OPTIMUM HEALTHCARE

Compliance Plan

And

Fraud, Waste, and Abuse (FWA) Prevention

Approval Date: April 13, 2012

COMPLIANCE PLAN AND FWA PREVENTION PLAN GOVERNANCE

The CMS Regional Office – Account Manager is the coordination point for all compliance activities for Medicare Advantage Part C and the Prescription Drug Benefit Policy Group for compliance activities for Medicare Advantage Part D.

The Optimum HealthCare Compliance Plan and FWA Prevention Plan (hereinafter referred to as the "Plan") is designed to promote adherence to appropriate standards of business conduct throughout all aspects of the organizations operation and to ensure conformance with applicable federal and state regulatory obligations by the organization and its employees (executive, management, and support staff), partners, vendors, independent agents, independent brokers and its first tier entities, downstream entities, and related entities (FDRs).

The Plan is designed with direct reference to the compliance elements recommended in the U.S. Office of Inspector General's (OIG's) Compliance Program Guidance, Vol. 64, No. 219 of the Federal Register dated November 15, 1999, and in the Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse, published by the Centers for Medicare and Medicaid Services (CMS). The Plan also reflects the requirements described and established by the Agency for Health Care Administration (AHCA). The regulatory guidelines for designating a Privacy Officer are found at 45 CFR 164.530. The plan also complies with all Federal and State requirements, including but not limited to:

Title XVIII of the Social Security Act.
• Medicare regulations governing Parts C and D found at 42 C.F.R. §§ 422 and 423 respectively.
• Federal and State False Claims Acts (31 U.S.C. §§ 3729-3733).
• Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)).
• The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5)).
• Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn).
• Health Insurance Portability and Accountability Act.
• Fraud Enforcement and Recovery Act of 2009.
• Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the Federal government.
• Other applicable criminal statutes.
• Applicable provisions of the Federal Food, Drug, and Cosmetic Act.
• All sub-regulatory guidance produced by CMS such as manuals, training materials, HPMS memos, and guides;
• Contractual commitments.

Compliance is conforming to activities, practices or policies in accordance with the requirements or expectations of an external authority. In managed care, it means meeting the expectations of

those who regulate our business. The best approach to compliance is to take a proactive stance in meeting our regulatory obligations on a day-to-day basis. An effective compliance program must be backed up with solid, ongoing management and organizational processes to prevent detect and correct violations of federal and state requirements.

Optimum HealthCare has created this Plan to enforce its commitment to federal and state regulatory obligations. Optimum HealthCare maintains high standards of business and personal ethical conduct. The Plan outlines the organization's compliance program, promoting moral and ethical integrity. Optimum HealthCare will take immediate steps to correct any violations of the Plan, including but not limited to imposing appropriate disciplinary actions and implementing corrective measures to prevent future violations. Our compliance program is one of the key components of our commitment to the highest standards of corporate conduct.

The integrity and support of the Compliance Plan is made at the highest level – the Optimum HealthCare Board of Directors. The compliance program requires a resolution of the full governing body stating the health plan's commitment to compliant, lawful and ethical conduct. On at least an annual basis, the Compliance Officer and Committee reviews and updates the Plan and presents it for approval to the organization's Board of Directors. If regulatory or statutory guidance is revised, the Plan will be updated accordingly and presented to the Board for approval.

COMPLIANCE PLAN COMPONENTS

Compliance promotes the prevention, detection and resolution of instances of conduct that do not conform to Federal and State law and Federal and State health care program requirements.

A variety of external methods of compliance enforcement exist including, but not limited to: CMS routine monitoring visits, CMS focused monitoring visit, MA-PD self-reporting, industry policing, beneficiary complaints, and Congressional inquiries. The goal of Federal enforcement is threefold: (1) protection of the Medicare beneficiary, (2) protection of the Medicare Trust Fund, and (3) protection of the taxpayer.

The Florida Agency for Health Care Administration (AHCA) has similar expectations from health plans regarding compliance to their regulations.

As described in the Code of Federal Regulations (CFR) 422.503(b)(4)(vi), the organization's compliance plan, at a minimum, must include the following elements:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards.
2. The designation of a compliance officer and a compliance committee who are accountable to senior management.
3. Effective training and education between the compliance officer and organization employees.
4. Effective lines of communication between the compliance officer and the organization's employees.
5. Enforcement of standards through well-publicized disciplinary guidelines.
6. Procedures for internal monitoring and auditing.
7. Provisions for ensuring prompt response to detected offenses and development of corrective action initiatives.
8. Fraud Waste and Abuse Prevention

Optimum HealthCare's compliance plan incorporates a comprehensive fraud, waste and abuse plan as listed in the Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse. The health plan also addresses its commitment to HIPAA regulations through policies and procedures designed and implemented under the auspices of the Privacy Officer.

POLICIES & PROCEDURES AND STANDARDS OF CONDUCT

Optimum HealthCare has written policies, procedures, and Standards of Conduct clearly stating the organizations commitment to comply with all applicable Federal and State standards, including but not limited to, all applicable statutes, regulations, and sub-regulatory guidance. The Policies and Procedures and the Standards of Conduct are written in a format that is easy to read and comprehend, is reviewed at least annually, and approved by senior management, including the CEO and other senior officials, as well as the full Board of Directors. The Standards of Conduct include the health plans mission, commitment to comply with law, commitment to conduct business with the highest ethical standards, procedures to avoid and address conflicts of interest and FWA prevention, detection and correction. The Standards of Conduct specify the disciplinary actions that can be imposed for violation of law and ethics, Medicare program noncompliance and FWA, including oral or written warnings or reprimand, suspensions, terminations, financial penalties and potential reporting of the conduct to law enforcement. Policies and Procedures are specific to the duties employees perform in their day to day work in order to achieve compliance with the Medicare program and to avoid FWA. The detailed policies assist the health plan in identifying and addressing risks such as violations of state and federal regulations and to remediate areas of weakness.

Optimum HealthCare's policies, procedures and standards of conduct implement the operation of the compliance program. They include the following components:

1. Commitment to comply with all applicable statutory, regulatory, and other program requirements (such as policies and procedures)

2. Describes the Compliance expectations as embodied in the Standards of Conduct including potential ramifications faced by employees and FDRs for failure to meet the expectations laid out in policies, procedures, and standards of conduct.

3. Implements the operation of the compliance program.

4. Provides guidance and expectation to employees FDRs and others on dealing with Medicare compliance, and Fraud Waste and Abuse issues.

5. Identifies how to communicate compliance issues to the appropriate compliance personnel. This includes the obligation to communicate potential compliance or FWA violations.

6. A description of how potential compliance and FWA issues are investigated and resolved

7. Requirements for non-intimidation and non-retaliation against employees or FDRs 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.

8. Obligation of employees, board members, and FDRs to report program noncompliance to the sponsor, AHCA, CMS, CMS Designee (such as Medic), and or to law enforcement.

9. Process for board members, employees, volunteers, consultants, and P&T committee members to submit a conflict of interest upon hire and at least annually. FDRs are required to obtain these upon hire and at least annually thereafter. FDRs must attest that they have obtained from their board members and employees, volunteers, consultants, and P&T committee conflict of interest at least annually. The process for how to notify appropriate personnel whenever a potential conflict of interest arises is also outlined.

10. Requirements for screening all board members, employees, volunteers, consultants, P&T committee members to be screen against the OIG and GSA exclusions lists upon hire and monthly thereafter. This also includes the process for requiring the FDRs to attest to screening all board members, employees, volunteers, consultants, and members of the P&T committee to be screened upon hire and at least monthly thereafter.

11. Expectations for immediate removal of any excluded persons or entity from any position directly or indirectly related to Federal health care programs. This includes expectations that appropriate correct action will be taken (such as repayment) for items or services paid for by federal funds that were ordered, furnished or prescribed by an excluded provider or entity. All employees, volunteers, board members, consultants, P&T members, and FDRs are required to disclose their exclusions and or that or their employees from participation in Federal health care programs.

Distribution of Standards of Conduct and Policies and Procedures

The Standards of Conduct and policies and procedures are made available to employees and board members at the time of hire, (within 90 days of hire), when the standards are updated, and annually thereafter. The health plan policies and procedures are available on the company intranet at all times. As a condition of employment, Optimum HealthCare's employees are required to certify that they have received, read, and will comply with all written standards of conduct.

Optimum HealthCare requires first tier entities, downstream entities, and related entities to adopt and follow a code of conduct particular to their own organization that reflects a commitment to detecting, preventing and correcting fraud, waste and abuse in the administration or delivery of Part C & D benefits. Optimum HealthCare also shares our Standards of Conduct with First tier entities, downstream entities, and related entities. Optimum HealthCare requires attestation from FDRs that they have obtained written or electronic certification from their employees and as condition of employment/contract, they have received, read, understood and will comply with all written Standards of Conduct.

The health plan's compliance policies and procedures and standards of conduct are made available at the time of initial contracting (within 90 days), upon revision, or annually thereafter. The policies and procedures are available on the company provider and agent portals.

COMPLIANCE OFFICER & COMPLIANCE COMMITTEE & High Level Oversight

Compliance Officer

The Compliance Officer is a full time employee of the health plan, parent organization, or corporate affiliate and charged with overall responsibility for the effectiveness of the Compliance Program and is a member of senior management. The Compliance Officer devotes full time to the compliance program and reports directly to the CEO and is responsible for implementation of the Compliance Program and defines the programs structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all personnel and FDRs. The Compliance Officer must have training and/or work experience in the Medicare Advantage, Medicare Advantage Prescription Drug program with senior management's empowerment and support to establish and operate an effective Compliance Program. At any time, the Compliance Officer may, at his or her discretion, escalate compliance issues directly to the Company's executive management team, compliance committee, or the Board of Directors, the government body of the company, who are accountable for ensuring the Company's compliance goals are met. The Compliance Officer reports at least quarterly to the Board of Directors, the governing body of the plan, on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

The Compliance Officers duties include, but are not limited to, the following:

1. Ensuring a Medicare Compliance report is provided at least quarterly to the Compliance Committee, CEO, and the BOD on the status of program implementation, identification and resolution of potential or actual instances of noncompliance and oversight and audit activities.
2. Interact with operational departments of the company and be involved and aware of the daily business activity of the company.
3. Create, coordinate, or appropriately delegate the educational training program to employees, directors, managers, officers, FDRs and other individuals working with the Medicare Program to ensure knowledge with the Plan, Standards of Conduct, policies and procedures, and applicable statutory and regulatory requirements.
4. Develop and implement methods and programs that encourage managers and employees to report noncompliance and suspected FWA and other misconduct without fear of retaliation.
5. Maintain a reporting mechanism and closely coordinate with the audit team and Special Investigations Unit (SIU).
6. Respond to reports of potential instances of FWA, including coordination of the investigations and development of appropriate corrective or disciplinary actions as necessary, and be flexible to design and coordinate internal investigations.

7. Coordinate personnel issues with the Human Resource Department or appropriate other departments to ensure the HHS OIG exclusion lists and GSA debarment lists have been checked for all employees, officers, directors and FDRs monthly.
8. Maintain documentation of reported potential noncompliance or FWA received from any source or any method which describe the initial report, the investigation and it's results, and any corrective actions or disciplinary actions including dates, names and contact information of all parties involved.
9. Oversee the development and implementation of corrective actions
10. Coordinate potential fraud investigations/referrals with SIU and MEDIC, as appropriate including facilitating documentation and procedural requests with any external agencies or organizations when FWA issues involve multiple parties.

The Compliance Officer has the authority to:

- Interview or delegate the responsibilities to interview relevant individuals regarding compliance issues,
- Review and retain contracts and documents pertinent to the Medicare program,
- Review or delegate the responsibility to review submissions of data to CMS to ensure that it is accurate and in compliance with reporting requirements,
- Independently seek guidance from legal counsel,
- Report misconduct to CMS, its designee, or law enforcement,
- Conduct and direct internal audits and investigations of any FDR.

The Compliance Officer also functions as the organization's Privacy Officer. The regulatory guidelines for designating a Privacy Officer are found at 45 CFR 164.530. The regulatory guidance indicates the roles and responsibilities of the privacy official including the following: training, implementing appropriate administrative, technical and physical safeguards to protect PHI; developing a process for individuals to make complaints; apply appropriate sanctions against members of the workforce; mitigate harmful effects of the use or disclosure of PHI; refrain from intimidating or taking retaliatory action against individuals making complaints; and make provision to change policies and procedures as necessary and appropriate to comply with changes in law.

The Compliance Officer is responsible for carrying out, achieving and maintaining compliance with the Compliance Plan and FWA Prevention Plan. For any compliance, fraud, waste and abuse, or privacy issues, the Compliance Officer may be directly contacted. This is the same person to whom whistleblowers may report suspected or actual incidents of non-compliance and fraud, waste and abuse in confidence without fear of retaliation.

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Optimum HealthCare's Compliance Department provides support to the Compliance Officer in promoting ethical conduct, instilling a company-wide commitment to compliance, and exercising diligence in ensuring the overall Compliance Program requirements are met. For investigation of compliance concerns or fraud, waste and abuse issues, the Compliance Officer may delegate the investigation to the Special Investigations Unit (SIU) and/or the appropriate Compliance associate.

Compliance Committee

Optimum HealthCare's Compliance Committee (the "Committee") is charged with assisting the Board of Directors and senior management in overseeing the Company's compliance program. The Committee is responsible for implementing, maintaining, and revising the Compliance Program, including FWA, under the leadership of the Compliance Officer.

The Committee is responsible for assisting the Compliance Officer in achieving and maintaining compliance throughout the organization.

- The Committee is chaired by the Compliance Officer and reports to the Chief Executive Officer. The Committee is comprised of leadership Associates from key business and operational areas across the enterprise. The Committee also includes Board Members as part of the committee. The Committee meets on a regular basis but no less then quarterly. The Committee also reports at least quarterly to the board of directors on activities and status of the compliance program, including compliance and FWA issues identified, investigated, and resolved by the compliance program. This will ensure the governing body is knowledgeable about the content and operation of the compliance program to exercise reasonable oversight with respect to the implementation and effectiveness of the compliance program.

The specific responsibilities and activities of the Compliance Committee are as follows:

1. *Compliance Programs, Policies and Procedures:* The Committee shall oversee the Company's compliance efforts with respect to relevant Company policies, the Company's Standards of Conduct, and other relevant laws and regulations to ensure they are appropriate and up to date.

2. *Training:* The Committee shall oversee and review and approve the Company's specialized, compliance, and first tier, downstream and related entities ("FDR") training programs and ensure it is effective and appropriately completed.

3. *Risk Assessment, Audits and Monitoring:* The Committee shall assist with the creation, implementation and approve the risk assessment. The Committee shall assist with the

creation and implementation of the auditing and monitoring work plan. The Committee shall oversee all (including delegation) audit and monitoring activities conducted by the internal audit and monitoring area of Compliance. This includes, but is not limited to, review of the number of activities completed, timeliness of closure, review of findings, and requesting additional audit/monitoring activities.

4. *Corrective Action Plans ("CAPs"):* The Committee shall develop innovative ways to implement appropriate corrective and preventative action and oversee the appropriate closure of all internal and external CAPs to ensure corrective action plans are implemented and monitored for effectiveness. The committee shall review and approve CAP's and have the right to request additional CAPs as necessary based on their review.

5. *Reporting Violations:* Ensure there is a confidential and anonymous (if desired) system for employees and FDRs to report potential compliance violations and/or instances of fraud, waste or abuse without fear of retaliation.

6. *Investigations/FWA:* The Committee shall oversee the investigation of, and may also request the investigation of, any suspected instances of noncompliance or FWA consistent with federal or state laws or the Company's Compliance Programs, policies or procedures, that are reported to the Committee.

7. *Enforcement of Standards:* The Committee shall oversee that appropriate disciplinary actions are taken when there is a deviation from required compliance standards.

8. *Transparency and Disclosure:* The Committee shall oversee and regularly review the Company's efforts toward internal/external transparency and disclosure of its business practices to appropriate federal and state regulatory authorities

9. *Proactive Measures:* The Committee shall determine appropriate strategies/approaches to promote compliance within the Company and the detection of any potential violations.

10. *Staffing:* Support the Compliance Officer's needs for sufficient staff and resources to carry out his or her duties.

11. *Internal Controls*: The Committee shall oversee a system of internal controls designated to ensure compliance with regulations in daily operations.

12. *Other Duties:* The Committee shall also carry out such other duties as may be delegated to it by the Company's Board of Directors from time to time.

Governing Body

Optimum HealthCare's governing body, the Board of Directors ("BOD"), is ultimately accountable for overseeing the company Compliance Program and the overall compliance within the organization. The Compliance Program oversight is delegated by the BOD to the Compliance Committee; however, the BOD remains accountable as a whole for the effectiveness of the Compliance Program. The BOD has outlined the scope of delegated functions to the Compliance Committee in the committee charter.

The Compliance Officer will have unrestricted access to the BOD. The full BOD's oversight will be accomplished through reports (including measureable metrics) from the Compliance Officer as evidence the Program is detecting and correcting noncompliance on a timely basis and indicating the program is reducing the risk of noncompliance and FWA at a minimum on a quarterly basis or ad hoc as necessary.

The BOD must receive compliance training and education regarding the structure and operations of the Compliance Program. In order for the BOD to be knowledgeable about the company's compliance risks and strategies, understand measurements of outcome, and gauge the effectiveness of the Compliance Program, the company's Annual Risk Assessment is prepared and approved by the Compliance Officer and Compliance Committee for the full BOD's ultimate approval.

The BOD participation in the development and implementation of the Compliance Program ensures reasonable oversight by the governing body. The BOD responsibilities, or as delegated to a designated committee, include but are not limited to:

1. Approval of the Standards of Conduct and Compliance Policy and Procedures
2. Approval of compliance and FWA training
3. Approval of the Compliance Program structure and operations
4. Development and approval of the risk assessment
5. Review of internal and external audits
6. Approval of corrective action plans resulting from audits
7. Regularly scheduled updates (reporting) from the Compliance Officer
8. Review and approval of performance goals for the Compliance Officer
9. Review and evaluation of the performance of the Compliance Program, at least annually
10. Evaluation of the senior management's commitment to ethics and the Compliance Program

TRAINING AND EDUCATION

Training and education are an important element of Optimum HealthCare's overall Compliance Program. Optimum HealthCare provides effective training and education between the Compliance Officer or designee, and the health plans employees, the Chief Executive Officer and other senior administrators, managers, governing body members, and the health plans first tier, downstream and related entities. Such training and education must occur annually at a minimum 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. Certification of compliance and specialized training is required at least annually.

All employees and board members who have responsibilities or oversight related to the Medicare program are required to have training outlined below upon initial hire and annually thereafter:

Standards of Conduct

This part of the training focuses on ensuring that employees are in compliance with Standards of Conduct and ethical behavior for all Associates and members of the Board of Directors.

Compliance Training

This training reviews the laws and regulations that govern the healthcare industry and guide the company's relations with members, regulators, shareholders, and the communities in which it does business.

HIPAA:

This training provides an overview of the HIPAA laws, CMS Data Use Agreement and the importance of maintaining confidentiality of personal health information (PHI).

FWA:

This training provides an understanding of health care fraud and its effects on all parties. It also explains the differences between fraud, waste, and abuse, outlines basic steps for identifying potentially fraudulent schemes, and provides instruction on how to report suspected incidents of fraud, waste and abuse for investigation.

Specialized Training:

Employees receive specialized training on issues posing compliance risks based on their job function (e.g., pharmacist, statistician, etc.) upon initial hire, when requirements change, or when an employee works in an area previously found to be non-compliant

with program requirements or implicated in past misconduct, and at least annually thereafter as a condition of employment. At Optimum HealthCare, all areas are required to provide this training to their associates. Optimum HealthCare has developed a process to ensure there is oversight of specialized training.

FDRs

Optimum HealthCare requires all FDRS' employees (non-deemed) to receive general compliance, FWA training upon initial hiring/contract and then annually thereafter. 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. The plan monitors those FDRs who do not receive the health plan's FWA training, meet the requirement to be designated deemed. All non-deemed employees of FDRs are required to have FWA training upon hire and at least annually thereafter. FDRs are also required to have specialized compliance, and FWA (including importance of PHI) training related to their Medicare (parts C and or D) responsibilities. FDRs have the option of taking Optimum HealthCare's training or to utilize their own training. If FDRs utilize their own training, they are required to supply their material to Optimum HealthCare for prior approval. Pharmacies are provided training materials from our PBM (Pharmacy Benefit Manager).

Measuring Effectiveness

To ensure our training is effective, Optimum HealthCare requires all areas to measure the effectiveness of the required training through a Post training test, metric review, Quality monitoring or other similar methods.

Training Records

Optimum HealthCare requires all departments including FDRs to keep adequate training records such as attendance logs, materials used, tests, surveys…etc. The compliance department has developed a process to ensure there is oversight to ensure full adherence to regulatory requirements is met in the training.

EFFECTIVE LINES OF COMMUNICATION

A key component of the compliance program is the ability to establish and implement effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the plan's employees, managers and governing body, and the plan'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.

Optimum HealthCare works diligently to foster a culture of compliance throughout the organization, by regularly communicating the importance of performing our jobs in compliance with regulatory requirements, and reinforcing the Company's expectation of ethical and lawful behavior.

The Company has systems in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees (including executive management and Board of Directors), members and FDRs.

To encourage two-way communication, the Compliance Department has developed the below communication strategy:

Compliance Intranet Website

The Compliance Department maintains an intranet website dedicated to educating Associates in key compliance areas related to Medicare lines of business. On the compliance site, associates can find, among other things:

- Compliance Plan
- Fraud Waste and Abuse Plan
- Standards of Conduct
- Training Materials (Compliance, HIPAA, Medicare)
- Compliance Handbook
- Instructions for reporting potential incidents of non-compliance, fraud, waste or abuse
- Links to Medicare compliance-related websites

Newsletters

The Compliance Department publishes and distributes to all employees a Compliance Newsletter. The newsletters are an additional avenue for the Compliance Officer to communicate important changes to regulations and processes. They also provide reminders and helpful tips for employees to perform their responsibilities in a compliant and ethical manner. Compliance newsletters, alerts and other compliance

communications are sent to the entire organization through the Compliance News email distribution and available on the corporate intranet.

In addition, Optimum HealthCare produces Member Newsletters which are distributed to Medicare members. Included in the newsletters are internal and external resources for members to report noncompliance and fraudulent activity, ensuring confidentiality and non-retaliation against those who report such incidences.

Company Wide Communication

The Compliance officer or a designee sends periodic compliance communication out to all staff members. Communication is focused on the importance of compliance, importance of reporting non-compliance or FWA issues, or related to other important compliance news.

Communicating Compliance Concerns

Optimum HealthCare strives to foster an environment where associates and FDRs seek and receive prompt guidance on compliance issues. Whenever an associate questions the compliant or ethical nature of a particular action, the associate is encouraged to seek guidance from any number of sources, including:

- Company policies
- A supervisor or manager
- Compliance Officer or other Compliance Personnel
- Compliance Hotline
- The Legal Department
- Human Resource Area

The plan requires concerns or inquires reported to other departments or supervisors that relate to noncompliance (including FWA) be reported to the compliance department.
Optimum HealthCare Associates or FDRs aware of any violation of Standards of Conduct, or FWA have an obligation to report the violation. Optimum HealthCare does not tolerate retaliation against any employees (including Board of Directors), members or FDRs who make good-faith reports of potential or suspected violations. The following methods are made available to report suspected or confirmed fraud, waste and abuse issues or other compliance concerns as they are identified:

Internal:

- **Compliance Hotline: 1-888-548-0094 (**24 Hours a Day/7 Days a week)
    - The Compliance Hotline is a toll-free resource available to associates and FDRs, and enrollees twenty-four hours a day, seven days a week to report violations of, or raise questions or concerns relating to, compliance, FWA or the Optimum

HealthCare's Standards of Conduct. Calls to the Hotline can be made anonymously and confidentially by employees (including Board of Directors), enrollees and FDRs.

- **Compliance Fax: 1-888-548-0092 (**24 Hours a Day/7 Days a week)
    - Faxes can be sent anonymously and confidentially by employees (including Board of Directors), enrollees and FDRs.
- **Compliance Email: compliancereporting@americas1stchoice.com (**24 Hours a Day/7 Days a week)
- **Compliance Drop Boxes (employees only): secured boxes located within each office** (Business Hours)
    - Drop boxes can be used anonymously and confidentially by employees (including Board of Directors), enrollees, and FDRs.
- **Compliance Post Office Box: P.O. Box 152137, Tampa, FL 33684 (**24 Hours a Day/7 Days a week)
    - PO Box can be used anonymously and confidentially by employees (including Board of Directors) enrollees, and FDRs.

External:

There are many external sites provided by regulators where employees, members, or FDRs can go to report Compliance, FWA and HIPAA issues. Below are a few of the agencies:

- State Attorney General: 1-866-966-7226
- Agency for HealthCare Administration at 1-888-419-3456.
- Dept. of Financial Services, Div. of Insurance Fraud: 1-800-378-8445
- Office of Inspector General at HTTP://OIG.HHS.GOV
- Department for Health and Human Services (DHHS): WWW.HHS.GOV/OCR/HIPAA
- Centers for Medicare and Medicaid Services: WWW.CMS.GOV

The Corporate Compliance Department widely publicizes the methods of reporting Medicare program noncompliance and FWA for FDRs, Employees, and Enrollees through a variety of materials, published at intervals throughout the year, including:

- Member Newsletters
- Provider Manual
- Website (Internet and Intranet)
- Employee Newsletters
- Training Materials for FDRs and Employees

We also require FDRs to widely publish to their employees the method of reporting Medicare program non-compliance and FWA. Through the Member newsletter and website, we instruct enrollees on how to recognize potential FWA.

The Company tracks all reported violations to ensure proper investigation and resolution of reported matters; and to identify patterns and opportunities for additional training or corrective action. All complaints are investigated by the Company's Compliance Officer or her designee. Results of investigations are reported back to the source, when available. The plan initiates investigations stemming from reported inquiries and complaints related to non-compliance within two weeks of receiving the inquiry or complaint. The plan initiates investigations of FWA reports within three days of receipt of report.

ENFORCEMENT OF STANDARDS

As part of the Company's compliance program, Optimum HealthCare's disciplinary policy is widely publicized through compliance training, compliance policies, intranet, Standards of Conduct, and the Employee Handbook. The disciplinary standards are implemented and enforced through policies that encourage good faith participation in the compliance program by all affected individuals, including policies that identify noncompliance or unethical behavior, articulate expectations that require every associate or FDRs to report any issues related to compliance and FWA and assist in their resolution and provide for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined. All Optimum HealthCare disciplinary standards are clear and specific in identifying the consequences for violation of Standards of Conduct. All associates and FDRs are informed that violations of the Standards of Conduct, policies, regulations or laws may result in appropriate disciplinary action, up to and including termination of employment or contract as referenced in the disciplinary policy.

FDRs must also comply with standards Optimum HealthCare has established or demonstrate that they have implemented similar standards of conduct. FDRs are required to take appropriate disciplinary action when noncompliance or unethical behavior is determined.

Any suspected compliance violation is investigated by the Compliance Officer and/or his/her designee. Each action is considered on a case-by-case basis and provide for timely, consistent, and effective standards enforcement of the standards in the event of non-compliance or unethical behavior.

Following an investigation that confirms an individual or FDR has violated one or more of the elements of the Standards of Conduct and/or the organization's compliance program, disciplinary action is undertaken. The Compliance Officer reserves the right to combine or skip levels in the disciplinary process depending upon the facts of each situation and the nature of the compliance violation. Some actions or compliance violations may subject an employee or FDR to immediate suspension or termination of employment or contract.

MONITORING AND AUDITS

Monitoring and auditing are critical elements in Optimum HealthCare's Compliance Program. The plan has established and implemented an effective system for routine monitoring and identification of compliance risks. This includes internal monitoring and audits, as appropriate, external audits, to evaluate the plans, including first tier, downstream and related entities' compliance with CMS requirements and the overall effectiveness of the compliance program.

Internal monitoring and auditing test for our organization's as well as FDRs compliance with Medicare regulations, FWA (including counties designated as high risk) sub-regulatory guidance, contractual agreements, applicable federal/state laws, and internal policies and procedures and standards of conduct. Optimum HealthCare has developed a monitoring and auditing work plan that addresses the risks associated with the Part C and D benefit for both the organization and FDRs.

The monitoring and auditing work plans are developed and prioritized based on a risk assessment that analyzes Optimum HealthCare's as well as FDR's part C and D operations. The risk assessment is conducted at least annually. The risk assessment evaluates the risk of non-compliance with Medicare Parts C and D requirements as and applicable Federal and State laws. The risk assessment also evaluates the risk for FWA. The risk assessment is based on many factors such as: executive feedback, self-reporting, internal/external audits, readiness assessment, FWA (including counties designated as high risk), OIG/CMS risk areas, corrective action plans, new guidance, and Star Reports.

The work plan includes information regarding all the components and activities needed to perform monitoring and auditing, such as:

1. Internal Audit Department Requirements,
2. Audit Schedule and Methodology, and
3. Types of Auditing.
4. Responsible Internal Audit Staff Member
5. Start and Completion Date
6. Whether or not it will be a desk audit or an on-site audit

Following the established work plan, the Compliance department conducts monitoring and auditing activities throughout the year such as desk type audits, on-site audits, etc.

Internal audit area within the compliance department is devoted solely to the auditing function. All personnel are required to be completely independent and objective. All audit personnel also have access to relevant FDRs, staff, information, records, and areas of operation under review so that they can adequately perform the audits. Audits of FDRs and internal areas test for Fraud Waste and Abuse (FWA) and compliance with regulatory requirements. Audits are conducted by personnel with expertise in the area under review. If expertise doesn't exist within compliance, the audit is conducted in conjunction with outside subject matter experts

(Physicians, nurses, pharmacist…etc). Optimum HealthCare also at times may employ an outside vendor to conduct audits. Each audit performed by the Compliance department will identify the objectives, scope, methodology, findings (condition, cause, criteria, and effect), recommendations, corrective action plans, and follow-up to ensure identified problems are resolved. Any deficiencies identified by the Compliance department resulting in a corrective action plan of a respective area(s) or FDR, will be tracked and monitored until the deficiency is cured and actions are in place to prevent re-occurrence.

Optimum HealthCare has a system of ongoing monitoring that is reflective of its size, organization and resources and is coordinated, overseen or executed by the Compliance Officer to assess performance in, at a minimum, areas identified as being at risk. The monitoring system includes Compliance Officer receiving regular reports of performance, documentation review, and updates on peripheral issues such as systems, staffing, metrics, etc. Results of dashboards, scorecards or other measurements are tied to staff, management, and executive compensation. FDR are also monitored based on dashboards, scorecards and other types of measurement. FDR compensation is tied to them meeting performance standards with plan and regulatory requirements. In order to avoid overutilization of prescription medication, as typically seen in fraudulent drug seeking behavior and diversion, we required the use of point of sale safety edits to prevent the payment of redundant prescriptions.

Compliance Measurement

In addition, the effectiveness of the compliance area is measured at least annually. This measurement is generally done by an independent body. This evaluation is reported to the CEO, Compliance Committee, and the Board of Directors. The Compliance area uses dashboards, scorecards, and other mechanism to measure the compliance program. These measurements are reviewed continuously and presented to the CEO, Compliance Committee and the Board of Directors at least quarterly. Operational leaders are also required to utilize dashboards, score cards, and other mechanism to monitor their own area. These results are shared with staff on an individual or group level depending on the type of metric.

The Compliance officer or designated staff maintains a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, and provides updates on the monitoring and auditing results and corrective action to the CEO, compliance committee and Board of Directors on at least a quarterly basis. When appropriate, Optimum HealthCare informs CMS, the MEDIC or law enforcement of aberrant findings.

Auditing by Federal Agencies or External Parties

Optimum HealthCare views regulatory audits and reviews as an opportunity to confirm our ongoing compliance efforts are effective and successful. In cases where an audit outcome indicates we have not met a regulatory requirement, Optimum HealthCare uses the audit findings to perform root cause analysis and develop corrective action plans to address identified areas of

non-compliance. Optimum HealthCare may also contract with external companies to perform compliance related reviews and assist with programmatic changes to help drive the organization's compliance.

Optimum HealthCare cooperates with federal agencies or eternal parties when audits are conducted and provides auditors access to information and records related to Optimum HealthCare's business processes and those of Optimum HealthCare's FDRs.

ENSURING PROMPT RESPONSE & DEVELOPMENT OF CORRECTIVE ACTIONS

Optimum HealthCare has established and implemented procedures and a system for promptly responding to compliance and FWA issues as they are raised, investigating potential compliance self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

Optimum HealthCare may identify the incident of non-compliance through a variety of sources, such as self-reporting channels, CMS audits, AHCA audits, internal monitoring, internal audits, FDR audit, hotline calls, external audits or member complaints. Whenever Optimum HealthCare identifies an incident of misconduct, non-compliance or fraud, waste or abuse, the Compliance Officer or designated staff takes prompt action to investigate the matter, determine root cause and outline effective corrective action.

If the plan discovers evidence of misconduct related to payment or delivery of items or services under the contract, the Compliance Officer will conduct a timely, reasonable inquiry into that conduct.

Optimum HealthCare initiates investigation into evidence of misconduct related to payment or delivery of items or services within three business days of its discovery. These are identified as Fraud Waste and Abuse cases.

All research, inquiries, and other investigative activities are kept within the smallest number of individuals in order to ensure confidentiality whenever feasible. Factual information is assembled, interviews conducted and recorded, and written responses obtained in order to ensure that the inquiry remains objective. Upon completing the inquiry, the Compliance Officer and/or his/her designee will complete a written summary of the findings.

The organization corrects compliance and FWA problems promptly after they are identified. In the case of compliance violations which have been clearly demonstrated to be founded and supported by evidence, the Compliance Officer or appropriate designee will prepare a corrective action plan (CAP). The CAP will be appropriate (i.e. repayment of overpayments, disciplinary actions against responsible employee and FDRs) in response to the violation.

Optimum HealthCare has developed a process to voluntarily self-report to CMS, AHCA, or its designee (such as Medic) significant program violations and potential FWA or misconduct.

FRAUD, WASTE AND ABUSE (FWA) PREVENTION

The Optimum HealthCare FWA Prevention is a subset of the overall Compliance Program at Optimum HealthCare. Elements of FWA prevention activities are integrated into each of the seven elements of an effective compliance program. Please refer to each of the sections outlined below for details on how Optimum HealthCare prevents fraud waste and abuse:

- Written Policies and Procedures and Standards of Conduct
- Compliance Officer and Compliance Committee
- Training and Education
- Effective Lines of Communication
- Enforcement of Standards through well publicized disciplinary guidelines
- Monitoring and Auditing
- Prompt Responses to Detected Offenses and Corrective Action Procedures

Fraud Waste and Abuse definitions, examples, important laws, and the SIU area are highlighted below.

What is Fraud, Waste, and Abuse?

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste: An overutilization of services or improper billing practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather through the misuse of resources.

Abuse: Gross negligence or reckless disregard for the truth in a manner that could result in an unauthorized benefit and unnecessary costs either directly or indirectly.

Definitions and examples of fraudulent activities are cited below.

Health Plan Fraud

Fraud committed by the health plan is defined as acts committed through deception, misrepresentation or concealment by the health plan's employees as directed by leadership of the health plan. Such acts can include but are not limited to:

- Failure to provide medically necessary services
- Marketing schemes
- Improper bid submissions
- Payments for excluded drugs
- Multiple billing
- Inappropriate formulary decisions
- Inappropriate enrollment/disenrollment
- False information
- Inaccurate data submission

Fraud by Agents/Brokers

Fraud committed by agents/brokers is defined as deception, misrepresentation or concealment by a licensed representative to obtain something of value for which he/she would not otherwise be entitled. Some examples of agent/broker fraud can include but are not limited to:

- Helping individuals fill out their enrollment information so they will be eligible for insurance
- Enrolling a group of individuals to form a nonexistent company
- Falsifying location of a group to gain insurance or obtain lower premium rates
- Adding false individuals to the group to avoid being medically underwritten
- False advertising

Fraud Due to Misrepresentation of Enrollment Information

Fraud due to misrepresentation of enrollment information is defined as commission of an act of deception, misrepresentation or concealment, or allowing it to be done by someone else, to obtain coverage for which one would not otherwise be entitled. Examples of eligibility fraud can include but are not limited to: Members not meeting the eligibility requirements (e.g., not working the required number of hours, not receiving a wage) Not disclosing medical conditions on an application.

Claims Fraud

Examples for Claims Fraud can include but are not limited to:

- Provider is not in the insured's geographic region
- Member is in a different state than the company and no group affiliations exist for that state
- Large bills incurred just prior to term date or immediately after effective date
- Inconsistencies in company information versus medical records.

Provider Fraud

Provider fraud is defined as "the devising of any scheme by any provider of health care or services to defraud for the purpose of personal or financial gain by means of false or fraudulent pretenses, representations, or promises." Examples of provider fraud can include but are not limited to:

- Billing for services not rendered
- Providing "free" services and billing the insurance company
- Nonqualified practitioners billing as qualified practitioners
- Providers being rewarded for writing prescriptions for drugs or products
- Billing for non-covered services using an incorrect code (American Medical Association (AMA) Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and/or diagnosis codes) to have the services covered.

Pharmacy Fraud

Examples of pharmacy fraud can include but are not limited to:

- Filling less than the prescribed quantity of a drug
- Billing for brand when generic drugs are dispensed
- Billing multiple payors for the same prescriptions
- Dispensing expired or adulterated prescription drugs
- Forging or altering prescriptions
- Refilling prescriptions in error.

Examples of pharmacy benefit management fraud can include but are not limited to:

- Prescription drug switching
- Unlawful remuneration
- Prescription drug shorting
- Failure to offer negotiated prices.

Member Fraud

Member fraud is defined as the commission of acts of deception, misrepresentation or concealment by any policyholder or group of policyholders in order to obtain something of value to which they would not otherwise be entitled. Examples of member fraud can include but are not limited to:

- Alteration of bills
- Submission of false claims
- Applying for insurance when you know you are not eligible
- Reselling drugs on the black market
- Doctor shopping
- Identity theft
- Forging or altering prescriptions
- Prescription stockpiling

- Improper coordination of benefits
- Failure to disclose information on applications, accident inquiries, continuation of benefits (COB) and full-time student information requests, etc.

Important Federal Laws:

There are a number of laws that address health care fraud. These laws define fraud and establish the framework for the prosecution of criminal acts and the initiation of civil suits by injured parties. Listed below are a few of the laws that address health care fraud:

Federal False Claims Act (FCA) – 31 U.S.C. Title 1347

The False Claims Act addresses any person or entity that does any of the following:

- Knowingly presents, or causes to be presented, to an employee of the United States government a false or fraudulent claim for payment or approval
- Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid
- Knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money to the government
- Has actual knowledge of the information
- Acts in deliberate ignorance of the truth or falsity of the information
- Acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

The False Claims Act imposes two sorts of liability:

- The submitter of the false claim or statement is liable for a civil penalty, regardless of whether the submission of a claim actually causes the government any damages and even if the claim is rejected

- The submitter of the claim is liable for damages that the government sustains because of the submission of the false claim.

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment by the government, are liable for three times the government's damages plus civil penalties of $5,000 to $10,000 per false claim.

Whistleblower (Qui Tam) Protection – 31 United States Code Service (USC) 3730 (h)

The whistleblower provision protects employees who assist the federal government in investigation and prosecution of violations of the False Claims Act. Whistleblower protections apply only to actions taken in furtherance of a viable False Claims Act case, which has been, or is about to be, filed. The provision prevents retaliation against employees such as firing them for assisting in the investigation and prosecution. If any retaliation does occur, the employee has a right to obtain legal counsel to defend the actions taken.

Physician Self-Referral Prohibition Statute commonly referred to as the "Stark Law" 1877 of the Social Security Act (42 USC 1395)

This statute prohibits physicians from referring Medicare patients for certain designated health services (DHS) to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a DHS furnished as a result of a prohibited referral.

Anti-Kickback Statute Section 1128(b) of the Social Security Act (42 USC 1320a-7b (b))

The federal anti-kickback laws that apply to Medicare prohibit health care professionals, entities and vendors from knowingly offering, paying, soliciting or receiving remuneration of any kind to induce the referral of business under a federal program. In addition, most states have laws that prohibit kickbacks and rebates. Remuneration under the federal anti-kickback statute includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Violators are subject to criminal sanctions such as imprisonment, as well as high fines, exclusion from Medicare and Medicaid, very costly civil penalties and possible prosecution under many similar state laws. The anti-kickback law is extremely broad and covers a wider range of activities than just traditional kickbacks. Federal regulations include safe harbors that protect certain technically prohibited activities from prosecution.

Antitrust Laws

State and federal antitrust laws prohibit monopolistic conduct and agreements that restrain trade. Optimum HealthCare is committed to competition and consumer choice in the marketplace. All health care professionals, entities and vendors must adhere to the antitrust laws and must avoid any agreements or understandings with competitors on price, customers, markets or other terms of dealing and avoid trade practices that unfairly or unreasonably restrain competition in dealings with providers or customers.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA was enacted to improve the efficiency and effectiveness of health information systems by establishing standards and requirements for the electronic transmission of certain health information. Regulations established standards for certain electronic transactions, along with minimum privacy and security requirements for individually identifiable health information that is held by covered entities. The protection of individual information may decrease chances of misuse of the information involving fraudulent activities. In addition, these measures may decrease the risk of identity theft.

SIU

Optimum HealthCare has established a Special Investigations Unit (SIU) to identify, investigate and resolve instances of fraud, waste and abuse committed by internal and external sources. These sources include providers, facilities, vendors, FDRs, employees, consulting partners, and members. Optimum's SIU resides within the Compliance department and works in conjunction with the Compliance Officer to defend against criminal behavior, unethical conduct, instances of false claims and improper billing and coding practices, and other schemes that adversely impact the safety of our members and the quality of health care services delivered.

SIU is responsible for the following:

- Reducing or eliminating Parts C and D benefit costs due to FWA;
- Ensuring proper value of Parts C and D benefits, including correct pricing, quantity, and quality;
- Utilizing real-time systems that ensure accurate eligibility, benefits, services, refills, and pricing and that identify potential adverse drug interactions and quality of care issues;
- Reducing or eliminating fraudulent or abusive claims paid for with federal dollars;
- Preventing illegal activities;
- Identifying members with drug addiction problems and other overutilization issues;

- Identifying and recommending providers for exclusion, including those who have defrauded or abused the system;
- Referring potential cases of illegal drug activity, including drug diversion, to the NBI MEDIC and/or law enforcement and conducting case development and support activities for NBI MEDIC and law enforcement investigations;
- Assisting law enforcement by providing information needed to develop successful prosecutions; and
- Providing fraud awareness training to the employees of the Sponsor. SIU works closely with the compliance trainer to achieve this objective.

The plan's compliance area and the SIU work with multiple departments to ensure all employees have been trained on identifying and reporting FWA cases as well as ensuring control mechanisms are in place to prevent Fraud, Waste and Abuse.

Below are a few examples of control points in some of the departments:

PBM

The Compliance area works with the Plan's PBM to provide ongoing oversight of the Part D FWA prevention program.

The Plan's PBM utilizesa Vendor to review claim activity and to conduct onsite pharmacy audits. The Vendors are known in the industry and have been conducting pharmacy audits for over 15 years.

They utilize software which is a combination of relational database technology, predictive modeling and highly developed algorithms to review claims and is designed to:

-Audit Claims.
-Deter, identify and refer fraudulent claims submission.
-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 either a desktop or onsite audits, audit activity reports are provided for each customer.

Vendor selects pharmacies for onsite audits and inspects prescriptions monthly as a part of the comprehensive site reviews process.

- **Desk Top Audits**

The audit department at the PBM conducts a complete analysis of pharmacy provider prescription claims. It utilizes 100% of the claims that process through the central Claims system.

Data is analyzed and reviewed using approximately 90 edits to find patterns, anomalies, errors, and potentially fraudulent activity that are designed to detect Medication Waste.

- **Onsite Audits**

The On-Site Audit program is a general overview and examination of the pharmacy's practices, procedures and general facility. Performed by pharmacy professionals, On-Site audits are designed to enhance program compliance and provide a sentinel effect to deter fraudulent or deviant behavior.

The onsite audit is also used to capture credentialing information. On-Site auditors will note items such as counseling availability, hours of operation, languages spoken by the staff and other special services provided, wholesalers used, and other quality-related items.

The On-Site Review program provides overpayment and fraud activity review. The program utilizes a suite of edits to automatically select, rank and score pharmacies across over 50 distinct criteria. The use of predictive modeling techniques as well as a proprietary 'fraud formulary' help identify not only individual stores for review, but specific prescriptions that may be worthy of actual inspection.

- **Selection**

The PBM generates various summary reports to statistically identify pharmacies deviating from the normal plan percentages. Through these specialized reports, which are incorporated into a proprietary ranking report card, the PBM selects a number of pharmacies to conduct on-site reviews. This selection process increases the odds of detecting fraudulent activity. Additional pharmacies may be selected as a result of State or client referral, patient complaints, physician complaints and or peer complaints.

- **Preparation & Visit**

Prior to visiting a pharmacy for an onsite audit, the PBM or its designee schedules appointments with the Pharmacy Manager/Owner, and in some instances, make arrangements through the corporate offices of chains in order to have a Regional or District Manager or other assistant available at the time of the audit. In preparing for the review, targeted prescriptions and patient records are selected prior to arrival for audit at the pharmacy. During all on-site visits, auditors collect information on store hours, patient counseling, clinical references, and other 'credentialing-type' information. The claims that are selected for audit are scanned into a laptop based program and stored securely.

Fraud Waste & Abuse Criteria and Variables

Multiple variables and criteria are used to identify claims to be audited.

- -high dollar claims
- -unusual/high quantities
- -unusual day's supply
- -excessive claims for controlled substances
- -brand use percent
- -controlled substance dispensing or prescribing percent
- -excessive rejections
- -high dollar or prescription volume for pharmacies or physicians
- –unusual package size items
- –less frequently billed items
- –items requiring special and/or restricted protocols
- –duplicate (double) billings
- –early refills
- –refills outside of State or Federal allowances (high number of refills)
- -excessive refills
- –incorrect quantity for days' supply
- –insulin and supply billing
- –high DAW percent
- –use of terminated NDC's
- -billing incorrect package sizes
- -physicians billing outside specialty
- -failure of physician ID validation for CII Drugs
- -high member Utilization
- -high compound percent
- -high $ compound claims
- -appearance of split billing to increase fees or bypass early refill edits
- -high percent of PA overrides
- -billing during periods when the pharmacy is closed, after hours or holidays
- -excessive reversal rates
- -high cost injectables
- -refill patterns
- -DUR interactions
- -invalid or terminated DEA, license numbers
- -infusion medications per member

Additional variables are reviewed when examining hard copy prescriptions-

- - completeness of prescription
- - member and physician information
- - medication descriptions
- - directions for use
- - refill directions
- - DAW information

- notes (PA, additional refill information etc.)

Sales/Marketing

The Compliance area works closely with our Sales/Marketing area to prevent FWA.

- All agents are trained by the Plan's Compliance Department or by using Compliance Department approved training material
- Only CMS approved marketing materials are used
- Audit of Agents' files to verify licensure and OIG/DFS blacklist
- Random check of actual marketing material
- "Ride Along" on sales calls
- Surprise/secret visits to seminar presentations
- Rapid disenrollment rate and cancellation rate analysis
- Member complaints on agents received from member services call logs, CMS complaint tracking module, grievance department logs and state agency referred cases.

Claims

The plan has proactively added in edits into our claims system to ensure FWA is prevented and detected.
Below are the edits inputted into the system:

- Invalid Diagnosis codes
- Invalid procedure codes
- CPT/Place of service miss-match
- Invalid CPT/modifier combination
- Excessive/Invalid units
- Incorrect bill types
- Duplicate services
- 3 day/1 day payment window

The claims area refers to SIU any cases where member contacts the plan advising care was not received. Medical records are also referred to SIU for providers that are flagged for possible fraudulent behavior.

Health Services

The plan's Health Services department may identify scenarios during authorization and utilization reviews indicating potential FWA

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- Prior authorization process – some of the services susceptible to fraud, waste and abuse may be identified through the prior authorization process. The process requires review of medical record documentation to support the need for the requested services. During this process, other authorizations are reviewed for consistency and could determine a pattern of fraudulent activity on occasion.

- Utilization management – this process involves the review of provider utilization of resources, especially in the area of over utilization identifying outliers of plan wide metrics.

Health Services refers to SIU any cases where FWA may be identified.

Enrollment

The Enrollment department refers suspicious enrollments to the SIU for investigation.