CFHP specialty codes to identify psychiatrists, pain management specialists, anesthesiologists, physical medicine, and rehabilitation specialists. The

software flags can detect by specialty code possible overuse and/or abuse of psychotropic and /or controlled medications by recipients who are treated by two or more physicians at least monthly.

The SIU requests medical records for the recipients in question if claim data review does not clearly determine evidence of overpayment. Upon the receipt of the records from the provider, the SIU reviews the documentation for appropriateness and to determine if it is necessary to seek guidance on appropriate actions such as reporting to the HHSC-OIG and the recovery process if necessary.

| |
|---------------------------------------------------------------------------------------------------------|
| Section (4) Procedures for investigating possible acts of waste, abuse, and fraud by recipients. |
|---------------------------------------------------------------------------------------------------------|

The SIU conducts preliminary investigations related to possible acts of waste, abuse and fraud by recipients within 15 working days of identification or report of the suspicion or allegation. All investigations are conducted under the guidelines previously described in Section (2) of this response.

Preliminary Investigation

The preliminary investigation includes but is not limited to the following

- Review of acute care and emergency room claims to determine:
 - utilization of non-emergent diagnosis by provider
 - utilization of non-emergent diagnosis by recipient
 - prescription of controlled substances and pain medicine by provider
 - prescription of controlled substances and pain medicine by recipient
 - comparison of emergency procedures by physicians and facility for possible up coding
 - outliers in number of visits to the emergency room by patient

- Review of pharmacy claim data, to the degree it is made available by HHSC, to determine:
 - higher than average or excessive use of controlled and non-controlled drugs

- higher than average prescriptions or inconsistent drugs based on the NDC and diagnosis codes
- If necessary pharmacy claim data is not available to conduct a review, CFHP will request the data within 15 working days of the initial identification and/or reporting of the suspected or potential waste, abuse or fraud.
- Comparison of procedures, tests, supplies, modifiers, and diagnosis submissions across lines of business.

Section (5) Internal procedures for referring and reporting possible acts of waste, abuse or fraud and the mandatory reporting of possible acts of waste, fraud and abuse by providers or recipients to the Texas Health and Human Services Commission-Office of the Inspector General (HHSC-OIG).

The responsibility and authority for reporting all investigations resulting in a finding of possible acts of waste, abuse and fraud to the Texas Health and Human Services Commission, Office of Inspector General (HHSC-OIG) at CFHP is:

Name: Patrina Fowler
Title: Vice President, Chief Operations Officer
Street Address: 12238 Silicon Drive, Suite 100
City State Zip San Antonio, TX 78249
Office Phone: (210) 358-6021
Fax: (210) 358-6045
Email: pfowler@cfhp.com

This individual has:

- Direct access to the organization's governing body, the CEO and all other senior management, and legal counsel;
- The authority to review all documents and other information that are relevant to waste, abuse and fraud compliance activities;
- Sufficient funding and staff to fully perform the duties;

To inform CFHP staff on how and what must be reported to the SIU regular education and training programs have been developed and implemented. Elements of the program are:

- All employees must attend annual training that defines fraud, waste and abuse and defines the process for reporting to the SIU;
- The SIU disseminates compliance information on an ongoing basis using the intranet, staff meetings or other appropriate media.
- Standard paper and electronic formats are utilized and distributed to all employees for the reporting of suspected acts of waste, abuse and fraud and training is available if employees require instruction on the procedures to be followed.
- A toll-free hotline has been established and its existence publicized to promote its use by providers, recipients and other individuals to report suspected acts.

Special emphasis is placed on defining specific acts of waste, abuse and fraud.

Acts of **waste** are defined as activities involving payment or the attempt to obtain payment for items or services where there was no intent to deceive or misrepresent but that the outcome of poor or inefficient methods results in unnecessary costs to the Medicaid/CHIP program.

Acts of **abuse** are defined as activities that unjustly enrich a person through the receipt of benefit payments but where the intent to deceive is not present or an attempt by an individual to unjustly obtain a benefit payment.

Fraud is an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person.

CFHP considers previous educational efforts when determining intent. Intentional misrepresentation, intent to deceive and or attempting to obtain unjust benefit payments is not considered unless there is documented previous education in writing or in person by CFHP regarding the same or similar adverse audit findings or there is obvious program violations.

As adopted from Texas Human Resources Code Chapter 36.002, fraud may be defined as having occurred when a person:

(1) Knowingly or intentionally makes or causes to be made a false statement or misrepresentation of a material fact on an application for a contract, benefit, or payment under the Medicaid/CHIP programs; or makes or causes to be made a false statement or misrepresentation of a material fact that is intended to be used to determine a person's eligibility for a benefit or payment under the Medicaid/CHIP programs;

(2) Knowingly or intentionally conceals or fails to disclose an event:

- that the person knows affects the initial or continued right to a benefit or payment under the Medicaid/CHIP programs to him or herself or another person on whose behalf the person has applied for a benefit or payment or is receiving a benefit or payment; or
- to permit a person to receive a benefit or payment that is not authorized or that is greater than the payment or benefit that is authorized;

(3) Knowingly or intentionally applies for and receives a benefit or payment on behalf of another person under the Medicaid/CHIP programs and converts any part of the benefit or payment to a use other than for the benefit of the person on whose behalf it was received;

(4) Knowingly or intentionally makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning:

- The conditions or operation of a facility in order that the facility may qualify for certification or recertification required by the Medicaid/CHIP programs, including certification or recertification as a hospital, a nursing facility or skilled nursing facility; a hospice; an intermediate care facility for the mentally retarded; an assisted living facility; or a home health agency; or
- information required to be provided by a federal or state law, rule,

regulation, or provider agreement pertaining to the Medicaid/CHIP programs;

(5) Except as authorized under the Medicaid/CHIP programs, knowingly or intentionally charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid/CHIP programs, a gift, money, a donation, or other consideration as a condition to the provision of a service or continued service to a Medicaid/CHIP recipient if the cost of the service provided to the Medicaid/CHIP recipient is paid for, in whole or in part, under the Medicaid/CHIP programs;

(6) Knowingly or intentionally presents or causes to be presented a claim for payment under the Medicaid/CHIP programs for a product provided or a service rendered by a person who:

- is not licensed to provide the product or render the service, if a license is required; or
- is not licensed in the manner claimed;

(7) Knowingly or intentionally makes a claim under the Medicaid/CHIP programs for:

- A service or product that has not been approved or acquiesced in by a treating physician or health care practitioner;
- A service or product that is substantially inadequate or inappropriate when compared to generally recognized standards within the particular discipline or within the health care industry; or
- A product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate;

(8) Makes a claim under the Medicaid/CHIP programs and knowingly or intentionally fails to indicate the type of license and the identification number of the licensed health care provider who actually provided the service;

(9) Knowingly or intentionally enters into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another person in obtaining an unauthorized payment or benefit from the Medicaid/CHIP

programs or a fiscal agent; or

(10) A managed care organization that contracts with the Health and Human Services Commission or other state agency to provide or arrange to provide health care benefits or services to individuals eligible under the Medicaid/CHIP programs knowingly or intentionally:

- Fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract;
- Fails to provide to the commission or appropriate state agency information required to be provided by law, commission or agency rule, or contractual provision;
- Engages in fraudulent activity in connection with the enrollment of an individual eligible under the Medicaid/CHIP programs in the organization's managed care plan or in connection with marketing the organization's services to an individual eligible under the Medicaid/CHIP programs; or
- Obstructs an investigation by the attorney general of an alleged unlawful act.

All training and educational materials include the requirement that any act of waste, fraud abuse identified by any CFHP officer, director, manager or employee will be reported to the SIU within 24 hours of the identification, referral or reporting of a suspected act .

CFHP communicates to employees, enrollees, and providers, written confidentiality and non-retaliation policies to encourage the communication and reporting of suspected or potential violations through its annual training, Employee Handbook, Provider and Member Newsletters and periodic training throughout the year.

CFHP communicates policies regarding disciplinary action for all employees who have failed to comply with the organization's standard of conduct, policies and procedures, contract requirements, Federal and/or State laws, or those who have engaged in otherwise illegal or unethical conduct related to the waste, fraud and abuse compliance.

Internal procedures for the SIU to report investigations resulting in a finding of waste, abuse, or fraud are to the assigned officer or director

The SIU will report to the Fraud Officer when the results of an investigation conclude that there is reasonable belief that an act of waste, abuse or fraud has occurred. Reasonable belief is defined as possessing knowledge of facts, which, although not amounting to direct knowledge, would cause a reasonable person, knowing the same facts, to reasonably come to the same conclusion. Evidence that may be used to establish and support reasonable belief includes:

- Billing records
- Claim copies
- Claim histories
- Correspondence
- Data analysis
- Investigator affidavits
- Medical records
- Enrollment applications
- Witness statements
- Any other information that appears reasonably related to the investigation.

Acts reasonably believed by the SIU to constitute acts of waste, abuse, or fraud will be reported to the Fraud Office within 15 working days of the determination.

Utilizing the HHSC-OIG fraud referral form, the designated Fraud Officer or her designee reports and refers all possible acts of waste, abuse or fraud to the HHSC-OIG within 30 working days of receiving the reports of possible acts of waste, abuse and fraud in the SIU.

The report and referral includes an investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of program rules and regulations violated for the time period in question; the estimated overpayment identified; a summary of interviews conducted; the encounter data submitted by the provider for the time period in question; and all supporting documentation obtained as the result of the investigation.

An expedited referral is required and will be made by the SIU when there is reason to believe that delay may result in:

- Harm or death to patients; or
- Loss, destruction or alteration of valuable evidence; or
- A potential for significant monetary loss that may not be recoverable; or
- Hindrance of an investigation or criminal prosecution of the alleged offense.

Section (6) Procedures for Determining General Overpayments

The following types of reviews are performed to assist in the determination of overpayments:

- Compliance audits
- Monitoring of service patterns
- Random payment review of claims
- Routine validation of claim payments
- Pre payment review
- Review of medical records
- Focused reviews
- Review of claim edits or other evaluation techniques
- Itemized hospital bill reviews

Findings that are considered general overpayments include the following:

- Billing errors
- Insufficient documentation to support billed charges
- Inappropriate use of modifiers
- Incorrect billing provider
- Duplicates
- Billing for a different authorized services
- Data matching of diagnosis and procedure codes
- Unbundling of services, procedures and/or supplies
- Claim processing errors

Time limitation for review of general overpayments:

- Recovery of discovered general overpayments will be initiated for a minimum of two years in which the explanation of original payment was made.
- Only the year of the payment and the year it was found to be a general overpayment enter into the determination of the calendar year period. The day and the month are irrelevant.

- Clear evidence of intentional fraud, waste, abuse or program violation is excluded from general overpayment reviews.
- Preliminary investigations and full investigations are excluded from determining general overpayment findings.

Considerations of general overpayments are determined when the following has not occurred previously:

- Previous investigation or report of fraud, waste or abuse by CFHP related to same or similar findings
- Educational training by CFHP related to same or similar findings
- Clear evidence of intentional fraud, waste, abuse or program violation,
- Clear pattern of billing errors has occurred.

| |
|----------------------------------------------------------------|
| Section (7) Procedures for Overpayment Recovery Process |
|----------------------------------------------------------------|

The SIU has established the following process regarding recovery of overpayments discovered through investigations including preliminary investigations.

Medicaid/CHIP program overpayments will be processed in the following manner:

- Upon completion of the investigation and final disposition of any administrative, civil, or criminal action taken by the state or federal government, the Health and Human Service Commission –Office of Inspector General (HHSC-OIG) will determine and direct the collection of any overpayment.
- Overpayments collected as a result of an investigation will be distributed to CFHP unless HHSC-OIG determines that an alternative distribution is indicated.
- If the HHSC-OIG determines that CFHP is not entitled to all or any portion of the distribution of funds collected as a result of an overpayment HHSC-OIG will provide CFHP with a written explanation indicating the rationale for the alternative distribution of funds.
- The minimum dollar threshold for referral to the OIG is \$5,000. CFHP will also refer Providers to HHSC-OIG with less than \$5,000 in error if

there is clear evidence of intentional conduct that indicates a pattern of fraud, waste or abuse.

- CFHP provides education to providers and documents educational efforts regarding audit findings and coding compliance.
- CFHP SIU recovers overpayments discovered by auditing and monitoring efforts (less than \$5,000) via claims adjustments and accounts for these recoveries in cost reports.

The SIU has established the following process regarding recovery of general overpayments discovered through reviews and audits excluding investigations.

Medicaid/CHIP program general overpayments will be processed in the following manner:

- Notification of overpayments will occur after the completion of an audit, or review.
- The notification will be in writing and include the specific claims and amounts for which a refund is due and;
- Provide the basis and specific reasons for the request for refund and;
- Include notice of the physician's or provider's right to appeal and,
- Describe the method and due date by which the refund will occur and,
- Describe actions that will occur if overpayment is not refunded.

Medicaid/CHIP program general appeal process:

- A physician or provider may appeal a request for refund by providing written notice of disagreement of the refund request not later than 45 days after receipt of overpayment notice.
- Upon receipt of written notice, the SIU shall begin the appeal process as provided in the contract with the physician or provider.
- A refund will not be recouped until:
 - the later of the 45th day after overpayment notification;
 - the physician or provider has made arrangements for payment with the SIU prior to the 45th day overpayment notification;
 - exhaustion of any physician or provider appeal rights according the physician or provider contract and/or documented attempts to

recover the overpayment.

- The appeal process does not apply in cases of fraud or a material misrepresentation by a provider. Fraud is considered and noted as intentional after a provider has been previously educated in writing or in person by CFHP regarding the same or similar audit, review or investigational findings or there is reasonable clear evidence of intent.

D. Non voluntary repayment of overpayments will result in any or all of the following actions:

- Recoupment of overpayment from future claims
- Payment hold
- Termination from the CFHP network
- Referral to the appropriate regulatory agency.

E. Time limitation for recovery of overpayments:

1. Recovery of discovered overpayments will be initiated from a minimum two year period in which explanation of original payment was made.
2. Only the year of the payment and the year it was found to be an overpayment enter into the determination of the calendar year period. The day and the month are irrelevant.

Section (8) Procedures for educating recipients, providers and training personnel to prevent waste, abuse and fraud

To establish effective internal procedures for referring possible acts of waste, abuse or fraud to the SIU, regular education and training programs have been developed and implemented for all CFHP employees.

- All CFHP employees are required to attend annual training that emphasizes the organization's commitment to Federal and State statutes and requirements related to fraud and abuse. Training is specific to the area of responsibility for the staff receiving the training and contains examples of waste, abuse or fraud in their area of specialization.
- All new CFHP staff receive training on waste, fraud and abuse within 90 days of

employment;

- The SIU disseminates compliance information on an ongoing basis using monthly newsletters, bulletins, websites or other appropriate media.
- Special emphasis is placed on defining acts of waste, abuse and fraud and how to report suspected waste, abuse and fraud.

CFHP has established several mechanisms that can be utilized by all CFHP employees for the reporting of suspected acts of waste, abuse and fraud. Training is conducted to instruct employees on the procedures to be followed. The Suspicious Activity Report (SAR) is available to all CFHP employees on the CFHP intranet. Two internal numbers are distributed to all CFHP employees which can be used to report any suspicious activity. Any CFHP can also send an internal email to either the Fraud Officer or the Coding and Compliance Specialist..

A fraud hotline has been established and the number has been published in both the Member and provider. Newsletters as well are posted on the CFHP website to promote its use to providers, recipients and other individuals for reporting suspected acts.

The SIU provides education and training for recipients, providers and CFHP employees to prevent waste, abuse and fraud.

Recipient and provider education

- **Recipients and providers are provided fraud, waste and abuse education through** a variety of avenues such as CFHP web site, member and provider newsletters, provider manuals, and member handbook. The information contained in the material includes the definitions of fraud, waste and abuse and how to report fraud, waste and abuse

Training of CFHP personnel with **direct** Medicaid/CHIP involvement to prevent waste, abuse and fraud.

On an annual basis, and within 20 working days of changes made to policy and/or procedure the SIU provides waste, abuse and fraud training to each CFHP employee who is directly involved in any aspect of Medicaid/CHIP. Training is required for all individuals responsible for data collection, provider enrollment or disenrollment,

encounter data, claims processing, utilization review, appeals or grievances, quality management, and marketing. The training is specific to the area of responsibility and contains examples of waste, abuse or fraud to the staff's particular area of responsibility.

The anti-fraud training program is conducted to develop and improve the anti-fraud awareness skills of CFHP employees. In addition to annual sessions and within 20 working days of changes made to policy and/or procedure of training is also available on an ad hoc basis when requested by any CFHP department or internal or external customer.

The training includes with relevant examples the following general topics:

- The function and purpose of the SIU
- Review of the written procedures established by the SIU regarding the identification, documentation and reporting of suspected waste, abuse and fraud to the SIU
- Instruction and distribution of standardized referral forms to report incidents of suspected waste, abuse and fraud to the SIU
- Necessity for expedited referrals in certain circumstances
- Statutory and regulatory definitions of waste, abuse and fraud
- Responsibility of the individual to report suspected waste, abuse and fraud
- Responsibility of other individuals to report suspected waste, abuse and fraud
- Identification and recognition of red flags or red flag events
- Common recipient waste, abuse and fraud schemes

- Presentation of specific requirements for mandatory waste, abuse and fraud reporting to State and Federal agencies.

Specific training includes relevant examples the following topics:

Data Collection

- Peer group provider comparisons by service type.
- Peer group provider comparisons by type and quantity of services per patient.
- Peer group provider comparisons by diagnosis
- High percentage of charges for most complicated level of subsequent hospital

care

- Billing by physicians for routine dialysis procedures
- Duplicate professional/facility billings for emergency room and other hospital services

Provider Enrollment

- Licensure requirements
- Prior disciplinary actions by state licensing boards
- Exclusion from federal programs
- PO Box or mail service location is identified as place of business
- Claims for services submitted within dates of licensure suspension

Provider Disenrollment

- Elements of due process
- Mandatory reporting of action

Encounter Data

- Peer member group analysis by service type.
- Peer member group analysis by type and quantity of services per member
- Peer member group provider analysis by diagnosis
- Underutilization of services
- Excessive referrals to specific providers.

Claims Processing

- Patient states service was not provided
- Provider's signature is missing from paper claim form or medical record
- Previously rejected claim is resubmitted with different diagnosis, billed amount and/or procedure code
- Provider states service was not provided after receiving remittance advice

Utilization Review

- High member utilization of acute care, emergency and urgent care facilities.
- Provider's medical credentials do not match type of service provided
- Excessive number of treatments for single date of service
- Same treatments are provided to multiple family members on same date of service
- Claims paid for non-covered benefits.

Appeals

- Diagnosis does not match treatment
- Services were not provided as charged
- Medical record suggests an inadequate level of care was provided

Grievances

- Excessive number of complaints regarding a particular provider

Quality Management

- Services are not documented in medical record
- Medical record does not substantiate submitted services

Marketing

- All advertising and marketing materials, and any other correspondence going to members, must be approved by HHSC. No documents can be subsequently altered without HHSC approval.
- Materials related to waste, abuse and fraud activities will support the Texas Health and Human Services Commission's objective to bring the public and private sectors together to reach the mutual goals of reducing healthcare fraud and abuse; improving CFHP's operational quality; improving the quality of healthcare; and reducing overall healthcare costs.

Training of CFHP personnel with **indirect** Medicaid/CHIP involvement to prevent waste, abuse and fraud.

General training is provided to all CFHP staff not directly involved in Medicaid/CHIP operations and to other individuals employed by CFHP. The training includes:

- The function and purpose of the SIU
- Introduction and review of the written procedures established by the SIU regarding the identification, documentation and reporting incidents of suspected waste, abuse and fraud to the SIU
- Instruction on standardized referral forms to report incidents of suspected waste, abuse and fraud to the SIU
- Statutory and regulatory definition of waste, abuse and fraud
- Responsibility of the individual to report suspected waste, abuse and fraud
- Responsibility of other individuals to report suspected waste, abuse and fraud
- Identification and recognition of red flags or red flag events
- Common recipient waste, abuse and fraud schemes including characteristics of bill alteration; identification of fabricated billings; and identification of misdirection of payment schemes
- Common provider waste, abuse and fraud schemes including characteristics of false claims; billings for services not provided; and examples of unethical billing practices including double billing, upcoding and unbundling
- Examples of current waste, abuse and fraud schemes and presentation of new and emerging insurance trends
- Presentation of specific requirements for mandatory waste, abuse and fraud reporting to State and Federal agencies.
- Updates of changes made to policy and/or procedure regarding waste, abuse and fraud are provided within 20 working days of the change.

The SIU maintains a training log to document all training pertaining to waste, abuse and/or fraud related to Medicaid/CHIP programs. The log includes the name of staff attending the training, which performed the training and the date and length of the training. The type of media will also be identified on the log and paper copies of all material provided in training sessions will be also be maintained with the log.

The log will be provided immediately upon request to any of the following parties:

- Texas Health and Human Services Commission, Office of Inspector General (HHSC-OIG)
- Office of the Texas Attorney General's (OAG)-Medicaid Fraud Control Unit (MCFU) and

- Texas OAG-Civil Medicaid Fraud Division (CMFD)
- United States Health and Human Services-Office of Inspector General (HHS-OIG).

Written standards of conduct, and written policies and procedures that include a clearly delineated commitment from CFHP and the SIU for detecting, preventing and investigating waste, abuse and fraud is documented. by the above Corporate Statement and by the development of SIU Policies and Procedures.

Policy and Procedures

The SIU staff together with the designated Fraud Officer is jointly responsible for compiling, maintaining and distributing the SIU Policy and Procedures.

The policies describe the procedures used by the SIU for its general operations; demonstrate compliance with state and federal requirements; and serve as a training resource for new members of the SIU.

| |
|-------------------------------------------------------------------------------------------------------------------------------------------------|
| Section (9) Notice To Recipients, Providers, Employees, Contractors and Agents Regarding the Deficit Reduction Act of 2005 Section 6032. |
|-------------------------------------------------------------------------------------------------------------------------------------------------|

Consistent with Section 6032 of the Deficit Reduction Act of 2005, Community First Health Plans has established guidance to educate recipients, providers, employees, contractors and agents regarding the reporting of fraud, waste or abuse. For clarification purposes, contractors and agents are defined by CMS as “one which, or one who, on behave of CFHP, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring health care”.

The following defines the False Claims Act and Texas State Whistleblower Act which allows all American citizens the right and responsibility to report or file suit regarding federally funded fraudulent claims. In addition, these laws outline the federal penalties for submitting false claims and provide protection to individuals who report any such

violations.

FALSE CLAIMS ACT

The **False Claims Act** (31 U.S.C. § 3729 *et seq.*, also called the "**Lincoln Law**") allows American citizens, whether affiliated with the government or not, to file actions against federal contractors claiming fraud against the government.

The False Claims Act was passed by Congress to prevent the United States Government from paying federal funds for fraudulent claims involving goods and services. For Community First Health Plans, this includes submitting false information to third party payors, such as Medicaid and Medicare, in order to receive a higher reimbursement. Examples of this include upcoding (i.e., coding a higher DRG than the documentation supports), lab unbundling (i.e., charging separately for procedures that are usually charged as one procedure), billing for services not actually rendered and duplicate billing.

The False Claims Act outlines the federal penalties for submitting false claims, as well as protections granted to an individual who reports a violation.

RULES AND PROCEDURES

A civil action involving false claims must be made within six years of the date the violation occurred. The government official notified of the civil action has up to three years to act after learning of the allegation. No action can be taken more than 10 years from the date the violation took place.

A false claims action can be filed in any judicial district where the defendant can be found, resides or transacts business.

The Attorney General, believing an individual has information pertaining to the false claims investigation, may serve the individual with a civil investigative demand requiring that the person:

- ▶▶ provide any documentation materials for inspection and copy,

- ▶▶ answer any written interrogation about the materials,
- ▶▶ give oral testimony on the materials or
- ▶▶ furnish any combination of the three listed above.

PROTECTIONS

Any person who commits a violation will have a reduced penalty if:

- ▶▶ the person provides the Attorney General's office with all the information known about the violation within 30 days,
- ▶▶ the person fully cooperates with any government investigation involving the violation, or
- ▶▶ the person comes forward in good faith and is not aware an investigation was pending.

Private individuals can file civil action (a lawsuit) against a firm participating in fraudulent activity on behalf of themselves and the United States Government. This civil action allows for an employee to file a lawsuit against his or her employer if the employer is fraudulently billing the federal government. This action is called a qui tam lawsuit. If the government proceeds with the action and collects, the individual is eligible to receive 15-25% of the settlement or proceeds of the action. The amount, if any, is dependent on the extent the individual contributes to the prosecution of the action.

However, the court may reduce the whistleblower's share of the proceeds if the court finds that the whistle blower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

PENALTY

The penalty for making a false claim is a fine of no less than \$5000 and not more than \$10,000 plus three times the amount of damages to the government.

SOURCE: (TEXAS GOV'T CODE ANN.,§554.001)

TEXAS STATE WHISTLEBLOWER ACT

Under the False Claims Act, any employee who is fired, demoted, suspended, harassed or otherwise discriminated against by his or her employer because of a claim, lawfully filed by the employee, is protected by the federal government and will be entitled to reinstatement, back pay and compensation for damages resulting from the discrimination.

Community First Health Plans employees are also protected by the Texas state law from retaliation for reporting a violation of law to government entities. According to this law:

- ▶▶ Community First Health Plans may not suspend, terminate or threaten an employee for reporting a violation to a law enforcement authority. Community First Health Plans may be held liable for any form of retaliation taken against an employee, student or volunteer who reports fraudulent activity.
- ▶▶ A Community First Health Plans employee who is suspended or terminated or has been threatened for reporting a violation is entitled to sue for injunctive relief, actual damages, court costs and reasonable attorney fees. In addition, the employee is entitled to return to the same or an equal position and to payment of lost wages.
- ▶▶ An employee suing Community First Health Plans may not recover damages in an amount that exceeds \$250,000.
- ▶▶ An employee must sue within 90 days of the alleged suspension, termination or threats. The suit must be filed in the district court of the county in which the retaliation took place or in a district court of Travis County.
- ▶▶ A supervisor, who suspends, terminates or makes threats against an employee for reporting a violation to a law enforcement authority can receive a civil penalty up to \$15,000.

SOURCE: (TEXAS GOV'T CODE ANN.,§554.001)

REPORTING YOUR CONCERNS

As stewards of the taxpayer's money, Community First Health Plans wants its resources used as economically and efficiently as possible. This doesn't leave any room for errors, fraud, abuse and/or waste.

Community First Health Plans encourages employees to use their chain of command when reporting concerns. This means giving their immediate supervisor the opportunity to resolve issues at this level before moving up to the next level. If the employee is not satisfied with the resolution from their immediate supervisor, they are empowered to move up the chain of command until they are assured that their concern is resolved.

COMMUNITY FIRST HEALTH PLANS AND THEIR PARENT COMPANY UNIVERSITY HEALTH SYSTEM REALIZES THAT SOMETIMES IT IS UNCOMFORTABLE FOR AN EMPLOYEE TO REPORT A CONCERN THROUGH THEIR CHAIN OF COMMAND, SO OTHER RESOURCES ARE OFFERED:

| | |
|----------------------------|-----------------|
| CFHP SIU HOTLINE | 358-6332 |
| PROTECTIVE SERVICES | 358-2450 |
| EMPLOYEE COUNSELOR | 358-2332 |
| HUMAN RESOURCES | 358-2271 |
| INTEGRITY SERVICES | 358-2193 |
| RISK MANAGEMENT | 358-1345 |
| SAFETY | 358-2448 |

ADDITIONAL RESOURCES

To demonstrate CFHP's commitment to preventing and detecting errors, fraud, waste and abuse, additional detailed information regarding state and federal False Claims Act and whistleblower protections is also made available through the following resources:

- Updated provider, member and employee handbook

- CFHP website
- CFHP intranet
- New employee hire training
- Annual employee training
- CFHP on-site fraud awareness posters
- University Health System web site (CFHP parent company)

Section (10) Identification of assigned plan officer

The CFHP individual responsible for carrying out the waste, abuse and fraud plan is:

Name: Patrina L. Fowler
Title: Vice President/Chief Operations Officer
Street Address: 12238 Silicon Drive, Suite 100
City State Zip San Antonio, TX 78249
Office Phone: (210) 358-6201
Fax: (210) 358-6014
Email: pfowler@cfhp.com

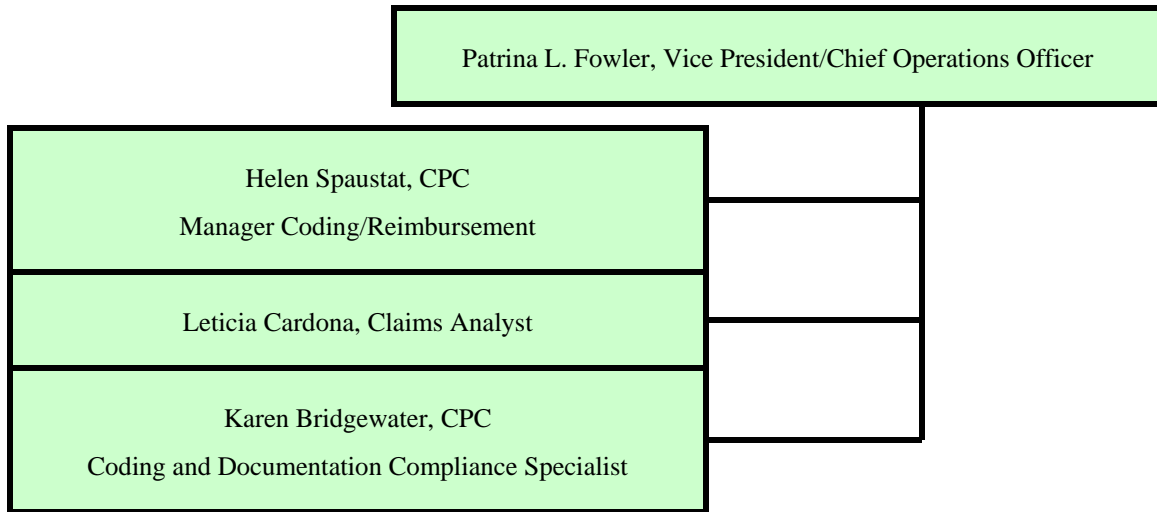
This individual is a member of CFHP executive management. Any personnel changes in this position will be reported to HHSC-OIG within 15 working days of the change.

The SIU individual responsible for carrying out the waste, abuse and fraud plan is:

Name Helen Spaustat, CPC
Title Coding and Reimbursement Manager
Street address 12238 Silicon Drive, Suite 100
City State Zip San Antonio, Texas, 78249
Office phone (210) 358-6337
Fax number (210) 358-6014
Email hspaustat@cfhp.com

Section (11) Personnel responsible for investigating and reporting possible acts of waste, abuse or fraud

The CFHP SIU personnel responsible for investigating and reporting possible acts of waste, abuse, or fraud are as follows.



Section (12) Advertising and marketing materials

Advertising and marketing materials utilized by CFHP completely and accurately reflect the information about CFHP. All Marketing and Advertising materials are approved by HHSC prior to utilization. CFHP understands that marketing materials include any informational materials targeted to recipients.

Advertising and marketing materials related to waste, abuse and fraud activities support the Texas Health and Human Services Commission’s objective to bring the public and private sectors together to reach the mutual goals of reducing healthcare fraud and abuse; improving CFHP’s operational quality; improving the quality of healthcare; and reducing overall healthcare costs.

Section (13) Other Provisions

The SIU on a quarterly basis submits to the HHSC-OIG a report listing all investigations conducted that resulted in no findings of waste, abuse, or fraud. The report includes the allegation, the suspected recipient's or provider's Medicaid number, the source, the time period in question, and the date of receipt of the identification and or reporting of suspected and/or potential waste, abuse, or fraud.

The SIU maintains a log of all incidences of suspected waste, abuse and fraud, received by CFHP regardless of the source. The log contains the subject of the complaint, the source, the allegation, the date the allegation was received, the recipient or providers Medicaid number, and the status of the investigation.

The SIU provides the incident log at a time of a reasonable request to the HHSC-OIG, OAG-MFCU, OAG-CMFD, and the HHS-OIG. A reasonable request means a request made during hours that the business or premises is open for business.

The SIU maintains the confidentiality of any patient information relevant to an investigation of waste, abuse, or fraud, in concert with HIPAA regulations concerning this type of investigation.

The SIU retains records obtained as the result of an investigation conducted by the SIU for a minimum period of five years or until all audit questions, appealed hearings, investigations, or court cases are resolved.

Failure of the provider to provide the records requested by CFHP's SIU result in the provider being reported to the HHSC-OIG as refusing to supply records upon request and the provider may be subject to sanction or immediate payment hold.

CFHP adheres to the Texas Administrative Code, Title 22, Part 9 Charter 165 Rule §165.1, regarding the amendment of medical records: "any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction."

For review purposes, the SIU does not accept amended documentation of existing records

under any circumstances. Examples of falsifying records or amending documentation of existing records include:

- Creation of new records when records are requested
- Adding or supplementing portions of records to existing records when records are requested
- Back-dating entries
- Pre-dating entries
- Post-dating entries
- Writing over entries

The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate for date of service rendered whether in written or electronic format.

In order to protect the integrity of the health information record, ensure appropriate reimbursement, and to provide quality patient care, copy functionality within the electronic health record should be used in conjunction with all applicable state and federal regulations. Noncompliant use of copy functionalities will follow the CFHP Fraud, Waste and Abuse program. For the purpose of this Work Plan, *copy* shall be understood to include cut and paste, copy forward, cloning, and any other intent to move documentation from one part of the record to another.