POLICY AND PROCEDURE

DEPARTMENT: Compliance/SIU	**DOCUMENT NAME:** Fraud, Waste and Abuse Plan
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~~SCOPE~~

~~Louisiana Healthcare Connections (LHCC) will operate a Compliance Department/Program Integrity Division with the support of Centene Corporation's Program Integrity Division. LHCC and Centene's Corporate Program Integrity Division will fully comply with all regulatory and statutory requirements including provisions of LHCC's Contract with LDH such as Section 4.2.7, Program Integrity Officer and Section 15, Fraud, Abuse, and Waste Prevention, as set forth below. This policy applies to all employees of LHCC across all lines of business (Medicaid and CHIP programs).~~

~~PURPOSE~~

~~The purpose of this policy is to implement a Fraud Waste and Abuse (FWA) plan across all lines of business that will fully comply with all regulatory and statutory requirements including provisions of LHCC's contract with the Department of Health (LDH). The intent is to protect members in the delivery of healthcare services through timely detection, investigation and prosecution of potential fraud.~~

~~POLICY~~

~~1) The Compliance Department will serve as LHCC's Program Integrity Division and will be the focal point of LHCC's program integrity and fraud, waste, and abuse prevention, detection, investigation, corrective action, and reporting activities. The LHCC Program Integrity Division will operate in collaboration with the program integrity infrastructure of Centene and will receive support from Centene's SIU, Compliance Coding and Cost Recovery, and Centene's technology infrastructure. A Program Integrity Officer experienced and trained in program integrity, health care, and risk management will head the Department/Division. LHCC's Vice President of Compliance will serve as the Program Integrity Officer. .~~

~~2) LHCC and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.608, 42 C.F.R. §438.611-438.812; La. R.S. 46:437.1-437.14; 42 CFR §455.12-455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act, Section 4.2.7, Program Integrity Officer and~~

~~Section 15, Fraud, Abuse and Waste Prevention, as set forth below. Compliance with 42 C.F.R. §438.610 is also required until the state has implemented its own screening of MCO-only providers and has notified LHCC that it has assumed this function.~~

~~3) LHCC's Program Integrity Officer and CEO or COO shall meet with LDH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly and at LDH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. LHCC's Program Integrity Officer shall serve as the primary point of contact for LHCC on issues related to Fraud, Abuse, and Waste Prevention.~~

~~4) LHCC and its subcontractors shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, CMS, the Office of Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of ten (10) years from the expiration date of the Contract (including any extensions to the Contract) or from the date of completion of any audit, whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of LHCC's Contract with LDH and any other applicable rules. MFCU shall be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hour admission will be allowed.~~

~~5) LHCC and its providers and subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above upon request. HHS, LDH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with LHCC clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by LHCC's Contract with LDH. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. LHCC and its providers and subcontractors shall provide~~

~~originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.~~

~~6) LHCC's employees, consultants, and its subcontractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.~~

~~7) LHCC and its subcontractors shall provide access to LDH and/or its designee to all information related to grievances and appeals files by its members. LDH shall monitor enrollment and termination practices and ensure proper implementation of LHCC's grievance procedures, in compliance with 42 CFR §438.228.~~

~~8) LHCC shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. LHCC shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, its Contract with LDH, and LDH policy.~~

~~9) LHCC will report to LDH, within three (3) business days, when it is discovered that any LHCC employee(s), network provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program via the designated LDH Program Integrity contact.~~

~~LHCC and its subcontractors shall have programs and procedures pursuant to (42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. LHCC shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.~~

~~10) Until the state implements its own screening of MCO-only providers and has notified LHCC that it has assumed this function, LHCC, as well as its subcontractors and providers, shall comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of LHCC's Contract with LDH shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting,~~

~~contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.~~

10) ~~LHCC, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. Part 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of LHCC's Contract with LDH shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or LHCC dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.~~

10) ~~LHCC shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist LHCC in preventing and detecting potential fraud, waste, and abuse. At a Minimum, LHCC shall have one (1) full-time investigator physically located within Louisiana for every 50,000 members or fraction thereof. These full-time positions are in addition to the Program Integrity Officer and will be located in-state. LDH may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.~~

10) ~~LDH or its designee will notify LHCC when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:~~

~~) The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or~~

~~) The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC) contractor; or~~

~~) When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.~~

~~11) The prohibition described in Section 15.1.15 of LHCC's Contract with LDH shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the LHCC obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, LHCC will return the funds to LDH.~~

~~11) LHCC shall confer with LDH before initiating any recoupment or withhold of any program integrity-related funds as defined in 15.1.15 (see 15.7 for audit coordination procedure) to ensure that the recovery, recoupment, or withhold is permissible.~~

~~PROCEDURE, REPORTING AND INVESTIGATING SUSPECTED FRAUD AND ABUSE~~

~~1) Following detection of potential FWA, LHCC's investigative processes will involve the LHCC Program Integrity Officer and Centene's Program Integrity staff, including SIU Investigators. LHCC's Program Integrity Officer will seek the assistance of Centene's Program Integrity Staff to conduct preliminary investigations and clinical and medical record reviews. The SIU Investigators will maintain the confidentiality of all FWA referrals, including those received through the Fraud Hotline. The SIU Investigators will follow the investigative process outlined in CC.COMP.16, which may include on-site medical audits.~~

~~1) If the SIU Investigator identifies fraud or abuse, the SIU Investigator will work closely with Centene's SIU and the LHCC Program Integrity Officer to determine the appropriate next steps, including reporting to LDH and/or the Louisiana Department of Insurance, as required, and appropriate corrective action.~~

~~1) LHCC and its subcontractors shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.~~

~~1) LHCC shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.~~

~~1) LHCC shall notify MFCU and LDH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to~~

~~Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, LHCC shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated.~~

1) ~~LHCC shall report all tips, confirmed or suspected fraud, waste and abuse to LDH and the appropriate agency as follows:~~

~~) All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within the previous month shall be reported to LDH Program Integrity monthly;~~

~~) Suspected fraud and/or abuse in the administration of the program shall be reported to LDH Program Integrity and MFCU;~~

~~) All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH Program Integrity and MFCU; and~~

~~) All confirmed or suspected enrollee fraud and abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the enrollee's parish of residence.~~

1) ~~When making a referral of suspected fraud, LHCC shall utilize a Fraud Reporting Form deemed satisfactory by LDH under the terms of its Contract with LDH. LHCC shall report suspected provider fraud using the LDH Provider Fraud Referral Form (Appendix F).~~

1) ~~LHCC shall be subject to a civil penalty, to be imposed by LDH, for willful failure to report fraud and abuse by employees, subcontractors, beneficiaries, enrollees, applicants, or providers to LDH or MFCU, as appropriate.~~

1) ~~LHCC shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or~~

~~suspected abuse and/or confirmed abuse, LHCC shall not take any of the following actions as they specifically relate to Medicaid claims:~~

~~) Contact the subject of the investigation about any matters related to the investigation;~~

~~) Enter into or attempt to negotiate any settlement or agreement regarding the incident; or~~

~~) Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.~~

~~1) LHCC shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.~~

~~1) LHCC and its subcontractors shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview LHCC employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.~~

~~1) LHCC and/or its subcontractors are to suspend payment to a network provider when the State determines there is a credible allegation of fraud, unless the State determines there is good cause for not suspending payments to the network provider pending the investigation. LHCC shall send the network provider the required notice and appeal rights as required by the Code of Federal Regulations.~~

~~1) LHCC understands that the State shall not transfer its law enforcement functions to LHCC.~~

~~1) LHCC and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with the provisions of Section 15 of LHCC's Contract with LDH.~~

~~1) LHCC shall notify LDH when the LHCC or its subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.~~

~~1) LHCC shall report overpayments made by LDH to LHCC within 60 calendar days from the date the overpayment was identified.~~

~~1) Unless prior written approval is obtained from LDH, LHCC shall not employ extrapolation methods to derive an overpayment in a provider audit.~~

~~FRAUD, WASTE, AND ABUSE COMPLIANCE PLAN~~

~~0) In accordance with 42 CFR §438.608(a), LHCC and its subcontractors, to the extent that the subcontractor is delegated responsibility by LHCC for coverage of services and payment of claims under the contract between LHCC and the state, shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud, Waste, and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.~~

~~0) In accordance with 42 CFR §438.608 (a)(1)(ii), LHCC's compliance program shall designate a Contract Compliance Officer who is responsible for developing and implementing written policies, procedures, and standards to ensure compliance with the requirements of LHCC's contract with LDH and all applicable Federal and State requirements, and who reports directly to the CEO and board of directors. LHCC shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer.~~

~~0) LHCC shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly, including coordinating with law enforcement agencies if issues are suspected~~

~~to be criminal in nature, to reduce the potential for recurrence, and conduct ongoing compliance with the requirements under its contract with LDH.~~

~~0) In accordance with 42 CFR §438.608(a)(1)(iii), the compliance program shall establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with oversight of the compliance program and its compliance with the requirements under this contract.~~

~~0) The Program Integrity Officer will serve as the plan lead of LHCC's Compliance Committee and the SIU Workgroup, and as LHCC's authority on fraud, waste, and abuse. The Program Integrity Officer will serve as LHCC's primary point of contact for communicating with regulatory authorities, including the MFCU, the Department of Insurance and LDH, regarding the LHCC Fraud Waste and Abuse Compliance Plan (FWACP) and other fraud, waste and abuse prevention and detection activities.~~

~~0) The SIU Workgroup will advise and assist the Program Integrity Officer in developing program integrity policy and in overseeing program implementation. The SIU Workgroup is comprised of LHCC staff from key operational areas that have the authority to commit resources to address noncompliance with program integrity requirements. The Committee's membership will include, but not be limited to staff from Claims, Compliance, Analytics, Finance, Provider Contracting, Corporate SIU Legal Counsel, Care Management, Network Administration, and Operations. The SIU Workgroup shall meet monthly and provide quarterly reports to Compliance Committee which will report to the LHCC Board of Directors.~~

~~0) LHCC shall submit its Fraud, Waste, and Abuse Compliance Plan within thirty (30) days from the date its Contract with LDH is signed, , and upon updates or modifications to LDH for approval at least thirty (30) days in advance of making them effective. LDH, at its sole discretion, may require that LHCC modify its compliance plan. The LHCC compliance program shall incorporate the policy and procedures as follows:~~

~~) Written policies, procedures, and standards of conduct that articulate LHCC's commitment to comply with all applicable federal and state standards;~~

~~) Effective lines of communication between the Contract Compliance Officer and LHCC's employees, providers and subcontractors;~~

- ~~) Enforcement of standards through well publicized disciplinary guidelines;~~

- ~~) Procedures for ongoing monitoring and auditing of LHCC's systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;~~

- ~~) Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Contract Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;~~

- ~~) Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4)-(6);~~

- ~~) Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.~~

- ~~) Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with LHCC. LHCC shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General;~~

- ~~) Procedures for prompt notification to LDH when LHCC receives information about changes in a member's circumstance that may affect the member's eligibility including changes in the member's residence and death of a member.~~

- ~~) Procedures for prompt notification to LDH when LHCC receives information about a change in a network provider's circumstance that may affect the network provider's eligibility to participate in the program.~~

- ~~) Procedures to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification on a regular basis.~~

-) Provision for LHCC's suspension of payments to a network provider for which LDH determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

-) Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);

-) Effective training and education system for the Contract Compliance Officer, senior management, program integrity investigators, managers, and members to ensure that they know and understand the federal and state standards and requirements of LHCC's contract with LDH.

8) Fraud, Waste and Abuse Training shall include, but not be limited to:

-) Annual training of all employees; and
-) New hire training within thirty (30) days of beginning date of employment.

9) LHCC will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws:

-) LHCC/Centene Code of Conduct Training
-) Privacy and Security - Health Insurance Portability and Accountability Act
-) Fraud, waste, and abuse identification and reporting procedures
-) Federal False Claims Act and employee whistleblower protections
-) Procedures for timely consistent exchange of information and collaboration with LDH;
-) Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and
-) Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' ***Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks***) issued by LDH, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

10) LHCC shall require and have procedures for a network provider to report to LHCC when it has received an overpayment, to return the overpayment to LHCC within sixty (60) calendar

~~days of the date on which the overpayment was identified, and to notify LHCC in writing of the reason for the overpayment.~~

~~11) LHCC shall have procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.~~

~~PROHIBITED AFFILIATIONS~~

~~0) In accordance with 42 CFR §438.610, LHCC and its subcontractors are prohibited from knowingly having a relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~0) LHCC may not knowingly have a relationship with an individual or entity that is an affiliate of an individual or entity that is debarred, suspended or excluded from participating in any federal health care program, in accordance with 48 CFR §2.101 and 42 CFR §438.610.~~

~~0) If LDH finds LHCC is not in compliance with 42 CFR §438.610(a) and (b), LDH:~~

- ~~) Shall notify the Secretary of the US Department of Health and Human Services (HHS) of the noncompliance;~~
- ~~) May continue an existing agreement with LHCC unless the Secretary of HHS directs otherwise;~~
- ~~) May not renew or otherwise extend the duration of an existing agreement with LHCC unless the Secretary of HHS provides to LDH and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations; and~~
- ~~) Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under Section 1128, 1128A, or 1128B of the Social Security Act.~~

~~0) LHCC and its subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. LHCC and its subcontractors shall screen~~

all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, LHCC shall conduct screenings to comply with the requirements set forth in 42 CFR §455.436. This section does not require ownership disclosure collection and screening once the state has implemented its own MCO-only provider screening and has notified LHCC that it has assumed this function.

0) LHCC shall search the following websites:

) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
) Louisiana Adverse Actions List Search (LAALS);
) The System of Award Management (SAM); and
) Other applicable sites as may be determined by LDH.

0) LHCC and its subcontractors shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered will be reported to LDH within three (3) business days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. (Section 1128(a)(6) of the Social Security Act and 42 CFR 1003.102(a)(2))

) An individual who is an affiliate of a prohibited person or entity described above can include:

i) A director, officer, or partner of LHCC;
i) A subcontractor of LHCC;
i) A person with beneficial ownership of five (5%) percent or more of LHCC's equity; or

i) A person with an employment, consulting or other arrangement with LHCC for the provision of items and services which are significant and material to LHCC's obligations under its contract with LDH; or.

i) A network provider.

) LHCC shall notify LDH in writing within three (3) days of the time it receives notice that action is being taken against LHCC or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of LHCC or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

) LHCC, through its Contract Compliance Officer, shall attest monthly to LDH that a search of the websites reference in Section 15.3.5 has been completed to capture all exclusions.

0) LHCC and its subcontractors shall retain the data, information, and documentation specified in 42 CFR §438.610, for a period of no less than ten (10) years.

PAYMENTS TO EXCLUDED PROVIDERS

0) Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services as specified in 42 CFR §1001.1901; and

0) LDH may recover from LHCC, via a deduction from LHCC's capitation payment, any money paid for services provided by an excluded provider.

REPORTING

0) LHCC and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state's Office of Attorney General MFCU, and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).

0) LHCC shall notify LDH within three (3) business days of the time it receives notice that action is being taken against LHCC or an LHCC employee, network provider,

~~subcontractor or subcontractor employee under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7), which could result in exclusion, debarment, or suspension of LHCC, network provider, or a subcontractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.~~

~~0) LHCC reporting shall include, but is not limited to, as set forth at 42 CFR §455.17:~~

~~) Number of complaints of fraud, abuse, waste, neglect and overpayments made to LHCC that warrant preliminary investigation (under 42 CFR §455.14); and~~
~~) Number of complaints reported to the Contract Compliance Officer.~~

~~0) For each complaint that warrants full investigation (defined at 42 CFR §455.15 and §455.16), LHCC shall provide LDH, at a minimum, the following:~~

~~) Provider Name and ID number;~~
~~) Source of complaint;~~
~~) Type of provider;~~
~~) Nature of complaint;~~
~~) Approximate range of dollars involved if applicable; and~~
~~) Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.~~

~~0) LHCC shall report to LDH Program Integrity at least quarterly all audits performed and all payments identified and recovered by LHCC and all of its subcontractors. [See 42 CFR §438.608(d)(3)].~~

~~0) LHCC shall report to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to LHCC and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.~~

~~0) LDH shall utilize LHCC overpayment and recovery data in calculating future capitation rates per 42 CFR §438.608(d)(4).~~

~~MEDICAL RECORDS~~

~~1) LHCC shall have a method to verify that services for which reimbursement was made were provided to members as billed. LHCC shall have policies and procedures to maintain, or require LHCC providers and contractors to maintain, an individual medical record for each member. LHCC shall ensure the medical record is:~~

~~) Accurate and legible;~~
~~) Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and~~
~~) Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.~~

~~1) LHCC shall ensure the medical record includes, minimally, the following:~~

~~) Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);~~
~~) Primary language spoken by the member and any translation needs of the member;~~
~~) Services provided through LHCC, date of service, service site, and name of service provider;~~
~~) Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by LHCC;~~
~~) Referrals including follow-up and outcome of referrals;~~
~~) Documentation of emergency and/or after-hours encounters and follow-up;~~
~~) Signed and dated consent forms (as applicable);~~
~~) Documentation of immunization status; and~~
~~) Documentation of advance directives, as appropriate.~~

~~1) Documentation of each visit must include:~~

~~b) Date and begin and end times of service;~~
~~b) Chief complaint or purpose of the visit;~~
~~b) Diagnoses or medical impression;~~
~~b) Objective findings;~~
~~b) Patient assessment findings;~~
~~b) Studies ordered and results of those studies (*e.g.* laboratory, x-ray, EKG);~~
~~a) Medications prescribed;~~

~~b) Health education provided;~~
~~b) Name and credentials of the provider rendering services (*e.g.* MD, DO, OD) and the signature or initials of the provider; and~~
~~b) Initials of providers must be identified with correlating signatures.~~

~~1) Documentation of EPSDT requirements including but not limited to:~~

~~) Comprehensive health history;~~
~~) Developmental history;~~
~~) Unclothed physical exam;~~
~~) Vision, hearing and dental screening;~~
~~) Appropriate immunizations;~~
~~) Appropriate lab testing including mandatory lead screening; and~~
~~) Health education and anticipatory guidance.~~

~~1) LHCC shall provide one (1) free copy of any part of a member's record upon member's request.~~

~~1) All documentation and/or records maintained by LHCC, its subcontractors, and any and all of its network providers related to all services, charges, operations and agreements under this contract shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.~~

~~RIGHTS OF REVIEW AND RECOVERY BY LHCC AND LDH~~

~~0) LHCC and its subcontractors are responsible for investigating and reporting possible acts of provider fraud, abuse, and waste for all services under its contract with LDH.~~

~~0) The Contractor and its subcontractors shall have the right to audit, review and investigate providers and enrollees within the Contractor's network for a one (1) year period from the date of payment of a claim via "automated" review. An automated review is one for which an analysis of the paid claims is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment. The collected funds from the Contractor's~~

automated reviews are to remain with the Contractor. The Contractor shall not recover from providers via automated review for claims older than one (1) year unless authorized by LDH.

0) The Contractor and its subcontractors shall have the right to audit, review and investigate providers and members within the Contractor's network for a five (5) year period from the date of service of a claim via "complex" review. A complex review is one for which the review of medical, financial, and/or other records, including those onsite, were necessary to determine the existence of an improper payment. The collected funds from the Contractor's complex reviews are to remain with the Contractor.

0) All complex reviews shall be completed within eight months (240 calendar days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.

LHCC shall ensure compliance with all requirements of La. R.S. 46:460.72 – 460.73, including the requirement to void all claims and encounters associated with fraud, waste and abuse for the purpose of reducing per-member, per-month rates, thereby returning overpayments to LDH.

1) Contact with a provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and submitted a referral of fraud to the Department, MFCU, or other appropriate law enforcement agency, unless approved by LDH.

1) If LHCC fails to collect at least a portion of an identified recovery after 365 days from the date LDH approved proceeding with the recoupment (per 15.1.17), unless an extension or exception is authorized by the LDH or LHCC has documented recovery efforts deemed sufficient by LDH upon review, including formally initiating collection efforts, LDH or its agent may recover the overpayment from LHCC and said funds will be retained by the State. Exception reasons may include, but are not limited to, LHCC cooperation with LDH or other government agencies, termination of provider participation with LHCC or dissolution of the provider's business.

1) LDH or its agent shall have the right to audit and investigate providers and members within LHCC's network via "complex" or "automated" review for a five (5) year period from the date of service of a claim. LDH may recover from LHCC, via a deduction from LHCC's capitation payment, any provider overpayments identified by LDH or its agent, and said

~~recovered funds will be retained by the State. LHCC may pursue recovery from the provider as a result of the State-identified overpayment.~~

~~1) LDH shall not initiate its own review on the same claims for a network provider which has been identified by LHCC as under a review. LDH shall track open LDH and LHCC reviews to ensure audit coordination.~~

~~1) In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the LHCC Special Investigation Unit (SIU) designee. The LDH notification of intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. LHCC shall have ten business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from LDH. If the LDH does not receive a response from LHCC within ten business days, the LDH may proceed with its review.~~

~~1) In the event the State or its agent investigates or audits a provider or member within LHCC's network, LHCC shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by LHCC and State. Document requests do not include medical records that shall be obtained from the provider.~~

~~1) LDH shall notify LHCC and the network provider concurrently of overpayments identified by the State or its agents.~~

~~1) LHCC shall not correct the claims nor initiate an audit on the claims upon notification of the identified overpayment by LDH or its agent unless directed to do so by LDH.~~

~~1)~~

~~1) In the event LDH or its agent recovers funds from LHCC due to a provider overpayment, LHCC may recover from the provider. If LHCC recovers state-identified improper payments, LHCC shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH.~~

~~1) LHCC and its subcontractors shall enforce LDH directives regarding sanctions on LHCC network provider and members, up to termination or exclusion from the network.~~

~~1) There will be no LDH provider improper payment recovery request of LHCC applicable for dates of services occurring before the start of the Bayou Health Contract period or for providers for which no LHCC relationship existed.~~

~~1) LHCC and its subcontractors shall retain all data, information, and documentation specified in 42 CFR §438.608 for a period of no less than 10 years.~~

POLICY STATEMENT:

The purpose is to articulate LHCC's commitment to comply with all applicable federal and state regulations thereby reducing costs to the health plans, providers, subscribers, enrollees, and others caused by FWA activities. The intent is to protect consumers in the delivery of healthcare services through timely detection, investigation, and prosecution of potential fraud.

PURPOSE:

The purpose of this policy is to implement a Fraud Waste and Abuse (FWA) plan across all lines of business that will fully comply with all regulatory and statutory requirements including provisions of LHCC's contract with the Department of Health (LDH). The intent is to protect members in the delivery of healthcare services through timely detection, investigation, and prosecution of potential fraud.

SCOPE:

Louisiana Healthcare Connections (LHCC) will operate a Compliance Department/Program Integrity Division with the support of Centene Corporation's Program Integrity Division. LHCC and Centene's Corporate Program Integrity Division will fully comply with all regulatory and statutory requirements including provisions of LHCC's Contract with LDH such as Section 2.2.2.4.4.7, Contract Compliance Officer, Section 2.20, Fraud, Abuse, and Waste Prevention and the Louisiana Medicaid Managed Care Organization Manual, as set forth below. This policy applies to all employees of LHCC across all lines of business (Medicaid and CHIP programs).

POLICY:

DEPARTMENT: Compliance/SIU	**DOCUMENT NAME:** Fraud, Waste and Abuse Plan
PAGE: 21 of 56	**REPLACES DOCUMENT:**
APPROVED DATE: 03/02/21	**RETIRED:**
EFFECTIVE DATE: 12/1/2015	**REVIEWED/REVISED:** 8/15, 12/15, 3/16, 6/16, 12/16, 1/17, 2/18, 12/18, 4/19, 11/19, 03/21,12/21, 12/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.COMP.16

The Compliance Department will serve as LHCC's Program Integrity Division and will be the focal point of LHCC's program integrity and fraud, waste, and abuse prevention, detection, investigation, corrective action, and reporting activities. The LHCC Program Integrity Division will operate in collaboration with the program integrity infrastructure of Centene and will receive support from Centene's SIU, Compliance Coding and Cost Recovery, and Centene's technology infrastructure. A Program Integrity Officer experienced and trained in program integrity, health care, and risk management will head the Department/Division. LHCC's Vice President of Compliance will serve as the Program Integrity Officer.

PROCEDURE:

1. Fraud, Waste and Abuse Prevention

A. General Provisions (2.20.1)

1) LHCC and its subcontractors shall comply with all applicable Federal and State laws, regulations, rules, policies, procedures, and manuals relating to Fraud, Abuse, and Waste in the Louisiana Medicaid Program, including, but not limited to, 42 C.F.R. §438.1-438.608; La. R.S. 46:437.1-437.14; 42 C.F.R. §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and1902(a)(68) of the Social Security Act.

2) The Contract Compliance Officer and CEO or COO shall meet in person, unless otherwise approved by LDH in writing, with LDH and MFCU at LDH's request to discuss Fraud, Abuse, Waste, neglect, and overpayment issues. For purposes of this Section, the Contract Compliance Officer shall serve as the primary point of contact for LHCC on issues related to Fraud, Waste, and Abuse Prevention.

3) LHCC and its subcontractors shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Abuse, or Waste. During Business Hours, CMS, the OIG, HHS, LLA, the Office of the Attorney General, GAO, LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of ten (10) years following termination of LHCC's contract with LDH or from the date of completion of any audit, whichever is later, shall

have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of LHCC's contract with LDH and any other applicable rules. MFCU shall be allowed access to LHCC's place of business and to all Louisiana Medicaid Program records of any contractor, subcontractor, or provider during Business Hours, except under special circumstances determined by the MFCU when afterhours admission shall be allowed.

4) **LHCC and its providers and subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above upon request. HHS, OIG, LDH, GAO, LLA, the Office of the Attorney General, and/or the designees of any of the above shall have Timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with LHCC clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by LHCC's contract with LDH.**

5) **LHCC and its providers and subcontractors shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.**

6) **LHCC's employees, consultants, and its subcontractors and their employees shall cooperate fully and be available in person for interviews, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other investigative or judicial processes.**

7) **LHCC shall certify all statements, reports, and claims, financial and otherwise, as true, accurate, and complete. LHCC shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to applicable Federal and State laws, regulations, rules, policies,**

procedures, and manuals, the State Plan, Waivers, LHCC's contract with LDH, and the MCO Manual.

8) LHCC and its subcontractors shall have programs and procedures pursuant to 42 C.F.R. §438.608(a)(1) to safeguard Louisiana Medicaid Program funds against unnecessary or inappropriate use of Medicaid Covered Services and against improper payments. LHCC shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected Fraud, Waste, and Abuse activities.

9) LHCC, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. Part 1002) on exclusion and debarment screening. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or LHCC dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

10) LHCC shall have adequate staffing and resources to investigate unusual incidents and develop and implement Corrective Action Plans to assist LHCC in preventing and detecting potential Fraud, Waste, and Abuse. At a minimum, LHCC shall have one (1) full-time investigator physically located within Louisiana for every fifty thousand (50,000) Enrollees or fraction thereof. LDH may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.

11) Reporting and Investigating Suspected Fraud and Abuse:

- **a) LHCC shall have methods for identification, investigation, and referral of suspected Fraud cases (42 C.F.R. §455.13, §455.14, and §455.21) both internally and for its subcontractors.**
- **b) LHCC shall report all tips, confirmed or suspected Fraud, Waste, and Abuse to LDH and the appropriate agency as follows:**
  - **i. All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within**

the previous month) shall be reported to LDH Program Integrity monthly;

ii. Triage and/or substantiate tips and provide updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated;

iii. Suspected Fraud and/or Abuse in the administration of the program shall be reported in writing to LDH Program Integrity and MFCU within five (5) Business Days of LHCC becoming aware of the issue;

iv. All confirmed or suspected provider Fraud and Abuse shall immediately be reported in writing to LDH Program Integrity and MFCU; and

v. All confirmed or suspected Enrollee Fraud and Abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the Enrollee's parish of residence.

c) When making a referral of suspected Fraud, LHCC shall utilize the LDH Provider Fraud Referral Form available in the MCO Manual.

d) LHCC shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed Fraud and Abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting Fraud or suspected Fraud and/or suspected Abuse and/or confirmed Abuse, LHCC shall not take any of the following actions as they specifically relate to Louisiana Medicaid Program claims:

i. Contact the subject of the investigation about any matters related to the investigation;

ii. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

iii. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

e) LHCC shall provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.

f) LHCC and its subcontractors shall seek to reduce prospective financial loss to health Fraud, Waste, and Abuse when fraudulent and/or criminal activity is suspected through pre-payment or post-payment review, audit, or investigation.

i. LHCC may mitigate loss of funds to Fraud by employing procedures including, but not limited to, pre-payment edits, prior authorization, medical necessity review, verification of services being rendered as billed, payment withhold in full or in part, Corrective Action Plans, termination of the provider agreement, or other remedies.

ii. Pursuant to La. R.S. 46:460.76, Pre-Payment Review shall be limited to requirements that are implemented directly by LDH and in accordance with the provisions of the Medical Assistance Programs Integrity Law, La. R.S. 46:437.1 et seq. LHCC shall submit a request to LDH for written approval prior to subjecting a Network Provider or Out-of-Network Provider to Pre-Payment Review.

g) LHCC and/or its subcontractors shall suspend payment to a Network Provider when the State determines there is a credible allegation of Fraud, unless the State determines there is cause for not suspending payments to the Network Provider pending the investigation. LHCC is responsible for sending the Network Provider the required notice and appeal rights as required by 42 C.F.R. §455.23.

12) LHCC and/or its subcontractors shall include in all of its provider agreements a provision requiring, as a condition of receiving any amount of Louisiana Medicaid Program payment, that the provider complies with this Section 2.20 of LHCC's contract with LDH.

B. FRAUD, WASTE, AND ABUSE COMPLIANCE PLAN (2.20.2)

In accordance with 42 C.F.R. §438.608(a), LHCC and its subcontractors, to the extent that the subcontractor is delegated responsibility by LHCC for coverage of services and payment of claims under the Contract between the Contractor and the state, shall implement and maintain a compliance

program that includes arrangements or procedures designed to prevent and detect Fraud, Waste, and Abuse (2.20.2.1). In accordance with 42 C.F.R. §438.608(a), the arrangements and procedures of the compliance program shall include all of the following elements (2.20.2.2):

1) **Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under LHCC's contract with LDH, and all applicable Federal and State requirements.**

2) **The designation of a Contract Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of LHCC's contract with LDH and who reports directly to the Chief Executive Officer and the board of directors.**

3) **The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under LHCC's contract with LDH.**

4) **A system for training and education for the Contract Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under LHCC's contract with LDH.**
   a) **Fraud, Waste and Abuse Training shall include, but not be limited to:**
      i. **Annual training of all employees; and**
      ii. **New hire training within thirty (30) Calendar Days of beginning date of employment.**
   b) **The Contractor shall require new employees to complete and attest to training modules within thirty (30) Calendar Days of hire related to the following in accordance with applicable Federal and State laws, regulations, rules, and policies:**
      i. **Contractor Code of Conduct Training;**
      ii. **Privacy and Security – Health Insurance Portability and Accountability Act;**

iii. Fraud, Waste, and Abuse identification and reporting procedures;

iv. The False Claims Act and employee whistleblower protections;

v. Procedures for Timely consistent exchange of information and collaboration with LDH;

vi. Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and

vii. Provisions that comply with 42 C.F.R. §438.608 and 438.610 and all relevant State and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by LDH, HHS, CMS, and OIG, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its agencies.

5) Effective lines of communication between the Contract Compliance Officer and LHCC's employees.

6) Enforcement of standards through well-publicized disciplinary guidelines.

7) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under LHCC's contract with LDH.

8) Procedures for prompt notification to LDH when the Contractor receives information about changes in an Enrollee's circumstance that may affect the Enrollee's eligibility including changes in the Enrollee's residence and death of an Enrollee.

9) Procedures for prompt notification to LDH when LHCC receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the program.

10) Procedures to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrollees and the application of such verification on a regular basis.

11) Provision for LHCC's suspension of payments to a Network Provider for which the State determines there is a credible allegation of Fraud in accordance with 42 CFR §455.23.

12) Procedures for a prompt response to detected offenses and for development of corrective action initiatives related to LHCC's contract with LDH.

13) Protections to ensure that no individual who reports program integrity related violations or suspected Fraud, Waste, and/or Abuse is retaliated against by anyone who is employed by or contracts with LHCC. LHCC shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidential to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General.

14) Procedures for a Network Provider to report to LHCC when it has received an overpayment, to return the overpayment to LHCC within sixty (60) Calendar Days of the date on which the overpayment was identified, and to notify LHCC in writing of the reason for the overpayment.

15) Procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential Fraud.

In addition to the arrangements and procedures specified in 42 C.F.R. §438.608(a), LHCC's compliance program shall incorporate the following requirements (2.20.2.3):

1) **Detection and prevention of Louisiana Medicaid Program violations and possible Fraud, Waste and Abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.**

2) **Descriptions of specific controls in place for prevention and detection of potential or suspected Fraud, Waste and Abuse, including: lists of pre-payment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms, and references in provider and member materials relative to identifying and reporting Fraud to LHCC and law enforcement.**

3) **Provisions for the confidential reporting of plan violations, such as a dedicated toll-free hotline to report violations and a clearly designated individual, such as the Contract Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of Fraud so that such reports cannot be diverted by supervisors or other personnel.**

4) **Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.**

Effective implementation of a well-publicized email address for the dedicated purpose of reporting Fraud. This email address must be made available to Enrollees, providers, LHCC employees and the public on the LHCC's website required under LHCC's contract with LDH. LHCC shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly and investigate and act on such complaints as warranted. LHCC shall submit to LDH or its designee the Fraud, Waste, and Abuse Compliance Plan as part of Readiness Review, annually thereafter, and upon updates or modifications for written approval at least

thirty (30) Calendar Days in advance of making them effective. LDH, at its sole discretion, may require that LHCC modify its compliance plan. (2.20.2.4) LHCC's Fraud email address, FWAReport@LouisianaHealthConnect.com, is available to enrollees, provides and the public on LHCC's website.

C. PROHIBITED AFFILIATIONS (2.20.3)

1) In accordance with 42 CFR §438.610, LHCC and its subcontractors are prohibited from knowingly having a relationship with:
   - **a) An individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or**
   - **b) An individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.**

2) LHCC shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with (2.20.3.2):
   - **a) An individual convicted of crimes described in 42 U.S.C. §1320a-7(b)(8)(B);**
   - **b) Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or**
   - **c) Any individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.**

3) LHCC is prohibited from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with:

a) Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

b) Any individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a;

c) Any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

d) Any individual or entity that would provide those services through an individual or entity excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

4) LHCC is prohibited from being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8).

5) If LDH finds LHCC is not in compliance with 42 C.F.R. §438.610(a) and (b), LDH:

a) Shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) of the noncompliance;

b) May continue an existing agreement with LHCC unless the Secretary of HHS directs otherwise;

c) May not renew or otherwise extend the duration of an existing agreement with LHCC unless the Secretary of HHS provides to LDH and to Congress a written statement describing compelling reasons

that exist for renewing or extending the agreement despite the prohibited affiliations; and

d) Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under 42 U.S.C. §1320a-7, §1320a-7a, and §1320a-7b.

6) LHCC and its subcontractors shall comply with all applicable provisions of 42 C.F.R. §438.608 and §438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. LHCC and its subcontractors shall screen all employees, contractors, and Network Providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the LHCC shall conduct screenings to comply with the requirements set forth at 42 C.F.R. §455.436 (2.20.3.6).

7) LHCC and its subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 C.F.R. §1003.102(a)(2).] (2.20.3.7)

8) An individual who is an Affiliate of a prohibited person or entity described above can include:

a) A director, officer, or partner of LHCC;

b) A subcontractor of LHCC;

c) A person with an employment, consulting, or other arrangement with LHCC for the provision of items and services which are significant

and material to LHCC's obligations under LHCC contract with LHCC; or

d) A Network Provider.

9) The Contractor shall notify LDH in writing within three (3) Calendar Days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of 42 U.S.C. §1320a-7(a) or (b) or any contractor which could result in exclusion, debarment, or suspension of LHCC or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549 of February 18, 1986, which states that debarment or suspension of a participant in a program by one agency shall have government-wide effect.

10) LHCC, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all employees and subcontractors as specified in the Debarment/Suspension/Exclusion section to capture all exclusions.

11) The Contractor and its subcontractors shall retain the data, information, and documentation specified in 42 CFR §438.410, for a period of no less than ten (10) years following termination of the Contract.

D. PAYMENTS TO EXCLUDED PROVIDERS (2.20.4)

1) Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services as specified in 42 CFR §1001.1901; and

2) LDH may recover from LHCC, via a deduction from LHCC's capitation payment, any money paid for services provided by an excluded provider.

E. REPORTING (2.20.5)

1) LHCC and its subcontractors shall be responsible for promptly reporting suspected Fraud, Waste, Abuse, and neglect information to the state's Office of Attorney General MFCU, and LDH as soon as practical after

discovering suspected incident, but no later than three (3) Business Days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).

2) LHCC shall notify LDH within three (3) Business Days of the time it receives notice that action is being taken against LHCC or an LHCC's employee, Network Provider, subcontractor, or subcontractor's employee under the provisions of 42 U.S.C. §1320a through 1320b, which could result in exclusion, debarment, or suspension of LHCC, Network Provider, or a subcontractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

3) LHCC shall report to LDH, within three (3) Business Days, when it has discovered that any LHCC employee(s), Network Provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal health care benefit program via the designated LDH Program Integrity contact.

4) LHCC reporting shall include, but is not limited to, the following, as set forth at 42 CFR §455.17:
- **a) Number of complaints of Fraud, Abuse, Waste, neglect, and overpayments made to LHCC that warrant preliminary investigation (under 42 CFR §455.14); and**
- **b) Number of complaints reported to the Contract Compliance Officer.**
- **c) For each complaint that warrants full investigation conducted in accordance with 42 CFR §455.15 and §455.16, LHCC shall provide LDH, at a minimum, the following:**
  - **i) Provider Name and ID number;**
  - **ii) Source of complaint;**
  - **iii) Type of provider;**
  - **iv) Nature of complaint;**
  - **v) Approximate amount of dollars involved if applicable; and**
  - **vi) Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.**

5) LHCC shall report to LDH Program Integrity monthly all audits performed, and all overpayments identified and recovered by LHCC and all of its subcontractors. [See 42 CFR §438.608(d)(3)].

6) LHCC shall report overpayments made by LDH to the Contractor within sixty (60) Calendar Days from the date the overpayment was identified.

7) LHCC shall report to LDH Program Integrity monthly all unsolicited provider refunds, which shall include any payments submitted to LHCC and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.

F. RIGHTS OF REVIEW AND RECOVERY BY LHCC AND LDH (2.20.6)

1) LHCC and its subcontractors are responsible for investigating and reporting possible acts of provider Fraud, Abuse, and Waste for all services under its contract with LDH.

2) LHCC and its subcontractors shall have the right to audit, review and investigate providers and Enrollees within LHCC's network for a one (1) year period from the date of payment of a claim via "automated" review. An automated review is one for which an analysis of the paid claims is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment. The collected funds from LHCC's automated reviews are to remain with LHCC. LHCC shall not recover from providers via automated review for claims older than one (1) year unless authorized in writing by LDH.

3) LHCC and its subcontractors shall have the right to audit, review and investigate providers and Enrollees within LHCC's network for a five (5) year period from the date of service of a claim via "complex" review. A complex review is one for which the review of medical, financial, and/or other records, including those onsite, were necessary to determine the existence of an improper payment. The collected funds from LHCC's complex reviews are to remain with LHCC.

4) All complex reviews shall be completed within ten months (three hundred (300) Calendar Days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.

5) LHCC shall ensure compliance with all requirements of La. R.S. 46:460.72 - 460.73, including the requirement to void all claims and encounters associated with Fraud, Waste and Abuse for the purpose of reducing PMPM rates, thereby returning overpayments to LDH. LHCC shall comply with the timeliness specified in the MCO Manual for voiding such encounters.

6) LDH or its designee will notify LHCC when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one (1) or more of the following criteria:

a) The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid Program directly or as part of a resolution of a state or federal investigation, audit, and/or lawsuit including, but not limited to, False Claims Act cases; or

b) When the issues, services or claims that are the basis of the recoupment or withhold are the subject of pending State or Federal investigation, audit, and/or lawsuit.

7) The prohibition described in the preceding section shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims. In the event that LHCC obtains funds in cases where recovery, recoupment or withhold is prohibited under this Section, LDH may recover the funds from LHCC.

8) Contact with a provider shall be prohibited in instances resulting from suspected Fraud, which LHCC has identified and submitted a referral of Fraud to LDH, MFCU, or other appropriate law enforcement agency, until approved by LDH in writing.

9) If LHCC fails to collect at least a portion of an identified recovery after three hundred sixty-five (365) Calendar Days from the date LDH approved proceeding with the recoupment, unless an extension or exception is authorized in writing by LDH and LHCC has documented recovery efforts deemed sufficient by LDH upon review, including formally initiating collection efforts, LDH or its agent may recover the overpayment from LHCC and said funds will be retained by the State. Exception reasons may include, but are not limited to, LHCC cooperation with LDH or other government agencies, termination of provider participation with LHCC, or dissolution of the provider's business.

10) LDH or its agent shall have the right to audit, review and investigate providers and Enrollees within LHCC's network via "complex" or "automated" review. LDH may recover from LHCC, via a deduction from LHCC's Capitation Payment, all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not:

- **Monetary Penalties assessed in accordance with the SURS Rule (LAC 50:I.4161.A.18);**
- **State-identified improper payments and overpayments;**
- **Overpayments determined through statistical sampling (extrapolation); and**
- **Investigation costs.**

a) These recovered funds shall be retained by the State.

b) LHCC may pursue recovery from the provider. However, LHCC is prohibited from recouping a State-identified overpayment from a provider when the LHCC is responsible for the overpayment, unless approved in writing by LDH. LHCC shall submit corrected Encounter Data within forty-five (45) Calendar Days of notice of the overpayment from LDH, regardless of whether LHCC recovers the overpayment from the provider.

11) LDH shall not initiate its own review on the same claims for a Network Provider which has been identified by LHCC as under a review approved

by LDH. LDH shall track open LDH and LHCC reviews to ensure audit coordination.

12) In the event LDH or its agent initiates a review on a Network Provider, a notification shall be sent to LHCC's Special Investigation Unit (SIU)designee. The LDH notification of the intent to review shall include provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. LHCC shall have ten (10) Business Days to indicate whether the claims were corrected or adjusted prior to the date of the notification from LDH. If the State does not receive a response from LHCC within ten (10) Business Days, the State may proceed with its review.

13) In the event the State or its agent investigates, reviews or audits a provider or Enrollee within LHCC's network, LHCC shall comply with document and claims requests from the State within fourteen (14) Calendar Days of the request, unless another time period is agreed to in writing by LHCC and State.

14) LDH shall notify LHCC and the Network Provider concurrently of overpayments identified by the State or its agents.

15) Upon the conclusion of provider rebuttals and appeals, if applicable, the State or its agent shall notify LHCC of the overpayment. LHCC shall correct or initiate its own review on the identified encounters within fourteen (14) Calendar Days of notification from LDH and correct the identified Encounters within forty-five (45) Calendar Days of notification from LDH. LHCC shall submit confirmation that the corrections have been completed.

16) LHCC and its subcontractors shall enforce LDH directives regarding sanctions on LHCC Network Providers and Enrollees, including, but not limited to, termination or exclusion from the network.

17) There shall be no LDH provider improper payment recovery request of LHCC applicable for the dates of service occurring before the Operational Start Date or for providers for which no MCO relationship existed.

18) LHCC shall not remit payment to any provider for which the State issued Medicaid Provider Identifier number has been revoked or terminated by LDH.

19) LHCC and its subcontractors shall retain all data, information, and documentation specified in 42 CFR §438.608 for a period of no less than ten (10) years following termination of LHCC's contract with LDH.

G. PROGRAM INTEGRITY REQUIREMENTS (2.20.7)
LHCC shall meet following requirements:

1) Notify LDH upon contact by any investigative authorities conducting Fraud and Abuse investigations, except in situations where investigative authorities make it illegal to provide such notice. LHCC, and where applicable any LHCC Subcontractors or Material Subcontractors, shall cooperate fully with the agencies that conduct investigations; full cooperation includes, but is not limited to, Timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. LHCC shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding;

2) Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of $25,000, even if there is no suspicion of fraudulent activity; and

3) Report annually to LDH, in a form and format specified by LDH, on the Contractor's recoveries of overpayments in accordance with 42 C.F.R. §438.608.

2. ADDITIONAL SIU PROCESSES AND PROCEDURES

FWA Education and Training

In order to maintain a high standard of knowledge and administer a successful FWA plan, the SIU staff will be responsible for attending at least 20 hours of training per year, through either FWA seminars or in-house trainings. The SIU management team will be responsible for developing/reviewing a FWA training program. At a minimum, training will include the following items:

- A definition of Fraud, Waste, and Abuse
- The Purposes and Goal of the program
- How to identify FWA including 'red flags'
- Common forms of FWA – Unbundling, Up-coding, Misrepresentation, etc.
- When, Where and How to report concerns
- Applicable state and federal laws/regulations
- Qui Tam (whistleblower) Provision
- The False Claims Act
- The Anti-Kickback Statute

FWA Investigative Leads

1) There are two types of FWA leads – reactive referrals and proactive leads. A reactive referral is defined as a person or agency, outside of SIU or LHCC, who forwards information to the SIU for further review. A proactive lead is defined as the identification of a suspicious pattern or patterns through datamining or through conducting independent research.

2) Reactive referrals are often identified using one of the methods mentioned below:
   a) ***Hotline Number*** - A toll-free hotline number has been established to report potential FWA activities.
      i. Name, address and telephone number of individual calling (if willing to provide).
      ii. Relationship to the provider/member to be investigated (i.e. patient, provider associate, provider office staff).

iii. Name of provider/member to be investigated.
iv. Address and phone number of member/provider to be investigated (if available)
v. If information relates to a provider, identify the type of provider (i.e. physician, hospital, pharmacy, DME supplier).
vi. As much detail as possible about the suspected FWA issue.
vii. Any evidence or documentation from the individual related to the investigation.
viii. The hotline number is 1-866-685-8664.

b) ***Explanation of Benefits (EOB)*** – In order to identify phantom providers or services not performed, LHCC will send EOB's to members. LHCC will select a sample size of members to receive a service verification of services; which will meet federal and state requirements.

c) ***FWA Email Box*** – An SIU FWA email box has been established to report potential FWA activities. The email box is monitored by SIU staff. All allegations are sent directly to a member of the SIU management and analyst team. The SIU FWA email box is: Special_Investigations_Unit@centene.com.

3) Proactive leads involve several different types of software and tactics to help identify potentially fraudulent, wasteful, or abusive patterns:
   a) ***Analytical Fraud Product***– SIU uses software that systematically identifies billing irregularities based on hundreds of industry standards. SIU uses a tool that contains over 1,500 fraud rules and algorithms. Examples of the fraud algorithms include high dollar alerts, provider is rendering services in a foreign country, payment spikes, procedure code spikes, inappropriate edits billed, etc. The tool is used by SIU Analysts and Investigators to proactively identify provider's aberrant billing patterns. The tool can be utilized by any member of the organization including the SIU, medical management, provider relations, quality improvement and legal.

   b) ***Media and Social Networking*** – Media and social networking are helpful sources for investigatory information. When the SIU discovers articles, postings, or advertisements that cause concern, a preliminary review will be conducted. All preliminary reviews will receive a case number and be tracked in the SIU tracking

system, CaseShield. SIU will utilize Facebook, LinkedIn, and any additional social media website to further investigatory research.

c) ***Internal Business Sources*** – Certain employees have a greater opportunity to detect and deter fraud due to the nature of their job responsibilities, (i.e. claims department, Vision, Dental and/or Pharmacy, call center, etc.). All employees are encouraged to report instances of potential FWA to the SIU through the fraud hotline or through direct contact with the SIU.

d) ***Special Investigation Resource and Intelligence System (SIRIS)*** – SIRIS is a fraud fighting tool sponsored by the National Health Care Anti-Fraud Association (NHCAA). Each SIU Investigator or Analyst enters case information into SIRIS including the nature and evidence of suspected fraud. SIRIS shares critical information, including an overview of health care fraud schemes, patterns, investigations, and trends, with law enforcement agencies. The investigation resources and tools of SIRIS can drive action and prosecution of insurance fraud, both criminal and civil.

e) ***Ad-Hoc Data Mining*** – The SIU uses analytical data-aggregation tools, to conduct ad-hoc data mining efforts to identify potential FWA.

f) ***Pharmacy Benefits Manager (PBM)*** – The SIU and PBM work collaboratively to ensure pharmacy benefits are properly utilized. The PBM will conduct investigative audits of pharmacies within their network

FWA Referral Intake and Triage

A specialized triage team within the SIU will first evaluate all referrals to the SIU. The triage team will be responsible for logging all FWA referrals into the SIU's case management system. Each referral will be automatically assigned a number for tracking purposes. All medical provider FWA leads will be initially evaluated utilizing the SIU's Risk Assessment tool. This tool will be used to determine a lead or referral's priority by scrutinizing

the provider's financial exposure, member vulnerability, risk of reoccurrence, and possible regulatory violations.

FWA Review and Investigation

1) At the onset of an investigation, prior to provider communication, the SIU Investigator will review applicable contract and regulatory requirements to verify that the suspicious activity warrants further investigation. During this review, the SIU and LHCC must work closely together to ensure that all steps/actions are completed accurately and timely. After the intake and triage stage, the case is then assigned to an Investigator. The Investigator is responsible for ensuring all the steps below are completed timely and actively engaging LHCC. The Investigator will document any delays noted within the case as well as escalate any necessary delays to ensure the case is moving as required. The Investigator will follow the timelines below, unless otherwise indicated by federal/state specific rules and/or regulations.

2) Preliminary Review – Completed within 30 days. The preliminary review may include the following information:

    a. Full identification of the provider/member.
    b. Review of relevant internal policies and procedures relating to the allegation.
    c. Examination of historical information relevant to the investigation (previous investigations, prior education).
    d. Contract and credentialing file review, if applicable.
    e. Claims data analysis.
    f. Public record searches.
    g. Interviews, if applicable.
    h. Internet searches.
    i. Prior authorization reviews.
    j. License verifications.
    k. Prescription requests, if applicable.

3) Once a preliminary review has been completed, the SIU Analyst will prepare a preliminary report detailing the findings from above and submit to SIU Management for approval. The SIU Manager will share the approved preliminary report and recommended next steps with LHCC.

4) Recommended next steps may result in the following:
    a) No further action, if the review revealed no suspicious activities or validated a legitimate reasoning for the suspicious patterns.
    b) Education and recovery when medical records will not invalidate the findings. Some examples are listed below:
        i. Unbundling – certain codes should never be billed together.
        ii. Member's eligibility has expired, sex or age is inappropriate. Office visits billed within global surgical period (same diagnosis)
        iii. Individual lab tests billed verses a lab panel code.
        iv. Even after medical record review, the recovery amount would be less than $5,000.
    c) Postpayment medical record review:
    i. Prescription record review to ensure validity.
        ii. Referral for Administrative Pharmacy or provider lock-in.
        iii. Prepayment medical record review.
        iv. Member interviews or surveys.
        v. Referral to state regulatory and/or investigatory agencies.
        vi. Referral to a department within Centene or LHCC for assistance or further action.
        vii. Member case management.
        viii. Physician prescribing restrictions – if warranted, SIU will recommend an NPI block on a prescriber to restrict the processing of pharmacy claims attributed to the prescribers NPI.
        ix. Contract termination of the provider or pharmacy from the network.

5) Following the completion of the preliminary review, the Investigator will notify LHCC of the intent to pursue one of two types of medical records investigations; Prepayment Review or Postpayment Review. LHCC should review the allegations and determine

whether any special circumstances, prior communications or instructions to the provider, or other potential risk may affect the investigation

6) Prepayment Review of Medical Records

a. ***Notification Letter*** – Once the determination is made to place a provider on prepayment review, the Analyst prepares and sends a notification letter requesting that the provider submit medical records for review. The letter will specify a deny/contest code that will appear on forthcoming explanations of payment (EOPs).

b. ***Claim Counts*** – In order to ensure only 20-50 services are included in the review, the SIU Analyst receives a daily report indicating claim-count denials. The Analyst counts these claims on a daily basis. When the number of claims to be reviewed is met, the Analyst removes the provider from prepayment review. SIU will then wait 30-60 days for medical records to be submitted by the provider.

c. ***Prepayment Approval Rate*** - When providers are placed on prepayment review, a quality check (QC) of reviewed services will be completed to ensure that the provider is meeting a 75% threshold of payable claims. If the approval rate is lower than 75%, a request will be made to have additional claims flagged for review. Upon completion of additional reviews, the provider's summary/claim history will be reviewed to determine the following steps for the provider:

   i. Remove the provider from prepayment review.
   ii. Continue additional reviews if the provider's denial rate may be lowering but not at a desired rate yet.
   iii. Recommend a retro review of the provider's claims.

d. ***Clinical Review*** – Once records are received, they are scanned-in by the claims department and submitted to the SIU clinical queue for review. The clinicians review the records to ensure that clean-claim guidelines are followed. A clean claim is a claim that can be processed without obtaining additional information from the provider on the service or from a third party.

e. ***Denial Letter*** – If the clinicians review the medical records and note that the claim should not be submitted for reimbursement, a denial letter will be sent to the provider indicating the reason for denial.

f. ***Educational Call/Letter*** – Depending upon the egregiousness of the findings, the SIU may send an educational letter or set-up an educational call with the provider to discuss the findings and ensure that the issues are corrected.

7) Postpayment Medical Record Request

A records request will be completed within 15 working days of completing the preliminary investigation, unless otherwise specified by state regulations/contract. As directed or permitted by LHCC's contract with LDH, SIU will utilize an extrapolation methodology. Upon approval, the SIU staff may use the Statistical Analysis System (SAS) to randomly select a sample equal to at least a 90% confidence interval with a 10% precision rate. If extrapolating, the investigation must be isolated to one Tax Identification Number (TIN). If a provider services more than one group/facility/clinic, extrapolation cannot be made across TINs. Therefore, the Investigator must decide to either:

a. Do a claim-by-claim recovery;
b. Limit the investigation to one particular TIN for the servicing provider; or
c. Extrapolate to all claims by the provider at that group/facility/clinic.

8) ***Medical Record Audit Types*** – The patient population will be predetermined and selected by the Investigator/Analyst based upon the following audit types:

a. Statistically Valid Random Sample (SVRS) Audit: Statistical sampling may be used to identify a statistically valid sample of claims from the entire sampling universe. Statistical sampling eliminates bias and uses the results of the sample to extrapolate the findings to the provider's entire sampling universe.

b. Probe Audit: Probe audits are conducted to determine if allegations of FWA can be substantiated. A probe audit is a smaller sample to review a specific allegation. If it is determined that there is an error rate (industry/CMS standards vary, however, a minimum of 5% error is typical), then a more comprehensive audit should be conducted.

c. Full Audit: A full audit may be conducted when the total population of claims within the universe is less than 30 and meets the selection criteria. If the population exceeds the SIU maximum of 75 records, a SVRS or Probe Audit should be conducted.

Onsite Medical Audit Procedures

1) ***Determination of Onsite Audit*** – The SIU/Health Plan will determine if an on-site audit is necessary based on the following criteria:
   a. Seriousness of allegation.
   b. Dollars involved.
   c. Joint on-site audit with federal/state agencies.
   d. Patient care concerns.
   e. Delivery of services validation.
   f. Medical records validation.

2) ***Onsite Audit*** – The SIU will initiate telephonic/written contact with the party to be audited and, in a non-confrontational and accommodating manner, attempt to schedule an on-site record audit. Once an audit is scheduled, a confirmation letter pertaining to the audit should be faxed (preferably in order to obtain fax confirmation receipt) to the provider's office.

3) ***Unannounced Onsite Audit*** – Unannounced audits may be conducted in certain circumstances. An unannounced audit may take place if:
   a. The allegations are particularly serious, such as articulable and credible allegations of fraud.
   b. The allegations give rise to patient care concerns.
   c. Non-compliance of medical records request or regulatory requirements.

4) ***Onsite Audit Process***:
   a. If required, the SIU should seek state approval to move forward with an onsite audit and ensure that the case is properly opened in CaseShield.
   b. The Investigator/Analyst may not release a list of the patients selected for audit to the provider prior to the audit date. A list will be provided at the date and time of the audit, so as to maintain the veracity of the records and the integrity of the audit.
   c. The Investigator will confirm the audit with the provider 24 to 48 hours before the scheduled onsite audit date.
   d. The Investigator/Analyst will obtain any and all available documentation. This should include but not be limited to:
      i. Provider enrollment forms.
      ii. Provider agreement language from contract.
      iii. Participating provider/facility agreement language.
      iv. Patient ledgers.
      v. Medical records.
   e. The Investigator/Analyst/clinician will arrive at the audit on the scheduled date and time. If a delay occurs, the Investigator will notify the provider as soon as possible.
   f. A tour of the office will be requested to investigate whether:
      i. Provider's office has the equipment necessary for services they routinely bill for, i.e. tilt table.
      ii. Records are being altered at the time of the audit.
      iii. Additional providers are servicing members in the office.
      iv. Any Stark Law violations have occurred.
   g. When copies of documentation are to be collected, the SIU will first obtain approval from the provider or designated office staff. The SIU will bring their own copy paper. The SIU should maintain an inventory checklist of the records requested and subsequently check in and out when necessary. In all instances, the SIU should bring a scanner to the audit for use in the event that technical problems arise with the provider's copier.
   h. When practical, and appropriate, the Investigator/Analyst will copy the entire file/medical record.

i. Records should not be reviewed in the office unless there is a specific need requiring it.
j. The provider or his/her designee will be advised upon the completion of the review, that they will be notified of the audit results.
k. Upon the completion of the audit, the Investigator/Analyst/Clinical Reviewer (as needed) will document the details of the audit.
l. Records obtained via onsite audit should be accompanied by a certification of true copy.
m. The provider or their designee may be subject to a non-accusatory interview in order to gain additional information related to their practice and the allegation.

5) Postpayment Medical Record Review

A medical records review will be completed within 60 calendar days of receiving the medical records. Once medical records are collected, the SIU Clinical Reviewer will prepare a clinical review sheet (CRS) to use while reviewing the medical records. The spreadsheet will include all the CPT/HCPCS/Revenue codes to be reviewed (by member and date of service). The SIU Clinical Reviewer(s) (a certified coder and/or LPN/RN) will review the medical records and identify any abnormalities or inconsistencies.

6) Final Report Preparation

A final report will be completed within 30 calendar days of the completion of the clinical summary regarding the findings of the medical record review. After receiving the signed clinical findings summary, the SIU Investigator will begin writing the Final Investigative Report. The report will detail important case steps, provide a summary of investigative findings and outline recommended appropriate action. The report will be reviewed and approved by SIU Management and discussed at the next Special Investigations Committee (SIC) meeting. The report will include the following:

a. The allegation.
b. An executive summary outlining the Preliminary Findings.
c. Substantive findings.
d. Copies of the laws and regulations considered violated.
e. An estimate of the overpayment.
f. A summary of any interviews conducted.

g. The time period for the review.
h. Any supporting documentation obtained as a result of the review.
i. The result of the review.
j. SIU's recommended next steps.

Recommended Health Plan Action

1) ***Provider/Member Education*** – If LHCC and the SIU determine there is a billing error, but not abuse or fraud, the SIU will assist LHCC in assembling or preparing appropriate educational materials.

2) ***Corrective Action Plan*** (CAP) – LHCC staff, often with the Chief Medical Director, will develop a CAP to resolve the billing or service issues. Corrective measures vary but typically must be completed within six weeks of agreement. LHCC departments such as Quality Improvement and Provider Relation's staff will monitor progress and compliance, usually up to 180 days after CAP completion. The Compliance Officer will appropriately document CAP implementation and completion in Archer.

3) ***Federal/State Referral*** – Based on federal/state regulations and/or the seriousness of the violation, the case may be referred to federal or state agencies. When requested by LHCC, the SIU will complete any necessary forms and prepare the documents for presentation to the agency. LHCC will submit the form(s) or the SIU will submit them upon LHCC's request. Referrals may be prepared and submitted to the Louisiana Department of Health, Louisiana Department of Insurance, Louisiana Department of Justice/MFCU or Local Law Enforcement Agencies.

4) ***100% Prepayment Review*** – The provider may be placed on prepayment review in order to continually monitor the provider's billing to ensure compliance with any education resulting from an investigation.

5) ***No Additional Actions*** – Following the clinical review, if no additional actions are required, the case will be closed.

6) ***Recovery of Identified Overpayment and Education*** - LHCC will accept responsibility to collect the overpayment in accordance with federal/state regulations and/or ensure education is completed. The SIU will be responsible for providing any information requested by LHCC to assist with this process. The audit results/education letter will

describe the errors found during the review and the regulations violated. The letter will also include a notice of intent to recoup the overpayment and whether any services will be placed on prepayment review. The letter will include a statement that the resolution does not bind federal or state agencies from taking further action based on the facts that gave rise to the matter. The education should be summarized in a memo format and when possible the provider should be asked to sign the letter to acknowledge receipt of education. If no signature will be obtained, the letter should be sent via certified mail and the receipt verification added to the case file.

7) **Recoupments -** Once the investigation is completed, the SIU will identify and calculate all overpayments for recoupment. Findings audit documentation will be populated for LDH review and approval. After receipt of LDH approval, the findings and audit documentation will be sent to the provider to review the specific service lines that are recoupable, including the clinical comments with a detailed explanation of the noted deficiencies for recoupment. The SIU will indicate an overpayment by initiating outreach to the provider to notify them of the overpayment by overpayment/demand/educational letter. The provider is given 30 calendar days to review the overpayment letter.

8) The following actions, among others, may be taken in accordance with the outcomes from the provider including:

a. Implementing a negative balance or offsetting claims.
b. An appeals review.
c. Instituting a one-time payment or a payment plan.
d. Entering into negotiations or utilizing Centene's collections agency for non-participating providers.

ADDITIONAL REQUIREMENTS

1) LHCC shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR §438.610(a) and (b), and 42 CFR §1001.1901(b)]. LHCC will screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. LHCC will

search the Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, by accessing the following URL: https://oig.hhs.gov/exclusions/index.asp.

2) LHCC shall comply with LDH Policy 47.1, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH contractors who have access to electronic protected health information on Medicaid applicants and recipients. LHCC shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of the Contract with LDH.

3) Annually, LHCC will provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. LDH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].

4) LHCC shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.

5) LHCC shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. LHCC shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

6) LHCC shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. LHCC shall not pay any claim submitted by a provider that is on payment hold under the authority of LDH or its authorized agent(s).

7) LHCC shall ensure that the claims system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4 of its Contract with LDH.

8) Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) Pursuant to the requirements of federal laws, LHCC shall submit the **Medicaid Ownership and Disclosure Form** located at www.lamedicaid.com [link] is to be submitted to LDH annually and within thirty-five (35) days when any change in the LHCC's management, ownership or control occurs.

9) LHCC shall furnish to LDH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. LHCC understands that failure to comply with this requirement may result in termination of its Contract with LDH.

10) LHCC shall submit, within thirty-five (35) days of a request made by LDH, full and complete information about:

    a) The ownership of any subcontractor with whom LHCC has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and
    b) Any significant business transactions between LHCC and any wholly owned supplier, or between LHCC and any subcontractor, during the five (5) year period ending on the date of the request.
    c) For the purpose of LHCC's Contract with LDH, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the LHCC's total operating expenses whichever is greater.

11) LHCC shall report to LDH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.

12) LHCC shall make the information reported pursuant to Section 18.3.1 available to its members upon reasonable request.

13) Although federally qualified MCOs are exempt from this requirement, LHCC understands that LDH may require that the information on business transactions be accompanied by a consolidated financial statement for LHCC and the party in interest.

14) If LHCC has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed by LHCC.

15) The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment; therefore, all of LHCC's business transactions must be reported.

16) If the contract is renewed or extended, LHCC must disclose information on business transactions which occurred during the prior contract period.

17) LHCC shall furnish LDH information related to any person employed or contracted with LHCC convicted of a criminal offense under a program relating to Medicare (Title XVIII), and Medicaid (Title XIX), and Title XX as set forth in 42 CFR §455.106 and including SCHIP (Title XXI). Failure to comply with this requirement may lead to termination of LHCC's Contract with LDH.

18) LHCC agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to nonprocurement debarment and/or suspension. As a condition of enrollment, LHCC will screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, LHCC may search the following websites:

    a) Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp;
    b) the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp;
    c) the Louisiana Adverse Actions List Search (LAALS) https://adverseactions.LDH.la.gov; and/or
    d) the System for Award Management, http://www.sam.gov.

19) LHCC shall conduct a screen, as described in Section 25.13.1 of its Contract with LDH monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered shall be immediately reported to LDH. LHCC understands that any individual or entity that employs or subcontracts with an excluded

provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. LHCC also understands that this prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).

20) LHCC shall not make payments for the following:

a) Organ transplants, unless the state plan has written standards meeting coverage guidelines specified;
b) Non-emergency services provided by or under the direction of an excluded individual;
c) Any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
d) Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and
e) Any amount expended for home health care services unless LHCC provides the appropriate surety bond.

REFERENCES: Section 15 MCO RFP
ATTACHMENTS:
DEFINITIONS:

REVISION LOG

REVISION	**DATE**
Revisions to Section 15 per BH Carve-In Amendments.	8/2015
Revision to Section 15 per Final Version of BH Carve-In Amendment relative to suspension of payments to network providers when there is a credible allegation of fraud.	12/2015
Change name of Program Integrity Committee to Special Investigations Committee.	3/16
Removed provision that required LDH approval of provider recoupments.	6/16

POLICY AND PROCEDURE

DEPARTMENT: Compliance/SIU	**DOCUMENT NAME:** Fraud, Waste and Abuse Plan
PAGE: 56 of 56	**REPLACES DOCUMENT:**
APPROVED DATE: 03/02/21	**RETIRED:**
EFFECTIVE DATE: 12/1/2015	**REVIEWED/REVISED:** 8/15, 12/15, 3/16, 6/16, 12/16, 1/17, 2/18, 12/18, 4/19, 11/19, 03/21,12/21, 12/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.COMP.16

Reviewed policy. No revisions necessary.	12/16
Technical revisions, changed DHH to LDH throughout document, and clarified corporate SIU functions.	1/17
Revisions made to incorporate provisions of contract Amendment 11.	2/18
Technical revision made to correct RFP section citation and to clarify submission requirements for tips report.	12/18

Attachment A – CC.COMP.16	2/18
Revision regarding recovery of overpayments approved by LDH per Amendment #16.	4/19
Revisions incorporating new provisions from the Emergency Contract.	11/19
Revision incorporating new provisions from the Emergency Contract Amendment #3 and SIU processes and procedures.	3/2/21
Revision incorporating new provisions from the Emergency Contract Amendment #5.	12/21
Revision incorporating provisions from new Model Contract	12/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P's management software, is considered equivalent to a physical signature.

V.P. Compliance _____*Approval on file* _____