2.10.14.1 The Proposer should describe its fraud, waste and abuse program

Humana has participated in publicly financed healthcare programs since the mid-1980s, allowing us to develop deep expertise in the investigation and mitigation of fraud, waste, and abuse (FWA). Recognized as national leaders, we are actively involved with or hold a leadership role in multiple national anti-fraud organizations, including the National Health Care Anti-Fraud Association (NHCAA). We are also one of the founding members of the Healthcare Fraud Prevention Partnership, an innovative public-private partnership with the Department of Health and Human Services (HHS) following passage of the Affordable Care Act (ACA). We participate in Louisiana-based efforts such as the Louisiana Insurance Fraud Task Force.

We have provided services in Louisiana through our Medicare, commercial, and TRICARE lines of business for more than 15 years where we currently have FWA associates working in our Louisiana office. Our goal is to be a true partner to LDH, the Louisiana Medicaid Fraud Control Unit (MFCU) and the Office of the Inspector General (OIG). Humana has built its FWA efforts on a local-national structure, with associates dedicated solely to issues that arise in Louisiana who we support with additional corporate resources. Upon Contract award, we will appoint our Louisiana Medicaid Contract Compliance Officer (CCO), Mr. Thompson, (in compliance with Section 2.3.3.7 of the Model Contract) who will serve as a primary point of contact for LDH and report to our Louisiana Medicaid Chief Executive Officer (CEO), Mr. Mollica. We will also appoint a Program Integrity Officer (PIO) and additional Louisiana Medicaid dedicated Program Integrity associates, including investigators. In accordance with Section 2.3.1 of the MCO Manual, the PIO will oversee FWA monitoring and enforcement to prevent and detect potential violations and areas of risk, ensure reports are submitted properly and promptly, and implement any corrective action plans (CAPs).

Organizational Structure

Board of Directors: Humana's culture of compliance begins with our Board of Directors and executive leadership. Humana's President and CEO as well as the Audit Committee of the Board of Directors actively engage in oversight of our FWA functions.

Chief Compliance Officer and Corporate Compliance Committee: Humana's Chief Compliance Officer and Medicare-Medicaid Compliance Officer report directly to the Board and the CEO regarding compliance activities and administratively reports to the Chief Risk Officer. The Chief Compliance Officer is responsible for the day-to-day ownership of the Corporate Compliance Program and chairs the Corporate Compliance Committee. The committee monitors issues, metrics, and training as well as adherence to our compliance policies and procedures. The committee is accountable to and provides regular reports to the CEO and Audit Committee of the Board of Directors.

Enterprise Risk Management (ERM) Committee: This committee provides executive management oversight over Humana's ERM program, which is a formal, structured program to manage risk across Humana. It includes structural elements to identify, mitigate, and report risks internally and externally, if necessary. This comprehensive process applies to all lines of business and departments and includes a focus on fraud as an element of operational risk.

Medicare and Medicaid Compliance Committee: Our Medicare and Medicaid Compliance Committee regularly reviews SIU's activities in accordance with our Anti-Fraud Plan. This Committee is composed of our executive leadership, including our CCO and Chief Audit Officer, as well as other senior leaders. The Anti-Fraud Plan is designed to meet federal and State laws, rules, and regulations, including FWA detection, correction, and prevention guidelines that apply to Humana, our subcontractors, and providers.

Enterprise Investigations Consortium (EIC): Our EIC provides an integrated framework to develop and document investigations, including those related to FWA, criminal activity, ethics, and/or regulatory violations across all our operations. The EIC exists to optimize effectiveness within and across the various investigative groups and to ensure our investigative standards consistently exceed legal and compliance requirements. The EIC includes at least one member of each of the following departments: [redacted].

Compliance Plan: We detail our FWA efforts in our FWA policies, procedures, and Compliance Plan, which incorporates our Anti-Fraud Plan and describes our mechanisms to prevent and correct fraud risk events. Our Compliance Plan clearly delineates our expectations for our associates and subcontractors and mandates annual training for all providers, associates, and material subcontractors. After incorporating the HHS OIG guidance, we structured our Compliance Plan to adhere to all relevant federal and State requirements, including contractual and regulatory requirements. Along with our Code of Conduct, our Compliance Plan incorporates the requirements set forth in applicable federal and State anti-fraud laws, regulations, and policies, including 42 C.F.R. Part 438 and Part 455, Subpart A, La. R.S. 46:437.1-14, LAC 50:1, Subpart 5 and 42 U.S.C §1320a-7 1320c-5 and §1396a(a)(68), specifically describing:

- Written policies and procedures for investigating FWA
- Corporate commitment to oversight: Compliance Officers and Corporate Compliance Committee exercise clear oversight across the organization
- Mandatory training and education for all associates, providers, and subcontractors
- Effective lines of communication, including a dedicated email address that we check daily for tips, a well-publicized ethics hotline to report violations, an ethics helpline for assistance and questions, and multiple ways to anonymously reporting suspected FWA and ethics violations, including via our website, call centers, and ethics hotline
- Well-publicized disciplinary standards and strong enforcement mechanisms, including termination of employment or contracts for violations of our FWA policies and procedures, including our Standards of Conduct
- Routine monitoring and auditing to prevent and detect FWA, including service patterns for providers, subcontractors, and enrollees; random claims payment reviews; and code and payment edits
- Prompt response to compliance issues as defined by our policies and procedures

Anti-Fraud Plan: Our Anti-Fraud Plan articulates Humana's strategic efforts to detect FWA internally and amongst our enrollees, providers, and subcontractors. It describes the data we review, the types of reviews we conduct (e.g., monitoring of provider and subcontractor services patterns, use of code and payment edits, random claims payment reviews, and routine validation of data and services provided), the controls we have in place, and the steps we take throughout our investigation process. Our Anti-Fraud Plan also describes in detail our training plan for our associates, providers, and subcontractors, as well as enrollee FWA education. Our SIU Director is responsible for our Anti-Fraud Plan and our Louisiana-based PIO is responsible for ensuring we modify it to address the requirements of the Louisiana Medicaid managed care program.

Operational Structure

In September 2017, Humana took a progressive step within the healthcare industry by creating a Chief Risk Office, uniting our risk and compliance organizations to ensure easier collaboration while maintaining strong partnerships across our operations. The Chief Risk Office sets direction and establishes policy in the areas of enterprise risk management and compliance while building a strategy and a culture that manages risk appropriately and establishing a consistent definition of risk across the enterprise. An ERM team led by Humana's former SIU Director is building a framework to better identify FWA across the company, including areas traditionally considered FWA as well as other types of FWA, such as associate waste, and then reviewing how to mitigate it. This requires business process owners to think about fraud risk as part of their overall primary responsibility. ERM produces scorecards and other metrics to demonstrate risk reduction and success.

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Claims Cost Management (CCM): Operating for more than 30 years, CCM is Humana's overarching department responsible for carrying out our FWA efforts. CCM has more than [redacted], including associates based in Louisiana. Our CCM has a Shared Services team with cross-functional responsibilities such as the CCM Compliance team, as well as sub-units that have their own area of expertise, such as clinical audits, investigations, complex data analysis, and subrogation. Our CCM has systems to monitor for known FWA types or patterns and aggressively investigate new risk areas. Associates use data mining, query development, and medical record reviews to detect, identify, investigate, and mitigate FWA. CCM manages various services to monitor the accuracy of claim and encounter payments and limit Humana's exposure to fraudulent, wasteful, and abusive healthcare clinical and billing practices.

[redacted]

Special Investigations Unit (SIU): Formed in 1985, our SIU is a sub-unit of CCM and is responsible for all investigations related to fraud and abuse. The goals of Humana's SIU department include but are not limited to maintaining an anti-fraud program to protect Humana and government funds, conducting thorough and effective investigations into alleged FWA, reporting suspected fraudulent acts to the appropriate federal or State agencies, and cooperating with the agencies' subsequent actions.

[redacted]

Humana's SIU has more than [redacted] dedicated to this function, including Louisiana-based associates. While each referral and case are inherently unique, our SIU investigators employ a systematic set of investigational techniques to thoroughly complete each case review. The SIU tracks all incoming complaints and referrals in our proprietary Fraud Investigation Tracking (FIT) system, SIU's proprietary workflow and documentation system. As the case progresses, our investigators document the steps they take in FIT and attach electronic copies of all documents pertaining to the case and its resolution. Our SIU is responsible for all compliance procedures and communication with law enforcement officials. It will report any suspected fraud activity within five days in accordance with Section 2.20.1.12.2.3 of the Model Contract, or as required by federal and Louisiana laws, regulations, Contract requirements, or to the appropriate law enforcement and/or government agencies.

Case Example

[redacted]

SIU has a regular process in place for receiving and researching tips that complies with the requirements set forth in Section 2.20.1.12 of the Model Contract. [redacted]

Provider Payment Integrity (PPI): Also, a sub-unit of CCM, PPI conducts all reviews and audits related to waste and abuse, along with handling all written inquiries related to overpayments. PPI uses complex data analytics, including outlier analysis, trending, and link analysis to identify potential waste and abuse. PPI also conducts pre- and postpayment audits to identify potential overpayments and conducts clinical reviews. [redacted]

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[redacted]

Fraud Research Analytics and Concepts (FRAC) and Overpayment Solutions and Opportunities (OSO): Sub-units of CCM, FRAC and OSO work in tandem to conduct a variety of initiatives that proactively detect FWA. FRAC, which we discuss below, and OSO use state-of-the-art software applications such as QlikView and Tableau Dashboards to construct analytical, statistical, and predictive models that identify and detect FWA. We can focus these models on specialty or type of services we consider high risk. We select data based upon detailed investigation and research into potential fraud schemes and use data mining analysis to identify data markers that potentially indicate FWA, including outlier analysis, rules- based anomaly detection, trend analysis, and statistical analysis.

Additional CCM units:

- The Risk Adjustment Integrity Unit (RAIU) is responsible for investigating instances of FWA in Humana's provider network that impact risk adjustment submissions
- The Coordination of Benefits Unit proactively coordinates benefits for enrollees where there is another payer or CMS is the primary payer
- The Subrogation Capture Unit identifies, investigates, and conducts payment coordination with third-party liability holders

Regulatory Compliance (RC): RC is responsible for overseeing the effectiveness of Humana's compliance program, both operationally and administratively. Through an effective system of routine monitoring, auditing, and identification of compliance risks, RC can effectively monitor adherence to state and federal requirements. This system includes extensive risk-based assessments of key administrative and operational functions, internal monitoring and auditing, and (as appropriate) engagement of external monitoring and auditing to evaluate Humana's compliance with these requirements and the overall effectiveness of the compliance program. RC works closely with many internal departments including SIU, Internal Audit Group, Organizational Risk Management that engage in identifying compliance risks within Humana and our subcontractors. RC documents identified compliance deficiencies and corrective actions taken in an online tracking tool called Enterprise Solution Point (ESP). Our Regulatory Compliance associates, specifically our Louisiana Regulatory Compliance Officer (RCO), will have responsibility for oversight and monitoring of compliance with federal, state, and Contract requirements. In addition to our CCO and PIO, upon Contract award, we will appoint a full-time RCO dedicated to our Louisiana Medicaid Managed Care Contract.

Dedicated Teams for Specialized Functions: Our [redacted] with specific risks associated with particular Medicaid services or types of providers led us to develop dedicated teams who follow targeted procedures for monitoring providers and subcontractors. For example, we have specialized focus in areas such as [redacted]

2.10.14.1.1 Any training programs that the Proposer uses;

Associate Training: Before extending an offer of employment, we carefully screen prospective associates for eligibility to participate in a federal or state healthcare benefit program in accordance with Section 2.20.3 of the Model Contract. Upon hire, we require that all associates complete and attest to mandatory FWA training within 30 days of beginning employment and annually thereafter. This requirement applies to all Humana associates, including the CEO, all senior leaders, and the Board of Directors. The Corporate Learning Center tracks completion of the training and automatically turns off access to Humana systems for anyone who fails to complete the training. Our associate

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intranet enables easy access to our Ethics Every Day training, which associates and contractors can use as a resource. Content includes:

- Our comprehensive Code of Conduct and a description of our Compliance and Anti-Fraud Plans
- A description of applicable FWA laws, regulations, and requirements
- Information on how associates can report suspected cases of FWA
- Whistleblower protections for anyone who reports FWA

We tailor our training to state requirements and will modify our existing training to incorporate Louisiana's Medicaid requirements, applicable Louisiana laws, regulations, and LDH/MFCU policies. We have additional specialized training for CCM/SIU associates; for example, our SIU has extensive two-phase training designed to specifically address SIU's functions, processes, and applicable requirements. Supplemental training by SIU is also available upon departmental request. Along with our structured annual training, we use several methods to provide information and training throughout the year. For example, on a daily basis we update our intranet home page, which regularly includes topics related to FWA and other compliance topics. Associates also receive emails highlighting specific topics and updates.

Subcontractor Training: We apply the same requirements to subcontractors as we do to our own associates and many of our subcontractors require additional training for their employees. The first step we take in establishing a relationship is to carefully screen subcontractors to ensure they have not been suspended, excluded, or debarred from participation in a federal or Louisiana program. We repeat these checks monthly to ensure we uncover any changes to a subcontractor's eligibility. Next, subcontractors must complete the required training within 30 days (and annually thereafter) or we terminate their access to Humana's systems. Many subcontractors also complete specialized training related to their specific functions and are often subject to additional internal training. The content of this required training is the same as the training required for Humana associates. Subcontractors also receive supplemental training by our SIU/CCM upon request. Subcontractors who work on Humana's systems also have access to Humana's intranet and email education and updates.

Provider Training: As with associates and subcontractors, our first step in FWA prevention is to screen providers for eligibility to participate in federal and state healthcare benefit programs. Next, we conduct training for those screened providers on FWA in three phases: an initial mandatory training, annual refresher training, and ongoing training. The initial training is required within 30 days of inclusion in our provider network and includes comprehensive training on our Code of Conduct, our Compliance and Anti-Fraud plans, FWA, laws and regulations, reporting requirements, whistleblower protections, and specific Louisiana Medicaid requirements. We also include information about FWA and how to report it in our Provider Handbook and Provider Training Manual.

Along with mandatory annual refresher FWA training that Humana or the provider's office conducts, our CCM or Provider Relations (PR) representatives conduct additional training when:

- There are changes in Medicaid programmatic changes, FWA requirements, or Humana policies, procedures, or requirements
- Data analytics identify a trend or an opportunity for correction across all providers or a subset of providers (e.g., BH providers, laboratories, etc.)
- The Resolution or Critical Inquiry (CI) associates (the teams that resolve enrollee grievances and appeals) or the Provider Resolution team (the team that resolves provider complaints) identify a trend or opportunity for correction
- Our CCM, PPI, SIU, or the ERM team identifies an issue

2.10.14.1.2 How the Proposer engages enrollees in preventing fraud, waste and abuse;

Enrollees are often the first to identify or notice cases of FWA. We actively engage enrollees in preventing two types of FWA:

- FWA committed with or by the enrollee (such as submitting false claims, doctor shopping, altering bills, identity theft, or letting someone else use the enrollee's identification (ID) number)
- FWA committed by others (such as providers, Case Managers (CMs), or transportation vendors)

We specifically incorporate enrollees into our Anti-Fraud Plan and educate them through various channels. For example, our Enrollee Handbook includes information about FWA prevention and reporting. Our website prominently

features information about FWA and how to contact Humana to report a suspected violation. For enrollees who receive Explanation of Benefits (EOB) or Smart Summaries, we include FWA information on the summaries, with directions on how they can contact Humana to report discrepancies. Similarly, in accordance with our established policies and procedures, SIU specialists engage enrollees to conduct service verification. The SIU specialists use our data warehouse to randomly select enrollees who have received services and send letters verifying the service, ensuring that the sample is stratified so that all provider and claim types are represented in accordance with Section 2.18.11 of Model Contract. Member Services representatives contact the enrollee to confirm they received the letter and verify the service.

Case Example

[redacted]

For enrollees who want to contact us for information, provide a tip or report a suspected violation, we have a dedicated email address that we check daily, as well as a dedicated toll-free hotline. Our Member Services representatives will also take these calls, and our interactive voice response (IVR) system is configured to support enrollee tips. This information is available in our Enrollee Handbook and on our website.

2.10.14.1.3 The data analytic algorithms that the Proposer will use;

Our FWA prevention and detection techniques leverage sophisticated statistical analysis to detect anomalies and outliers. In order to establish a state-of-the-art FWA detection program, we evaluated the effectiveness of various off-the-shelf algorithm solutions, such as IBM's Fraud Abuse Management System (FAMS). Through this review we determined these systems would not allow us to meet the goals we sought to attain in preventing and detecting FWA. Instead, [redacted]

Prepayment Claim Edits: Prior to payment, our Claims Adjudication System (CAS) finds claims with inconsistent data such as type code, group number, or contracted provider number, and flags the claim as requiring manual processing. In addition to these reviews and audits, PPI routinely conducts prepayment reviews. [redacted]

Postpayment Claim Reviews and Audit Projects: We routinely assess paid claims postpayment to identify overpayments and underpayments for network and out-of-network (OON) providers. Retroactive review may occur after receiving a provider inquiry or additional information from our partners, or through automated processes generated when Humana receives updated enrollment and eligibility files. Humana runs queries monthly on all paid claims to identify claims likely to be over- or under-paid. Humana captures any retroactive changes to membership or provider contract changes and reviews claims for appropriate payment. Using established national guidelines, our PPI postpayment reviews help us confirm that enrollees received the most appropriate and cost-effective services and supplies, with contractual reviews being the most common. During these reviews, associates examine whether the bill

complies with the provider's contract (e.g., whether a bill for an MRI should be paid as part of an inclusive rate or at a separate emergency rate according to the contract). Our postpayment review confirms that enrollees received appropriate and cost-effective services and supplies. [redacted]

Provider Profiling: FRAC has built proprietary models to analyze provider behavior and identify outliers. FRAC's analysis utilizes variables such as [redacted]. FRAC is able to stratify providers' FWA risk levels and identify those in the "high risk" category.

Data Mining: FRAC uses proprietary software applications and systems to construct data algorithms, and analytical, statistical, and predictive models focused on specialty or types of services. FRAC associates then isolate high-risk behavior and build in custom edits for each algorithm and dashboard. FRAC associates select data to analyze based on detailed investigation and research into potential fraud schemes impacting various models. FRAC processes large amounts of data rapidly to identify unusual or suspicious billing patterns that warrant further investigation based on outlier, trend, and other statistical analysis, coupled with rules-based anomaly detection.

[redacted]

2.10.14.1.4 Methods the Proposer will use to identify high-risk claims

Our approach to high-risk claims continues to evolve as the nature of FWA changes. Each stage of the claims lifecycle is managed by a trained and experienced team responsible for tracking performance of our claims system, ensuring high risk claims and errors are caught and corrected immediately and claims are adjudicated accurately and efficiently. Our Claims team works in tandem with CCM and its sub-units (e.g., SIU, PPI, RAIU, etc.) using our automated processes and edits, reviews, and audits to identify high risk claims.

There are several indicators of high risk that we have incorporated across all our methods for identifying these claims.

[redacted]

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Automated Processes and Edits: Our claims processing system has multiple analytics in place to identify high-risk claims. Our Claims team has built more than [redacted] edits into our CAS to prevent improper payments. Our Claims team also regularly analyzes Interest Reports (on unpaid claims) and Drill Down Reports, by reason and code category, to identify high-risk claims. Our Claims Research Unit (CRU) identifies claims [redacted] as being high risk and refers these to the Claims team for additional examination. The Claims team pends these claims and checks each code for accuracy and appropriateness.

Prepayment and Postpayment Reviews: PPI associates review claims on routine basis to identify high-risk claims. These reviews focus on provider billing and coding errors, coordination of benefits issues, retrospective claims reviews, and identification of contracting errors. To identify high-risk claims, PPI completes medical record reviews that focus on billing and coding errors, medical necessity reviews, services not rendered, level of care validation, preventable readmission, and clinical diagnosis validation. PPI also leverages its investigative and reporting capabilities to respond to new types of high-risk claims or areas as Humana's business model evolves. [redacted]

Audits and Investigations*:* We have two teams within CCM that audit and assess levels of risk to ensure we are meeting compliance requirements. The CCM Quality Audit team and SIU use numerous factors to identify whether a provider's claim is high risk, including:

[redacted]

Electronic Visit Verification (EVV): SIU uses EVV to verify visits and the services provided during those visits in order to safeguard against inappropriate billing and FWA. We will start by verifying visits by in-home providers and include additional types of providers through a phased-in approach.

2.10.14.1.5 The Proposer's experience with provider recovery collection.

Humana's postpayment recovery approach aims to strike the appropriate balance between minimizing provider dissatisfaction with being good stewards of State Medicaid funds. We work to reduce friction with providers in several ways. These efforts include establishing a live line run by PPI to answer provider recovery questions and investing substantially in the CCM Issue Resolution team and Availity to improve self-service.

Humana's goal is to reduce the need for provider recovery collections as much as possible. To achieve this, we have developed a tool, [redacted]

PPI's Payment Recovery team has responsibility for overpayments and recoveries. We routinely assess paid claims postpayment to identify overpayments and underpayments for in-network and out-of-network (OON) providers.

Retroactive review may occur after receiving a provider inquiry or additional information from our partners, or through automated processes generated when Humana receives updated enrollment and eligibility files. PPI runs monthly queries on all paid claims to identify claims likely to be over- or underpaid and capture any retroactive changes to enrollment or provider contract changes, and reviews claims for appropriate payment. Our PPI associates track recoveries through our Financial Recovery System. In accordance with our written procedures related to recoveries, we contact the provider in writing, notifying the provider we will begin reducing future payments to the provider within [redacted] through our auto-remittance deduction process. Providers may choose to send us a payment. We work with an outside collection firm to recoup payments after [redacted]

2.10.14.2 The Proposer should provide a description of its capability to produce the required reports

Humana has produced regulatory reports for publicly-financed healthcare programs such as Medicare and Medicaid for more than three decades. As these reporting obligations evolve, we modify our systems to fulfill these obligations. For example, as reporting requirements became more detailed and we added additional programs and markets, CCM created the Compliance team to ensure we fulfill these obligations appropriately. CCM's Compliance team works in conjunction with our SIU and PPI to complete reporting requests. Once the reports are complete, the PIO and CCO collaborate with the CCM Compliance team to complete quality assurance reviews of the reports, checking for accuracy and quality of the information included.

Currently, the CCM Compliance team produces similar reports for several other state Medicaid agencies as well as numerous other reporting agencies, including CMS. In addition to these compliance reports, multiple states require reports regarding whether tips are substantiated. In accordance with Section 2.20.1.12.2 of the Model Contract, our SIU will report all confirmed and suspected provider fraud and abuse to LDH and MFCU. The CCM Compliance team uses a tracking system that displays all reports and deliverables with due dates and assigned owners, and includes a process for back-up coverage for associate absences to ensure we complete reports and referrals on time and accurately. Specifically, the CCM Compliance team submitted 126 FWA-related Medicaid reports including monthly, quarterly, and annual reports, to government agencies in 2018. This team submitted 100% of these reports on time.

Innovations for Reporting Data

Humana's CCM and SIU have long taken a leadership role in partnering with our state partners to adjust reports and develop new reports that account for new types and sources of available data, changes in FWA threats, and to improve the usefulness of the reports for the state. These conversations ensure our understanding of the data sought and open lines of communication for process improvements.

Case Example

[redacted]

In Louisiana, we anticipate that the collaboration with [redacted] could lead to innovative reporting opportunities not currently used in the State. We commit to collaborating with LDH to establish these requirements and determine the best way to capture the most relevant and accurate data that LDH, MFCU, and potentially other MCOs can use to improve prevention and detection efforts.

Innovative reporting approaches cannot be developed or implemented in an organization without clear operational vision. [redacted]

Humana also currently has several reports in place that are innovative within the industry. For example, we currently use our CCM Compliance Medicaid dashboards for other state Medicaid programs, summarizing Medicaid-specific SIU cases to identify trends unique to Medicaid. These dashboards include data such as referrals to SIU, cases being investigated, number of referrals transferred to an investigator, average number of days a case is open, how long a case is in triage (case aging), and reasons for closing a case. We share these dashboards with the Corporate Compliance Committee on a quarterly basis so that they are better able to monitor unique Medicaid risks.

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