



CARESOURCE ANTI-FRAUD PLAN

Special Investigations Unit

Revised 04/2018





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1.0 INTRODUCTION

CareSource understands the profound financial and personal effect healthcare fraud, waste and abuse (FWA) can have on everyone included in the healthcare process – members, providers, health plans, government agencies and tax payers.

Measuring the true financial losses suffered due to healthcare fraud is extremely difficult, as much of the time it goes undetected. The National Health Care Anti-Fraud Association has estimated these losses in the tens of billions of dollars each year. The consequences result in higher premiums, reduced benefits, and increased health care related business costs.

Beyond the financial impact, members are often the most victimized by healthcare FWA. Potentially, members can be subjected to medically unnecessary or even harmful procedures; false medical records and be given diagnoses to support false claims; and unauthorized use of their health insurance information to submit false claims. These practices are not only potentially harmful to a member's health, but can also affect their ability to receive benefits when legitimately necessary.

CareSource is committed to the fight against healthcare FWA and has established a Special Investigations Unit (SIU) to lead this effort. Katherine Leff, the Director of the SIU, is responsible for the department's FWA program, and this Anti-Fraud Plan. Kathy's contact information is located in section 10 of this document. The SIU has developed this Anti-Fraud Plan to support the broader CareSource Corporate Compliance Plan and achieve the following objectives:

- Follow all federal and state rules, laws, regulations and other requirements
- Deter and prevent future fraud, waste and abuse
- Ensure the highest quality of care for our members
- Facilitate the identification and investigation of fraud



2.0 SIU PURPOSE STATEMENT

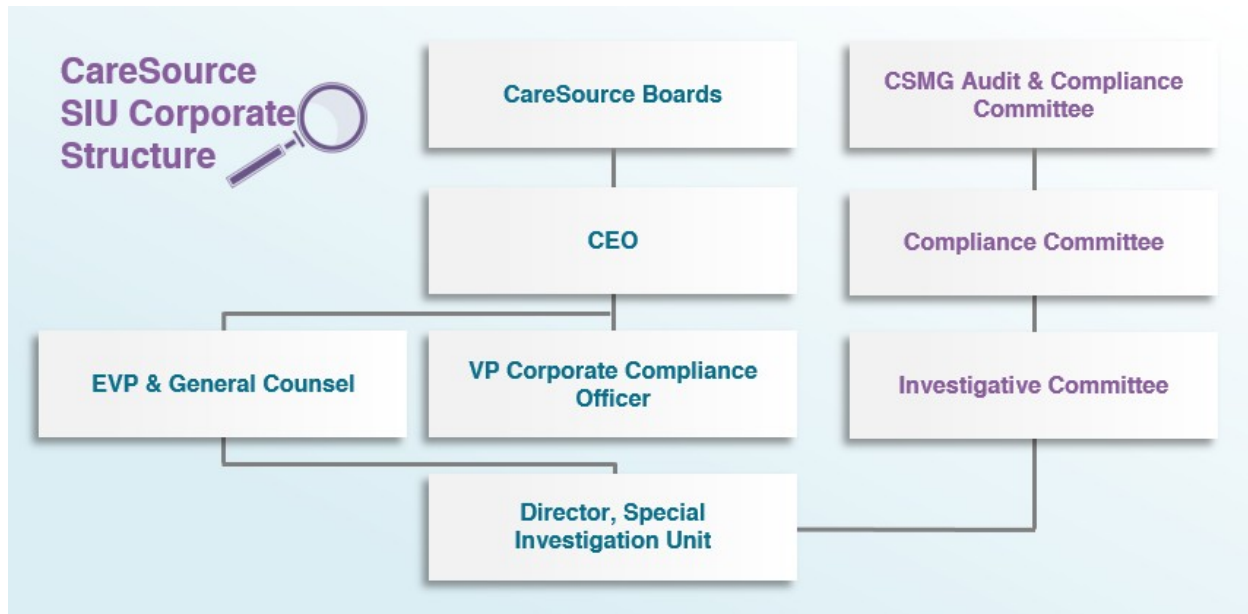
CareSource's mission is to make a lasting difference in our members' lives by improving their health and well-being. The CareSource SIU's contribution to this mission is to prevent, detect, investigate, mitigate, coordinate, and report healthcare FWA. This supports CareSource's fiduciary and regulatory responsibilities by ensuring our health care dollars are appropriately paid. It also protects our members from inappropriate and potentially harmful healthcare.



3.0 PROGRAM INTEGRITY AND COMPLIANCE

3.1 EFFECTIVE STRUCTURE AND OVERSIGHT

The CareSource SIU reports up through the Legal Counsel structure to Board of Directors as follows:



*See Appendix A for state-specific information

- **VP, Corporate Compliance Officer** – Reports directly to the CEO and has direct access to the CareSource Board of Directors.
- **Compliance Committee** – Chaired by the Corporate Compliance Officer and made up of senior management, this committee has oversight of all CareSource compliance processes and program integrity functions.
- **Investigation Committee** – Chaired by the Director, SIU, and comprised of Sr. Management staff, this Committee reports up to the Compliance Committee. This Committee provides direction, oversight and investigative case prioritization to the SIU.

The SIU maintains appropriate staffing to execute our mission and has the authority to direct SIU activities. The department includes the following positions:

- **Director** - Reports directly to the Executive Vice President & General Legal Counsel and provides direction for the Department. The Director, Katherine Leff, was the 2015 Chair of the National Health Care Anti-Fraud Association's (NHCAA's) Board of

Directors. She continues to sit on the Board. For nearly 30 years, NHCAA has been the leader in healthcare anti-fraud training and a tireless proponent of the power of information-sharing to fight fraud. NHCAA has a strong tradition as a private-public partnership and in driving change that protects patients from the harm of healthcare fraud.

- **Manager, SIU Pre-Pay** – Coordinates, manages, and oversees day-to-day SIU pre-pay investigative operations.
- **Manager, SIU Post-Pay** – Coordinates, manages, and oversees day-to-day SIU post-pay investigative operations.
- **Manager, SIU CareSource Indiana** - Coordinates, manages, and oversees day-to-day SIU investigative operations specific to Indiana Medicaid. (This role reports both to the SIU Director and to the CareSource Indiana Compliance Officer.)
- **Manager, Program Integrity** – Ensures program integrity compliance requirements are met.
- **Investigative Team Lead** – Manages investigators and associate investigators by overseeing and assisting with caseload.
- **Senior Fraud Examiner** – Runs investigations and oversees and assists investigators with cases.
- **Fraud Examiners** – Perform investigative activities on potential fraud issues related to providers, provider groups, pharmacies, vendors, and members.
- **Pharmacy Investigators** – Performs pharmacy related investigative activities and analysis.
- **Clinical Fraud Examiners** – Performs clinical investigative activities and analysis.
- **Fraud Claims Analysts** – Performs pre-pay reviews on claims scored high for fraud and abuse from the pre-pay predictive analytic software.
- **Clinical Review Specialists** – Performs pre-pay reviews on claims scored high for fraud and abuse from the pre-pay predictive analytic software from a clinical perspective.
- **Internal Control/Audit Analysts** – Develops and executes annual audit plan/audits of high risk fraud providers.
- **SIU Data Reporting Analysts/Data Project Lead** – Fulfills all data requests for investigators and outside agencies and data analytics for SIU investigators and projects.

- **Program Integrity Analysts** – Assists Manager, Program Integrity to ensure program integrity compliance requirements are met across all lines of business.
- **Fraud Analysts** – Triage incoming allegations of fraud and abuse. If allegation is validated, a case is moved to a full investigation with an investigator. Also compiles initial data for associate investigators, and make outbound calls to compile additional information.
- **Senior Administrative Coordinator/Administrative Coordinators** – Intakes all allegations of FWA into the SIU Case Tracking software and provides administrative support to the investigators.
- **Administrative Specialist** – Provides department administrative support.

These roles are filled by experienced professionals that have extensive experience and hold a number of designations and certifications including but not limited to: Registered Nurse/Bachelor of Science in Nursing (RN/BSN), Certified Professional Coder (CPC), Certification in Healthcare Compliance (CHC), Chartered Life Underwriter (CLU), Certified Managed Care Nurse (CMCN), Certified Pharmacy Technologist (CPhT), Health Care Anti-Fraud Associate (HCAFA), Accredited Health Care Fraud Investigator (AHFI), and Certified Fraud Examiner (CFE), JD (Juris Doctorate), ALHC (Associate, Life and Health Claims), CMCN (Certified Managed Care Nurse), LSW (Licensed Social Worker). To remain current on fraud issues and investigative skills, SIU staff will attend multiple educational seminars, webinars, workshops, and presentations each year on relevant FWA topics and CMS initiatives. Additionally, SIU staff participate in state, federal, and other trainings and meetings.

3.2 WRITTEN POLICIES AND PROCEDURES

For CareSource workforce members, the SIU has established comprehensive FWA policies and procedures that are readily available via links on MySource, CareSource's intranet site. Annually, or as needed, all SIU policies and procedures are reviewed and updated to ensure our commitment to compliance with all applicable Federal and State laws, regulations and contract requirements. All SIU policies are approved by the CareSource Policy & Procedure Committee. New policies are developed as necessary. SIU policies and procedures include but are not limited to the following:

- Antitrust Compliance

- Delegated Entity/FDR FWA
- False Claims Act
- Federal Anti-Kickback and Stark Law
- FWA Reporting
- Fraud, Waste and Abuse
- FWA Medicare Part D Monitoring and Auditing
- Program Integrity – Prohibited Affiliations
- Statistical Sampling and Extrapolation
- Verification of Member Service Explanation of Member Benefits
- Compliance and Ethics Hotline Investigation

The SIU policies and procedures listed above are utilized to create awareness of FWA among our workforce. They also ensure employees understand their responsibilities around FWA and provide a formal process for how to handle FWA concerns, describe the protection available for those who report, and act as an enforcement tool for confirmed instances of FWA.

3.3 RESPONSIBILITIES

Workforce Member, Subcontractor, Vendor, Delegated Entity Responsibilities include:

- Abiding by all laws, regulations, and contracts that apply to our business.
- Immediate reporting of any good faith allegation of fraud, waste, and abuse using the fraud reporting mechanisms detailed in Section 10.
- Supporting fraud, waste and abuse investigative efforts.
- Abiding by the Corporate Compliance Plan, Anti-Fraud Plan or an equivalent policy/plan/code of conduct.
- Completing all required FWA trainings.
- Reporting when prohibited affiliations are discovered.
- Providing access to records and data for the purpose of carrying out the functions and responsibilities required in state and federal contracts, laws, and regulations.

Often, individuals have questions regarding their responsibilities around fraud, waste and abuse, and how to handle these issues. Examples of some of these questions and answers are below. Please remember that it is always best to report any suspicion via the reporting

mechanisms in Section 10. This allows the SIU to investigate and complete due diligence for the company. You can always report anonymously.

Question: I work in the Claims department and I have seen a pattern of unusual billing coming in from a provider. I've checked with my co-workers, and we all find that this billing activity is irregular. How should I report this?

Answer: Contact the Fraud hotline, speak to an SIU staff member in person, or use any of the fraud reporting mechanisms listed in Section 10 or through a FACETS route.

Question: I work in Customer Advocacy, and recently a member indicated that her doctor, Dr. X, told her not to worry about her recent procedure because he knows how to bill it so that it will pay. Is this something I should report?

Answer: Yes. Dr. X is likely billing fraudulently to have procedures covered that are not in the scope of services. Always beware of any statements resembling this one. Refer this situation to SIU using the mechanisms in Section 10 or through a FACETS route.

3.4 RELEVANT FRAUD, WASTE AND ABUSE LAWS

The False Claims Act allows people to bring “whistleblower” lawsuits on behalf of the government – known as “qui tam” suits – against groups or other individuals that are defrauding the government through programs, agencies or contracts.

The False Claims Act applies when a company or person:

- Knowingly presents a false or fraudulent claim for payment,
- Knowingly uses a false record or statement to get a claim paid,
- Conspires with others to get a false or fraudulent claim paid,
- Knowingly uses a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.

“Knowingly” means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

An example would be if a health care provider, such as a hospital or a physician knowingly “upcodes” or overbills; resulting in overpayment of the claim using Medicaid or Medicare dollars.

The time period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the Government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.

It is the policy of CareSource to detect and prevent any activity that may violate the federal False Claims Act or the state Medicaid fraud laws. If any employee, provider, delegated entity, subcontractor or agent has knowledge or information that any such activity may have taken place, they should contact the Special Investigations Unit. Information may be reported anonymously.

In addition, federal and state law and CareSource policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file “whistleblower” lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to the Special Investigations Unit.

Federal Anti-Kickback Statute. This law prohibits the payment or receipt of any “remuneration” that is intended to induce the purchasing, leasing or ordering of any item or service that may be reimbursed, in whole or in part, under a Federal health care program, such as Medicare or Medicaid. It also prohibits the payment or receipt of any remuneration that is intended to induce the recommendation of the purchasing, leasing or ordering of any such item or service.

The Federal Anti-Kickback Statute also prohibits receipt of remuneration that is intended to induce purchases, or recommendations of purchases, of goods or services. For example, payment received by CareSource from pharmaceutical companies that are intended to induce CareSource’s purchase of drugs or CareSource’s recommendation of drugs to plans could violate the Federal Anti-Kickback Statutes.

The Federal government has created a number of regulatory “Safe Harbors” under the Federal Anti-Kickback Statute. If a transaction, relationship, or payment is structured in a manner that meets all of the requirements of a safe harbor, it can be protected from civil or criminal penalty under the Federal Anti-Kickback Statute.

Stark Act/Physician Self-Referral. Prohibits a physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation) unless an exception applies. It prohibits the entity from presenting or causing to be presented claims to Medicare or Medicaid (or billing another individuals, entity or third party payer) for those referred services. It established a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse. For more information, please see the SIU Federal Anti-Kickback Statute and Stark Laws Statute.

3.5 PROHIBITED AFFILIATIONS - STATE AND FEDERAL EXCLUSIONS, SANCTIONS & DEBARMENT

CareSource complies with all federal requirements on exclusion and debarment screening (per 42 C.F.R. §1002), and requires the same via contract terms with each of our subcontractors and providers. CareSource ensures these requirements are met through the following activities:

- CareSource performs provider checks when uploading a provider into our claims system and monthly thereafter against the System for Award Management (SAM), Death Master File, the List of Excluded Individuals/Entities (LEIE), and state-initiated exclusions from Medicaid lists. In addition, we screen providers against provider license boards and the Specially Designated Nationals list.
- The Credentialing department obtains provider ownership, controlling interest, and managing employee information at initial credentialing, and again in three years at recredentialing. Providers are instructed to notify us of any changes to ownership, controlling interest, and managing employees. Managing employees as indicated by the providers are checked against the SAM and LEIE lists.
- The Human Resources department screens new and existing workforce members against the SAM and LEIE lists upon hire and monthly thereafter.
- CareSource's Pharmacy Benefit Manager (PBM) screens all pharmacies and providers at the point of sale. A pharmacy claim will not pay if written by a prohibited prescriber or if filled at a prohibited pharmacy.
- The Enterprise Risk and Oversight department screens vendors prior to contracting and monthly thereafter.

- If CareSource discovers a payment was made to an excluded individual or entity, CareSource will attempt to recover these funds. Any amounts paid that cannot be recovered are allocated to non-Medicaid/Medicare funds.

CareSource utilizes Zebu, a database application tool, to review providers, vendors, and employees for prohibited affiliations, state sanctions, and license status. Zebu also allows for review and verification of the national terrorist list.

3.6 EDUCATION, TRAINING & OUTREACH

A comprehensive education and training program has been implemented to combat FWA with knowledge and awareness. By informing members, providers, vendors and our workforce on what to look out for and their responsibility to report potential issues to us, we have successfully expanded our fraud detection efforts. FWA education and training includes the following topics:

- Definitions of FWA
- Examples of provider, member, employee and vendor FWA
- How to access FWA/SIU policies and procedures
- Information regarding state and federal laws, including but not limited to the False Claims Act
- Protection afforded to those who report FWA
- How to report FWA
- Incorporates all CMS training curriculum standards listed in 42 C.F.R. §422.503(b)(4)(vi)(C)(3)(2014).

Throughout the training course, employees view various FWA scenarios and the appropriate handling of those scenarios. Employees learn their responsibilities for reporting FWA, examples of FWA, as well as how to report concerns. The training reinforces CareSource's no retaliation policy and outlines the laws and regulations applicable to FWA. Finally, the training educates employees on the location of FWA resources such as: Corporate Compliance Plan, Standards of Conduct, SIU Policies and Procedures, Employee Handbook, and the Anti-Fraud Plan.

The training is required for all CareSource workforce members, and is tracked for completion by the Compliance Department. Non-compliance with this requirement can result in disciplinary action up to and including loss of system access until trainings are complete.

CareSource's delegated vendors, first-tier, downstream and related entities (FDRs) are also required to complete an annual fraud, waste and abuse training. The entity many choose to use CareSource's training or their own as long as it satisfies Medicare and Medicaid contractual requirements for fraud, waste, and abuse training dependent upon the lines of business they support.

The SIU also verifies that delegated vendors receive FWA training via an annual attestation. The attestation includes:

- Definitions of FWA and examples of each
- The False Claims Act and any specific state laws
- Clarification of CareSource's no retaliation policy
- Information on other laws such as Prohibited Affiliations, Anti-Kickback and Stark Law
- Explanation of how to report FWA and provides reporting mechanisms

FDRs, delegated entities/subcontractors are also audited on an annual basis, and education requirements are checked during this time.

Staff training begins at hire for the entire CareSource workforce, as our formal FWA course is required to be completed within the workforce member's first 90 days. Ongoing training for all workforce members consists of an annual refresher course. SIU reviews and updates all education and training material on an annual basis, and as needed, to ensure it remains relevant and up-to-date with current laws, rules and regulations. Training records are maintained by CareSource University for a minimum of 10 years.

SIU ensures the information above is included in formal communications such as Member Handbooks, Provider Manuals, Corporate Compliance Plan and the Employee Handbook. MySource, the CareSource intranet website, and www.caresource.com, the CareSource internet website, contain web pages with helpful information such as fraud alerts. More informally, articles covering relevant FWA topics are included in member, provider and employee newsletters.

3.7 EXAMPLES OF FRAUD, WASTE AND ABUSE

Provider Fraud

- **Kickbacks** - Hidden financial arrangements between various health care providers. There is a variety of improper arrangements where providers will provide some material benefit in return for other providers prescribing or using their products or services. In most instances, such arrangements are illegal. Doctors are supposed to decide on the most appropriate treatment for their patients without consideration of their own financial interests. Kickbacks often result in medically unnecessary treatment.
- **Upcoding** - A pattern of assigning a code that reflects a falsely high level of patient acuity and medical service in order to generate higher reimbursement than the provider otherwise would receive.
- **Billing for services/supplies not provided.**
- **Billing for medically unnecessary services** – Billing a pattern of services that are not justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care and are used to generate higher reimbursement.
- **Incorrect coding** – Using an incorrect CPT, ICD-10, DRG, and HCPCS codes and modifiers to misrepresent the service that was provided to increase revenue.
- **Double billing** – Submitting a charge more than once, often with a slight modification, for the same service and same patient.
- **Unbundling** – The practice of separating and billing for the individual components of a medical service to increase revenue, rather than correctly billing with an all-inclusive procedure code.
- **Misrepresentation of services/supplies** – Providing one service but billing another to obtain reimbursement.
- **Substitution of services** – Billing for one type of service or supply but actually performing or providing another.
- **Submission of any intentionally false documents, addresses, phone numbers, etc.**
- **Overutilization of services** – Overutilizing certain services resulting in medically unnecessary treatment and financial gain.

Pharmacy Fraud

- **Prescription drugs not dispensed as written**– Dispensing other drugs than what is prescribed by the physician (e.g., generic vs. brand name).

- **Prescription splitting** – Separating prescriptions into multiple orders in order to seek additional reimbursement, such as dispensing fees.
- **Expired, fake, diluted or illegal drugs** - Dispensing inappropriate drug types to unsuspecting individuals that could create harmful situations.
- **Non-dispensed or non-existent prescriptions** – Billing for prescriptions that were not dispensed or picked up by the intended party.
- **Bait and switch** – Occurs when an individual is led to believe that a drug will cost one price, but at the point of sale, the individual is charged a higher amount.
- **Multiple prescription billing** – Billing multiple payers for the same prescriptions, except as required, for coordination of benefit transactions.
- **Brand name vs. generic** – Billing for a more expensive brand drug when a less expensive generic prescription is dispensed.
- **Quantity shortage** – Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fee.

Member Fraud

- **Controlled substances** - Obtaining controlled substances from multiple providers/pharmacies for non-medically necessary reasons and/or to sell.
- **Prescription forgery** – Altering and/or forging prescriptions for use or sale.
- **ID card fraud** - Loaning, sharing, or selling their ID Cards.
- **Eligibility fraud** – Misrepresenting their eligibility for coverage.

Workforce Member Fraud

- **Kickbacks/Stark violations** – Receiving gifts or kickbacks from CareSource vendors for goods or services purchased by CareSource.
- **Fraudulent credentials** – Falsify credentials submitted for employment.
- **Fraudulent enrollment and marketing practices** – Federal and state health program enrollment practices are heavily controlled. An example would be enticing potential members to enroll by presenting incorrect benefit information.
- **Embezzlement and theft** – The appropriation of company/Medicaid/Medicare monies by a workforce member for his/her own use or benefit.

- **Underutilization of services/benefits** – Denying or limiting access to Services/Benefits to which the member is entitled.

4.0 Anti-Fraud Activities

4.1 TOOLS AND RESOURCES FOR FRAUD DETECTION

The CareSource SIU utilizes a wide variety of pre- and post-payment fraud detection tools and resources to monitor and analyze various member, provider, and pharmacy data for potential FWA. These tools include but are not limited to the following:

Reporting Mechanisms

SIU offers multiple avenues for reporting FWA. Providing multiple reporting options ensure our members, providers, vendors and workforce are able to communicate their concerns in an anonymous and confidential manner to the extent allowable by law. Please see Section 10 – Reporting FWA for more details.

- Fraud Hotline
- Fraud Email Box
- Fraud Fax
- Fraud Reporting Form
- Internal Routing within the Claims Adjudication System
- Letters
- Ethics & Compliance Hotline
- In person reporting

Reporting options are publicized to workforce members through multiple communication efforts such as: print posters, intranet web pages, newsletters and employee badges. These communication efforts provide a gentle reminder of the importance of reporting concerns.

Other Fraud Detection Sources

FWA cases can be referred to or discovered by SIU through:

- Media Articles
- Information Sharing Meetings
- Excluded/Suspended/Debarment Listings
- Face-to-Face Employee Referrals
- Fraud Alerts

- Credible Allegation of Fraud Notices
- Explanation of Member Benefit Statements
- Special Investigation Resource and Intelligence System (SIRIS)
- FWA Information Sharing Meetings
- PLATO
- SAS Alerts
- Request for Investigative Assistance (RIAs)
- Health Fraud Prevention Partnership
- FWA trainings, seminars, and conferences
- Fraud Task Force Meetings

Claims Clearinghouse

CareSource utilizes a claims clearinghouse as the first step in ensuring payment integrity. Claims electronically sent from providers to CareSource pass through this system. The system checks for member eligibility and other billing issues like appropriate member sex for the type of surgery.

Claims System Edits

CareSource utilizes Optum Claims Edit System®, a pre-payment clinical editing software application used to ensure claim billing codes are in compliance with state requirements, medical/claims payment policies and national coding guidelines, including Correct Coding Initiative (CCI) edits and National Coverage Determinations (NCD)/Local Coverage Determinations (LCD) requirements. Some or more of these may be applied based on line of business/state-specific requirements.

Thousands of claim edits are utilized to prevent improper payments to providers of medical services due to coding errors such as unbundling, inappropriate modifier use, diagnoses mismatch, duplicate claims, etc. The edited data is updated quarterly with CPT/HCPCS and diagnosis codes changes. All claims are processed through this software prior to adjudication.

FICO Pre-Pay Predictive Analytic Fraud Detection System – CareSource recently implemented FICO's Insurance Fraud Manager. This is an enterprise class solution for healthcare payers designed to stop FWA. Based on FICO's market-leading adaptive predictive

models, it can analyze pre-pay (adjudicated, but not yet paid) claims by scoring for FWA and stopping claims from paying. It dramatically improves claims processing accuracy, payment integrity and compliance.

Daily, after the claim system has determined that a claim should be paid, the claim is sent to FICO to score each claim line. The claim lines are scored from 0 to 1000 with 1000 being the highest indication of fraud. SIU reviews claim lines with a high indication of fraud prior to payment and may request medical records be submitted prior to payment. This methodology prevents pay and chase.

Provider Pre-Pay Review

Providers under an audit or investigation may be placed on a pre-pay review prior to payment of claims. SIU will evaluate various sources of information for risk related practices. Prepayment reviews look for overutilization of services or other practices that, directly or indirectly, result in unnecessary cost to the health care industry. These audits confirm appropriate utilization of cost effective services and substantiating documentation to support services provided to the member.

Fraud Detection Software

The CareSource SIU utilizes Lexis Nexis Intelligent Investigator™, a post-payment, rules-based fraud detection software application that pinpoints patterns of suspicious behavior across all healthcare types. The advanced drill-down feature allows SIU staff to easily trace leads by provider, member/patient, transaction and other related data. Special screens are used to assist the reviewers in identifying providers or claims based on partial information or tips from fraud hotlines. A Composite Lead Indicator (CLI) built into Intelligent Investigator™ makes it easy to identify the leads with the most impact. The CLI tool prioritizes the potential savings and recovery probability of each lead in order to establish the recommended order of case sequencing. Other features of this software include provider specialty comparisons and triage reports, which SIU receives on a monthly/quarterly basis and uses to analyze claims data for known fraud scenarios such as:

- Upcoding of services
- Duplication of payments

- Unbundling of services
- Provider billing pattern changes
- High dollar providers within provider type
- Add-on CPT codes billed without the primary CPT code
- Spike Reports

Triage reports are reviewed and preliminary investigations are opened on any unexplained activity. Investigations are then assigned to an SIU associate investigator for in-depth review and exposure assessment.

FICO Predictive Analytic Post-Pay Software – This software evaluates and scores providers from 0 to 1000 with 100 being the highest indication of fraud. It scores all medical providers, pharmacy, and dental providers, and generates reports focusing on providers with billing aberrancies.

Claim payment files are submitted to FICO for appropriate scoring, and review high scored claims for possible FWA. Fraud Claims Analysts are able to review suspect providers and create claim processing rules to more swiftly react to suspected FWA schemes.

Data Analytics

The SIU has a data analytic team who supports the SIU through three primary activities: fraud detection, data reporting, and data analysis.

Fraud Detection. The data team analyzes multiple reports of known fraud scenarios generated by post-pay fraud detection software. In addition, they review check writes and create new reports based on newly identified fraud schemes. The data team often engages in special projects for, or in collaboration with other CareSource departments, financial analyses, or collaborations and partnerships with industry organizations and state/federal projects.

Data Reporting. The data team creates detailed operational/analytic reports and mapping utilizing BI software. Reports are compiled to manage various operational/compliance requirements. This team also generates data to meet compliance and regulatory requirements, and provide requested data to law enforcement agencies such as Attorney General, Office of Inspector General, MEDIC, Department of Justice, Medicaid Fraud Control Unit, etc.

Data Analysis. The data team is responsible for creating reports for identified fraud schemes identified in the OIG work plan, information sharing meetings, trainings, the SIRIS database (through NHCAA), and other sources as applicable.

The team then assists the investigator by running multiple data models to analyze the trends and patterns. Once the investigator determines an investigative course of action, this team assists with statistical validation of data for extrapolation and recovery.

Examples of fraud detection reports include:

- Provider Charged and Paid Spike Report – compares charges received from, and payment issued to, providers over the most recent four quarters.
- Utilization by All Percent – shows percentage of Utilization of Procedure Codes per provider.
- Utilization by Self Percent – shows utilization percentage of procedure codes by a provider.
- AVG00009 High UOS for Procedure Facility (Paid) – shows paid claim lines submitted by a facility where the units of services are higher than the average units of service associated with that procedure code.
- AVG00011 High UOS for Procedure Provider (Paid) – shows paid claim lines submitted by a provider where the units of service are higher than the average units of service associated with that procedure code.

PBM Data Analytics:

CareSource's PBM runs the following quarterly reports to identify trends or patterns of potential provider/pharmacy/member FWA per CMS Medicare Part D FWA monitoring requirements. The suites of FWA reports are designed to help identify outlier patients, prescribers, patients or trends. The FWA reports summarize data in several formats to look for stand-outs. These reports are subject to change based on industry trends or if PBM auditors are consistently identifying problem drugs in audits.

- Top 14 Report
 - o Members, by dollars. Each time the report is run, it will exclude the previous fourteen members. Example - do the drugs make sense? A

Med D HIV member was identified as harvesting HIV drugs as he obtained multiple and duplicating HIV drugs from multiple pharmacies and prescribers.

- o Prescribers, by dollars. List of the top 14 prescribers and specialty. Example – is there a dentist or pain management specialist or some other odd specialty that is a high prescriber?
- o Control Drug Prescribers – by dollars, lists the top control drug prescribers for the reporting period. Created for the client to review to determine if they have any outliers.
- o Pharmacies, by dollars. Lists the top pharmacies. Example – we expect to see specialty pharmacies, but look for potential diabetic mail orders, non-PBM specialty and determine if audit is warranted.
- Top drugs per pharmacy – shows if that drug is greater than 25% of CareSource's drug spend at that pharmacy versus CareSource's entire drug spend at that pharmacy.
- Top prescriber by pharmacy – shows if prescriber is greater than 15% of CareSource's drug spend at that pharmacy versus CareSource's entire drug spend at that pharmacy.
- All Meds Report – focuses on certain drug classes and will show if more than 4 claims for that drug are billed per quarter. Common drug classes include control drugs, HIV medications, drugs found to be billed fraudulently. Each class is summarized on separate tabs by member, by pharmacy, claims detail.
 - o HIV tabs – reviews HIV medications, but excludes acyclovir, a low cost HIV treatment. Drugs include: Novir, Fuzeon, Isentress, Atripla, Combivir.
 - o Combo tab – includes drugs in the narcotic analgesic class. These are often drugs of abuse and have a street value. Drugs include: oxycontin, oxycodone, Vicodin, hydrocodone, fentanyl, Xanax, APAP with codeine, etc.
 - o Drug Mix – reviews drugs found by Caremark investigative auditors as potentially fraudulently billed and includes Advair, Zyprexa, Lidoderm, Dovonex, Abilify, Geodon, Seroquel, Solaraze, etc.
 - o Creams and Ointments tab – will include expensive creams and ointments

found by PBM auditors and also reported to be subject to problem billings by other plans. Drugs include ciclopirox, desoximetasone, Dovonex, Solarze, Tazorac, Zovirax ointment.

- Sum Detail Reports – quarterly reports which detail, at a claim level, the audited claims (daily/concurrent review, onsite audits, and investigative audits) and the resulting savings for CareSource.
- Overutilization Monitoring System/Patient Safety Report – CMS sends quarterly reports to CareSource identifying beneficiaries with potential overutilization issues. These reports are sent to PBM, who reviews claims for potential FWA and identifies high risk profiles. If potential FWA is identified, the PBM sends the data to the OMS point of contact in the SIU and the data is reviewed to determine the most effective interventions.

The PBM analyzes the reports, identifies outliers, and records findings and recommendations in a cumulative audit log. In addition to this analysis, the PBM performs routine pharmacy audits, and logs all audits with discrepancies and recoveries. CareSource SIU and Pharmacy departments independently review these reports and meet with the PBM quarterly to discuss and determine appropriate action. By utilizing reports mentioned above, the Pharmacy Medicare Part D Fraud Specialist is able to track and review for any trends or additional exposure. Based on monitoring, SIU can recommend changes in formulary, refer to PBM for audit, recommend recovery, open a prescriber investigation, and refer to external agencies/law enforcement as appropriate.

The PBM performs monthly prohibited affiliation checks. Upon identification of a prohibited affiliation, the PBM notifies CareSource and determines if claims were processed during the exclusion period. Appropriate action will be taken (e.g. recovery or termination). The PBM also does point-of-sale prohibited affiliation checks before prescriptions are dispensed.

PBM Proactive Responsibilities:

CVS/Caremark's comprehensive audit process is designed to identify discrepancies; prevent and detect fraud, waste, and abuse; and provide a deterrence message to pharmacies. When fraud, waste, or abuse involving a network pharmacy is identified, CVS/Caremark works closely with the impacted clients to communicate the issues and provides the necessary support to correct any future problems. In addition, CVS/Caremark provides standard audit reporting to CareSource as requested. The typical reporting schedule is a quarterly audit results report which includes audits performed, audits in process, audits closed, and the resulting discrepancies/savings identified.

The audit process encompasses retrospective, concurrent and prospective elements which include:

- Pharmacy Exceptional Activity Report (PEAR)
- Daily Professional Review and Compound Review
- Payment trending analysis
- Claims analysis
- Ad hoc analysis for new trends
- Aberrant dosing reviews
- Member tracking
- Pharmacy data mining for fraudulent pattern recognition
- Education efforts
- External tips and follow-up

In addition to these tools/processes, Pharmacy Performance incorporates Medicare Part D fraud, waste and abuse requirements, specific guidelines regarding long-term care audits, and medication error identification program.

CVS Caremark conducts weekly on-site and off-site audits of certain retail participating pharmacies to help verify compliance with their respective pharmacy network agreement with CVS Caremark. Such audits include a daily review of claims submitted that are in

excess of one thousand dollars (\$1,000.00). If claims are not billed in accordance to the agreement, CVS Caremark makes reasonable attempts to collect and reconcile such audit discrepancies. Audit discrepancies are discussed during SIU's quarterly meeting with CVS Caremark.

CVS Caremark annually reviews the United States Department of Health and Human Services Office of Inspector General ("OIG") and the General Services Administration ("GSA") exclusion list of individuals or entities to determine whether any employees of CVS Caremark or its affiliates are named or any claims for prescription drugs are written by a prescriber named on an exclusion list. CVS Caremark requires its downstream contractors to review the exclusion list to determine if any downstream contractor's employees are named.

CareSource Monitoring of PBM, Pharmacy, and Part D Activities:

Pharmacy fraud examiner and the Medicare Part D fraud specialist collaborate with CareSource's PBM, CVS Caremark, when identifying and resolving FWA, and ensuring compliance with new or changing FWA state and federal regulations and processes. They also provide FWA expertise and input for the Pharmacy department operations, processes, and initiatives. In addition to ensuring compliance, the Pharmacy Medicare Part D Fraud Specialist serves as the Part D Overutilization Monitoring System Program point of contact. By utilizing reports provided by the PBM, such as - audit logs, all medications summary report, high unique drug dispensed, prescriber top 14 – the Pharmacy Medicare Part D Fraud Specialist is able to track and review for any trends or additional exposure. Based on monitoring, SIU can recommend changes in formulary, refer to PBM for audit, recommend recovery, and refer to external agencies/law enforcement as appropriate.

Based on investigations, SIU recommends changes to formulary, terminations from pharmacy network, and other corrective actions as necessary. Pharmacy termination recommendations are taken to Investigation Committee for review. Any recommendations on formulary changes are presented to the Pharmacy department. Pharmacy takes the recommendation to the appropriate Pharmacy and Therapeutics

Committee for review and decisioning. Cases are reported to state and federal agencies as appropriate, and loaded into PLATO.

Monitoring and Auditing

Review claims payment accuracy audits. The Operational Excellence Department conducts monthly claim reviews looking for claim processing aberrancies and payment inaccuracies. These reports are then provided to the SIU to review for irregular behavior, and to take appropriate action where necessary.

Review claim audits. The Claims department audits high dollar facility claims. The SIU has a high risk fraud audit process in place (see section 6.0).

Review re-credentialing providers. All re-credentialing providers are compared against our Investigative Case Tracking System to identify any prior or current investigation for potential FWA concerns.

Review grievance data. Member grievances are reviewed to trend for any FWA concerns. Grievances relevant to individual cases under investigation are reviewed as part of the investigative process.

Review check-writes. SIU, Claims and Finance Departments review claim payments being released to providers to identify any outliers.

Participate in regular committee meeting. SIU actively participates in multiple committee and workgroup meetings across the organization to identify potential risks and provide input from a FWA perspective.

Distribute Explanation of Benefits Statements. Members receive an Explanation of Benefits (EOB) statement to review and validate services paid for were received. Contact information for reporting concerns is provided on the statement. The frequency of and criteria for distribution is in accordance with the appropriate requirements. All EOB responses received are entered into an Investigative Case Tracking System for review. See the SIU – Verification of Member Service Explanation of Member Benefits Policy and Procedure for details.

Review the Annual OIG Fraud Work Plan. SIU reviews fraud schemes noted in the annual OIG Fraud Work Plan to develop investigative focus for the following year.

Prevent embezzlement and theft. Appropriate internal controls have been established to shield CareSource from instances of employee theft and embezzlement. These internal controls are established and maintained within our Finance and Internal Audit departments.

Review for prohibited affiliations. CareSource utilizes Zebu, a database application tool, to review providers, vendors and employees for prohibited affiliations, state sanctions and license status. Zebu also allows for review and verification of the national terrorist list. Provider, vendor and employee reviews are performed on a monthly basis (See Section 3.5).

4.2 INVESTIGATIONS

All SIU staff is committed to investigating all reported allegations/findings in a fair and impartial manner. SIU investigators strive to conduct investigations logically and thoroughly from referral to close. Cases are prioritized based on the greatest potential for impact to CareSource and our members.

Investigative Case Tracking System

SIU utilizes an investigative case tracking system for all FWA cases. The system is designed to manage investigative caseloads, case documentation and to provide a trail of investigative activity/evidence. The detailed tracking mechanisms and documentation features allow SIU to maintain strict adherence to department processes and respect for the integrity of the investigation.

Investigations

All allegations/findings undergo an initial review within 72 business hours. The initial review includes many elements to include research into other allegations, analysis of grievance and appeal data, and a full review of the provider's billing and payment history for both medical and pharmacy claims. All allegations with merit are moved to triage to determine validity, and then to a full investigation if warranted. Preliminary investigations where allegations are found to be without merit are closed.

Coordination Team

The SIU Coordination team operates within three fundamental activities: intakes, investigative support, and regulatory/law enforcement response support. Through the intake process, coordinators are responsible for constant review of all intake sources for allegations involving eminent patient harm as well as reviewing all fraud referrals in a timely fashion. This team loads all allegations/findings of FWA, and checks all systems (internal and external) for exposure and/or prior allegations, or investigations. The team supports the investigative staff through: creating and sending provider records requests, tracking outstanding records requests and following up as appropriate, scanning incoming records, facilitating pharmacy and medical data requests, collecting contracts and credentialing files, and loading paper files into the internal document workflow system. The regulatory and law enforcement support involves providing prompt response to regulators and law enforcement requests for information or investigative assistance. Anything identified as urgent is forwarded to Triage promptly.

Triage Team:

In triage, the fraud analysts work to validate allegations/findings with merit to determine legitimacy and move applicable cases to a full investigation. The team performs research to validate the suspicion of FWA by performing the following activities:

- Performing utilization analysis using fraud detection software and drilling down to confirm outliers
- Researching state and federal billing and coding rules
- Obtaining a sampling of medical records
- Interviewing relevant individuals to confirm findings
- Pursuing record review by clinical investigator/medical coding experts
- Creating and analyzing peer comparison reports
- Educating provider and sending “outlier notification” letters to providers when low impact FWA is identified.

Investigative Team:

Validated cases are moved to a full investigation. Each case is evaluated and handled on its own merit. Open cases are prioritized to ensure cases with the greatest potential impact are

given the highest priority. While each investigation is worked on its own merits an example of steps taken in a full investigation may include:

- High level data analytics and drill-down into medical, dental, behavior health and/or pharmacy claims data
- Provider scope of practice and license research
- Business ownership research
- Internet/social media and in-depth personal background research
- Credentialing and provider contract review
- Medical/payment policy
- Medical industry standard research
- Line of business rule and guideline research
- Phone or in-person interviews
- Statistically valid medical record request
- Expert clinical and coding review
- Onsite visit/surveillance
- Law enforcement collaboration

If the investigative findings support FWA, a report is submitted to all external agencies as required. If warranted, the Special Investigations Unit may pend provider claims until the investigation finalized.

The case resolution will vary greatly based on the investigative findings. Beyond the mitigation and corrective actions detailed in section 4.4, the investigative team has specific responsibilities to ensure an effective case resolution. Below are examples of activities that may be initiated in order to resolve a case:

- Provider education
- Formal corrective action plans (CAP) and monitoring of CAP compliance
- Provider termination for cause or not for cause termination
- Dollar recovery
- Arbitration or litigation
- Internal issue mitigation

Upon confirmation of potential FWA, the case is reported to the appropriate state and/or federal agency and cooperates with any investigation that may be pursued. More information on reporting procedures in the SIU Fraud, Waste and Abuse Reporting policies.

4.3 MEDICAID PHARMACY AND MEDICARE PART D FWA PROGRAMS/ACTIVITIES

SIU monitors CareSource's pharmacy benefit for FWA and ensures compliance with FWA-related Medicare Part D guidelines and regulations. Our pharmacy investigators review and analyze pharmacy and Medicare Part D data to identify patterns, trends, and data aberrancies/schemes for FWA across all lines of business. Investigators provide oversight and monitoring around monthly/quarterly CMS required patient safety reports and ensure operational readiness by providing regular reporting and communications to management, stakeholders, and departments.

The pharmacy investigators and the Pharmacy Medicare Part D Fraud Specialist collaborate with CareSource's PBM, CVS Caremark, when identifying and resolving FWA, and ensuring compliance with new or changing FWA state and federal regulations and processes. They also provide FWA expertise and input for the Pharmacy department operations, processes, and initiatives. In addition to ensuring compliance, the Pharmacy Medicare Part D Fraud Specialist serves as the Part D Overutilization Monitoring System Program point of contact. Based on investigations, SIU recommends changes to formulary, terminations from pharmacy network, and other corrective actions as necessary. Cases are reported to state and federal agencies as appropriate.

MEDICAID PHARMACY ACTIVITIES

SIU monitors CareSource's Medicaid pharmacy benefit for FWA and ensures compliance with Medicaid guidelines and regulations. Our pharmacy investigators review and analyze pharmacy data to identify patterns, trends, and data aberrancies/schemes for FWA across all Medicaid lines of business. Investigators provide oversight and monitoring through review of quarterly internal reports and communicate the results to management, stakeholders, and applicable departments. Quarterly reports include but are not limited to: high volume of controlled substances, high dollar prescriptions, and high volume of prescriptions. The FICO system will flag suspicious pharmacy-related claims activity, which may result in an investigation if

appropriate. Any referrals or notifications from CareSource's PBM's audit plan will be reviewed to monitor for exposure. If exposure exists, CareSource completes a full exposure check across all lines of business and takes the appropriate actions. Cases are reported in accordance with state Medicaid regulations as required.

4.4 MITIGATION & CORRECTIVE ACTIONS

SIU has coordinated with the relevant operational departments to ensure swift, effective and appropriate corrective actions can be taken with minimal disruption to our members. The corrective actions taken are driven by the specific facts of the case, and are overseen by the SIU Director and/or the Investigative Committee. This ensures consistent and proportionate application and timely execution of all corrective actions. Corrective actions may include, but are not limited to:

- Provider written warnings and/or education
- Formal Corrective Action Plans
- Provider with cause and without cause termination
- Claim dollar recovery
- Legal action
- Submission to and cooperation with Law Enforcement Agencies
- Recommendation for member disenrollment
- Medical Board and/or National Practitioner Database (NPDB) Reports
- Repayment of embezzled/stolen funds
- Provider pre-pay review

Beyond just the individual cases of FWA, SIU continues to work with all necessary operational departments to effect broader company changes to prevent the fraudulent activity from reoccurring. Some examples include:

- Company fraud prevention information updates
- Fraud detection software modification to detect new fraud schemes
- Addition or modification of additional claims adjudication system edits
- Addition or modification of new medical and payment policies
- Prior authorization requirements

4.5 REPORTING

Upon confirmation of potential FWA, CareSource SIU promptly reports cases to the appropriate state and federal agencies. Those agencies include, but are not limited to, the state Medicaid Agencies, state Attorney General Medicaid Fraud Control Units, MEDIC, HHS-OIG, and the state Departments of Insurance. In addition, Medical Boards, Pharmacy Boards, local and state law enforcement, FBI, and DOH are notified as necessary depending on the line of business and the investigative findings.

SIU cooperates with any state or federal investigation that may be pursued. For more information, please reference the SIU reporting policies.

4.6 MEASURING EFFECTIVENESS

Measuring and evaluating the effectiveness of the CareSource SIU is important. Therefore, various metrics have been developed to ensure the quality of our operations and demonstrate our valuable contributions to the company and state and Federal programs.

To ensure the quality of our operations, SIU monitors investigative case activity metrics each month. These measures are reported to Investigative Committee and Compliance Committee.

SIU measures our value by the money we recover and prevent from being paid, that includes money saved as a result of internal weaknesses identified and corrected. Savings are captured according to the following categories: hard dollar recoveries, denial savings, prevented losses, identified losses, and court ordered restitution.

5.0 COORDINATION WITH FEDERAL, STATE AND LOCAL AGENCIES

5.1 PARTNERSHIP

Our goal is to create and foster effective partnerships with the state and federal agencies, including Medicaid Fraud Control Units, MEDIC and Office of Inspector General that are focused on preventing, detecting and correcting FWA. SIU reaches out to state and federal law enforcement agencies during investigations to alert them to findings and to cooperate by providing case information and claims data. SIU attends any training as required by state and federal agencies provided reasonable advance notice in addition to providing training at national conferences or other meetings.

5.2 INFORMATION SHARING

- SIU has access to and utilizes the SIRIS database wherein NHCAA member companies upload new fraud schemes and specific providers under investigation.
- CareSource SIU participates in the Health Fraud Prevention Partnership (HFPP), which is an effort led by CMS. CareSource provides claim data that is combined with data from CMS and other plans in order to look for fraud from a broader perspective.
- SIU attends state and national information sharing meetings and roundtable discussions as well as contributing to state Medicaid Program Integrity meetings.

6.0 Auditing Program

6.1 DESCRIPTION

The SIU has developed an audit program to support its mission to detect, prevent, and correct potential fraud, waste and abuse and to safeguard against improper payments. There are two auditing programs in place – (1) an internal auditing function, and (2) an external high risk for fraud audit function. A high risk for fraud audit plan is created annually and serves as the guide for each year's auditing activities.

Departmental Monitoring Function:

The internal audit function consists of monitoring of investigative processes to ensure compliance with departmental policies and procedures, as well as develop and implement corrective action plans as needed. Cases are selected and audited based on a management approved audit tool. These cases are scored accordingly. Managers track these scores by investigator in order to monitor performance, and identify improvement measures.

High Risk Auditing Function:

The audit process serves to ensure that procedures and payment mechanisms are consistent with regulatory and MCO contractual requirements. The audit methodology measures against a set of standards, such as compliance with provider agreement requirements, state and federal statutes and regulations, as well as CareSource's clinical and payment policies. This affords CareSource the opportunity to implement systematic and independent examination of provider records, claims data, and other relevant documents to identify and reduce the occurrence of inappropriate and overpayment of claims.

The audit program also prioritizes, tracks, and reports on any internal improvements identified during an audit to the appropriate department with recommendations for necessary internal control implementation. The intent is to work with key departments to drive process improvements critical to preventing FWA.

SIU's external audit program aligns with CMS' definition of auditing by performing formal retrospective reviews of a subset of providers with a methodical approach and sampling of requested documentation. The objectives of the external provider program are to: ensure

claims paid to providers are for care and services that are appropriately evidenced and documented, that appropriate coding is used in billing for care and services, that services are covered by CareSource, and that these services are delivered according to state and federal regulations. Audits may be performed via medical record review as well as through an onsite audit depending on circumstances.

CareSource SIU performs both announced and unannounced site visits and field audits. Whether a visit/audit is announced depends on the issue identified. If there is no suspicion that the provider will modify or destroy medical documentation, SIU may provide a short notification period to ensure the provider and staff will be present when CareSource arrives. If, on the other hand, SIU concerns that the provider will destroy or modify medical documentation, SIU will proceed with an unannounced audit. In either case, the majority of medical records are requested on the day of the visit so there is no ability to modify them. SIU brings a copy service or scanner to copy the medical records. If an onsite audit is performed, medical records may be reviewed onsite to allow questioning of staff and provider.

7.0 DELEGATED ENTITIES

7.1 CARESOURCE POLICY

A delegated entity is a business relationship between the organization and a first-tier entity or vendor/subcontractor as defined by Medicaid contractual requirements to perform certain functions that otherwise would be the responsibility of the organization to perform. The organization oversees and is accountable for any functions or responsibilities that are delegated to other entities whether the functions are provided by the first-tier and other downstream entities or subcontractor. CareSource delegated entities are contractually bound to abide by and comply with the Federal False Claims Act requirements and any applicable state false claims statutes and are responsible for reporting any concerns or allegations of fraud, waste or abuse in accordance with the CareSource Corporate Compliance Plan. Our delegated entities are also required to screen for prohibited affiliations upon hire/contract and monthly thereafter. Any identified prohibited affiliates are to be reported to CareSource immediately.

On an annual basis delegated entities are provided a letter containing information on general compliance, HIPAA and HITECH, FWA, False Claims Act, whistleblower protections, Anti-Kickback Statute, Stark Law, prohibited affiliations, disclosure of ownership, debarment and criminal convictions, and FWA reporting requirements and mechanisms. The delegated entities are required to complete an attestation confirming their understanding of the information provided and their compliance with those requirements.

The CareSource Enterprise Risk and Oversight and Credentialing departments perform assessments prior to the execution and implementation of a delegated arrangement. This process assesses for compliance with all state and federal laws, rules and regulations. On-going compliance of delegated entities is ensured through monthly, quarterly, semi-annual and/or annual monitoring. Appropriate corrective actions, up to and including revocation and/or termination of delegation, are imposed when deficiencies are identified.

The CareSource SIU will assess the size, scope of functions performed and susceptibility to FWA of the delegated entity and implement the appropriate level of monitoring and coordination to ensure FWA is prevented, identified, investigated, mitigated, corrected and reported. (See SIU – Delegated Entity/First Tier, Downstream Related Entity FWA Policy & Procedure).

8.0 RECORD RETENTION AND DOCUMENTATION

8.1 CARESOURCE POLICY

It is the policy of CareSource to retain records, regardless of media, in accordance with applicable federal, state, and local statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), and guidelines set forth by NCQA, URAC, and other industry standards.

CareSource SIU maintains program integrity and FWA documents according to our CareSource corporate policy. (See Legal – Retention of Records Policy & Procedure).

Requirements vary by contractual requirements, lines of business, and type of collateral.

9.0 PROGRAM INTEGRITY WORK PLAN

9.1 DESCRIPTION

The Program Integrity Work Plan encompasses all of the compliance related activities for the department. It captures overarching compliance themes, applicable lines of business, regulatory citations, activities completed to maintain compliance, and documentation references to support those activities, as well as business owners for each task. The work plan functions as a repository of regulatory requirements to ensure program integrity within the organization. The Program Integrity function within SIU is also responsible for updating and maintaining this Anti-Fraud Plan in addition to working closely with the Corporate Compliance department to review and ascertain appropriate documentation for all requirements.

10.0 Reporting Mechanisms

Fraud, Waste, and Abuse/Ethics/Compliance Reporting Mechanisms

All reports may be **anonymous** and are **confidential** to the extent permitted by law.

SIU Director (responsible for CareSource's FWA program and the Anti-Fraud Plan):

Katherine Leff, RN, CLU, ALHC, CFE, AHFI, CHC; Director, SIU

Phone: 937-531-3451

Fax: 937-487-0290

Email: Katherine.leff@caresource.com

Address: P.O. Box 1940; Dayton, OH 45401-1940

Fraud Hotlines – Follow the Prompts to Report Fraud:

LOB	Member Line	Provider Line
IN Just4Me	877-806-9284	866-286-9949
IN Medicaid	844-607-2829	844-607-2831
IN Medicare Advantage	800-418-0172	855-202-0557
GA Medicaid	855-202-0729	855-202-1058
KY Medicaid	855-852-7005	855-852-7005
KY Just4Me	888-815-6446	855-852-5558
KY Medicare Advantage	800-833-3239	855-202-1059
OH Medicaid	800-488-0134	800-488-0134
OH MyCare	855-475-3163	800-488-0134
OH Just4Me	800-479-9502	800-488-0134
West Virginia Just4Me	855-202-0622	855-202-1091
Internal Ethics and Compliance Hotline	Employees: 844-784-9583	

Written Report: Write a letter or use the Fraud, Waste and Abuse Reporting Form at www.caresource.com or in the provider manual and send to:

CareSource
Attn: Special Investigations Unit
P.O. Box 1940
Dayton, OH 45401-1940

You do not have to use your name when you write or call.

Non-anonymous options for reporting include:

- ☐ **Email:** fraud@caresource.com
- ☐ **Fax:** 800-418-0248

Additional Ohio Medicaid reporting is available:

- ☐ Ohio Department of Medicaid (ODM) 1-614-466-0722 or at <http://medicaid.ohio.gov/RESOURCES/HelpfulLinks/ReportingSuspectedMedicaidFraud.aspx>;
- ☐ Medicaid Fraud Control Unit (MFCU) 1-800-642-2873 or at

- <http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud>; and
- The Ohio Auditor of State (AOS) 1-866-FRAUD-OH or by email at fraudohio@ohioauditor.gov

11.0 DEFINITIONS, HELPFUL LINKS, LAWS & REGULATIONS

11.1 DEFINITIONS

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient/member practices that result in unnecessary costs to the Medicaid program. (42 CFR 455.2). Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends upon specific facts and circumstances, intent and prior knowledge, and available evidence among other factors. Abuse involves payment for items or services when there is no legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Anonymous – Given without name or other identifying information.

Anti-kickback Statute – A federal statute that protects patients and Federal health care programs from fraud and abuse by prohibiting any person from knowingly offering or paying, soliciting or receiving, anything of value (including any kickback, bribe or rebate) in return for referring an individual for, or purchasing or ordering or arranging for or recommending purchasing or ordering of, any item or service reimbursable by a of Federal health care program business. An individual need not have actual knowledge of the Anti-Kickback Statute or specific intent to commit a violation of the Anti-Kickback Statute in order to meet the “knowingly” element of an Anti-Kickback violation.

CareSource – CareSource is a family of managed healthcare plans that includes all of our plans in all of our states of operation, all of our products including CareSource Advantage and the CareSource Foundation.

Compliance and Ethics reporting mechanisms – The methods employees should use to report internal compliance concerns. This reporting system is managed by an outside vendor to assure employees anonymity, if preferred, when reporting a concern. Contact information can

be found in the Reporting a Concern section. Reports can be made anonymously and are kept confidential to the extent permitted by law.

Confidential – Revealed in the expectation that anything done or revealed will be kept private. Reported concerns are kept private to the extent permitted by law.

Corporate Compliance Officer – The Corporate Compliance Officer oversees the corporate compliance program, functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization.

Corrective Action Plan (CAP) – A written notification outlining the mandatory steps to be implemented in order to maintain compliance with state, federal, NCQA, URAC and/or CareSource-designated requirements.

Downstream Entity - Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

E-Learning – A term to describe web-based distance learning.

Entity – Includes a governmental agency, an organization, a unit, a corporation, a partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State plan approved under Title XIX or under any waiver or such plan, totaling at least \$5 Million annually. [A government agency that merely administers the Medicaid program, in whole or part, is not an entity for purposes of Section 6032 of the DRA. However, if a governmental component provides Medicaid health care items or services for which Medicaid payments are made, it would qualify as an entity.]

False Claims Act – This act permits individuals to help reduce fraud against the federal government by allowing them to bring “whistleblowers” lawsuits on behalf of the government (known as “qui tam” suits) against groups or other individuals that are defrauding the

government through programs, agencies, or contracts. Refer to CareSource's False Claims Act Policy for more detailed information.

Ethics – The discipline of dealing with what is good and bad and with moral duty and obligation.

First Tier Entity – Any party that enters into a written agreement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

An intentional deception or misrepresentation made by a recipient or a provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or provider or to some other person. It includes any act that constitutes fraud under applicable federal or state laws.

Knowingly or willfully executing or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

FWA reporting mechanisms – Ways an employee, provider, member or other may report allegations of fraud, waste and abuse to CareSource. Reports can be made anonymously and are kept confidential to the extent permitted by law. Contact mechanisms are identified in the Reporting a Concern section.

HIPAA – Health Insurance Portability and Accountability Act. Health Insurance Portability and Accountability Act of 1996, and implementing regulations (45 CFR 142, 160, 162 and 164) all as may be amended. A United States legislation that provides data security and security provisions for safeguarding medical information.

Integrity – The adherence to a moral code, reflected in honesty and harmony in what one thinks, says and does.

Knowingly – To conduct or to a circumstance described by a statute defining an offense, that a person is aware that his conduct is of that nature or that the circumstance exists. To act with actual knowledge, reckless disregard, or deliberate indifference to the truth or falsity of information.

Privacy – We are required by many state and federal laws to safeguard our members' confidentiality. Some of these laws also give individuals additional privacy rights such as the right to access their medical records, request an amendment to their records and receive a list of individuals and/or entities to whom CareSource has disclosed their information.

Proprietary – Of or relating to private ownership with exclusive rights of use.

Related Entity - The term related entity means any entity that is related to the Sponsor by common ownership or control and:

1. Performs some of the Sponsor's management functions under contract or delegation;
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the Sponsor at a cost of more than \$2,500 during a contract period.

Retaliation – A negative consequence for something done in good faith. This can include things like demotion, hostility, adverse changes in job requirements or other undesirable actions by an employer, supervisor or coworker. Retaliation against an employee for a good faith action is strictly prohibited.

Special Investigations Unit (SIU) – The unit at CareSource that handles program integrity by preventing, detecting, investigating, mitigating, correcting and reporting FWA.

Stark Law – A law that prohibits physician self-referrals. The law applies to physicians that provide care to Medicare, Medicaid, or other federal health program recipients and states that a physician cannot refer a patient for certain designated health services to any entity with which the physician has a financial interest. There are exceptions to this rule.

Unbundling – A fraudulent practice in which provider services are broken down to their individual components, resulting in a higher payment by the payor.

Upcoding – A practice of assigning a billing or diagnosis code that reflects a falsely high level of patient acuity and medical service in order to generate higher reimbursement than the provider otherwise would receive

URAC – A nonprofit organization promoting healthcare quality by accrediting healthcare organizations.

Vendor – Subcontractors, Delegated Entities, First Tier or Downstream Entities.

Whistleblower – A person that files an action under the False Claims Act is informally called a whistleblower. A person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either private or public.

11.2 LINKS

CareSource

<https://www.caresource.com/>

CareSource Corporate Compliance Plan

<http://departments.caresource.corp/sites/RABD/Lists/myFeatureContent/2014%20Compliance%20Plan%20v2.pdf>

CareSource Employee Handbook

<http://departments.caresource.corp/sites/HumanResources/Shared%20Documents/2014%20Employee%20Handbook.February%2002%2024%202014.Final.pdf>

CareSource Ethics Hotline

<http://caresource.ethicspoint.com>

Centers for Medicare & Medicaid Services

<http://www.cms.gov/>

Code of Federal Regulations (Title 42)

http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42tab_02.tpl.

Georgia Department of Community Health (Medicaid)

<https://dch.georgia.gov/medicaid>

Indiana Department of Insurance

<http://www.in.gov/idoi/>

Indiana Department of Medicaid

www.indianamedicaid.com

Kentucky Department of Insurance

<http://insurance.ky.gov/>

Kentucky Department for Medicaid Services

<http://chfs.ky.gov/dms/>

Medicaid

<http://www.medicaid.gov/>

NCQA

<http://www.ncqa.org/>

Ohio Association of Health Plans

<http://www.oahp.org/>

Ohio Department of Insurance

<https://www.insurance.ohio.gov/>

Ohio Department of Job and Family Service

<http://jfs.ohio.gov/>

Ohio Revised Code (ORC)

<http://codes.ohio.gov/orc/>

U.S. Department of Health and Human Services

<http://www.hhs.gov/>

CMS' Web-based FWA and General Compliance Training

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

Office of Inspector General (OIG) – A Roadmap for New Physicians Avoiding Medicare and Medicaid Fraud and Abuse

<http://oig.hhs.gov/compliance/physicianeducation/index.asp>

Health and Human Services (HHS) OIG - Exclusions Database

<http://exclusions.oig.hhs.gov/>

System for Award Management (SAM)

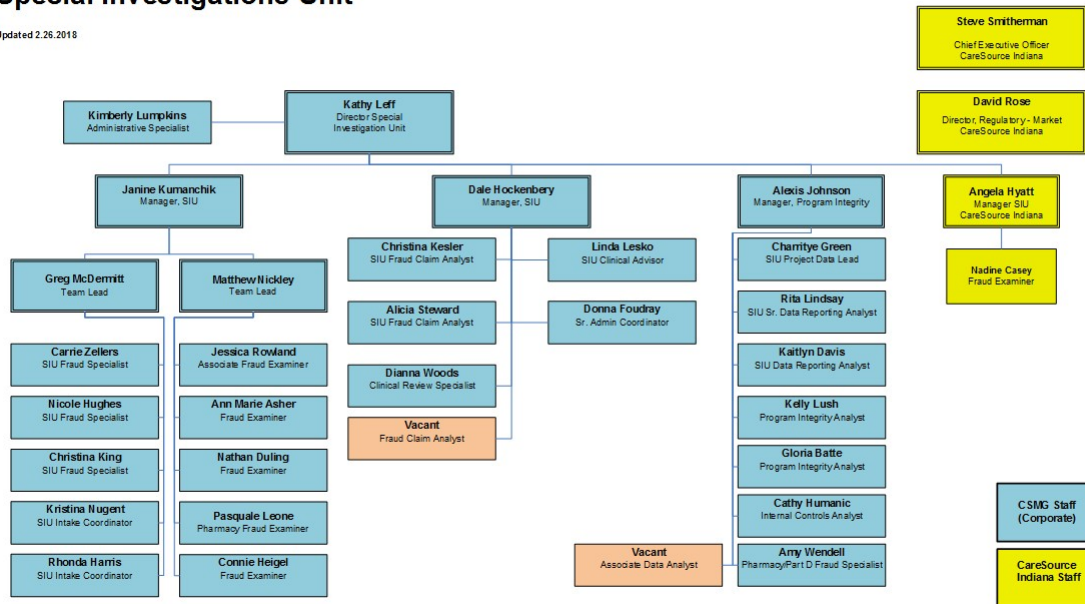
<https://www.sam.gov/portal/public/SAM/>

West Virginia Department of Insurance

<http://www.wvinsurance.gov/>

CareSource Special Investigations Unit

Updated 2.26.2018



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