ANTI-FRAUD, WASTE AND ABUSE PLAN
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ANTI-FRAUD, WASTE AND ABUSE PLAN

INTRODUCTION

[Name] is committed to a comprehensive plan to detect, correct and prevent fraud, waste and abuse (“FWA”). The Anti-Fraud, Waste and Abuse Plan (“Plan”) is integral to [Name’s] compliance program and applies to all [Name] business including commercial plans, Medicare Advantage plans, Medicare Prescription Drug plans, Medicaid managed care plans, and Federal Employee Health Benefit Plans (“FEHBP”).

The Plan is established and maintained for the purpose of preventing, detecting, and correcting FWA in compliance with applicable federal and state health care laws and regulations and any contracts [Name] may have with government agencies. It is also a good business practice for managed care organizations to have a FWA program. The Plan sets forth specific procedures to detect, prevent and correct health care FWA; is reviewed at least annually; and is revised as needed when laws or regulations change.

The [Name] Special Investigations Unit (“SIU”) is responsible for the Plan. The SIU staff investigates potential FWA and works with appropriate [Name] staff, vendors (e.g. pharmacy benefit manager), and government and law enforcement agencies when dealing with health care FWA.

I. ANTI-FRAUD, WASTE AND ABUSE LAWS

[Name] is committed to complying with all applicable federal and state laws, regulations and other requirements pertaining to FWA. [Name] will not tolerate health care FWA in any of its relationships with internal and external parties. [Name] will identify, report, monitor, and when appropriate, refer for prosecution, situations in which suspected fraud or abuse occurs.

There are numerous laws, both federal and state, that address health care fraud. These laws define fraud and establish the framework for prosecuting criminal acts and the initiation of civil proceedings. Some of the most significant laws are:

Federal False Claims Act

The Federal Civil False Claims Act prohibits knowingly submitting, or causing to be submitted, or conspiring to submit, a false or fraudulent claim for payment or approval by the government or the use of a false record or statement in support of a claim for government payment, or concealing, avoiding or reducing an obligation to pay or transmit money or property to the government. ‘Knowingly’ can include deliberate ignorance or reckless disregard of facts that make the claim false and requires no proof of a specific intent to defraud.

Violators are liable for three times the government’s damages plus civil monetary penalties of $5,500 to $11,000 per false claim.
Most states also have their own FWA provisions similar to, but sometimes even broader than, the federal laws listed on the previous screen.

**Whistleblower Protection**

The whistleblower provisions of the Federal False Claims Act protect employees who report suspected misconduct and/or assist in investigations or prosecution. Employees are made aware of these protections through the [Name] Code of Business Conduct and Ethics.

**Anti-Kickback Statute**

The Federal Anti-kickback Statute prohibits knowingly or willingly offering, paying, soliciting, or receiving anything of value to induce referrals of items or services payable by a federal health care program. Violations are considered felonies, punishable by criminal fines and imprisonment. A violation may also lead to the imposition of civil monetary penalties and possible exclusion from participation in federal health care programs.

Many states also have their own anti-kickback laws; these laws can vary widely and, in contrast to the federal statute, may not be restricted to federal health care programs.

**Health Information Portability and Accountability Act of 1996 (“HIPAA”)**

HIPAA established, among other things, standards for certain electronic transactions and minimum privacy and security requirements for individually identifiable health information. The protection of individual information may reduce chances of misuse of the information for fraudulent purposes and may reduce the risk of identity theft.

[Name] maintains written policies regarding compliance with specific federal and state fraud, waste and abuse laws. These policies are available to all employees through the company intranet and can be accessed from the [name of company’s intranet site] homepage by clicking on the link to essentials or the Policies and Procedures link, then selecting Special Investigations (CSO) under Topic Navigation.

**II. EDUCATION/TRAINING**

Compliance and Ethics Program training, including FWA, is required of all [Name] employees at the time of hire and annually thereafter. Successful completion of this mandatory training is a condition of employment.

Compliance and Ethics Program training, including FWA, is required upon appointment or election of new board members and CEOs, upon contracting with new first tier, downstream and related entities (“FDRs”), and upon hire for FDR’s new employees assigned to [Name] business. The training is required annually thereafter.

The FWA training aims to increase awareness and promote the reporting of suspected FWA. The training is reviewed annually and revised as needed when laws or regulations change.
The FWA training includes, at a minimum:

- Review of laws and regulations related to FWA (e.g. False Claims Act, Anti-Kickback statute, HIPAA);
- A process for reporting suspected FWA;
- Non-retaliation for good faith reporting;
- Examples of types of FWA that can occur in various settings; and
- For FDRs, the obligation to have policies and procedures to address FWA.

Additionally, the SIU publishes a quarterly employee newsletter sent by broadcast email that includes, but is not limited to, highlighting current FWA activities and schemes and promoting employee reporting of suspected FWA.

FWA information, including instruction on how to report suspected FWA, is communicated to members through one or more sources, such as new member materials, member handbooks, explanation of benefits, and [Name] web sites.

**SIU Staff Education/Training**

[Name] will conduct training for new and existing SIU staff that includes but is not limited to:

- The duties and functions of the SIU;
- SIU overview;
- Overview of [Name] Health Plans;
- Systems overview;
- On the Job Training: Processing referrals/Cases and other daily functions;
- Instruction for SIU investigators regarding general investigation guidelines, conducting interviews, report writing, information disclosure, and law enforcement relations;
- Potential healthcare and pharmacy fraud indicators;
- The process to be employed when a suspicious claim is identified;
- The procedure for referral of a claim to the SIU;
- The procedure for referral of a claim to the pharmacy benefit vendor and coordinating investigations with the pharmacy benefit vendor;
- The investigation process for suspected member fraud;
- The post-referral procedure for communication between Health Plan and the SIU; and
- The procedure for recommending referral of suspected fraud to the appropriate authorities.

**III. DETECTION**

The SIU has processes in place for the detection, investigation, and corrective actions for various forms of FWA.

Potential FWA is detected through a variety of internal and/or external sources, including but not limited to:

- Analytic reports
• PBM referrals
• Reports to the SIU hotline
• Reports to the SIU email inbox
• Reports sent to the SIU fax number
• Medicaid State Agencies
• Medicaid Fraud Control Units
• State Office of Inspector General and Attorney General Offices

Employees are directed to report suspected FWA by calling the SIU hotline or sending an email to the SIU.

Providers or members can report suspected FWA by calling the [Name] Customer Service Center, as instructed on the member handbook, member explanation (where applicable) of benefits or provider remittance advice. The Customer Service Center forwards reports of suspected FWA to the SIU for investigation.

Vendors are directed to report suspected FWA by contacting the SIU according to the instructions in their [Name] compliance training materials.

Exclusion/Debarment Review

[Name] reviews the Department of Health and Human Services Office of Inspector General (“OIG”) exclusion list (LEIE); the General Services Administration excluded parties list (SAM/EPLS); and state exclusion databases (collectively, “Databases”), as applicable, for:

• all prospective new hires, re-hires, independent contractors, officers and boards members prior to the individual’s start date and monthly thereafter;
• contracted providers at credentialing and monthly thereafter;
• non-contracted providers prior to claim payment and monthly thereafter;
• brokers/agents at the time of contracting and monthly thereafter; and
• vendors at the time of contracting and monthly thereafter.

FDRs, including the [Name] PBM, are required to review their employee’s assigned to [Name’s] business at the time of hire and annually thereafter. They are also required to screen their downstream entities.

In addition, to comply with federal Medicaid regulations and state contractual requirements, [Name] collects ownership and controlling interest information for all Medicaid providers and subcontractors and reviews the Databases for those persons and entities disclosed as having an ownership or controlling interest. Medicaid Subcontractors are required to review their employees at the time of hire and annually.

IV. INVESTIGATIONS

Investigative Process

When the SIU receives a referral, it is entered into the SIU Case Tracking database, reviewed and triaged to the appropriate staff to complete a preliminary investigation. Each referral is
evaluated to determine if the merits or substance of the referral support the allegation of fraud and/or abuse.

If during the initial evaluation the possibility of fraud and/or abuse is eliminated, the referral is closed. If fraud and/or abuse cannot be definitively eliminated, an investigation will be initiated.

All information received or discovered by the SIU is treated as confidential and the results of investigations are shared only with those who have a legitimate reason to receive the information (e.g., state and federal authorities, [Name] legal staff, [Name] medical directors, [Name] compliance personnel, [Name] and PBM pharmacy audit teams, [Name] senior management).

Tracking Suspected Fraud
The SIU records all referrals and cases of suspected fraud and abuse in the SIU Case Tracking database. All aspects of an investigation are recorded, documenting the various steps of the investigation.

Conducting the Investigation
All investigations are conducted in accordance with applicable policies of the specific area handling the investigation. Investigations can be performed utilizing any of the following investigative measures:

- Interviews may be completed via telephone or by sending confirmation letters.
- Research is performed to validate information using the tools available to the SIU.
- Depending on the type of fraud, medical records may be reviewed to confirm if the services billed were actually rendered and/or were medically necessary. The SIU may coordinate with [Name] Medical Directors to review and incorporate findings into the case.
- Law enforcement agencies may be contacted regarding the case.

1. Medical Claims
The SIU is responsible for investigating suspected fraudulent activity or abuse by providers when the provider claims are processed through the [Name] claims processing system. Additionally, the SIU is responsible for investigating suspected employee and member medical claim fraud. Suspect claims are identified from a variety of sources including, but not limited to the following:

- Fraud Identification Analytics and Software;
- Tips from members, providers and Customer Service Center personnel;
- Referrals from claims personnel or provider relations personnel;
- Information obtained through [Name’s] involvement in the National Health Care Anti-Fraud Association;
- Information obtained through contact with other insurers and managed care plans; and
• Referrals from Federal and State regulatory and law enforcement agencies.

2. Role of Pharmacy Benefit Manager in FWA

[Name] contracts with a pharmacy benefit manager (“PBM”) to administer pharmacy benefits for all lines of business, including Medicare Part D. The PBM, through its audit and/or special investigations unit is responsible for the detection of FWA involving pharmacy claims. For purposes of this Plan, the term “pharmacy claims” means those pharmacy benefit claims processed through the PBM’s claims system(s).

The PBM will analyze [Name’s] various pharmacy claims, both pre- and post-payment and will conduct on- and off-site post-payment audits. The audits are designed to:

• verify the accuracy of pharmacy claims submitted through observation of original records including, among other things, prescription hard copies and patient signature logs; and
• identify erroneous billings through review of reports based on utilization and cost data.

The PBM will identify pharmacies to audit based on, but not limited to, the following:

• statistical review of the pharmacy claims submitted by pharmacies and auditing those pharmacies with claim activities indicating unusual or improper behavior and possible noncompliance to program parameters;
• high dollar and abnormally submitted pharmacy claims (i.e., reasonableness of quantity and dosage form); and
• tips from outside sources such as boards of pharmacy, law enforcement agencies, National Health Care Anti-Fraud Association, National Association of Drug Diversion Investigators, and other pharmacy organizations.

The PBM, through their audit function, meets regularly with the [Name] SIU to review findings, collaborate on cases and share information. The PBM, through their auditing, identifies recovery opportunities which are realized through the recovery functions of the contract. The PBM also has the capacity to flag potentially abusive or fraudulent prescribers to prevent their scripts from being filled at the point of sale.

The [Name] SIU evaluates the PBM’s performance and offers feedback to both the PBM and [Name] Pharmacy Operations on how to improve the relationship and improve processes. The relationship between the PBM and the [Name] SIU, and the work that is done between the two, is essential to fulfilling [Name] anti-fraud commitment.
3. **Member or Group Enrollment/Eligibility**

   Investigations of enrollment misrepresentation, and fraudulent member and group eligibility are conducted by appropriate [Name] personnel based on the nature of the situation, including but not limited to the SIU, Customer Service Center enrollment staff, health plan compliance staff and Broker Services.

4. **Broker and Agent Fraud**

   Suspected fraud perpetrated by brokers and agents selling Medicare Part C and D plans is managed by the Medicare Operational Compliance Agent Review Unit. Suspected fraud perpetrated by brokers and agents selling commercial products is referred to the particular health plan for investigation.

**Closing the Investigation**

A case report is prepared documenting the findings of each investigation. The report includes the allegation, an executive summary, case notes and recommendations. The SIU will present the applicable case reports to each Health Plan Fraud, Waste and Abuse Committee and to the FWA Subcommittee of the Medicare Compliance Committee. Each committee reviews their applicable cases and determines the appropriate actions. Such actions will be based upon analysis of the report findings, interpretation of applicable law, and contractual requirements, if applicable. Possible actions include, but are not limited to:

- Recover any overpayments identified through the investigation;
- Deny or pay any pending claims identified through the investigation;
- Report the provider or member to the appropriate state and/or federal agency;
- Take action with respect to a member or group’s eligibility status;
- Term the contract of a participating provider or broker/agent;
- Monitor the provider by reviewing claims prior to payment;
- Referral to MEDIC.

V. **REPORTING FRAUD AND ABUSE**

   When the [Name] SIU reasonably suspects FWA has occurred and/or is occurring, the SIU will make contact, and when necessary, report to appropriate state or federal agencies, including law enforcement agencies, when appropriate. Any such reports shall comply with any applicable state and federal privacy laws.

   [Name] SIU is required to submit a written notification to the U.S. Office of Personnel Management (OPM) OIG within 30 working days of becoming aware of a FWA issue where there is a reasonable suspicion that a fraud has occurred or is occurring against the FEHB Program. Reportable FWA issues include the identification of emerging fraud schemes; suspected internal fraud or abuse by Carrier employees, contractors, or subcontractors; suspected fraud by providers who supply goods or services to FEHBP members; suspected fraud by individual FEHBP members; issues of patient harm, and Carrier participation in class action lawsuits. There is no financial threshold for these initial case notifications. The [Name] SIU will take any further required steps based on the response from OPM-OIG regarding case
To the extent the suspected FWA involves Medicare Advantage or Medicare Part D members, the SIU will report such FWA to the Medicare Drug Integrity Contractors (“MEDIC”) and, as appropriate, to the U.S. Department of Health and Human Services, Office of Inspector General. Similarly, in the event the suspected FWA involves Medicaid members, the FWA will be reported by the health plan to the state Medicaid agency, as required by law and [Name’s] state Medicaid contracts.

**MEDIC Relationship**

The [Name] SIU has been designated as the point of contact for managing the inbound and outbound exchange of information between [Name] and the MEDIC. The SIU tracks all inbound and outbound exchanges in the SIU Case Tracking database and reports back to the Medicare Compliance Committee at least biannually the frequency, volumes and types of information exchanges that occur between [Name] and the MEDIC. When the Medicare Fraud, Waste and Abuse Subcommittee deems it necessary to self-report incidents and issues to the MEDIC, the SIU is assigned the task.

**VI. AUDITING**

[Name will fully cooperate to the extent required by law, with government authorities responsible for FWA detection and prosecution activities in arranging for or participating in, any audit or review of [Name] to determine whether [Name] is complying with this Plan. Such agencies may include, but are not limited to State Departments of Insurance, Medicaid Fraud Control Units, the U.S. Department of Health and Human Services Office of Inspector General, individual State Offices of the Inspector General, state Medicaid agencies, Office of Personnel Management Office of the Inspector General, and United States Justice Department. This cooperation shall include allowing access, in accordance with applicable law, to relevant SIU and [Name] offices upon reasonable notice and at reasonable hours to conduct on-site reviews of [Name’s] compliance with the Plan. [Name] and the SIU will also cooperate fully in all reviews, investigations and any subsequent legal action brought by appropriate governmental agencies against providers, contractors, or members related to FWA issues. [Name] will maintain complete claims data that is accessible and retrievable for examination. All records shall be retained in accordance with applicable law and [Name] policies.

The SIU will evaluate the effectiveness of the Anti-Fraud Plan on an annual basis. Annually, a report will be presented to the Medicare Compliance Committee, the Medicaid Compliance Committee and the Commercial Compliance Committee, the corporate compliance Program Integrity Officer, and the [Name] Board of Directors. Significant trends in FWA will be reviewed as well. As part of the review, the SIU will also determine if its procedures and/or the SIU Investigator education/training should be modified.

**VII. OVERSIGHT OF FWA ACTIVITIES**

**A. Health Plan FWA Committees**

Each Health Plan maintains a Fraud, Waste, and Abuse Committee that meets on a
regular basis and is responsible for reviewing reports of alleged FWA. Committee membership includes, but is not limited to, representatives from the SIU, Compliance, Legal and medical staff. The committees are charged with deciding the disposition of cases and the actions that will be taken with regard to corrective action and reporting. Actions are based on analysis of the report findings, interpretation of applicable law, the provisions of the Health Plan’s contractual requirements and its provider contracts, if applicable.

The committees maintain minutes and records of their meetings and the investigations conducted on their behalf. The SIU reports findings of Health Plan fraud to the corporate Commercial Compliance Committee.

B. **FWA Subcommittee of the Medicare Compliance Committee:**

The FWA Subcommittee of the Medicare Compliance Committee meets on a regular basis and is responsible for reviewing reports of alleged Medicare fraud, waste and abuse. Committee membership includes but is not limited to representatives from the SIU, Compliance, Legal and medical staff. The Subcommittee is charged with deciding the disposition of cases and the actions that will be taken with regard to corrective action and reporting. Actions are based on analysis of the report findings and interpretation of applicable law.

The FWA Subcommittee maintains minutes and records of its meetings and the investigations conducted on its behalf. The SIU reports findings of fraud to the Medicare Compliance Committee and Federal and/or state agencies (including but not limited to, MEDICs, the Office of Inspector General of the U.S. Department of Health and Human Services.

C. **Medicaid Compliance Committee**

The Medicaid Compliance Committee meets on a regular basis and receives compiled reports from the Medicaid Health Plan Committees of Medicaid FWA activities and the actions taken by each Medicaid Health Plan. Committee membership includes but is not limited to the Compliance leader of each Medicaid plan, corporate compliance staff and SIU staff.

D. **Corporate Compliance Program Integrity Officer**

The Corporate Compliance Program Integrity Officer (“PIO”) is a member of the FWA Subcommittee of the Medicare Compliance Committee, the Medicaid Compliance Committee, and an ex-officio member of each Health Plan FWA committee. The PIO receives reports and minutes from the Health Plan FWA Committee meetings, the FWA Subcommittee of the Medicare Compliance Committee, the FWA reports presented to the Medicaid Compliance Committee and the SIU summary FWA reports for the Audit Committee of the [Name] Board of Directors.

E. **[Name] Board of Directors**
The SIU prepares quarterly summary reports of FWA activities and presents them to the PIO for inclusion in the Chief Compliance Officer’s quarterly report to the Audit Committee of the [Name] Board of Directors.

Approved by: ______________________________________________________________

Date: _______________________________________________________________