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Waste, Abuse, and Fraud Prevention Compliance Plan

In meeting client expectations compliant to appropriate state and federal regulations, ValueOptions of Texas, Inc. submits the following Waste, Abuse, and Fraud Prevention Compliance Plan.

Revision History

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ValueOptions of Texas' Compliance/Program Integrity Department maintains the original electronic version of this document. Any changes or revisions made are the responsibility of the Compliance/Program Integrity Department.

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Texas - NorthSTAR
Waste, Abuse, and Fraud Prevention Compliance Plan

I. INTRODUCTION.

It is the policy of ValueOptions of Texas, Inc. (“TXNS”), and ValueOptions, Inc. (“VO”), to comply with all laws governing its operations and to conduct business in keeping with legal and ethical standards. It is also the policy of TXNS to deal with employees and behavioral health recipients using the highest clinical and business ethics as well as to maintain a culture which promotes the prevention, detection and resolution of possible violations of laws and unethical conduct. Compliance is a priority built into all levels of operations. This plan is reviewed annually and as needed by the TXNS Director of Compliance/Program Integrity and/or the Texas Compliance Committee. Necessary revisions are forwarded to the Texas Health and Human Services Commission – Office of Inspector General (HHSC-OIG), the Texas Department of State Health Services (TX-DSHS), and the North Texas Behavioral Health Authority (NTBHA) for approval.

TXNS supports the government in its goal to decrease financial loss from false claims and has as its own goal, the protection of the State of Texas through the reduction of potential exposure to fraud, waste and abuse. TXNS shall operate its anti-fraud program under the direction of the VO National Legal & Compliance Department. TXNS shall have access to an array of resources to support its compliance efforts and to implement an anti-fraud plan. TXNS shall also have a Compliance/Program Integrity Department and Compliance Committee vested with the appropriate authority to administer the fraud and abuse program.

II. PLAN OVERVIEW.

The reporting of suspected fraud and abuse is intended to avoid the misappropriation of Federal, State, and Local funds. In the context of this plan, fraud is considered an act of purposeful deception committed by a person or behavioral health provider to gain an unauthorized benefit. Abuse committed by a behavioral health provider means activities that are inconsistent with standard fiscal, business, or medical practices, and that result in unnecessary costs to the TX-DSHS programs. Persons receiving care in the behavioral health system can also commit acts of abuse (e.g., by loaning or selling their identification cards).

Behavioral health providers must be cognizant of suspected fraud and abuse within the public behavioral health system. When detected, behavioral health providers are obligated to report such occurrences to TXNS or the appropriate state entity. Fraud and abuse can result in the misuse of Federal and State funds, can jeopardize the care and treatment of persons receiving behavioral health services, and can result in monetary fines, criminal prosecution, termination of providers, and prohibition from participation in Medicare/Medicaid Programs. Procedures to report suspected cases of fraud and/or abuse for behavioral health providers who are contracted with TXNS are included herein.

TXNS distributes annually a memorandum and requires training regarding TXNS Waste, Abuse, and Fraud Prevention Compliance Plan for all service center employees. The memorandum instructs employees to use due diligence regarding suspected fraudulent activities and explains how to report suspected fraudulent activities that could jeopardize the integrity of the benefits program or VO. The memorandum further explains that there is a zero tolerance for improper business conduct or fraudulent behavior. Waste, abuse, and fraud issues that may result in the potential loss of State property, monies, assets or associated confidential information must be reported to HHSC-OIG and TX-OAG-MFCU.

III. PURPOSE AND SCOPE.

The purpose of the TXNS Waste, Abuse, and Fraud Prevention Compliance Plan is to develop a mechanism to prevent and detect fraud, waste, or abuse in the behavioral health system under the scope of the TXNS contract with the TX-DSHS, through effective communication, training, review, and investigation. It is intended to be a systematic process aimed at ensuring that TXNS and its subcontractors comply with applicable laws, regulations, and standards in addition to contractual obligations. The TXNS Waste, Abuse,

and Fraud Prevention Compliance Plan serves as a guiding document in the development, implementation, evaluation and maintenance of all related fraud and abuse operations and procedures, and it establishes a process for identifying and reducing risk and improving internal controls.

IV. DEFINITIONS.

Abuse – provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (*42 CFR 455.2*).

Elements of Abuse:

- Inconsistency (pattern of not following known laws, rules, regulations, contracts or industry practices/procedures);
- Costs (unnecessary loss of money to a governmental program);
- Medically unnecessary/does not meet standards (general disregard for professional or industry standards and practices).

Dispute – a request made by a provider or member for a neutral party to review an adverse action taken by TXNS to determine whether the action complied with the Medicaid laws, regulations, and/or policy. The dispute shall be governed by TX-DSHS' regulations and any and all applicable laws and court orders.

Claim – an itemized statement requesting payment for services rendered by health care providers (such as hospitals, physicians, or other professionals, etc.), billed electronically or on the CMS 1500, and/or UB-92.

Company – partnership of ValueOptions, Inc. (VO) and ValueOptions of Texas, Inc., established as ValueOptions NorthSTAR (TXNS).

Compliance Plan – same as anti-fraud plan, waste, abuse, and fraud prevention compliance plan, or program integrity plan.

Covered Service – medically necessary behavioral health and case management services for Medicaid and Indigent members as described in Article VII of the TXNS Contract (No. 2012-039051).

Disclosing Entity – a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent (*42 CFR 455.101*).

Federal Health Care Program – any plan or program providing healthcare benefits, whether directly through insurance or otherwise, that is funded directly, in whole or part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program (*42 CFR 1001.2*).

Fraud – the intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit. It includes any act that constitutes fraud under applicable Federal or State law (*42 CFR 455.2*).

Elements of Fraud:

- The act (evidence of wrong-doing);
- Knowledge and intent (willfully intended to commit act – generally evidenced by a pattern of wrong-doing); and

- Benefit (some type of measurable benefit obtained from the act by the person committing the act).

HHSC-OIG – Texas Health and Human Services Commission – Office of Inspector General

Incidents – situations of suspected fraud and/or abuse, which have the potential for liability to the State of Texas, TX-DSHS, TXNS, or its subcontracted providers.

Knowingly, or knowingly and willfully – a person, with respect to information:

- (a) Has actual knowledge of the information
- (b) Acts in deliberate ignorance of the truth or falsity of the information; or
- (c) Acts in reckless disregard of the truth or falsity of the information; and
- (d) No proof of specific intent is required (*42 CFR 402.3*)

Material Violations – substantial overpayments or a matter that a reasonable person would consider a potential violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusions may be authorized. A material deficiency may be the result of an isolated event, or a series of occurrences.

Medical Necessity – an item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Medicaid policy.

Medical Record – a single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, medical services ordered for the member and medical services received by the member.

Member – an individual having current Medicaid or NorthSTAR eligibility who shall be authorized by TX-DSHS to receive behavioral health services.

NTBHA – The North Texas Behavioral Health Authority serves as the local behavioral health (mental health and substance abuse) authority for the entire NorthSTAR service area, and functions include planning, oversight, single portal authority functions, as well as a local problem solving resource that includes ombudsman services.

Preponderance of the Evidence – evidence that shows a fact to be proved is more probable than not.

Probable Cause – a reasonable ground for belief, based on the facts that fraud and abuse has occurred; more than mere suspicion.

Provider – an institution, facility, agency, person, corporation, partnership, or association enrolled with TX-DSHS which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with TXNS.

Provider Agreement – an agreement between a TXNS and a provider or TXNS' subcontractor and a provider of behavioral health services, which describes the conditions under which the provider agrees to furnish covered services to TX-DSHS' members.

Services – see covered service.

Service Authorization – the act of authorizing specific services or activities before they are rendered or activities before they occur (formerly called prior authorization).

State – Texas.

State Medicaid Fraud Control Unit – a unit certified by the Secretary as meeting the criteria of 42 USC § 1396b (q) and § 1002.305 (42 CFR 1001.2).

Subcontractor – any State approved organization or person who provides any function or service for TXNS specifically related to securing or fulfilling TXNS' obligations to TX-DSHS under the terms of the TXNS Contract (No. 2012-039051).

TX-DSHS – Texas Department of State Health Services

TX-OAG-MFCU – Texas Office of Attorney General – Medicaid Fraud Control Unit

Under-coding – coding for a service rendered through the use of a code which pays/encounters at a lower rate than the service actually provided.

Up-coding – coding for a service rendered through the use of a code which pays/encounters at a higher rate than the service actually provided.

Utilization Management – the process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Texas Administrative Code (“TAC”) – contains regulations of all of the Texas State Agencies.

Waste – thoughtless, careless expenditure, consumption, mismanagement, use or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems or controls.

V. COMPLIANCE PLAN CRITERIA.

TXNS shall establish and maintain a Compliance Program that, to the extent applicable, conforms to the Compliance Program Guidance issued by the Office of the Inspector General of the U.S. Department of Health and Human Services and other relevant state compliance program guidelines that directly affect the operations of TXNS.

1. A clear commitment to compliance. TXNS, in partnership with VO, has adopted a standardized Code of Conduct. The Code of Conduct Handbook explains the Company's commitment to ethical standards and sets expectations for all employees in achieving and maintaining these standards. Employees are trained on the Code of Conduct upon hire and periodically thereafter. Training includes review of the Code and the Compliance Program, various compliance related case studies and provides the opportunity for clarification and questions. At the conclusion of training, employees are required to certify that they have read and understand the Code, agree to abide by its principles and report any suspected or possible violations. The Code of Conduct may be updated periodically and establishes the ethical standards employees must uphold in critical areas and aspects of the Company's operations.
2. Designation of a Director of Compliance/Program Integrity and Compliance Committee – Oversight. The day-to-day operations of the compliance/program integrity program and compliance

plan shall be administered by the TXNS Compliance/Program Integrity Department, led by the Director of Compliance/Program Integrity, who shall report directly to the VO National Director of Compliance, Program Integrity and the TXNS Service Center Vice-President (“SCVP”). TXNS compliance/program integrity staff shall have appropriate qualifications and experience.

TXNS shall establish a Compliance Committee to provide oversight for the compliance program and be responsible for regularly reviewing the compliance plan, recommending and authorizing changes as needed and assuring that related TXNS policies and procedures are in accordance with the compliance plan. The Compliance Committee shall consist of representatives from primary departments including: Quality Management, Claims, Clinical, Information Technology, Network Operations, Credentialing, Provider Relations and Finance. It shall be chaired by the Director of Compliance/Program Integrity or designee (*42 CFR 438.608*).

The Director of Compliance/Program Integrity and Compliance/Program Integrity Department shall function independently of any other TXNS department and have several responsibilities, including, but not limited to:

- Establishing and maintaining all necessary policies and procedures to support the compliance plan;
- Conducting reviews and fields audits;
- Reporting findings to the SCVP and Compliance Committee; and
- Reporting suspected fraud, waste and abuse to HHSC-OIG and TX-OAG-MFCU.

Committee member responsibilities include, but are not limited to:

- Reviewing new regulations affecting compliance issues and revising strategies accordingly;
- Reviewing new and ongoing compliance issues, including corrective action plans;
- Identifying suspected fraud and abuse issues that may put TXNS, TX-DSHS, the State of Texas, and the program at risk and developing strategies to avoid such problems;
- Understanding fraud and abuse procedures and to provide this information to each functional area and its employees to ensure effective communication and understanding regarding fraud and abuse detection and deterrence;
- Developing training programs that support the prevention and detecting of fraud and abuse;
- Reviewing the Compliance Plan annually to assure that it is meeting the needs, requirements and contractual obligations of TXNS relating to fraud and abuse;
- Assisting TX-DSHS and cooperating with any performance reviews to provide copies of all records and documentation arising out of TXNS’ performance of contractual obligations;
- Assist in the development of any corrective action plans required by TX-DSHS in the event a review identifies and deficiencies;
- At the request of any contracted or non-contracted providers, offer technical assistance and support, as needed;
- Developing/modifying contract language to support required federal and state laws/regulations; and
- Developing and monitoring audit processes and out-lier reporting processes.

The Compliance Committee shall meet every other month or as needed to review and discuss significant cases from the past period. Each committee meeting shall include an update from the Director of Compliance/Program Integrity on cases opened, cases closed, cases referred, new trends and new vulnerable areas along with updates on other functions of the Compliance/Program

Integrity Department. All Compliance Committee discussions, findings, decisions, etc. shall be documented and signed by the Director of Compliance/Program Integrity and the TXNS SCVP.

It is important to remember the sensitive nature of the information and topics the Committee shall be discussing and to assure that each member does not share information on investigations outside of the Committee. In order for the Compliance/Program Integrity Department audits and investigations to be conducted properly and to maintain the integrity of any possible future civil or criminal actions taken against a subject, strict confidentiality must be maintained by the Committee and any related TXNS employee. On an annual basis, each Committee Member will sign a Confidentiality and Non-Disclosure Agreement as part of their compliance related duties of VO and its affiliates. Copies of these agreements will be kept by the Director of Compliance/Program Integrity.

If there are any revisions made to the Waste, Abuse, and Fraud Prevention Compliance Plan, TXNS employees will be notified within twenty (20) day of that revision.

3. Effective training and education programs. TXNS shall require all employees and providers to attend training on the Compliance Program; identifying fraud and abuse, reporting fraud and abuse; compliance-related policies, procedures, and standards; and the Code of Conduct.
4. Auditing and monitoring. To detect and discourage fraud and abuse, the Compliance/Program Integrity Department shall ensure that appropriate monitoring, reviewing, and auditing are performed. These activities, referred to generally as audits, shall be focused on identified high-risk areas and vulnerable processes and systems. Various and appropriate audit methods shall be used to provide a reasonable assurance of detecting fraud and abuse. The audit methods used shall include, but are not limited to:
 - Data Review, Verification and Validation;
 - Random and Targeted Field Audits;
 - Desk Reviews of Data and Documents.

The purpose of Compliance audits shall be to detect and correctly identify instances of suspected fraud, waste or abuse based on the totality of the circumstances, information and evidence. The audits shall be conducted in accordance with applicable laws, standards, policies and procedures and shall result in a report detailing findings of fact. The Compliance/Program Integrity Department shall not provide opinions or recommendations unless requested by the Compliance Committee. See the *Compliance Audit Process* section for additional information.

5. Effective lines of communication. VO, a partner of TXNS, maintains an Ethics & Privacy Hotline and other procedures to foster an open atmosphere for employees, members, and providers to report issues and concerns, free from retaliation. Employees and management are encouraged to ask questions and report any problems or concerns which they may have about the company or its operations. Employees may direct any questions or concerns to their supervisor, manager, operating unit executives, the TXNS Director of Compliance/Program Integrity, or any member of the Compliance Committee. In addition, employees, members, and providers may use the Ethics & Privacy Hotline or other communication systems to report issues or concerns which may require investigation to assure compliance with the requirements of the Compliance/Program Integrity Program and applicable laws. Written procedures are available to all employees who may want advice on certain policies and procedures, or who wish to report actual or suspected violations of law or applicable company policies and procedures.

Effective lines of communication shall also be maintained between TXNS and all of its employees, agencies, subcontractors, providers and clients operating under the scope of the compliance plan. Communication shall be conducted using the best and most appropriate means available, by way of direct mail, telephone, e-mail, web-site and Committee meetings.

6. Internal investigation and disciplinary processes. TXNS may use internal processes to evaluate compliance, including, but not limited to, on-site review; interview of personnel involved in management, operations, finance, and other related activities; questionnaires developed to solicit impressions of a broad cross-section of employees; review of financial and compliance related documents; financial, claim, or record auditing; trend analyses that seek deviations in specific areas over a specific period of time. These investigations shall be reported to the Compliance Committee and any corrective action, if applicable, shall be developed for areas of non-compliance according to a corrective action protocol.
7. Response to identified offenses and application of corrective action initiatives. TXNS, with its legal counsel when necessary, shall promptly respond to and investigate all allegations of illegal or improper activities by its employees, agents, members, or providers, whether the allegation is received through the Ethics & Privacy Hotline or in any other manner. Following such investigation, TXNS shall use reasonable efforts to correct the problem and develop appropriate corrective action plans if necessary. See the *Fraud and Abuse/Compliance Audit Process* section for additional information.
8. Advertising and Marketing. TXNS manages a NorthSTAR program for the TX-DSHS for a defined Medicaid and indigent population for seven (7) North Texas counties. Marketing and advertising has been limited to the enrollee handbook that is distributed via the enrollment broker for Medicaid and as requested by indigent consumers.

VI. FRAUD AND ABUSE CRITERIA.

Unless otherwise directed, the following is the criteria TXNS shall use for determining if fraud or abuse is suspected.

At least one of the following criteria must be met:

- Evidence of knowing and intentional:
 - Duplicate billings;
 - Upcoding;
 - Miscoding;
 - Unbundling;
 - Misrepresentation of services;
 - Billing for services not rendered;
 - Evidence of false or altered documents;
 - Evidence of missing documentation;
 - Evidence of irregularities following sanctions for same problem;
 - Evidence of unlicensed or excluded professional or facility at time of services;
 - Evidence of management knowledge of fraudulent activity;
 - Reports of material irregularities by more than one reliable source.

And all of the following criteria must be met:

- Pattern of occurrence of irregularities;

- Actual loss to a governmental program;
- Loss would be considered material for nature and type of activity and provider.

Or at least one of the following criteria is met:

- Direct personal knowledge of fraudulent activity by known reliable individual;
- TXNS documented audit findings that show suspected fraud;
- Report showing evidence of suspected fraud from another government or law enforcement agency.

VII. FRAUD AND ABUSE REPORTING AND INVESTIGATING.

Upon receipt of TXNS internal reports or its own reasonable indications of suspected noncompliance, the Compliance/Program Integrity Department shall investigate the allegations to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. If it is determined that there is a current deficiency or area of noncompliance, the Compliance Department shall oversee the development of a corrective action plan to resolve the problem. The corrective action plan may include the appointment of a task force, the engagement of legal counsel and, in certain circumstances, the return of any overpayments and sanctions. TXNS shall notify HHSC-OIG if a problem is identified with the recoupment.

All instances of potential or actual fraud and abuse must be reported within thirty (30) business days of initiation of any investigative action by TXNS. Reports shall be sent to HHSC-OIG and TX-OAG-MFCU in writing via email or fax and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities (*See TAC Rule 353.502*). All instances of potential or actual fraud and abuse investigated and/or reported to, or by TXNS shall be logged and tracked by the Director of Compliance/Program Integrity and subsequently reported monthly to HHSC-OIG and TX-OAG-MFCU.

The log shall include, and is limited to:

- Case Number;
- Date Case Opened;
- Date Case Completed;
- Allegation(s);
- Source of Allegation;
- Time Period of Allegation;
- Provider Name;
- MCO Provider #;
- State Issued TPI # (if available);
- Provider Tax ID;
- Provider NPI;
- Description of Complaint / Allegations;
- Description of MCO Investigative Actions to Date;
- Description of Findings;
- Number of Client, Claims, Details, Dollars in Population;
- Number of Clients, Claims, Details, Dollars Found in Error;
- Number of Records Reviewed;
- Description of Actions Taken;
- Total Dollars Identified for Recovery;
- Overpayment \$-4-\$ or Extrapolated;
- Dollars Recovered to Date;

- Date of Final Recovery;
- Case Closed (Y or N);
- Date Case Closed; and
- Comments

If fraud is suspected, an investigation shall be initiated and may include interviews and a review of relevant documents. During the investigation, the provider or member must allow access to originals or copies of all pertinent documents and to any data stored electronically and in the form specified by TXNS. A full investigation shall continue until sufficient evidence is gathered to determine, by a preponderance of the evidence that the alleged fraud and abuse has occurred, or has not occurred. All cases where fraud is suspected or detected shall be referred to HHSC-OIG and TX-OAG-MFCU prior to the initiation of any actions or recoupment efforts. TXNS shall cooperate with all fraud and abuse investigation efforts by TX-DSHS and other State and Federal entities and shall provide support to HHSC-OIG and TX-OAG-MFCU on matters relating to specific cases involving detected or suspected fraud. In addition, the Compliance/Program Integrity Department shall review the specific facts and circumstances to determine whether the problem is systemic and whether modifications to the Compliance Program are necessary or advisable to increase the likelihood that similar situations will be detected and prevented in the future.

Any contractor, subcontracted provider of care, or non-contracted provider who fails to report suspected fraud and/or abuse, has committed an act of unprofessional conduct and may be subject to disciplinary action by the appropriate professional regulatory board or department and shall be referred to the appropriate professional regulatory board or department.

Verification of Member Services. TXNS has an established process for the verification of member services (42 CFR 455.20). The process is conducted and overseen by the Compliance/Program Integrity Department.

The process is:

- TXNS verifies receipt of member services received based on claims paid for TXNS members to TXNS providers;
- The verification process occurs monthly for a sample of the previous month's paid claims;
- The sample methodology targets no less than 500 Medicaid members per month across multiple outpatient provider locations representative of the majority of the services provided to TXNS members;
Note: Inpatient verification is managed outside of this process as VO Clinical department conducts pre-authorization and daily continued stay review for Inpatient levels of care.
- The sample is pulled monthly and notification letters are sent to members within 15 business days for services paid in the prior month;
- The member notification letter verify the following with the member:
 - Date of Service;
 - Facility/Provider Name; and a
 - Call back number for disputes or reporting potential fraud.
- TXNS' tracking process to determine the effectiveness of the verification of member services process includes the following elements, and occurs monthly:
 - Track the total number of notification letters mailed;
 - Track the total number of returned notification letters and log the reason(s);
 - Track the total number of responses about the notification letters;
 - Track the total number of referrals made to SIU based on member's response to notification letters;
 - Track the total number of referrals made to HHSC-OIG and TX-OAG-MFCU based on member's response to notification letters;

- Track the total number of complaints based on the notification letters.

Pharmacy Benefits Manager. TXNS Pharmacy Benefits Manager's (PMB) definitions, process, and procedure for performing audits:

On-Site Audit: A PBM staff member/designated auditor visit a pharmacy. During this audit pharmacy data is evaluated for compliance with state and federal law, plan benefit parameters and billing accuracy.

Claims are selected for audit by reviewing:

- High dollar or prescription volume for pharmacies or physicians;
- Refill patterns;
- Dispensing discrepancies;
- Physician DEA number;
- Reported cost;
- Quantities and day supply; or
- Patient information.

Note: Complete list of variables is described in the Fraud Waste & Abuse Criteria and Variables section of the Pharmacy Fraud, Waste, and Abuse Plan.

Claims information is compared to the prescription record on file at the pharmacy and the following information is verified:

- Method of prescription order (phone or written);
- Patient information;
- Prescribing physician information;
- Directions for use;
- Refill information;
- Quantity of the drug requested;
- Actual product filled as compared to written description of filling; or
- Signature logs to determine if prescriptions were picked up by the member.

This audit consists of:

- 100-150 unique prescriptions are reviewed for accuracy and completeness

The audit may also include:

- Validating all licenses;
- Observing interactions with customers;
- Mailing Rx verification letters to patients;
- Validating HIPAA compliance;
- Validating correct NDC;
- Facility Review; or
- Exit interview and educational intervention.

Desk / In-house Audits: An audit similar to an On-Site Audit except conducted via mail, telephone or fax rather than in person. During this audit, pharmacy data is evaluated for compliance with state and federal law, plan benefit parameters and accuracy of billing of claims.

- An audit package is sent by mail, telephone or fax to the pharmacy with detailed instructions.
- Request for copies of prescriptions.
- Request for copies of licenses, signature logs, and HIPAA compliance material.

- Audit Report generated to pharmacy with any follow-up and necessary corrective actions.

Specific Claim Audits: An audit that is customized to analyze specific claims information (i.e., drug classes, high cost claims, etc. or other areas of potential error that are recognized by the PBM). This audit can either be a desk or onsite audit.

Stratification: A monthly data analysis of 100% of claims from network pharmacies to identify claims to be audited by on-site or desk audits.

Fraud, Waste & Abuse Description: PBM currently utilizes contracted audit vendors and PBM internal staff to review claim activity and conduct pharmacy audits.

Proprietary programming is used to:

- Audit Claims;
- Identify and refer fraudulent claims submissions for investigation;
- Identify recoveries;
- Protect the financial integrity of the prescription benefit;
- Identify areas of concern and potential problems;
- Prescriptions that require further inspection are identified for both a desktop and/or onsite audits and audit activity reports are provided; or
- Desk Top and Desk Audits are performed by audit vendors and PBM internal staff.

SIU Referrals:

- The identifying staff member will refer potential cases of waste, abuse, and fraud to the Director of Compliance/Program Integrity as soon as possible.
 - Compliance/Program Integrity - SIU inquiry queue: D1TXCOMWAF.

Withholding Payment:

- Federal regulations under 42 C.F.R. § 455.23 (2011) make payment suspensions mandatory where an investigation of credible allegations of fraud exists under the Medicaid program.
 - TXNS with assistance from VO have a process in place to adhere to the aforementioned federal regulation.

Assigned Officer for reporting all investigations:

Jason L. Martin, MBA, CFE, AHFI
National Director, Compliance/Program Integrity
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Norfolk, VA 23502
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VIII. COMPLIANCE AUDIT PROCESS.

Periodic audits are conducted to ascertain compliance with applicable fraud and abuse requirements. These audits are used to ascertain that the compliance plan is being followed and focuses on risk areas which may be identified by the government from time to time. They include periodic claims sampling and documentation reviews to assess TXNS operations. The goal of the audits is to assure personnel competency and uncover

improper claims activity (patterns of improper activity in particular, e.g., up-coding) before potential violations become significant enough to warrant government-imposed penalties. Feedback is provided to the individuals involved in the various phases of claim development and submission.

Specific controls TXNS shall have in place for the prevention and detection of fraud and abuse, include:

- Claim edits – The VO claims system, utilized by TXNS, shall perform validation edits that include, but may not be limited, to the following:
 - Service authorization – Certain services must be prior-authorized to receive payment;
 - Valid dates of service – the system assures that dates of services are valid dates and not in the future;
 - Duplicate claims – the system automatically informs the provider that the current claim is an exact or possible duplicate and denies that claim;
 - Covered service – the system shall verify that a service is a valid covered service and is eligible for payment under TX-DSHS' behavioral health benefit for that eligibility group;
 - Provider validation – the system approves for payment only those claims received from providers that would have been paid in the absence of other primary insurance coverage for Medicaid and Indigent covered services;
 - Eligibility validation – the system confirms the member for whom a service was provided was eligible on the date the service was incurred;
 - Quantity of service – the system validates claims to assure that the quantity of services is consistent with TX-DSHS' rules and policy;
 - Rejected claims – the system determines whether a claim is acceptable for adjudication and reject claims that are not;
 - Managed care organizations (MCO)– the system rejects claims that should rightly be processed and paid by a member's MCO for any and all physical health treatments;
 - Other insurance coverage – the system rejects claims that should rightly be processed by a member's primary health care carrier;
 - Service limits – the system verifies that a service is not covered outside of TX-DSHS' established service limits, including but not limited to once in a lifetime procedures; and
 - Correct payment amounts – the system pays the claim at the lesser of the billed amount or VO' allowable amount, other third party pay coverage, etc.
- Post-processing review of claims – TXNS produces reports that show overlapping dates of service to determine if any claims have been submitted and were adjudicated for services that did not fail the claim edit logic.
- Provider profiling and credentialing – All providers must be registered with TX-DSHS with the appropriate provider type and categories of service and be credentialed by VO prior to contracting or entering into a single-case agreement.
- Contract provisions – the TXNS provider agreement requires providers to report any incidents of suspected fraud or abuse to TXNS.
- Training for employees – During new-employee orientation and in regular training, meetings and/or forums, employees receive training on fraud and abuse.
 - VO and TXNS maintain a training log for all training pertaining to waste, abuse and/or fraud in Medicaid. The log includes the name and title of the trainer/facilitator, names of all staff attending the training and the date and length of the training. The log will be provided upon request from the TX-HHSC-OIG, TX-OAG-MFCU, and OAG-Civil Medicaid Fraud Division (CMFD), and the United States Health and Human Services-Office of Inspector General (HHS-OIG). (*1 TAC 353.502 (Medicaid)*)
- Member and subcontracted provider training and education – Fraud and abuse training shall be made available to providers routinely and at least annually.

IX. DISCIPLINARY ACTIONS/CORRECTIVE ACTION PROTOCOL.

In order to fully benefit from the detection of material mistakes, inaccuracies and instances of fraud and abuse, TXNS shall take corrective action with those relevant individuals and/or organizations. If directed by the Compliance Committee and in coordination with TX-DSHS, TXNS may also recommend a process for improving the systems involved. Corrective actions recommended by TXNS for its providers may include:

- Repayment of funds;
- Fines and sanctions;
- Mandatory remedial training;
- Referral to law enforcement for criminal investigation and prosecution;
- Referral to other regulatory authorities; or
- Termination of contract.

If the results of an initial or follow-up audit disclose encounters without supporting documentation, those encounters shall be reversed and the funds shall be recouped prior to assessing the additional data obtained in the audit.

Upon completion of an audit, the total number of claims in error (undocumented encounters, correctness issues and timeliness issues) is divided by the total number of claims used in the sample-size to determine the error rate. The resulting error rate is utilized in the following manner:

If the results of an initial audit indicate an error rate greater than 10%, the following steps shall be taken:

- Compliance Committee apprised of findings;
- Provider notified of non-compliance;
- Cure-time allowed;
- Follow-up audit scheduled to be conducted within 6 – 9 months following the initial audit.

If the results of a follow-up audit indicate an error rate greater than 5%, the following steps shall be taken:

- Compliance Committee apprised of findings;
- Provider notified of non-compliance;
- Recoupment of funds associated with incorrect and/or untimely claims;
- Sanctions issued in coordination with TXNS' contract with the provider;
- Probationary period implemented;

The error rate associated with every audit conducted of a provider shall be maintained and tracked via a graph and trend line to indicate an overall performance level. The Compliance Department shall routinely review these trends and report consistent noncompliance to the Compliance Committee as necessary.

X. COMPLIANCE/PROGRAM INTEGRITY UNIT.

Jason L. Martin, MBA, CFE, AHFI is TXNS' National Director of Compliance/Program Integrity. As the TXNS National Director of Compliance/Program Integrity, Mr. Martin has access to all aspects of the activities performed by TXNS for the State of Texas as the NorthSTAR Contract holder. He is in the best position to implement processes articulated in this Waste, Abuse, and Fraud Prevention Compliance Plan.

The National Director of Compliance/Program Integrity serves as the primary point of contact for the HHSC-OIG and their authorized representatives. All questions regarding the administration of this Plan and TXNS' compliance with this Plan should be first directed to the National Director of Compliance/Program Integrity. Where contacting TXNS prior to or during an investigation does not compromise an investigation, HHSC-OIG, TX-OAG-MFCU, TX-DSHS, and NTBHA should include the National Director of Compliance/Program Integrity in all communications with the TXNS staff.

XI. SUMMARY.

The TXNS Compliance Plan confirms the establishment of a National Director of Compliance/Program Integrity, a Compliance Committee, and a program for effective training and education, auditing and monitoring. Effective and clear lines of communication have been established and internal investigation and disciplinary processes developed. Specific controls have been set in place to prevent and detect fraud and abuse, and procedures for the reporting of fraud and abuse are in place. TXNS has established a clear commitment to compliance.

As the foundational document for TXNS' fraud and abuse control activities, this compliance plan shall be reviewed and amended as necessary. The Compliance Committee Chair (representing the Compliance Committee) shall direct the Compliance/Program Integrity Department in regards to any revisions and shall have final approval for all changes.

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