Fraud, Waste, and Abuse Program

2016

Vantage Health Plan's Fraud, Waste, and Abuse Program

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INTRODUCTION

Vantage Health Plan, Inc. ("Vantage") has adopted this Fraud, Waste, and Abuse ("FWA") Program ("Program") to address the prevention, detection, and correction of FWA in connection with Vantage's operations.

At the core of this Program is Vantage's commitment that its activities be conducted in an ethical and lawful manner. To this end, the Program shall serve as a guide to assist those associated with Vantage in preventing, detecting, investigating, and helping correct conduct which is considered to be fraudulent, wasteful, and/or abusive. A culture of compliance with regard to FWA shall be promoted and adopted at each level of Vantage's organization.

This Program is also applicable to the operations conducted by Vantage's wholly-owned subsidiary, Affinity Health Group, LLC ("Affinity").

This Program is intended to satisfy the requirements of Louisiana Revised Statute 22:572.1, which mandates the establishment of an *anti-fraud plan* by all insurers and health maintenance organizations licensed to operate in Louisiana. This Program, along with any material changes in the future, will be on file with the Louisiana Department of Insurance ("LDOI").

Vantage offers Medicare Advantage products and is a Part D drug plan sponsor. As such, it is subject to the requirements of federal law[1] which mandate the implementation of measures to prevent, detect, and correct fraud, waste, and abuse. This Program is intended to adopt and implement the FWA prevention, detection and correction measures required of a Medicare Advantage Plan and Part D drug plan sponsor. As additional regulations are issued by the Centers for Medicare and Medicaid Services ("CMS") with regard to FWA, this Program shall be updated accordingly.

The statute and regulations mentioned herein are found in the attached appendix. If there are questions concerning this Program, please do not hesitate to contact any member of Vantage's Compliance Department or Vantage's General Counsel, Robert Bozeman.

[1] 42 CFR 422.503 (b)(4)(vi) and 42 CFR 423.504 (b)(4)(vi)

Section I

ORGANIZATIONAL OVERVIEW AND STANDARDS OF CONDUCT

1.1 Vantage Board of Directors

The Board of Directors is the ultimate decision-making body of Vantage. The directors have a fiduciary duty to the corporation and its shareholders. As a *fiduciary*, each director shall act at all times in the best interest of the entity and its owners, the shareholders. In carrying out its fiduciary responsibility, the Board provides meaningful oversight of Vantage's operations. The Board expects that compliance with this FWA Program will be promoted and adopted at each level of Vantage's organization. The Board of Directors shall require regular updates on Vantage's efforts to prevent and detect FWA and regular briefings on any ongoing FWA investigations. The updates and briefings to the Board shall be the responsibility of Vantage's General Counsel. With regard to Medicare Advantage and Part D Plan issues, Vantage's Medicare Compliance Officer shall advise and consult with General Counsel on such issues.

1.2 Vantage Leadership

Vantage's President, Executive Vice President, and Chief Financial Officer, along with all department directors, are committed to Vantage conducting its activities in a lawful and ethical manner. Leadership's expectation is that if an employee encounters a situation which is questionable from a legal or ethical standpoint, the employee will immediately report that situation to his/her supervisor, department director or other leadership. In being proactive, Vantage will strive to detect and resolve any FWA incidents.

1.3 Employee's Responsibility

Every Vantage employee is expected and encouraged to report any activity which may be considered "out of the ordinary" or "suspicious". By doing so, this should help Vantage minimize occurrences of FWA. Vantage does not permit any form of intimidation or retaliation for good faith participation in this Program, including but not limited to reporting potential FWA issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

Section II

DEFINITIONS

2.1 **Fraud**

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person engaged in the deception or others.

2.2 **Waste and Abuse**

Waste and abuse as used in this Program means "healthcare spending that can be eliminated without reducing the quality of care." This definition includes those activities which are inconsistent with legal, ethical, accepted and sound business, fiscal or medical practices that could result in unnecessary cost to Vantage programs, or in reimbursement for services which are not medically necessary or which fail to meet professionally recognized standards for health care.

Examples[2] of FWA are as follows:

- Abuse of the Healthcare System by Members Due to Drug Addictions
- Alteration of a Claim
- Billing for Services Never Provided
- Brand Name Drug Prescribed When Generic Available
- Double Billing
- Embezzlement
- Falsifying Claims
- Fraudulent Credentials
- Identity Theft
- Incorrect Coding
- Intentional Provision of Unnecessary or Inappropriate Services
- Misrepresentation of Medical Condition (Past and Present)
- Misrepresentation of Services/Supplies
- Over-Utilization of Testing (e.g. Lab, Imaging) for Hospitalized Patients
- Prescription Forging
- Soliciting, Offering, or Receiving a Kickback or Bribe

Section III

FWA COMPLIANCE COMMITTEE

3.0 Oversight and Implementation

The ongoing oversight and implementation of the FWA Program shall be the responsibility of the FWA Compliance Committee ("FWA Committee"). Vantage's Medicare Compliance Officer shall have responsibility for day-to-day oversight of compliance issues related to the Medicare Advantage Program and Vantage's Part D Plan. Vantage's Commercial Plans Compliance Officer shall have responsibility for day-to-day oversight of compliance issues related to Vantage's Commercial Plans including those Plans offered on the Health Insurance Marketplace ("Exchange"). The Compliance Officers shall consult with and advise General Counsel on all such issues.

[2] This list is not exhaustive.

3.1 FWA Compliance Committee

a. FWA Committee shall consist of Vantage's Executive Vice President, Chief Financial Officer, and department directors or their designees.

b. Vantage's Compliance Department shall assist the FWA Committee with the oversight and implementation of the FWA Program.

c. The FWA Committee shall regularly update Vantage's Continuous Quality Improvement Committee ("CQI") on issues related to FWA. These updates shall be coordinated by Vantage's Compliance Department.

Section IV

DETECTION AND PREVENTION OF FWA

4.0 Overview of FWA Detection and Prevention

The detection and prevention of FWA with regard to Vantage's operations is the responsibility of everyone associated with Vantage. According to the White House Office of Management and Budget, estimates suggest that as much as $700 billion a year in healthcare costs do not go toward improving health outcomes. Much of this unnecessary expense is attributable to wasteful, abusive, and fraudulent practices that do not provide value to members and sometimes expose them to unnecessary medical risks. FWA detection and prevention shall be a priority, particularly for all Vantage employees, agents, business associates, and members.

4.1 Employees, Agents, and Business Associates

a. Employee FWA

1. Pre-employment screening of all prospective employees shall be conducted by Vantage's Human Resources Department ("HR"). This screening shall include, but not be limited to a criminal background check.

2. HR shall confirm that no prospective or current Vantage employee is disqualified or subject to being disqualified from participating in Federally-funded health care programs. This confirmation, which shall be done by reviewing the Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities ("LEIE"), shall take place prior to an employee being hired and, once hired, at regular intervals thereafter.

3. If it is determined that a Vantage employee is listed on the LEIE, that person shall no longer be allowed to work for or contract with Vantage or any of Vantage's affiliated entities.

4. Upon hiring, all employees shall undergo training on how to prevent, detect, and report FWA. This training shall also consist of educating employees on the proper

handling of protected health information ("PHI").[3] Employee education and training, which is more specifically addressed below, shall be a continuous process. It shall be coordinated and implemented by HR and the Compliance Department.

b. Agent FWA

Vantage shall strive to ensure its agents are compliant with its FWA policies as well as applicable state and federal rules and regulations. Those agents who are marketing and selling Vantage products, who are often referred to as producers, shall be required to maintain liability insurance. These agents also must undergo annual training on marketing and enrollment rules governing the sale of Vantage's commercial and Medicare Advantage products.

1. Agent Licensure

Upon initial appointment and annually thereafter, Vantage shall verify through LDOI records that each agent is properly licensed and appointed with Vantage.

2. Medicare Advantage Enrollment Election Forms Submitted by Agents

Vantage's Member Services Department ("Member Services") shall place an Enrollment Verification Call ("EVC") call to each Medicare Advantage beneficiary when enrollment election forms are received and an agent is listed. The EVC phone call shall confirm the beneficiary intended to enroll in a Vantage Medicare Advantage Plan and verify that the beneficiary understands the plan in which he/she has requested enrollment.

c. Business Associates FWA

Business associates are those that use or have access to PHI when providing services to or on behalf of Vantage. All business associates shall execute an approved business associate agreement ("BAA") with Vantage. The BAA shall be in conformity with all applicable federal regulations.[4] Requiring execution of an approved BAA by all business associates shall help safeguard and protect the PHI to which the business associates may have access.

4.2 Internal Controls for Claims Processing

Vantage shall implement internal controls for claims processing. These internal controls shall be maintained by Vantage's Claims Department ("Claims Department"). Claims processing controls shall guard against altering of claims prior to payment. As the claims are received and entered into the processing system, individual claims shall be grouped by vendor and randomly distributed to the Claims Department personnel for review. Each claim shall be reviewed for accuracy. The review shall utilize appropriate claims analysis software.

a. Limitation of Access to Employee Claims

[3] The handling of PHI is the subject of multiple Vantage policies and procedures. Please refer to those policies/procedures for any questions you may have regarding the use and disclosure of PHI.

[4] The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") contains an expansion of the Health Insurance Portability and Accountability Act ("HIPAA") privacy and security regulations. Business associates of Vantage must now develop and implement written security policies and procedures with respect to the electronic PHI they handle.

Examiners within the Claims Department shall be granted limited, role-based access to claims processing system functions. For example, only certain examiners shall be given access to employee and employee dependent claims. However, the designated employees with access to employee and employee dependent claims shall not process claims for himself/herself or his/her dependents. After reviewing claims for payment, random audits shall be conducted to ensure accuracy before the claims are finalized for payment.

b. Incorrect Coding

Claims analysis software shall be used by the Claims Department to identify erroneous and potentially fraudulent or abusive coding issues before claims have been released for payment. Some examples of incorrect coding include, but are not limited to:

1. Unbundling;
2. Invalid or missing modifiers; and
3. Wrong place of service.

c. Billing for More Services Than Performed

Reports shall be generated on a weekly basis by the Claims Department to identify frequent billing of high level services.

1. Once a provider has been identified as potentially over-utilizing a specific high-level service, the provider's claims for that specific code shall be denied by the Claims Department and medical records shall be requested to determine medical necessity.
    i. When medical records are received, they shall be reviewed to ensure the level of service billed can be substantiated.
        A. If the level of service is warranted, the claim shall be subsequently paid.
        B. If Medical Management, however, can't verify that the level of service billed was warranted, the code being billed shall be denied as "Bill does not match submitted medical records".

d. Billing for Services Not Rendered

Claims for services that were not rendered may be identified by:

1. A member[5] reviewing his/her Explanation of Benefits ("EOB") or Certificate of Coverage ("COC") and contacting Member Services about any questionable charges on the EOB.

2. A provider submitting multiple claims for a member on the same date of service with unrelated diagnoses and/or services.

3. When claims that require an authorization are received and the procedure has not been authorized by Medical Management, the claim shall be denied for no

[5] HMO plan members only receive EOB's when services have been received from out-of-network providers.

authorization and the provider will be required to submit documentation for review as an appeal.

e. Duplicate Claims

The Claims Department shall generate a weekly report to identify any claims that have been billed more than once by the same provider for the same member, procedure, and date of service.

1. If a claim has been identified as a duplicate of a claim previously processed for payment, the claim shall be denied as a duplicate.

f. Claims Department Auditing

Claims Department shall audit claims for accuracy on a regular basis. Audited scenarios may include, but are not be limited to:

1. Review of New Patient Visits
   i. As provider reimbursement is greater for a "new patient", a member's claims history shall be reviewed via the Medical Service History module within the claims processing system to determine whether he/she has received services by that physician, or another physician within the same office, or a physician of the same specialty, within three (3) years of the new patient visit.

2. Lab and Physician Duplicate Billing
   i. For lab work performed in a physician's office, either the physician or the lab may bill for services rendered, but not both.
   ii. If a situation is identified where the laboratory and physician have both submitted a claim for the same services, the claims examiner shall notify Vantage's Provider Relations Department ("Provider Relations"). Provider Relations shall contact the physician's office to confirm which provider should receive payment.

3. Corrected Claims
   i. If a provider submits a corrected claim containing a higher level of service or the provider is billing for additional services, the claims examiner shall notify Provider Relations which shall contact the provider. Provider Relations shall verify the provider's intention with regard to the changes submitted on the claim.
   ii. If the claim in question involves a procedure considered to be unusual or if there is a significant change in requested reimbursement, medical records may be requested for review.

4. Claims Containing Unrelated Diagnosis
   i. When a claim containing a diagnosis or diagnoses unrelated to the procedure(s) billed is identified, the claim shall be denied and the provider shall be informed that the diagnosis(es) does not match the procedure(s).
   ii. Providers shall be provided with the option to dispute these claim denials via the appeals process. As needed, Medical Management or Provider

Relations shall request necessary documentation to determine the validity of the relationship between the billed diagnosis(es) and procedure(s).

4.3 Medical Management

Medical Management shall implement the following practices to help reduce fraudulent claims and reduce waste and abuse of benefits and services.

a. Service and Supply Requests

When Medical Management receives a request from a provider for authorization of services or supplies, the relevant portion of the member's medical records, as well as claims history, shall be reviewed to verify medical necessity and determine if the member has previously received the requested service or supply.

b. Home Health

Vantage shall have home health case managers on staff within Medical Management who shall assess a member's need for home health services when requested by a physician. The assessment shall include a home visit by the case manager to verify the need for home-based services and the level of care requested by the physician.

c. Case Management Clinics

Vantage shall follow its members who are receiving treatment in an Affinity case management clinic for purposes of monitoring chronic conditions to ensure services requested by providers outside the case management clinic are medically necessary. These members shall also be monitored to determine if other services would be more appropriate in lieu of, or in addition to, the requested services.

d. Medical Record Review

As necessary, Medical Management shall review members' medical records when claims for procedures are submitted to ensure that the procedures the provider is billing were actually performed. Records shall also be reviewed to ensure all services billed were performed in conjunction with the authorized covered procedure and not part of a non-covered procedure performed during the same session as a covered procedure.

e. ER Utilization Monitoring

Medical Management shall monitor members who have an excessive number of emergency room ("ER") visits for indicators of abusive or fraudulent behavior. These members shall be identified by Medical Management nurses who are responsible for analysis of the "QER Report" which contains a list of all ER visits which do not meet ER criteria. If ER visits for these members are consistent in not meeting emergency criteria (i.e., member presents with general pain complaints) the claims shall be denied and the member shall be held responsible for all accrued charges associated with the ER visits.

1. Members shall be advised of their right to appeal a decision for denial; and if, upon appeal, a provider or member is able to produce evidence of emergent medical necessity, the decision for denial may be rescinded.

4.4 Health Risk Management

a. Vantage's Health Risk Management Department ("HRM Department") shall work with the staff of Vantage's Pharmacy Benefit Manager to monitor members' prescription drug utilization, frequency of prescribed medications by physicians, as well as identifying FWA.

1. Monthly reviews of members, at random, shall be performed by the HRM Department to check accuracy of co-pays charged to the member as well as amounts charged for each drug.

2. The HRM Department shall perform on-going audits of scenarios including the following:
   i. Member complaints regarding medications not provided as billed or paid;
   ii. Inappropriate billing for wrong medication dose/unit of measure;
   iii. Overutilization of medication;
   iv. Double billing medications;
   v. Polypharmacy – using multiple pharmacies to obtain drugs from the same therapeutic class;
   vi. Treatment(s) and/or medication(s) prescribed by more than one provider which appears to be duplicative, excessive or contraindicated;
   vii. Members/patients using more than one physician to obtain similar treatments and/or medication;
   viii. High volume of emergency room visits with a non-emergent diagnosis;
   ix. Report(s) of forged prescriptions; and,
   x. Report(s) of member identification cards being shared with others.

4.5 Security of Data Processing Systems

Vantage's data processing systems shall be configured and maintained by Vantage's Information Technology Department ("IT Department") in order to avoid compromising data integrity and impede an employee's opportunity for FWA behavior.

a. User Restrictions

Employee access to any data processing system shall be role-based which is defined by his/her current department, individual job functions, and need for access.

b. User Tracking

The IT Department shall implement software programs which track a user's activity based on his/her user identification and password combination.

1. The data processing system shall have the capability of tracking which user last edited a claim, member file, provider file, authorizations, etc.

c. Building Access

Access to Vantage's building shall be limited to certain hours for most employees. After hours access to the building shall only be granted with permission of a department supervisor. Each area of the building that is restricted from the general public shall be secured with card reader access.

d. Server Room Access

Vantage's Server Room shall be in a secure environment with only a limited number of employees having access. These employees may include the IT Director, IT Supervisor, System Administrators and Hardware Technicians.

Section V

EDUCATION AND TRAINING

5.0 A sound FWA education and training program increases awareness among employees, agents, and business associates creating an environment in which fraud, waste, and abuse should be more readily detected and prevented. Education and training regarding FWA detection and prevention shall be an ongoing process for all those associated with Vantage. As appropriate, education and training shall be offered through in-house seminars, webinars, web-based training, dissemination of materials through the Compliance Department, and/or participation in programs sponsored by CMS, LDOI, and Louisiana Department of Health and Hospitals, and private organizations such as the Louisiana Association of Health Plans, or other recognized leaders in the health insurance industry.

5.1 FWA Training

a. Once the program is underway, new employees, under the direction of HR, shall be required to successfully complete FWA training via an online training module and review this Program within the first 30 days of employment.

1. During FWA training, each employee shall be equipped with the knowledge and skills necessary to help prevent FWA, identify FWA schemes, report incidents of FWA, and to understand the corrective action Vantage may take in addressing FWA.

2. Successful completion of initial FWA training shall require an 85% passing score on the administered training exam.

b. Existing employees shall be required to successfully complete a refresher FWA course via an online training module and review this Program and any updates or changes on an annual basis.

1. The refresher course will review all skills and techniques presented in the initial FWA training course.

2. Successful completion of the refresher FWA training course shall require a passing score of 85% during testing.

Section VI

CORRECTION OF FWA

6.1 On-Going Internal Review and Resolution

a. As issues of suspected waste and/or abuse are encountered, if they are minor in nature (in the judgment of the employee who has identified the issue and his/her department director), they should be resolved in a timely manner. If there are any questions concerning this suspected waste or abuse or if the issue cannot be resolved, the employee should report the issue to the Compliance Department.

b. If issues of FWA involve suspected abusive or wasteful activity of a nature considered significant or any type of suspected fraudulent activity, these incidents shall be reported immediately to the Compliance Department. The Compliance Department shall have the responsibility of investigating any significant abusive or wasteful practice and any suspected fraudulent activity.

c. The occurrence of any fraudulent activity shall be documented, and if warranted, shall be reported by the Compliance Department to the Louisiana Department of Insurance Fraud Section or CMS, as applicable.

6.2 Member Complaints

a. When Vantage is notified by a member of possible FWA:

1. The allegation of FWA shall be logged by the employee to whom the allegations are reported in the "Call Tracking" module. All information logged shall subsequently be forwarded to the Compliance Department.

2. The Compliance Department shall review the FWA allegation and, if appropriate, contact the member for additional information regarding the alleged FWA. Alternatively, Member Services may be asked to contact the member for the additional information.

3. Depending upon the circumstances, the member may be asked to meet with Vantage's General Counsel to discuss the FWA allegation. The discussion from any such meeting shall be documented and retained by General Counsel.

4. Allegations of FWA shall be researched by designated personnel reviewing appropriate medical records, claims history, provider records and/or other records maintained by Vantage. Public records involving the party or parties at issue may also be reviewed.

5. If an allegation of FWA is confirmed and it relates to the actions of an employee, provider, agent, business associate, member or others associated with Vantage, appropriate remedial action shall be taken to correct the act(s) of FWA and to ensure that the behavior does not reoccur.

6. FWA committed by an employee may result in disciplinary action including, but not limited to termination. FWA committed by a provider, agent or business associate may result in Vantage terminating its relationship with that person or entity. FWA committed by a member may result in the termination of that member's insurance coverage.

7. If the confirmed activities involve fraud or wasteful/abusive activities of a significant nature, the responsible party's conduct may be referred to governmental and/or law enforcement authorities. If such actions have caused or are likely to cause a financial loss to Vantage, legal recourse may be undertaken against the party or parties at fault.

6.3 Reporting FWA

a. Reporting to Vantage

Members, employees, agents, business associates, and others shall be encouraged to report FWA directly to Vantage. The reporting can be done by contacting Vantage's Compliance Department, utilizing the FWA Hotline maintained by Vantage, or by contacting Vantage's General Counsel.

b. U. S. Department of Health and Human Services

For FWA which involves Medicare Advantage beneficiaries, claims, policies, or other related issues, reporting may be made directly to the Office of Inspector General of the U.S. Department of Health and Human Services. Online reporting is available at: http://oig.hhs.gov.

c. Louisiana Department of Insurance

Members who have individual or group health insurance coverage through Vantage may contact the LDOI with any concerns over FWA. Online reporting to the LDOI is available at: http://www.ldi.state.la.us/legal_Services/

d. Fraud Hotline

Vantage shall maintain a toll-free, confidential hotline for reporting FWA. All information received on Vantage's Fraud, Waste, and Abuse Reporting Hotline shall be recorded and stored in a confidential mailbox. The toll-free number for accessing this hotline is: 1-(888)-607-0058

e. Internal Fraud Reporting

Vantage shall provide employees, who prefer to submit a report in writing, with a fraud reporting form which, upon completion, shall be forwarded to the Compliance Department for further investigation. Employees shall have the option of anonymous submission by omitting his/her name from the fraud report and forwarding it to the Compliance Department via interoffice mail.

6.4 Whistleblower Protections

a. Vantage shall encourage employees, agents, business associates, and others to report, through appropriate channels, concerns regarding actual or potential non-compliance with federal and/or state laws and/or Vantage's internal policies and procedures. (Appropriate channels for reporting FWA are detailed above.) Vantage is aware that employees may be reluctant to report suspected fraudulent acts due to a fear of intimidation, retaliation, retribution or harassment. With this knowledge, Vantage shall promote internal awareness of "whistleblower" protections and shall provide means of confidential reporting in an effort to facilitate open lines of communication for reporting suspected FWA.

Federal law, specifically 31 USC § 3730(h) ("False Claims Act"), contains language protecting "whistleblowers" from reprimand or negative consequences by his/her employer:

> *(h) Any employee…shall be entitled to all relief necessary to make that employee…whole, if that employee…is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee…in furtherance of an action under this section…Relief shall include reinstatement with the same seniority status…2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees.*

b. In addition to the Federal False Claims Act, Louisiana law also protects "whistleblowers". Louisiana Revised Statute 23:967 states:

> *A. An employer shall not take reprisal against an employee who in good faith, and after advising the employer of the violation of law:*
>
> *(1) Discloses or threatens to disclose a workplace act or practice that is in violation of state law.*
>
> *(2) Provides information to or testifies before any public body conducting an investigation, hearing, or inquiry into any violation of law.*
>
> *(3) Objects to or refuses to participate in an employment act or practice that is in violation of law.*
>
> *B. An employee may commence a civil action in a district court where the violation occurred against any employer who engages in a practice prohibited by Subsection A of this Section. If the court finds the provisions of Subsection A of this Section have been violated, the plaintiff may recover from the employer damages, reasonable attorney fees, and court costs.*
>
> *C. For the purposes of this Section, the following terms shall have the definitions ascribed below:*
>
> *(1) "Reprisal" includes firing, layoff, loss of benefits, or any discriminatory action the court finds was taken as a result of an action by the employee that is protected under Subsection A of this Section; however, nothing in this Section shall prohibit an employer from enforcing an established employment policy, procedure, or practice or exempt an employee from compliance with such.*

(2) "Damages" include compensatory damages, back pay, benefits, reinstatement, reasonable attorney fees, and court costs resulting from the reprisal.

D. If suit or complaint is brought in bad faith or if it should be determined by a court that the employer's act or practice was not in violation of the law, the employer may be entitled to reasonable attorney fees and court costs from the employee.

Section VII

PURSUIT OF RESTITUTION FOR FWA

7.0 When appropriate, restitution shall be pursued from those persons or entities who have committed acts of FWA which have caused financial loss to Vantage.

7.1 A recommendation to pursue restitution shall be made by General Counsel to Vantage's President, Executive Vice President, and Chief Financial Officer. Depending upon the circumstances, the question of whether to pursue restitution may also be presented to the Board of Directors for consideration.

7.2 Pursuit of restitution may involve alternative dispute resolution efforts as well as the initiation of litigation against any persons or entities that have caused Vantage to suffer a financial loss.

7.3 If restitution is pursued by Vantage for a loss deemed to be material for financial reporting purposes, such an action shall be disclosed in a timely manner to the Louisiana Department of Insurance and/or CMS, as applicable.

Section VIII

PROGRAM UPDATES

8.0 Vantage shall review this Program on a continuing basis. This Program is intended to remain current with Vantage's operations and the applicable federal and state laws which regulate and control Vantage's activities. As material changes are made to this Program, these changes shall be reported to LDOI as detailed herein.

Section IX

LDOI FILING REQUIREMENTS

9.0 Vantage shall comply with Louisiana Revised Statute 22:572.1 with regard to the submission of this Program to the LDOI. On an annual basis, beginning in 2012, Vantage shall submit to LDOI a supplemental report regarding this anti-fraud plan and an annual summary report of its suspected fraud referrals to the LDOI Fraud Section for the preceding calendar year. In the said annual summary report, Vantage shall provide to LDOI the number of claims processed in Louisiana in the previous calendar year and the number of those claims which were referred to LDOI's Fraud Section as suspicious. The Compliance Department shall have the responsibility of compiling this information and submitting it in a timely manner to LDOI.

APPENDIX

C
West's Louisiana Statutes Annotated Currentness
Louisiana Revised Statutes
Title 22. Insurance Code (Refs & Annos)
Chapter 2 Requirements for Insurers and Other Risk Bearing Entities (Refs & Annos)
Part III Financial Solvency and Reporting Requirements
Subpart A Financial Reporting Requirements
⇨ **§ 572.1. Insurance anti-fraud plan**

A Each authorized insurer and each health maintenance organization licensed to operate in this state shall prepare, implement, and maintain an insurance anti-fraud plan for the insurer's or health maintenance organization's operations in this state

B The insurance anti-fraud plan utilized by each authorized insurer and each health maintenance organization in this state shall be filed with the commissioner of insurance and shall outline specific procedures, actions, and safeguards that are applicable, relevant, and appropriate to the type of insurance the authorized insurer writes or the type of coverage offered by the health maintenance organization in this state and shall include how the authorized insurer or health maintenance organization will:

(1) Detect, investigate, and prevent all forms of insurance fraud, including fraud involving the insurer's or health maintenance organization's employees or agents; fraud resulting from misrepresentations in the application, renewal, or rating of insurance policies; fraudulent claims; and security of the insurer's or health maintenance organization's data processing systems

(2) Educate appropriate employees on fraud detection and the insurer's or health maintenance organization's anti-fraud plan

(3) Provide for fraud investigations, whether through the use of internal fraud investigators or third-party contractors.

(4) Report a suspected fraudulent insurance act, as defined by R.S. 22:1923(1), to the Department of Insurance as well as appropriate law enforcement and other regulatory authorities engaged in the investigation and prosecution of insurance fraud.

(5) Pursue restitution for financial loss caused by insurance fraud, when applicable, relevant, and appropriate

C The commissioner shall review the insurance anti-fraud plan submitted by each authorized insurer and each health maintenance organization to determine compliance with the requirements of this Section

D The commissioner shall have the authority to investigate and examine the records and operations of each authorized insurer and each health maintenance organization to determine if the insurer or health maintenance organization has implemented and maintained compliance with the insurance anti-fraud plan

E The commissioner is authorized to direct any authorized insurer or health maintenance organization to make any modification to the insurer's or health maintenance organization's insurance anti-fraud plan necessary to obtain and

APPENDIX (cont.)

maintain compliance with the requirements of this Section, and the commissioner may require any other reasonable remedial action to the insurer's or health maintenance organization's insurance anti-fraud plan if the investigation and examination reveals substantial noncompliance by the insurer or health maintenance organization with the terms of the insurer's or health maintenance organization's insurance anti-fraud plan.

F. The anti-fraud plan and any summary report shall be filed with the commissioner on or before April first of each calendar year. Either on a calendar year basis or on whatever other interval he deems appropriate, the commissioner is authorized to require that each authorized insurer and each health maintenance organization file a summary report of any material change to the insurance anti-fraud plan, including the total number of claims and the number of claims referred to the commissioner as suspicious, and the commissioner is authorized to direct each insurer and each health maintenance organization as to the format of the summary report.

G. The insurance anti-fraud plan submitted to the department, as well as the summary report of the insurer's or health maintenance organization's insurance anti-fraud activities and results, are not public records and are exempt pursuant to R.S. 44:1 et seq., and specifically R.S. 44:4.1(B)(10), shall be and are hereby declared to be company proprietary and business confidential records and not subject to public examination or subpoena.

CREDIT(S)

Added by Acts 2010, No. 688, § 1, eff. Jan. 1, 2011.

LSA-R.S. 22:572.1, LA R.S. 22:572.1

Current through the 2010 Regular Session.

END OF DOCUMENT

APPENDIX (cont.)

Effective: June 7, 2010

Code of Federal Regulations Currentness
Title 42 Public Health
Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter B Medicare Program
Part 422 Medicare Advantage Program (Refs & Annos)
Subpart K Application Procedures and Contracts for Medicare Advantage Organizations (Refs & Annos)
⇒ § 422.503 General provisions.

(a) Basic rule In order to qualify as an MA organization, enroll beneficiaries in any MA plans it offers, and be paid on behalf of Medicare beneficiaries enrolled in those plans, an MA organization must enter into a contract with CMS

(b) Conditions necessary to contract as an MA organization. Any entity seeking to contract as an MA organization must:

(1) Complete an application as described in § 422.501

(2) Be licensed by the State as a risk bearing entity in each State in which it seeks to offer an MA plan as defined in § 422.2.

(3) Meet the minimum enrollment requirements of § 422.514, unless waived under § 422.514(b)

(4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following:

(i) A policy making body that exercises oversight and control over the MA organization's policies and personnel to ensure that management actions are in the best interest of the organization and its enrollees

(ii) Personnel and systems sufficient for the MA organization to organize, implement, control, and evaluate financial and marketing activities, the furnishing of services, the quality improvement program, and the administrative and management aspects of the organization.

(iii) At a minimum, an executive manager whose appointment and removal are under the control of the policy making body

(iv) A fidelity bond or bonds, procured and maintained by the MA organization, in an amount fixed by its policymaking body but not less than $100,000 per individual, covering each officer and employee entrusted with the handling of its funds The bond may have reasonable deductibles, based upon the financial strength of the MA organization

(v) Insurance policies or other arrangements, secured and maintained by the MA organization and approved by CMS to insure the MA organization against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks

(vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse The compliance program must, at a minimum, include the following core requirements:

(A) Written policies, procedures, and standards of conduct that--

(1) Articulate the organization's commitment to comply with all applicable Federal and State standards;

(2) Describe compliance expectations as embodied in the standards of conduct;

(3) Implement the operation of the compliance program;

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(4) Provide guidance to employees and others on dealing with potential compliance issues;

(5) Identify how to communicate compliance issues to appropriate compliance personnel;

(6) Describe how potential compliance issues are investigated and resolved by the organization; and

(7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials

(B) The designation of a compliance officer and a compliance committee who report directly and are accountable to the organization's chief executive or other senior management

(1) The compliance officer, vested with the day-to-day operations of the compliance program, must be an employee of the MA organization, parent organization or corporate affiliate The compliance officer may not be an employee of the MA organization's first tier, downstream or related entity

(2) The compliance officer and the compliance committee must periodically report directly to the governing body of the MA organization on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program

(3) The governing body of the MA organization must be knowledgeable about the content and operation of the compliance program and must exercise reasonable oversight with respect to the implementation and effectiveness of the compliance programs

(C)(1) Each MA organization must establish and implement effective training and education between the compliance officer and organization employees, the MA organization's chief executive or other senior administrator, managers and governing body members, and the MA organization's first tier, downstream, and related entities Such training and education must occur at a minimum annually and must be made a part of the orientation for a new employee, new first tier, downstream and related entities, and new appointment to a chief executive, manager, or governing body member

(2) First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse

(D) Establishment and implementation of effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the MA organization's employees, managers and governing body, and the MA organization's first tier, downstream, and related entities Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified

(E) Well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals These standards must include policies that--

(1) Articulate expectations for reporting compliance issues and assist in their resolution,

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(2) Identify noncompliance or unethical behavior; and

(3) Provide for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined

(F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MA organization, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program

(G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements

(1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct

(2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section

(3) The MA organization should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee

(5) Not accept new enrollees under a section 1876 reasonable cost contract in any area in which it seeks to offer an MA plan

(6) The MA organization's contract must not have been non-renewed under § 422.506 within the past 2 years unless--

(i) During the 6-month period beginning on the date the organization notified CMS of the intention to non-renew the most recent previous contract, there was a change in the statute or regulations that had the effect of increasing MA payments in the payment area or areas at issue; or

(ii) CMS has otherwise determined that circumstances warrant special consideration

(7) Not have terminated a contract by mutual consent under which, as a condition of the consent, the MA organization agreed that it was not eligible to apply for new contracts or service area expansions for a period of 2 years per § 422.508(c) of this subpart

(c) Contracting authority Under the authority of section 1857(c)(5) of the Act, CMS may enter into contracts under this part without regard to Federal and Departmental acquisition regulations set forth in title 48 of the CFR and provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if CMS determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program

(d) Protection against fraud and beneficiary protections

(1) CMS annually audits the financial records (including data relating to Medicare utilization, costs, and computation of the bid) of at least one-third of the MA organizations offering MA plans These auditing activities are subject to monitoring by the Comptroller General

(2) Each contract under this section must provide that CMS, or any person or organization designated by CMS has the right to:

Appendix (cont.)

(i) Inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the MA contract;

(ii) Inspect or otherwise evaluate the facilities of the organization when there is reasonable evidence of some need for such inspection; and

(iii) Audit and inspect any books, contracts, and records of the MA organization that pertain to--

(A) The ability of the organization or its first tier or downstream providers to bear the risk of potential financial losses; or

(B) Services performed or determinations of amounts payable under the contract

(e) Severability of contracts The contract must provide that, upon CMS's request--

(1) The contract will be amended to exclude any MA plan or State-licensed entity specified by CMS; and

(2) A separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made

[65 FR 40327, June 29, 2000; 70 FR 4736, 4737, Jan 28, 2005; 70 FR 52027, Sept 1, 2005; 70 FR 76198, Dec 23, 2005; 72 FR 68722, Dec 5, 2007; 75 FR 19809, April 15, 2010]

SOURCE: 63 FR 35099, June 26, 1998; 70 FR 4714, Jan 28, 2005; 74 FR 1542, Jan 12, 2009, unless otherwise noted

AUTHORITY: Secs 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh)

42 C F R § 422 503, 42 CFR § 422 503

Current through February 24, 2011; 76 FR 10265

Effective: June 7, 2010

Code of Federal Regulations Currentness
Title 42 Public Health
Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter B Medicare Program
Part 423 Voluntary Medicare Prescription Drug Benefit (Refs & Annos)
Subpart K Application Procedures and Contracts with Part D Plan Sponsors
→ § 423.504 General provisions.

(a) General rule Subject to the provisions at § 423.265 of this part concerning submission of bids, to enroll beneficiaries in any Part D drug plan it offers and be paid on behalf of Part D eligible individuals enrolled in those plans, a Part D plan sponsor must enter into a contract with CMS The contract may cover more than one Part D plan.

(b) Conditions necessary to contract as a Part D plan sponsor Any entity seeking to contract as a Part D plan sponsor must--

(1) Complete an application as described in § 423.502 demonstrating that the entity has the capability to meet the requirements of this Part, including those listed in § 423.505

(2) Be organized and licensed under State law as a risk bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Part D plan, or have secured a Federal waiver, as described in subpart I of this part (Fallback entity applicants need not be licensed as risk-bearing entities, nor are they required to obtain State licensure demonstrating that the applicant is eligible to offer health insurance or health benefits coverage in each State in which it applies to operate)

(3) Meet the minimum enrollment requirements of § 423.512(a) unless waived under § 423.512(b)

(4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following:

(i) A policy making body that exercises oversight and control over the Part D plan sponsor's policies and personnel to ensure that management actions are in the best interest of the organization and its enrollees

(ii) Personnel and systems sufficient for the Part D plan sponsor to organize, implement, control, and evaluate financial and marketing activities, the furnishing of prescription drug services, the quality assurance, medical therapy management, and drug and or utilization management programs, and the administrative and management aspects of the organization

(iii) At a minimum, an executive manager whose appointment and removal are under the control of the policy making body

(iv) A fidelity bond or bonds, procured and maintained by the Part D sponsor, in an amount fixed by its policymaking body but not less than $100,000 per individual, covering each officer and employee entrusted with the handling of its funds The bond may have reasonable deductibles, based upon the financial strength of the Part D plan sponsor

(v) Insurance policies or other arrangements, secured and maintained by the Part D plan sponsor and approved by CMS to insure the Part D plan sponsor against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks

(vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct noncompliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse The compliance program must, at a minimum, include the following core requirements:

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(A) Written policies, procedures, and standards of conduct that--

(1) Articulate the Part D plan sponsor's commitment to comply with all applicable Federal and State standards;

(2) Describe compliance expectations as embodied in the standards of conduct;

(3) Implement the operation of the compliance program;

(4) Provide guidance to employees and others on dealing with potential compliance issues;

(5) Identify how to communicate compliance issues to appropriate compliance personnel;

(6) Describe how potential compliance issues are investigated and resolved by the Part D plan sponsor; and

(7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials

(B) The designation of a compliance officer and a compliance committee who report directly and are accountable to the Part D plan sponsor's chief executive or other senior management.

(1) The compliance officer, vested with the day-to-day operations of the compliance program, must be an employee of the Part D plan sponsor, parent organization or corporate affiliate The compliance officer may not be an employee of the Part D plan sponsor's first tier, downstream or related entity

(2) The compliance officer and the compliance committee must periodically report directly to the governing body of the Part D plan sponsor on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program

(3) The governing body of the Part D plan sponsor must be knowledgeable about the content and operation of the compliance program and must exercise reasonable oversight with respect to the implementation and effectiveness of the compliance programs

(C)(1) Each Part D plan sponsor must establish, implement and provide effective training and education for its employees including, the chief executive and senior administrators or managers; governing body members; and first tier, downstream, and related entities

(2) The training and education must occur at a least annually and be a part of the orientation for new employees including, the chief executive and senior administrators or managers; governing body members; and first tier, downstream, and related entities

(3) First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse

(D) Establishment and implementation of effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the Part D plan sponsor's employees, managers and governing body, and the Part D plan sponsor's first tier, downstream, and

Appendix (cont.)

related entities Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified

(E) Well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals These standards must include policies that--

(1) Articulate expectations for reporting compliance issues and assist in their resolution;

(2) Identify non-compliance or unethical behavior; and

(3) Provide for timely, consistent, and effective enforcement of the standards when non-compliance or unethical behavior is determined.

(F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the Part D plan sponsors, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program

(G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements

(1) If the Part D sponsor discovers evidence of misconduct related to payment or delivery of prescription drug items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct;

(2) The Part D sponsor must conduct appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) in response to the potential violation referenced above.

(3) The Part D plan sponsor should have procedures to voluntarily self-report potential fraud or misconduct related to the Part D program to CMS or its designee

(5) Not have non-renewed a contract under § 423.507 within the past 2 years unless--

(i) During the 6-month period, beginning on the date the entity notified CMS of the intention to non-renew the most recent previous contract, there was a change in the statute or regulations that had the effect of increasing Part D sponsor payments in the payment area or areas at issue; or

(ii) CMS has otherwise determined that circumstances warrant special consideration

(6) Not have terminated a contract by mutual consent under which, as a condition of the consent, the Part D plan sponsor agreed that it was not eligible to apply for new contracts or service area expansions for a period up to 2 years per § 423.508(e) of this subpart

(7) For a full risk or limited risk PDP applicant, not submitted a bid or offered a fallback prescription drug plan in accordance with the following rules.

(i) CMS does not contract with a potential PDP sponsor for the offering of a full risk or limited risk prescription drug plan in a PDP region for a year if the applicant--

(A) Submitted a bid under § 423.863 for the year (as the first year of a contract period under § 423.863 to offer a fallback prescrip-

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tion drug plan in any PDP region;

(B) Offers a fallback prescription drug plan in any PDP region during the year; or

(C) Offered a fallback prescription drug plan in that PDP region during the previous year

(ii) Construction For purposes of this paragraph (b)(6), an entity is treated as submitting an application to become qualified to contract as a full risk or limited risk PDP sponsor, if the entity is acting as a subcontractor for an integral part of the drug benefit management activities of a full risk or limited risk PDP sponsor or applicant The previous sentence does not apply to entities that are subcontractors of an MA organization except insofar as the MA organization is applying to act as a full risk or limited risk PDP sponsor

(c) Contracting authority CMS may enter into contracts under this part, or in order to carry out this part, without regard to Federal and Departmental acquisition regulations set forth in Title 48 of the CFR and provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if CMS determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program

(d) Protection against fraud and beneficiary protections

(1) CMS annually audits the financial records (including, but not limited to, data relating to Medicare utilization and costs, including allowable reinsurance and risk corridor costs as well as low income subsidies and other costs) under this part of at least one-third of the Part D sponsors offering Part D drug plans

(2) Each contract under this section must provide that CMS, or any person or organization designated by CMS, has the right to--

(i) Inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the Part D plan sponsor's contract;

(ii) Inspect or otherwise evaluate the facilities of the Part D sponsor when there is reasonable evidence of some need for the inspection; and

(iii) Audit and inspect any books, contracts, and records of the Part D plan sponsor that pertain to--

(A) The ability of the organization or its first tier or downstream providers to bear the risk of potential financial losses; or

(B) Services performed or determinations of amounts payable under the contract

(e) Severability of contracts The contract must provide that, upon CMS' request--

(1) The contract could be amended to exclude any State-licensed entity, or a Part D plan specified by CMS; and

(2) A separate contract for any excluded plan or entity must be deemed to be in place when a request is made.

[72 FR 68732, Dec. 5, 2007; 73 FR 20507, April 15, 2008; 75 FR 19820, April 15, 2010]

SOURCE: 70 FR 4525, Jan 28, 2005; 73 FR 30683, May 28, 2008, unless otherwise noted.

AUTHORITY: Sections 1102, 1106, 1860D-1 through 1860D-42, and 1871 of the Social Security Act (42 U.S.C. 1302, 1306, 1395w-101 through 1395w-152, and 1395hh)

42 C F R. § 423 504, 42 CFR § 423.504

Current through February 24, 2011; 76 FR 10265