# Anti-Fraud Plan/FWA Compliance Plan

## FRAUD PREVENTION AND DETECTION PLAN

## Introduction

Highmark Health Options (HHO) hereby establishes this Plan for the Detection and Prevention of Fraud, or FWA Compliance Plan, as required by Section 3.16.6 of the Delaware Department of Health and Social Services (DHSS), Division of Medicaid & Medical Assistance (DMMA) MCO Contract. The purpose of the plan is to organize and implement an anti-fraud strategy to identify and reduce costs to HHO and its beneficiaries. The detection, prevention and elimination of fraud, waste and abuse (FWA) is essential to maintaining an insurance system that is affordable to current and future beneficiaries.

1. HHO's Fraud Prevention and Detection plan is filed with State insurance entities in accordance with their applicable State insurance statutes;
2. HHO's Fraud Prevention and Detection Plan hereby provides that in accordance with HHO's Delaware Medicaid contract and the Centers for Medicare and Medicaid Services (CMS) guidance, HHO's Financial Investigations and Provider Review (FIPR) Division establishes procedures for the investigation of referrals of suspicious or fraudulent applications and claims. Referrals will be made to the appropriate insurance or law enforcement entity as required; and
3. HHO's Fraud Prevention and Detection Plan hereby provides anti-fraud education and training to all employees, as well as anti-fraud education to providers and beneficiaries.

## Organization

HHO hereby establishes a full-time Financial Investigations and Provider Review (FIPR) Team to combat FWA. The FIPR Team works closely with the HHO Compliance Officer to coordinate related compliance activities to ensure compliance with all federal, state and local laws and regulations. The Director of FIPR reports to the Vice President (VP) of FIPR. Both the Director and VP are responsible for notifying the Compliance Officer upon discovery of significant noncompliance and/or FWA issues. The Compliance Officer reports at least four times a year to the Corporate Compliance Committee on activities and status of the Anti-Fraud Plan, including allegations of possible noncompliance and FWA.

FIPR is currently comprised of a Compliance Officer, Vice President, Director, Managers, Compliance Consultant, Senior Business Solutions Consultant, Lead Investigator, Senior Investigators, Investigators, Associate Investigators and Investigation Coordinators. HHO's Investigators possess at least a bachelor's degree or a minimum of four years of experience in the insurance industry and/or healthcare fraud investigations. The FIPR Team is composed of professionals with deep and diverse clinical, audit and law enforcement backgrounds, including Certified Professional Coders (CPC), Certified Healthcare Compliance Professionals (CHC), Certified Fraud Examiners (CFE), Data Analysis Professionals, Accredited Healthcare Fraud Investigators (AHFI), Attorneys and Medical Ethicists. FIPR is supported by a clinical fraud advisory team that includes clinicians from different specialties including doctors, nurses, pharmacists and behavioral health therapists.

HHO has dedicated workspaces located in Wilmington, DE; Camp Hill, PA; Pittsburgh, PA; and Parkersburg, WV. FIPR's accessibility and knowledgeable staff are available to address all matters related to the prevention and detection of fraud as well as conducting investigations in a timely manner.

The FWA Leadership Subcommittee is delegated the authority from the Compliance Committee to provide oversight of FWA activities within HHO and provide guidance to the Special Investigations Unit (SIU). The Subcommittee is chaired by the Director of FIPR. Membership includes the Chief Compliance Officer (or designee), VP of FIPR and other HHO leadership from business areas most susceptible to FWA. The Subcommittee assists the Compliance Committee in monitoring FWA activities within HHO, reviewing reports of alleged FWA and providing guidance to the SIU on responses and corrective actions. The Subcommittee reports to the Compliance Committee on the status of FWA activities within HHO. Such reports are incorporated into the updates the Compliance Officer's report to the Audit and Compliance Committee of the Board of Directors, as necessary.

**Detection of Fraud, Waste and Abuse**

HHO's FIPR Team works to ensure that claims are paid correctly by both monitoring and auditing methods and in accordance with recipient benefits and provider contracts. Examples of FWA auditing and monitoring activities are listed below:

- *Claims Edits:* FIPR coordinates with the HHO Claims Department to implement claims edits that will deny claims that are contrary to Federal, State and Contractual requirements.
- *Pre-payment Edits and Reviews:* FIPR contracts with vendors to monitor claims prior to payment to ensure claims accuracy. FIPR has the capability to suspend claims to conduct pre-payment reviews prior to releasing payment to flagged Providers.
- *Post-payment Edits and Reviews:* FIPR contracts with vendors to audit claims through retrospective reviews, including itemized bills and chart reviews.
- *Data Mining:* FIPR runs monthly reports to search for aberrant claims patterns, including historically known FWA schemes and emerging trends. FIPR utilizes vendors that conduct data mining to test for and assign, as appropriate, risk scores to providers who may be engaged in FWA schemes.
- *Trending Analysis:* FIPR performs various trending analyses including but not limited to provider billing and prescribing trends, review of retrospective findings, as well as claim edit reviews.
- *Recipient Verification:* HHO calls a monthly sample of members to verify that services paid were provided or received. The following multi-faceted approach is used to conduct recipient verification:
    - Monthly member selection for outgoing member calls
        - HHO Member Services (MS) identifies members who received services for which HHO made a payment.
        - Members are reviewed for medical, pharmacy and dental claims.
        - HHO Member Services randomly selects a fixed sample size of the members satisfying the above referenced requirement.

        - As part of this sample selection, HHO also targets and includes members receiving high-risk services or those that are receiving services from high-risk providers, including, but not limited to, Long-Term Services and Support (LTSS) and self-directed care services, as well as other high-risk services such as durable medical equipment (DME) and pain management services.
        - Following the selection, Member Services attempts to contact each of the members. If MS is successful with contact and the member is willing to participate, an MS representative verifies the services received during the month.
        - Results of all calls are tracked and reviewed by FIPR. Any issues identified, including services billed that could not be confirmed, are investigated and tracked until resolution which could include referral to various federal, state or local agencies for further action when warranted.
        - All statistics regarding this process are reported in accordance with contractual obligations.
    - Verification calls to members are performed by FIPR during case investigations as warranted.
    - FWA referrals from hotline or other services.
    - HHO has supplemented this existing phone call verification with a secure SMS/text message outreach to make verifying member services easier and more efficient.
- *Sanctioned Screenings:* HHO uses tools designed by the Office of the Inspector General (OIG), the General Services Administration (GSA) and contracts with vendors to identify individuals or entities excluded, sanctioned, disqualified or otherwise ineligible from working in a federal healthcare program. Specifically, HHO conducts the following screenings:
    - Provider files: the credentialing department within HHO conducts a monthly screening of all provider files against the System for Award Management (SAM), the HHS-OIG List of Excluded Individual Entities (LEIE), the National Plan and Provider Enumeration System (NPPES), the SSA DMF, Master Death File as well as the State exclusion sites.
    - Employees are screened in different ways:
        - All potential employees undergo a background check which includes U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), US General Services Administration (GSA), LEIE, Office of Foreign Asset Control (OFAC) as well as State exclusion lists. If a potential employee appears on these lists, the employee will not be hired or contracted.
        - Current employees are screened against the state exclusion lists monthly. If an employee appears on the exclusion list, appropriate action will be taken in accordance with HHO's disciplinary guidelines.
        - All non-employees (temporary and contracted) are screened against the state exclusion lists prior to starting their assignment and monthly thereafter. If a non-employee appears on the exclusion list, appropriate action will be taken in accordance with HHO's disciplinary guidelines.

    - HHO does not employ, with or without pay, or form a contract with, purchase from, or enter into a business relationship with any individual or entity that is convicted of a criminal offense involving government business, listed by a Federal agency as debarred, proposed for debarment or suspension or otherwise excluded from Federal program participation.
- *Inactive Providers:* HHO monitors provider activity to ensure that providers with inactivity for 12 consecutive months are terminated from the network due to inactivity.
- *Long-Term Services and Support:* HHO conducts specific reviews for FWA in LTSS. Activities include the following, but are not limited to:
    - Monitor diagnosis for LTSS members indicating an injury due to a fall or other diagnosis that may indicate a quality-of-care issue. Quality of care referrals are completed as appropriate.
    - Investigate any incidents that are reported by the provider including reports of abuse, neglect, misappropriation or death of a member.
    - Data analytics to determine billing of personal care services while a member is hospitalized or in a care facility.

**Investigation of Fraud, Waste and Abuse**

HHO's SIU is responsible for the thorough investigation of suspected FWA. HHO's FIPR Team has established policies and procedures that provide guidance to SIU investigators conducting investigations and ensure uniform reporting. At a minimum, investigations by the SIU shall be composed of the following integral activities:

- HHO's FIPR Team conducts investigations of issues referred by providers, members, subcontractors, employees and beneficiaries when red flags are identified concerning claims, applications, providers, policies and beneficiaries.
    - FIPR initiates an investigation to determine risk score, and the case is assigned to an Investigator.
    - FIPR concludes its preliminary investigation within ten (10) business days of identifying the suspected Fraud, Waste or Abuse.
    - The Investigator will develop the case by building a plan of action. The case can result in a variety of outcomes, including, but not limited to education, corrective action plan, claim adjustments and referral to the appropriate regulatory agencies.
- FIPR will refer an investigation, if there is a reasonable suspicion that an infringement may have occurred, to DMMA's Program Integrity Unit and Medicaid Fraud Control Unit (MFCU) within two (2) business days of completing the preliminary investigation on the State-approved notification form. FIPR will also refer an investigation, if there is a reasonable suspicion that an infringement may have occurred to any other law enforcement entity, in accordance with applicable Federal and State statutes; and will pursue restitution, where appropriate, for financial loss caused by fraud.
    - Unless prior written approval is obtained from the State, after notifying DMMA's Program Integrity Unit and MFCU of suspected Fraud, Waste or Abuse, HHO shall not take any of the following actions:

        - Contact the subject of investigation about any matter related to the investigation.
        - Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
        - Accept any monetary or other type of consideration offered by the subject of the investigation in connection with the incident.
    - If directed by the State, HHO shall conduct a full investigation and provide the result of its full investigations in writing to both DMMA's Program Integrity Unit and MFCU within two (2) business days of completing the investigation and will include information specified within the State contract. HHO's *Results of a Full Investigation* must include the information specified in Section 3.21.14 of the DMMA MCO Contract.
    - Upon notification by the State, HHO shall suspend payments to identified providers.
    - If a provider is suspended or terminated from participating in the Delaware Medicaid program by the State, HHO shall also suspend or terminate the provider.
    - If a provider is terminated from Medicare, another Federal healthcare program, or another state's Medicaid or CHIP program, the HHO shall terminate its provider participation agreement with that provider
    - HHO shall notify the State within two (2) business days of taking any action against a provider for program integrity reasons.
- FIPR will act as a liaison with DMMA, Surveillance & Utilization Review Unit (SUR), MFCU and other law enforcement personnel and entities, as needed. FIPR will also cooperate with insurance and law enforcement entities in the prosecution of suspected fraud cases, including but not limited to testimony at trials.
- FIPR maintains a database of all investigations, which contains the names, addresses and other identifying information regarding all parties to the investigation.
- FIPR hereby assures that all relevant evidence related to investigations referred to FIPR including, but not limited to, checks issued in payment of claims, medical records, recorded statements, original receipts and original documents submitted by a person or entity in support of or in opposition to a claim applicant, will be identified, collected and preserved in order to be turned over to the appropriate State insurance or law enforcement entities in accordance with applicable Federal and State statutes.
- Investigators are required to record all findings and recommendations within the case management system. Investigational notes updating the case status are required every thirty (30) days. Prior to the closure of a case, all findings and outcomes are updated in the case management system, so that the information for reportable cases is able to be submitted in written form to applicable oversight agencies for reporting purposes. The written report will be uploaded to the case files.
- HHO issues the Code of Conduct and Business Ethics to educate HHO employees regarding their responsibility to report any incidents of fraud.
- FIPR conducts audits on providers to identify possible FWA. FIPR also conducts special audits as requested by Senior Management.

- HHO allocates budgetary resources to provide staffing opportunities for FWA investigations.
- External vendors are utilized as subcontractors to provide payment policy development and management. HHO staff works collaboratively with external vendors to assure collection of all monies in need of recovery and to configure system updates.
- FIPR maintains metrics on the utilization of the case management system. Training on best practices and procedures is conducted with all investigators who utilize the tool for documenting case activity.

*Delegate Investigations*

In our continued effort to prevent and detect FWA, HHO's FIPR Team utilizes delegates for audits including facility type audits and other audits when internal resources are not available. The Vendor Management Office (VMO) manages these delegates to ensure FWA requirements are met and they meet monthly with HHO leadership. Delegates must provide FWA and general compliance training to all employees and downstream entities assigned to provide required administrative and/or healthcare services for HHO. CMS has developed a free, standardized, web-based compliance training module that is available to employers and their employees who provide services related to Medicare, Medicaid and other Federal healthcare programs. In accordance with 42 CFR §422.503(b)(vi)(C)(3), 423.504(b)(vi)(C)(4) and subsequent CMS Guidance, all HHO Delegates must use CMS' FWA Training and General Compliance Training available on the Medicare Learning Network.

*Employee Investigations*

HHO's FIPR Team coordinates with the Human Resources and the Enterprise Risk and Governance Department when FWA referrals and investigations include HHO's employees or temporary contractors.

**Auditing of Fraud, Waste and Abuse**

HHO's FIPR Team conducts announced and unannounced audits of providers, members, subcontractors, employees and beneficiaries to detect FWA as well as ensure compliance with appropriate State and Federal regulations. FIPR performs the following activities to protect HHO from FWA; to prevent unnecessary cost; and to avoid reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare:

- Performs audits to review the following:
    - Duplicate claims
    - CPT quantity billing issues
    - Date of death reviews
    - Disenrollment reviews

- Peer review ranking reports to identify outlier providers and members including referral activities.
- Periodic audits with an emphasis placed on audits identified in the yearly OIG Work Plan, National Health Care Anti-Fraud Association (NHCAA) annual trend report and CMS and delegate activities related to FWA.
- Scheduled audit validation, as well as periodic member utilization reviews, to confirm services billed to HHO were received by member.

*Internal Audit*

- HHO currently outsources its Internal Audit (IA) to Highmark, Inc. Within the framework of that relationship, Highmark, Inc. IA is accountable for understanding and evaluating the design and operating effectiveness of the internal controls that support the annual CEO and CFO attestations submitted to regulators. Supplemental to this effort, the integrated audit and advisory services include engagements and projects, respectively that encompass such scope areas as enterprise end user computing, premium billing, vendor compliance, claims processing, as well as business continuity and HIPAA.

*Annual Risk Assessment and Audit Plan*

HHO is required to conduct audits for potential FWA. To properly audit and monitor FWA, a risk assessment is conducted. Once the risk assessment is completed, FIPR implements an audit work plan that includes the identified risk(s). HHO's FIPR Team determines the greatest exposure for FWA by comparing and analyzing the key areas by high spend threshold and likelihood of the risks according to the following:

- CMS's Medicaid high risk provider types
- OIG's Annual Report
- NHCAA's Annual Report and Fraud Trend Alerts
- Annual Fraud Employee Survey of select internal staff
- Annual assessment of provider specialties
- Trends in previous FWA cases
- Collaboration with FWA delegates throughout the year to proactively identify key areas of spend.
- Trends identified through Highmark's partnership with and participation in Healthcare Fraud Prevention Partnership (HFPP) studies.

Additionally, HHO reserves the right to perform announced and unannounced site visits and field audits. The FIPR team works closely with the Provider Relations department to plan and execute these visits.

*Progressive Audits*

HHO's SIU relies on a progressive audit model. The providers advance through progressive stages of the audit based on claims billing and documentation error rates. The progressive audit stages are the discovery reviews, expanded audits and outcomes:

- *Discovery Reviews*: Probes and samples to determine if the claims billing and documentation errors are valid. The Discovery Reviews can include the subsequent auditing tools:
    - Probe samples of provider medical records
    - Data analysis and provider profiling
    - Member verification of services
    - Provider and member interviews
    - Provider Compliance Assessments
- *Expanded Audits:* When the Discovery Reviews confirm provider overpayment issues, documentation deficiencies or claims billing errors, the reviews are expanded. The Expanded Audits are designed to determine the entire exposure and can prompt additional auditing components, such as:
    - Statistical random samples or 100% claims reviews
    - Provider compliance evaluations
    - On-site assessment and audits
- *Outcomes:* After HHO's FIPR progresses through the audit, the SIU notifies the providers of the audit results and can require additional actions and audits from the provider which can include the following:
    - Provider corrective action plans (CAP)
    - Provider self-audit of the remaining populations based on OIG and Medicaid requirements
    - HHO's Recovery of identified overpayments

If at any point in the progressive audits the SIU suspects potential fraud, the provider will be referred to law enforcement agencies; and additional provider actions may be taken in coordination with Medicaid oversight (such as payment suspension and potential provider termination).

**Recovery of Fraud, Waste and Abuse Overpayments**

HHO has FWA functions that are responsible for ensuring claims payment accuracy and to detect and prevent FWA and overpayments which include:

- Pre-payment claims edits
- Retrospective claims reviews
- Provider education
- FWA investigations and audits
- Provider self-audits and overpayment reporting

HHO's FIPR functions rely on reimbursement policies, medical record standards and coding requirements that are outlined in the following: Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Correct Coding Initiative (NCCI), National Committee for Quality Assurance (NCQA) and State Medicaid regulations.

HHO will conduct pre-payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. HHO will recover claims payments that are contrary to national and industry standards. HHO will conduct progressive reviews, such that, providers may be requested to submit additional samples or documentation during the reviews.

HHO also provides a mechanism for providers to report self-identified overpayments to the team through the provider self-audit form, as well as a self-submission portal with Trend Health Partners.

If any of the FWA efforts identify overpayments, the following activities will occur:

- HHO will comply with all Federal and State guidelines to identify overpayments;
- HHO will notify the state within five (5) business days of overpayment identification;
- HHO will notify the provider in writing of the intent to recover an overpayment prior to recovery. Additionally, HHO will allow the provider thirty (30) calendar days from receipt of the notice to provide a response disputing the overpayment or requesting a payment arrangement or settlement. If disputed, a final determination will be issued to the provider within thirty (30) calendar days;
- If a payment arrangement or settlement is requested by the provider HHO will submit the details to DMMA for prior approval;
- HHO will pursue recoveries of overpayments through claims adjustments with recoveries by claims offsets or provider checks within 60 days or settlement negotiations;
- HHO will refer suspected FWA to appropriate agencies, such as DMMA SUR and MFCU; and
- HHO may recommend corrective actions that may include pre-payment review, payment suspension and potential termination from HHO's provider network.

HHO may conduct pre-payment or post-payment audits and pursue overpayments for the following reasons (but is not limited to):

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| NCCI Procedure to Procedure (PTP) edits |
| NCCI Medically Unlikely (MUE) edits |
| NCCI Add-On Code edits |
| Retrospective coordination of benefits |
| Retrospective termed member eligibility |
| Retrospective rate adjustments |
| Incorrect fee schedule applied to claim |
| Provider excluded |
| Provider license terminated or expired |
| Provider does not meet the requirements to render services |
| Different rendering provider |
| No authorization or invalid authorization |
| Inaccurate claim information |

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| Duplicate claims |
| Non-covered service |
| Outpatient services while member was inpatient |
| Overlapping services |
| Patient different than member |
| Per diem services billed as separate or duplicate charges |
| Services provided outside of practice standards |
| Group size exceeds limitations |
| No services provided including no-shows and cancellations |
| Missing records |
| Missing physician orders |
| Missing medication records |
| Missing laboratory results |
| Invalid code or modifier |
| Invalid code combinations |
| Diagnosis codes that do not support the diagnosis or procedure |
| Add-on codes reported without a primary procedure code |
| Clinical documentation issues |
| Claims documentation issues |
| Insufficient documentation |
| Potential fraudulent activities |
| Excessive services |
| Altered/forged records |
| Inpatient readmissions (up to 10 days) |

**Reporting**

HHO's FIPR Team relies on external sources for referring potential incidents of FWA. All reporting of FWA will be kept confidential as allowed by law.

*Internal Referrals*

HHO employees who suspect or are aware of FWA or violations of HHO's code of conduct, internal policies, contractual requirements or State or Federal rules and regulations have an obligation to make a good faith report of that conduct. Employees can anonymously report suspicions of FWA through the following sources:

- *Fraud, Waste and Abuse Hotline:* Employees can report FWA through SIU's dedicated hotline by calling 1-844-325-6256
- *Inter-office mail:* Employees can report FWA to HHO's SIU via inter-office mail

- *Internal Referral Form:* employees can report FWA through completing a FWA referral form located on the Fraud, Waste, and Abuse section of the HHO website found at www.Highmarkhealthoptions.com
- *SIU email:* Employees can report FWA by sending an email to the SIU's dedicated inbox at SIU_HHO@Highmark.com

Employees can also make a report directly to FIPR through in-person meetings, business phone or email. Pursuant to HHO's Non-Retaliation policy, retaliation, or threatening staff for reporting compliance concerns in good faith is prohibited.

*External Referrals*

HHO members and providers can make anonymous referrals of FWA through the following channels:

- *Member & Provider Services:* the Member or Provider Services representative will create a referral to the SIU;
- *Hotline*: Telephone calls can be placed to the Fraud, Waste and Abuse Hotline at 1-844-325-6256; or
- *Website*: Individuals can complete and submit a FWA Referral Form through the "Report Fraud, Waste, and Abuse" link in the Fraud, Waste, and Abuse section of the HHO website found at www.Highmarkhealthoptions.com

*Reporting to Law Enforcement & Regulatory Agencies*

HHO's FIPR Team is responsible for reporting credible allegations of fraud to law enforcement, regulatory agencies and professional boards. Policies and procedures are maintained to align with contractual requirements and Federal and State regulations (including, but not limited to, DMMA and MFCU). Policies and procedures define processes to identify and obtain evidence of suspected FWA. When credible allegations of fraud are suspected, FIPR reports the allegation to the appropriate agencies according to relevant policies, State and Federal requirements and agency instructions. Designated senior FIPR staff shall review referral content for quality and appropriate supporting evidence prior to the submission of such a referral. Specifically, HHO's FIPR will make the following referrals to Delaware agencies:

- Once Fraud, Waste or Abuse is suspected the case is referred to DMMA within two (2) business days and FIPR continues with its preliminary investigation.
- Preliminary investigation results are reported to DMMA and MFCU within two (2) business days on the State-approved FWA referral form.
- If directed by the State to perform a full investigation, results of such investigation are to be reported in writing within two (2) days of completion.
- Potential overpayments are referred to DMMA via a SUR form within five (5) days of identification.

Reporting of credible allegations of fraud will include:

- Subject information
- Scope of review

- Review findings
- Communications or actions taken in response to findings
- Applicable Federal and State statutes, laws and regulations that are suspected of being violated

Federal, State and local law enforcement agencies may seek information from HHO to further their own investigations or prosecutions of FWA. HHO's FIPR fully cooperates with, and promptly responds to, all fraud, waste and abuse investigation efforts by regulatory, State and Federal agencies and law enforcement agencies. This includes timely responses to requests for information (RFI's), obtaining requested information from appropriate departments for requests and coordinating with the appropriate staff to provide evidence, interviews or testimony as needed.

FIPR has access to run system-generated reports for audits and to identify information necessary for HHO to complete required reports in accordance with Medicaid contracts. HHO will submit, when required, reports regarding fraud data in accordance with applicable State insurance statutes. Specifically, HHO provides the following reports to the State in an effort to communicate effectively:

- Monthly MCO Tracking report
- Quarterly Member Service Verification Report
- Quarterly Fraud, Waste and Abuse report
- Submission of an annual FWA Compliance Plan
- Annual Program Integrity MCPAR report
- Any additional reporting requested by DMMA

In addition to coordinating communications with law enforcement and State and Federal agencies, FIPR may be involved in submitting information to central database systems.

If HHO has reasonable grounds to believe that reported misconduct constitutes a violation of criminal or civil law or administrative regulations relating to government contracts, particularly related to reporting data pertaining to payment and potential fraud or similar misconduct, a recommendation is made by the HHO Compliance Officer to voluntarily self-report such conduct to appropriate oversight agencies and to proceed with the corrective action. HHO follows all regulatory and contractual requirements regarding referring fraud cases to appropriate oversight, government or law enforcement agencies.

## Education and Training

### *HHO Personnel*

FWA education will be provided for all employees, including Senior Management and the Board of Directors. The education includes a detailed and comprehensive program of fraud awareness and education designed to prepare all employees for fraud prevention, detection and the multiple means by which alleged incidences of FWA can be reported to the appropriate area.

The training program includes Basic Entry Level Training and Continuing Education Training addressing specific aspects of fraud associated with the company's product lines. FIPR utilizes a variety of methods to conduct training such as classroom instruction, self-guided instruction, videotape, seminar and computer based online training. Training is provided as follows:

- The Basic Entry Level Training consists of one (1) hour of computer-based training. FWA Basic Entry Level Training is provided to all new employees including Senior Management and the Board of Directors within 90 days from the commencement of their employment or appointment. Training includes but is not limited to the following areas:
    - Definitions of FWA
    - Various Federal and State regulations and statutes concerning FWA, including the False Claims Act, Stark Law, Anti-Kickback Statute and Deficit Reduction Act
    - Examples of member and provider FWA
    - An overview of the FIPR team and SIU
    - Identifying and referring FWA

- FWA Continuing Education Training consists of one (1) hour of training per year for all existing employees. This one (1) hour of FWA Continuing Education Training is provided to all employees including Senior Management and the Board of Directors and stresses the importance of identifying red flags and reporting alleged incidences of FWA to the appropriate area. Training includes, but is not limited to, the following areas:
    - Information on who pays the cost for insurance fraud;
    - Identifying "red flags";
    - When and how to refer suspicious claims to FIPR;
    - Various Federal and State regulations and statutes; and
    - Current trends in healthcare FWA.

- FIPR also conducts skills-oriented training for departments by focusing on key red flags, trends and regulations that would impact their department.

Further information regarding the FIPR Team's efforts to detect, investigate, prevent and report FWA is outlined in FWA policies and procedures. FWA policies are located on the internal PolicyWeb. FWA policies and procedures contain information including, but not limited to, the following:

- Information for all employees regarding general investigation guidelines, unfair claims practices, conducting interviews, report writing, information disclosure and law enforcement relationships;
- The process to be employed for reporting to applicable State insurance or law enforcement entities, including DMMA and MFCU, in accordance with applicable Federal and State statutes;

- The specific facts and circumstances that, when identified in connection with a claim or application upon further FWA investigation, lead to a reasonable conclusion that a violation has occurred;
- "Red flags" or "indicators" for insurance fraud, application fraud and claims fraud;
- The duties and functions of the SIU;
- The procedure for referring an issue to the SIU;
- The post-referral procedure for communication between the reporting entity and the SIU;
- Procedures for both scheduled and random audits;
- Instructions for reporting potential incidents of FWA through various channels, including:
    - *Member Services:* the Member Services representative will create a referral to the SIU;
    - *Hotline:* Telephone calls can be placed to the Fraud, Waste and Abuse Hotline at 1-844-325-6256;
    - *Website:* Individuals can complete and submit an FWA Referral Form through the "Report Fraud, Waste, and Abuse" link in the Fraud, Waste, and Abuse section of the HHO website found at www.Highmarkhealthoptions.com; or
    - *In-Person:* Employees can make a report directly to an Investigator via inter-office mail, email, phone or in-person
- List of suspected or potential violations if an employee reports violations of law and policy;
- List of third-party vendors that perform external audit and data analytic functions and also established monitors to prevent fraud and abuse in the following areas: utilization management, credentialing/re-credentialing, claims processing and fraud and abuse sanctions and violations; and
- Ongoing education requirements for HHO personnel to stay up-to-date on current FWA schemes and investigative techniques.

All training materials and other resources regarding the prevention, detection and reporting of FWA are accessible to the HHO organization through the company website. Through the SharePoint website, HHO employees can find information regarding Federal healthcare fraud statutes, contact information for FIPR members and the available methods to report FWA. Investigative procedures are implemented into the training of the investigators. Desk level procedures are also developed to ensure consistent performance for repeated processes.

*Special Investigations Unit*
In addition to the FWA training completed by all HHO personnel, SIU investigators stay current regarding developments in the detection and investigation of FWA through attendance at annual professional conferences and monthly workshops.

*First Tier, Downstream and Related Entities*
HHO is responsible for ensuring that appropriate training is provided to all HHO First Tier, Downstream and Related Entities (FDRs) in accordance with CMS guidelines. HHO maintains oversight by requiring FDRs to complete semi-annual attestations, which is administered by the Medicaid Vendor Management Office (VMO).

## Public Awareness

The FIPR Team ensures that its beneficiary and provider populations are also educated on healthcare FWA issues. Methods of education include:

1. HHO's website by accessing the "Fraud, Waste, and Abuse" link at the following web address: www.Highmarkhealthoptions.com;
2. Fraud statements on all claims forms and credentialing applications;
3. Quarterly and ad-hoc newsletters (to members and providers);
4. Fraud, Waste and Abuse Hotline number;
5. Provider and Member forums;
6. Provider FWA Training;
7. Audit Finding notifications, including Corrective Action Plans;
8. Explanation of Benefits (provides a fraud statement which includes the FWA hotline number);
9. Provider Manual and Member Handbook; and
10. Community Engagement Training

## Retention of Records

HHO's FIPR Team maintains up-to-date and accurate records in its Case Management System including the name of the subject, referral date, costs, savings/recoveries, subject's address and date closed. All records will be retained for a minimum of ten (10) years as stipulated by CMS guidelines and HHO's Record Retention policy.

## Investigation Assistance

Federal, State and local law enforcement agencies may seek information from HHO to further their own investigations or prosecutions of FWA. HHO's FIPR Team fully cooperates with and promptly responds to all fraud, waste and abuse investigation efforts by regulatory, State and Federal agencies and law enforcement agencies.

## Compliance and Ethics

HHO is committed to making every effort to prevent, detect, investigate and report violations of FWA as defined by applicable laws and regulations. Pursuant to corporate policy, all HHO personnel have an obligation to report any known or suspected violations of the Code of Conduct and Business Ethics, policies and procedures or laws and regulations. The Code of Conduct and Employee Handbook reinforce that disciplinary actions may be taken for failure to report, prohibiting others from reporting or occurrences of wrong doing. The Code of Conduct and Employee Handbook outline the expectations and guidelines for managing employee performance and/or misconduct. They also cover situations that may result in progressive discipline, suspension and/or termination of employment. Violation of these standards could result in termination from the healthcare program. HHO prohibits retaliation or threatening staff for reporting compliance concerns in good faith, pursuant to the Non-Retaliation policy.