Orange County Health Authority
dba CalOptima Health

2023 Anti-Fraud, Waste, and Abuse (FWA) Plan

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I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, CEO, the CalOptima Health Board, and Regulatory Agencies. The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- 42 C.F.R. 438.08
- Applicable regulatory guidance

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to Members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

II. DEFINITIONS

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. FWA TRAINING

FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. First-tier, downstream and related parties (FDRs) are also required to complete FWA training. CalOptima Health's FWA training provides guidance to Board Members, Employees, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Common types of Member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health Members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the CalOptima Health Programs, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average Member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a

particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- ► How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- ► CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- ► Information on the False Claims Act and CalOptima Health's requirement to train Employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima Health shall provide Board Members, Employees, FDRs, and Members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, Employees, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- ► CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- ► Claims data history;
- ► Encounter data;
- ► Medical record Audits;
- ► Member and provider complaints, appeals, and grievance reviews;
- ► Utilization Management reports;
- ► Provider utilization profiles;
- ► Pharmacy data;
- ► Auditing and Monitoring Activities;
- ► Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- ► Internal and external surveys, reviews, and Audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by Members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;

- ► Peer to peer comparisons within specialties;
- ► Analysis of provider medical billing activity within their own peer group;
- ► Analysis of pharmacy billing and provider prescribing practices;
- ► Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- ► Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis may be focused on the following characteristics:

- ► Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the Member or arranges to provide the balance but bills for the prescribed amount.
- ► Bait and switch pricing, which occurs when a Member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- ► Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- ► Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- ► Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- ► Failure to offer negotiated prices, which occurs when a pharmacy charges a Member the wrong amount.

d. Sample Indicators

No one indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- ► Claims that show any altered information (dates, codes, names).
- ► Photocopies of claim forms and bills, or handwritten claims and bills.
- ► Provider's last name is the same as the Member/patient's last name.
- ► Insured's address is the same as the servicing provider.

- ► Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- ► Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Chief Compliance Officer, and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- ► The allegation is logged into the case management system;
- ► The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- ► SIU develops an investigative plan;
- ► SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- ► Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- ► Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- ► SIU interviews the individual who reported the FWA, affected Members and/or FDRs, or any other potential witnesses, as appropriate;
- ► SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- ► Review of FDR enrollment applications, history, and ownership, as necessary;
- ► Review of Member enrollment applications and other documents, as necessary;
- ► All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- ► After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- ► The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- ► If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- ► If the investigation results in recommendations for disciplinary or corrective actions, the

results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. When the root cause of the potential FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board Members, Employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement

agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare or PACE programs.

Potential cases that should be referred include, but are not limited to:

- ► Suspected, detected, or reported criminal, civil, or administrative law violations;
- ► Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- ► Allegations involving known patterns of FWA;
- ► Patterns of FWA threatening the life, or well-being, of CalOptima Health Members; and/or
- ► Schemes with large financial risk to CalOptima Health, or its Members.

c. Cooperation with regulatory investigations or prosecutions

Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1408: Pharmacy Audits and Reviews
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions

- HH.2005: Corrective Action Plan
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual FWA, Violations of Applicable Laws, and/or CalOptima Policies
- HH.2020: Conducting Compliance Investigations
- HH.2028: Code of Conduct
- HH.3012: Non-retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.1615: Corrective Action Plan for Practitioners
- MA.6104: Opioid Medication Utilization Management