

2027 Anti-Fraud Plan

2027 FRAUD PREVENTION AND DETECTION PLAN

Introduction

Highmark Wholecare hereby establishes this Plan for the Detection and Prevention of Fraud. The purpose of the plan is to organize and implement an anti-fraud strategy to identify and reduce costs to Highmark Wholecare 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. Highmark Wholecare's Fraud Prevention and Detection plan is filed with State insurance entities in accordance with their applicable State insurance statutes;
2. Highmark Wholecare's Fraud Prevention and Detection Plan hereby provides that in accordance with Highmark Wholecare's Pennsylvania Medicaid contract and the Centers for Medicare and Medicaid Services (CMS) guidance, Highmark Wholecare's Financial Investigations and Provider Review (FIPR) Team 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;
3. Highmark Wholecare'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

Highmark Wholecare hereby establishes a full-time Financial Investigations and Provider Review (FIPR) Team. The FIPR Team works closely with the Highmark Wholecare 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. The Director and VP of FIPR 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, Business Consultants, Lead Investigators, Senior Investigators, Investigators, Associate Investigators and an Investigation Coordinator. Highmark Wholecare's Investigators possess at least a bachelor's degree or equivalent experience in the health insurance industry and/or healthcare fraud investigations. The FIPR Team is composed of professionals with deep and diverse clinical, audit and law enforcement experience, including Certified Professional Coders (CPC), Certified Fraud Examiners (CFE), Data Analysis Professionals, and Accredited Healthcare Fraud Investigators (AHFI). FIPR is supported by a clinical fraud advisory team that includes clinicians from different specialties including doctors, nurses, pharmacists and behavioral health therapists.

Highmark Wholecare's main office is located in Pittsburgh, PA; but the company also has dedicated workspaces located in Parkersburg, WV; Wilmington, DE; and Camp Hill, PA. FIPR's accessibility and knowledgeable staff are made 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 Highmark Wholecare 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 Highmark Wholecare leadership from business areas most susceptible to FWA. The Subcommittee assists the Compliance Committee in monitoring FWA activities within Highmark Wholecare, reviews reports of alleged FWA and provides guidance to the SIU on responses and corrective actions. The Subcommittee reports to the Corporate Compliance Committee on the status of FWA activities within Highmark Wholecare. 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

Highmark Wholecare'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 Highmark Wholecare 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 by conducting 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.
- *BEAR Edits*: The BEAR edit process assists the FIPR Team with the identification and review of claims data to detect potential overpayments. There are approximately 245 non-complex edits and 13 complex edits that can be applied to claims.
- *Data Mining:* FIPR routinely runs 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.
- *Recipient Verification:* Highmark Wholecare calls a monthly sample of recipients to verify that services paid were provided or received.

    - Highmark Wholecare 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*: Highmark Wholecare uses tools designed by the Office of the Inspector General (OIG) and the General Services Administration (GSA) to identify individuals or entities excluded, sanctioned, disqualified or otherwise ineligible from working in a federal healthcare program.

Investigation of Fraud, Waste and Abuse

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

- Highmark Wholecare'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 will refer an investigation if there is a reasonable suspicion that an infringement may have occurred, to the applicable State insurance department, Centers for Medicare and Medicaid Services (CMS), Medicare Drug Integrity Contractor (MEDIC), Department of Human Services (DHS) Bureau of Program Integrity (BPI), Medicaid Fraud Control Unit (MFCU) or other law enforcement entity, in accordance with applicable Federal and State statutes; and will pursue restitution, where appropriate, for financial loss caused by insurance fraud.
- FIPR will act as a liaison with State insurance fraud departments, CMS, MEDIC, DHS BPI, 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 insurance 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 ensures 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. Prior to the closure of a case, all findings and outcomes are required to be submitted to applicable regulatory oversight agencies in a written report. The written report will be uploaded to the case files.
- Highmark Wholecare issues the Code of Conduct to educate Highmark Wholecare employees regarding their responsibility to report any incidents or concerns of fraud.

- FIPR conducts audits on providers to identify possible FWA. FIPR also conducts special audits as requested by Senior Management.
- Highmark Wholecare allocates budgetary resources to provide staffing opportunities for FWA Investigations.
- External vendors are utilized as subcontractors to provide payment policy development and management. Highmark Wholecare staff works collaboratively with external vendors to ensure collection of all claims 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, Highmark Wholecare's FIPR Team utilizes delegates for audits including facility type audits and other audits when internal resources are not available. FIPR maintains oversight of the delegates by conducting routine monitoring. Additionally, the Vendor Management Office (VMO) manages these delegates to ensure FWA requirements are met and meet monthly with Highmark Wholecare 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 Highmark Wholecare. 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)(4)(vi)(C)(1), 42 CFR §423.504(b)(4)(vi)(C)(1), and subsequent CMS Guidance, all Highmark Wholecare Delegates must use CMS' FWA Training and General Compliance Training available on the CMS Medicare Learning Network.

Employee Investigations

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

Auditing of Fraud, Waste and Abuse

Highmark Wholecare'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 Highmark Wholecare 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:

- Audits to review the following:
    - Duplicate claims
    - CPT quantity billing issues
    - Date of death reviews
    - Disenrollment reviews
- Peer reviews 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 Highmark Wholecare were received by members.

Highmark Wholecare manages a fully operational Electronic Visit Verification (EVV) system for in-home personal care and home health services that complies with the requirements of 42 U.S.C. § 1396b(l). Highmark Wholecare ensures that no individual Provider exceeds the manual edit threshold established and communicated by the Department of Human Services (DHS) via Medical Assistance (MA) Bulletin for more than one quarter. Highmark Wholecare conducts quarterly reviews of EVV providers to ensure compliance with these manual edit thresholds. If a provider exceeds the established manual edit threshold for two or more consecutive quarters, Highmark Wholecare will impose corrective action requirements or penalties.

Annual Risk Assessment and Audit Plan

Highmark Wholecare 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). Highmark Wholecare'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' Medicaid high risk provider types
- OIG's Annual Report
- NHCAA's Annual Report and Fraud Trend Alerts
- Annual Risk Employee Survey of 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 spending.
- Emerging trends identified through Healthcare Fraud Prevention Partnership (HFPP) research and studies.

Progressive Audits

Highmark Wholecare'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 consist of discovery reviews, expanded audits and outcomes, as outlined below:

- *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
    - Claims extrapolation
- *Outcomes:* After Highmark Wholecare's FIPR Team 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 (CAPs)
    - Provider self-audit of the remaining populations based on OIG and Medicaid requirements
    - Recoveries of identified overpayments

If at any point during a progressive audit the SIU suspects potential fraud, the provider will be referred to law enforcement; and additional provider actions may be taken in coordination with the Medicare and Medicaid oversights (such as payment suspension and potential termination from Highmark Wholecare's provider network).

Recovery of Fraud, Waste and Abuse

Highmark Wholecare has FWA processes that are responsible for ensuring claims payment accuracy and to detect and prevent FWA which include:

- Pre-payment claims edits
- Retrospective claims reviews

- Provider education
- FWA investigations and audit
- Provider self-audits and overpayment reporting

Highmark Wholecare's FIPR processes 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.

Highmark Wholecare will conduct pre-payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. Highmark Wholecare will recover claims payments that are contrary to national and industry standards. Highmark Wholecare will conduct progressive reviews, which may require providers to submit supplementary documentation or samples during the reviews.

Highmark Wholecare also provides a mechanism for providers to report self-identified overpayments to FIPR through the provider self-audit overpayment form, as well as a self-submission portal maintained by a third-party vendor.

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

- Highmark Wholecare will comply with all Federal and State guidelines to identify overpayments;
- Highmark Wholecare will notify the provider in writing of the intent to recover an overpayment prior to recovery. Additionally, Highmark Wholecare 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;
- Highmark Wholecare will pursue recoveries of overpayments through claims adjustments with recoveries by claims offsets or provider checks within 60 days or settlement negotiations;
- Highmark Wholecare will refer suspected FWA to appropriate agencies, such as Medicaid oversight and CMS Medics; and
- Highmark Wholecare may recommend corrective actions, including pre-payment review, payment suspension and potential termination from Highmark Wholecare's provider network.

Highmark Wholecare may conduct pre-payment or post-payment audits and pursue overpayments for the following reasons including, but is not limited to:

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
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 30 days)

Reporting

Highmark Wholecare'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

Highmark Wholecare employees who suspect or are aware of FWA or violations of Highmark Wholecare'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 844-718-6400
- *Inter-office mail:* employees can report FWA to Highmark Wholecare's SIU via inter-office mail
- *SIU email:* employees can report FWA by sending an email to the SIU's dedicated inbox at SIU@Highmark.com
- *Internal Referral Form:* employees can report FWA through completing a FWA referral form located on the Fraud & Abuse webpage on Highmark Wholecare's website

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

External Referrals

Highmark Wholecare 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 844-718-6400; or
- *Website:* individuals can complete and submit a FWA Referral Form located through the "Fraud and Abuse" hyperlink at the bottom of the Highmark Wholecare public facing website

Reporting to Law Enforcement & Regulatory Agencies

Highmark Wholecare'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 rules and regulations (including but not limited to MFCU, BPI and MEDIC agencies). Policies and procedures define processes to identify and obtain evidence of suspected FWA. When credible allegations of fraud are suspected, the FIPR Team reports the allegation to the appropriate agencies in accordance with applicable 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.

Reports 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 Highmark Wholecare to further their own investigations or prosecutions of FWA. Highmark Wholecare'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. 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 Highmark Wholecare to complete required reports in accordance with Medicaid contracts. Highmark Wholecare will submit, when required, quarterly and annual reports regarding fraud data in accordance with applicable State insurance statutes.

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

Education and Training

Highmark Wholecare 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 and detection.

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:

- FWA Basic Entry Level Training consists of one (1) hour of computer-based training. FWA Basic Entry Level Training is provided for 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. The 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.

Highmark Wholecare's FIPR Team utilizes an on-line intranet environment to make information regarding the detection, investigation, prevention and reporting of FWA

available to all Highmark Wholecare employees. Through the SharePoint website, Highmark Wholecare employees can find information regarding Federal healthcare fraud statutes, contact information for FIPR members and the available methods to report FWA.

Further Information regarding the FIPR Team's efforts to detect, investigate, prevent and report FWA is outlined in FWA's policies and procedures. FWA policies are located on the internal PolicyWeb. The 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 for reporting to applicable State insurance or law enforcement entities, including the MEDIC, MFCU and BPI, 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 & 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 844-718-6400;
    - *Website:* individuals can complete and submit an FWA Referral Form through the "Fraud and Abuse" link at the bottom of the Highmark Wholecare public facing website; 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 established monitors to prevent fraud and abuse in the following areas: Utilization Management, Credentialing/Re-credentialing, Claims Processing, Fraud and Abuse Sanctions and Violations; and
- Ongoing education requirements for Highmark Wholecare 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 Highmark Wholecare organization through the company intranet. 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 Highmark Wholecare personnel, SIU investigators stay current regarding developments in the detection and investigation of FWA through attendance at professional conferences and workshops.

First Tier, Downstream and Related Entities

Highmark Wholecare is responsible for ensuring that appropriate training is provided to all Highmark Wholecare's First Tier, Downstream and Related Entities (FDRs) in accordance with CMS guidelines. Highmark Wholecare maintains oversight by requiring FDRs to complete an annual risk assessment.

Public Awareness

Highmark Wholecare's FWA ensures that its beneficiary and provider populations are also educated on healthcare FWA issues. Methods of education include:

1. Highmark Wholecare's website by accessing the "Fraud and Abuse" link;
2. Provider FWA Training, with on-demand access available on the Highmark Wholecare Provider Resource Center;
3. Fraud statements on all claim forms and credentialing applications;
4. Monthly, quarterly and ad-hoc newsletters (to members and providers);
5. Fraud, Waste and Abuse Hotline number;
6. Audit finding notifications, including corrective action plans;
7. Explanation of Benefits (provides a fraud statement which includes the Fraud, Waste and Abuse hotline number);
8. Provider Manual and Provider Forums;
9. Member Handbook; and
10. Community Engagement Training

Opioid Abuse Training

Highmark Wholecare's FIPR Team strives to work within the communities and provide critical knowledge around issues plaguing the nation, such as the opioid epidemic. The

Opioid Abuse Training is aimed at achieving CMS recommendations specific to over-prescribing, impact of misuse and standards of care for diagnoses and procedures. Additionally, the Highmark Wholecare SIU will present educational interventions to specific providers identified as potential outlier opioid prescribers.

Elder Abuse Training

Highmark Wholecare SIU monitors evolving fraud schemes and provides education which can include free webinars, community resources and participation in law enforcement and public events. Pennsylvania has one of the highest percentages of elderly residents in the United States which results in an increased risk for abuse and exploitation. In 2027, FIPR will continue to facilitate training to promote awareness and prevent harm and abuse of our senior populations.

Retention of Records

The Highmark Wholecare 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 the Record Retention policy.

Investigation Assistance

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

Compliance and Ethics

Highmark Wholecare 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 Highmark Wholecare personnel have an obligation to report any known or suspected violations of the Code of Conduct, policies and procedures or laws and regulations. Highmark Wholecare prohibits retaliation or threatening staff for reporting compliance concerns in good faith, pursuant to the Non- Retaliation policy.

This information is issued on behalf of Gateway Health Plan, Inc. d/b/a Highmark Wholecare, an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare provides Medicaid coverage for Blue Shield in 13 counties in central PA and Blue Cross Blue Shield in 14 counties in western PA. Highmark Wholecare provides Medicare Dual-Eligible Special Needs Plans (HMO D-SNP) for Blue Shield in 30 counties in central and northeastern PA, 5 counties in southeastern PA, and for Blue Cross Blue Shield in 27 counties in western PA.