2015

Anti-Fraud Plan

Scripps Health Plan Services, Inc.

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Scripps Health Plan Services, Inc.
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I. PURPOSE

The purpose of the Scripps Health Plan Services Anti-Fraud Plan is to establish methods for objectively and systematically evaluating and investigating potential fraud and/or abuse of the Scripps Health Plan Services Health Care delivery system. Scripps Health Plan Services strives to continuously improve the structure, processes and outcomes of its anti-fraud activities.

The Anti-Fraud Plan is a component of Scripps Health Plan Services' Quality Improvement Program. The plan has been implemented in conjunction with other Quality Improvement activities. The Scripps Health Plan Services Anti-Fraud Plan relies on senior management oversight and accountability, and integrates the activities of all departments in meeting the plan's mission and objectives. The Scripps Health Plan Services Anti-Fraud Plan involves all key departments and functions in the development, implementation and evaluation of anti-fraud activities.

II. GOALS AND OBJECTIVES

To develop a comprehensive fraud prevention, detection, and investigation function while maintaining a complementary relationship with our medical groups, contracted network partners and governmental agencies.

Scripps Health Plan Services anti-fraud objectives:

- Maintain member continuity of care and quality of care during fraud and abuse investigations.
- Improve provider and contracted networks understanding of fraudulent practices.
- Improve staff understanding of fraudulent practices.
- Respond to member and practitioner needs such as member and provider complaints and referrals.
- Prevent or detect false claims for benefits.
- Coordinate with all appropriate law enforcement and governmental agencies to develop cases.
- Improve organizational awareness and education.

III. PLAN FOCUS

The Scripps Health Plan Services Anti-Fraud Plan functions to ensure that the benefits covered by the Full Service Health Plans ("FSHP" or "HMOs" or "Payors") who contract with Scripps Health Plan Services are appropriately delivered and billed by contracted providers and appropriately utilized by members. Scripps Health Plan Services defers to the systems in place at the HMOs for identifying and investigating fraud and abuse related to issues of eligibility, enrollment, dis-enrollment, and payment of premiums. These functions are beyond the scope of Scripps Health Plan Services program administration responsibilities and are areas where Scripps Health Plan Services anti-fraud activities are secondary to the above organizations own fraud and abuse detection programs.

Fraud and abuse concerns include:

- Fabrication of claims.
- Falsification of claims.
- Unbundling of claims.
- Upcoding of claims.
- Use of benefits by non-covered persons.
- Excessive charges for services or supplies.
- Charges for benefits already included in the capitation rate.
- Soliciting, offering or receiving a kickback, bribe or rebate, e.g., paying for a referral of patients or assignment of members.
- Fraud and abuse perpetrated by plan staff and/or contracted network staff.
- Fraud and abuse perpetrated by plan staff and/or contracted network staff in collusion with providers, members, or applicants.

IV. PLAN AUTHORITY AND ACCOUNTABILITY:

The Anti-Fraud Plan is a component of the Scripps Health Plan Services Quality Improvement Program. The structure and authority of the Quality Improvement Program described here is the context in which the Anti Fraud Plan is implemented.

1. As part of the Utilization Management/Quality Improvement Committee responsibilities the committee would track, trend and analyze data in an effort to identify patterns of fraud. The Utilization Management/Quality Improvement Committee is responsible for analyzing data and creating confidential and proprietary reports targeting possible fraud. The fraud data analysis reports and recommendations are provided to the Healthcare Operations Oversight Committee for decision support.

2. The Management Advisory Committee is responsible for reviewing and approving the Quality Improvement Program on at least an annual basis. A component of the Quality Improvement Program is the Anti-Fraud Plan. The Scripps Health Plan Services Management Advisory Committee has ultimate accountability for the oversight and effectiveness of the Quality Improvement Program. The Management Advisory Committee has delegated authority for Quality Improvement Program implementation and planning to the Healthcare Operations Oversight Committee.

3. The Medical Director acts as the Chair of the Healthcare Operations Oversight Committee and is the Senior Healthcare Operations Oversight Member responsible for the direction and overall functioning of the Quality Improvement Program and ensures allocation of adequate resources and staffing. The Medical Director is also a member of the Utilization Management/Quality Improvement Committee. At least quarterly, the Medical Director presents reports on quality improvement to the Management Advisory Committee .

4. The Associate Medical Director of Quality Improvement is responsible for operational implementation of the Quality Improvement Program. The Associate Medical Director is a member of the Utilization Management/Quality Improvement Committee.

5. The Director of Compliance & Performance Improvement is responsible in identifying and analyzing data for trends and patterns that affect the quality of patient care and delivery of services working very closely with the Manager of Utilization ManagementThe Director of Compliance and Performance Improvement also receives reports from various departments throughout Scripps Health Plan Services, Scripps Health and our Scripps Medical Foundation that may assist in developing reports that identify potential fraud activity. Both the Director of Compliance & Performance Improvement & the Manager of Utilization management are members of the Healthcare Operations Oversight Committee and Utilization Management/Quality Improvement Committee.

6. The Director, Compliance & Performance Improvement is responsible for gathering support and evidence for fraud investigation and consulting with legal counsel, outside law enforcement, and prosecuting agencies. The Director Compliance & Performance Improvement Linda Pantovic, LVN is a certified member of AAPC with 4 years of investigative experience in the management of fraud investigation. AAPC is the nation's largest association of medical coders, billers, auditors, regulatory compliance experts, and physician practice management with more than 122,000 members.

7. The Director, Compliance & Performance Improvement is a member of and supports anti-fraud activities of the Healthcare Operations Oversight Committee and the Utilization Management/Quality Improvement Committee.

V. ANTI-FRAUD ACTIVITIES

To meet the purpose, goals and scope of this plan, anti-fraud activities are focused in the following areas:

A. Departmental data analysis targeting possible fraud activity. Sources utilized for tracking, trending and targeting include:

1. Claims data history.
2. Medical record audits.
3. Member and provider complaints, appeals and grievance reviews.
4. Utilization Management reports.
5. Provider utilization profiles.
6. Evaluation of the member capacity of a PCP's practice.

B. Coordinate the oversight of capitated providers in their performance of anti-fraud activities through:

1. Ensuring that contract language provides for the implementation of Scripps Health Plan Services policies and procedures that pertain to Anti-Fraud.

2. Immediate notification to Scripps Health Plan Services of any detection of fraudulent activities.

C. Overseeing member services including:

1. Periodic review and approval of a formal complaint, grievance process, and appeal process.

2. Semi-Annual review of quality indicators of member access to services, member complaints, appeals, grievances, and annual review of member's health network changes and reasons.

D. Coordinate and provide assistance to the anti-fraud process through:

1. Identifying areas that present risk for fraud to Scripps Health Plan Services and participating health networks.

2. Assist legal counsel in managing specific cases.

3. Increasing awareness of staff and providers related to legal and regulatory issues that present risk issues.

E. Evaluating the overall effectiveness of the Anti-Fraud Plan through an annual evaluation process that results in a written report to oversight committee that includes:

1. An assessment of the accomplishments, as well as the obstacles encountered in implementing the anti-fraud plan.

2. Evaluation of areas where innovations were achieved.

3. An evaluation of areas where further improvement can be obtained.

4. An evaluation of each fraud investigation carried out.

5. A summary of all anti-fraud activities identifying significant trends.

6. A review of organizational resources involved in implementing the plan.

7. Recommended revisions to the Anti-Fraud Plan.

VI. DELEGATED & NON-DELEGATED ACTIVITIES

A. Delegated Responsibilities to Scripps Health Plan Services' Contracted Provider Networks.

Contracted Provider Networks are contractually obligated to report fraud and abuse that become evident. Participating entities are required to implement Anti-

Fraud Plans that are consistent with Scripps Health Plan Services' Anti-Fraud Plan and relevant policies and procedures. Scripps Health Plan Services maintains oversight over all contracted entities anti-fraud efforts including but not limited to the following activities:

- Implementation of Scripps Health Plan Services anti-fraud policies and procedures.
- Utilization review activities and plans.
- Initial member and provider grievance investigation and review.
- Practitioner and provider credentialing.
- Claims processing.

B. The following activities are not delegated and remain the responsibility of Scripps Health Plan Services:

- Utilization Management/Quality Improvement Committee review of specific anti-fraud cases.
- Development of system-wide indicators, thresholds and standards.
- Survey of members and providers.
- Risk Management.
- Interfacing with state and federal agencies, medical boards, insurance companies and other managed care entities and health care organizations.
- Report any managed care compliance, privacy, HIPAA, fraud, waste or abuse activities if impacting a managed care patient or provider to the appropriate Full Service Health Plan (FSHP).

VII. EDUCATION & TRAINING

To prevent and detect fraud and abuse Scripps Health Plan Services is committed to educating internal staff at all levels, as well as the staffs of contracted health networks on fraud and abuse detection. Early recognition of fraudulent activity is emphasized allowing for early intervention. Ongoing training of all SHPS employees, contracted network providers including but not limited to governing bodies, claims and utilization management staff in identifying trends in financial and service data indicating potential fraud and/or abuse is a high priority.

Areas where fraud and abuse education and training take place:

- Scripps Health Plan Services staff participation in internal/external trainings and conferences.
- Scripps Health Plan Services departmental meetings and internal bulletins.
- Joint Operations Committee meetings with contracted health networks and HMOs.
- Provider Manual.
- New Employee Orientation or within 90 days of employment
- At the time of any policy or regulatory changes
- Annually electronically via the Learning Management System (LMS).

VIII. ANTI-FRAUD WORK PLAN

1. The Anti-Fraud Plan, as part of the Quality Improvement Program, is incorporated into the annual work plan. The annual Anti-Fraud Work Plan includes the following:

    a. Goals, scope and planned projects or activities for the year.

    b. Planned monitoring, tracking and trending of issues over time.

    c. Planned evaluation of the Anti-Fraud Plan.

    d. Continued development of anti-fraud and abuse strategies.

2. Resources for the program:

    Scripps Health Plan Services' budgeting process includes personnel and other administrative costs projected for the Quality Improvement Program. This budget will be revisited on a regular basis to ensure adequate support for Scripps Health Plan Services' Quality Improvement Program.

IX. PLAN EVALUATION AND REPORTING

The objectives, scope, organization and effectiveness of the Anti-Fraud Plan are reviewed and evaluated at least annually by the SHPS Compliance Committee, Utilization Management/Quality Improvement Committee, and SHPS Management

Advisory Committee. The Utilization Management/Quality Improvement Committee prior to submission shall review any mandated reporting to oversight agencies. In the evaluation, the following are reviewed:

1. The annual report of activities to the Department of Managed Health Care, regarding anti-fraud activities.

2. Recommended changes or revisions to the Anti-Fraud Plan.

Violations of the FWA Program, federal or state FWA law, and other types of misconduct are taken seriously. Scripps Health Plan Services will review and appropriately respond to all reports of potential FWA. If upon further investigation a violation of applicable law or requirements of the FWA Program has occurred, the Director of Compliance & Performance Improvement will take steps to correct the problem. The exact nature of the investigation varies according to the circumstances, but the review will be sufficient to identify the root cause of the problem.

Allegations of potential violations of law or policy will be assessed by legal counsel. Depending on the nature of the issue, an investigation may be conducted with the assistance of outside counsel or investigator. If an allegation involves a Human Resources concern, the case may be referred to the Human Resources Department. Scripps Health Plan Services will contract with the following entities that employ individuals with specific investigative expertise in the management of fraud investigations to assist the Director of Compliance & Performance Improvement to conduct any necessary investigation:

- Outside legal counsel which specialize in managed care laws/regulations and health care fraud and abuse;
- Certified public accountants ("CPAs"); and
- Other business consultants.

A. **LAW & REGULATIONS RELATED TO FWA:**

1. 42 CFR § 423.504(b)(4)(vi)(H)
2. CMS Prescription Drug Benefit Manual, Ch. 9 – Part D Program to Control FWA
3. Anti-Kickback Regulations – 42 U.S.C.A. § 1320a-7b(b)
4. Stark Law Amendments – 42 U.S.C. § 1395nn
5. Mail and Wire Fraud – 18 U.S.C. § 1341
6. False Claims Act – 31 U.S.C. § 3729-33
7. HIPAA – 45 CFR, Part 164
8. Provider Self-Disclosure Protocol – 63 Fed. Reg. 58,399-403 (1998)

B. Scripps Health Plan Services is strongly committed to the detection and prevention of FWA at the plan level, as well as within its first-tier entities, downstream entities, or related entities. To ensure timely and proper reporting to the appropriate entities in detecting and preventing suspected fraud, waste, and abuse (FWA), including but not limited to the:

1. U.S. Department of Justice (DOJ) and U.S. Department of Health & Human Services, Office of Inspector General (OIG)'s Health Care Fraud Prevention and Enforcement Action Team (HEAT),
2. Centers for Medicare & Medicaid Services (CMS)
3. Medicare Drug Integrity Contractor (MEDIC)
4. California Department of Managed Health Care Office of Enforcement (DMHC), and
5. California Department of Insurance (DOI).
6. Human Resources (Internal Corrective Action)
7. Federal or State Government
8. Referral to criminal and/or civil law enforcement authorities

C. **Reasonable Inquiry**
   1. When the Director of Compliance & Performance Improvement becomes aware of the potential instance of FWA, he/she should initiate a reasonable inquiry **immediately, but no later than two weeks** from the date that the potential misconduct is identified.
   2. If the Director of Compliance & Performance Improvement determines that Scripps Health Plan Services has adequate time, resources, and experience to investigate the potentially fraudulent activity, he/she should initiate such an investigation to determine whether potential fraud or misconduct has occurred.
   3. Scripps Health Plan Services must conclude investigations of potential misconduct within a reasonable time period after the potentially fraudulent activity is discovered.
   4. If after conducting a reasonable inquiry it is determined that potential fraud or misconduct has occurred, the conduct must be reported to the appropriate entity or entities **promptly, but no later than 30 days** after the misconduct has been detected, unless an alternate timeframe is specified.

D. **Determine Which Entity (or Entities) to Report to:** To be clear, a single incident may be reported to multiple entities. A report should be made to each entity that has jurisdiction over the incident.
   1. **Health Care Fraud Prevention and Enforcement Action Team (HEAT):** Reports of FWA to the DOJ and OIG's HEAT are made to the OIG. Such reports may include the following: false/fraudulent claims submitted to Medicare/Medicaid, kickbacks/inducements for referrals by Medicare/Medicaid providers, medical identity theft involving Medicare and/or Medicaid beneficiaries, door-to-door solicitation of Medicare/Medicaid beneficiaries, misrepresentation of Medicare private plans, abuse/neglect in nursing homes and other long term care facilities, and fraud/waste in American Recovery and Reinvestment Act grants. Reports of failure to safeguard medical information (i.e., HIPAA violations) should not be forwarded to the OIG, but rather the DHHS Office for Civil Rights. For additional examples of instances that should and should not be reported to the DHHS OIG, visit http://oig.hhs.gov/fraud/report-fraud/index.asp.
   2. **Centers for Medicare and Medicaid Services (CMS):** Potential internal and external marketing violations made known to Scripps Health Plan Services should be reported to CMS and/or the Full Service Health Plan.

3. **Medicare Drug Integrity Contractor (MEDIC):** Any suspected FWA in Medicare Part C or D should be reported to Corporate Compliance, the Full Service Health Plan and MEDIC. Fraud cases may involve beneficiaries, pharmacies, physicians or other providers, health plans, or other organizations. For specific examples, see the CMS Prescription Drug Benefit Manual, Ch. 9 § 70 or Pharmacy Policy and Procedure: Part D Program to Control FWA
4. **Department of Managed Health Care, Office of Enforcement (DMHC):** The DMHC ensures compliance with the Knox-Keene Act and enforces managed care laws. Suspected FWA relating to such may be reported to the DMHC. Scripps Health Plan Services files an annual report to the DMHC notifying it of the suspected FWA cases that Scripps Health Plan Services handled throughout the year.
5. **Reporting to California Department of Insurance** The Director of Compliance & Performance Improvement should fill out a Request for Assistance Form **within 60 days** of determining that a contracted agent, broker, or field marketing organization (FMO) engaged in marketing misconduct.
6. **Human Resources (Internal Corrective Action):**Corrective action plan, which could include discipline up to termination of employment or a contract
7. **Federal or State Government:** with specific reporting actions dependent upon internal analysis of case-specific facts to determine if mandatory or voluntary reporting is required and/or appropriate.
8. **Referral to criminal and/or civil law enforcement authorities**:

E. **Report** Unless otherwise specified, the Director of Compliance & Performance Improvement should develop a report that includes, to the extent available, the following:
   1. Plan name, organization, and contact information for follow up.
   2. Summary of the Issue Include the basic who, what, when, where, how, and why Any potential legal violations.
   3. Specific Statutes and Allegations List civil, criminal, and administrative code or rule violations, state and federal.
   4. Provide detailed description of the allegations or pattern of fraud, waste, or abuse
   5. Incidents and Issues (List incidents and issues related to the allegations)
   6. Background information (Contact information for the complainant, the perpetrator or subject of the investigation, and beneficiaries, pharmacies, providers, or other entities involved).
   7. Additional background information that may assist investigators, such as names and contact information of informants, relators, witnesses, websites, geographic locations, corporate relationships.
   8. Perspectives of Interested Parties
   9. Perspective of Plan, CMS, beneficiary
   10. Data Existing and potential data sources
   11. Graphs and trending Maps
   12. Financial impact estimates
   13. Recommendations in Pursuing the case next steps, special considerations, & cautions.

F. **Enforcement**, Violations of the Code of Conduct, policies and procedures, or federal and state laws may result in varying levels of disciplinary actions. Intentional noncompliance subjects violators to significant discipline, ranging from oral warnings to termination, as appropriate. Each situation will be considered on a case-by-case basis, taking into account all relevant factors, to determine the appropriate response. Scripps Health Plan Services will not employ or contract with any individual or entity that is excluded or debarred from participating in federal or state health care programs. All Employees are informed that they must immediately notify the Director of Compliance & Performance Improvement if they are charged with or convicted of a crime related to health care or face a proposed debarment, exclusion, or other ineligibility for participation in federal health care programs.

X. RETENTION OF RECORDS

Scripps employees and agents are responsible for ensuring that all records are created, used, maintained, preserved, and destroyed in accordance with this Record Retention and Destruction Policy.

Records will be maintained, retained and destroyed in accordance with Federal and state laws and regulations.

1. Reports and summaries of anti-fraud activities and all proceedings of the various committees will be kept either in original form, or on electronic or other media per Scripps record retention and destruction policy.

2. Copies of medical records would be securely filed regardless of the outcome of the review.

3. Copies of fraud and abuse investigation files would be securely filed regardless of the outcome of an investigation.

4. All Anti-Fraud training materials will be stored in original form or electronic version for a period of 10 years.

5. All UM denial files, claims, finance records, will be sent to iron mountain and stored in original or electronic form for a period 10 years in compliance with the Scripps record retention and destruction policy.

XI. COMMUNICATION

1. The Medical Director is responsible for communicating anti-fraud activities to the Board of Directors, through the Utilization Management/Quality Improvement Committee summary report which is presented quarterly.

2. The Director Compliance & Performance Improvement is responsible for communicating anti-fraud activities to all affected Scripps Health Plan Services departments and staff.

3. The Director Compliance & Performance Improvement is responsible for communicating and reporting any managed care compliance, privacy, HIPAA, fraud, waste or abuse activities if impacting a managed care patient or provider to the appropriate Full Service Health Plan (FSHP).

4. The Director Compliance & Performance Improvement is responsible for the communication and monitoring of the mandatory SHPS Compliance Program and Anti-Fraud training and requirements.

5. Communication of anti-fraud activities and information to Scripps Health Plan Services' contracted entities and providers is through the following:

- Provider participation in the Utilization Management/Quality Improvement Committee and subcommittees.

- Joint Operating Committee (JOC), Health Network Forums and other ongoing ad hoc meetings.

- Scripps Health Plan Services' provider manual.

- Beneficiaries are informed on how to file a complaint with Scripps Health Plan Services and the Full Service Health Plans through the Member Welcome Letter.

- Electronically at www.scripps.org under the Vendor Information Section which reviews code of conduct, how to report and detect fraud, and direct access to all compliance, privacy and vendor policies.

6. Yearly anti-fraud report shall be submitted to the Department of Managed Health Care, Health Plan Division.

XII. CONFIDENTIALITY

All information associated with anti-fraud investigations, open and closed, will be maintained in confidential files. Members of the Quality Improvement Committee and its subcommittees will sign a "Confidentiality Agreement." This Agreement requires the member to maintain confidentiality on any and all information discussed during the meeting.

XIII. REFERENCES

Scripps Health Plan Services Quality Improvement Program
Code of Federal Regulations, Title 42, Volume 3, Sec. 455.2
California Health and Safety Code Section 1348

XIV. CONTACTS

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