

South Country Health Alliance

Families & Children	<input checked="" type="checkbox"/>
MSC Plus	<input checked="" type="checkbox"/>
Senior Care Complete	<input checked="" type="checkbox"/>
AbilityCare	<input checked="" type="checkbox"/>
MnCare	<input checked="" type="checkbox"/>

Policy & Procedure

Policy Name	Fraud and Abuse Plan and Policy
Policy Number	AD 05
Regulatory Requirement(s)	DHS Managed Care Contract, Article 9 18 U.S.C. § 874; 31 U.S.C. § 3801, et. seq. False Claims Act - 31 U.S.C. §§ 3729 – 3733 Fraud Enforcement & Recovery Act of 2009, Pub.L. 111-21, 123 Stat. 1617; 42 C.F.R. § 438.604; 42 C.F.R. § 455.1(a)(2); 42 C.F.R. § 455.15(b); 42 C.F.R. § 455.106 42 C.F.R. §1001.1001; 42 C.F.R. § 1001.1901 42 C.F.R. § 1002.3(b) Social Security Act of 1935, §§1128, 1128A, 1902(a)(68)(A) US Sentencing Guidelines – USSG § 8B2.1 Minn. Stat. § 363A.36
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Responsible Position	Compliance Officer
Cross Reference(s)	AD 01, AD 06, AD 12-13, AD 15, AD 18, AD 21, AD 25, AD 28

Policy

All employees, agents or entities performing services on behalf of SCHHA must comply with fraud and abuse prevention and detection requirements.

Definitions

Abuse: the definition as set out in Minnesota Rules, Part 9505.2165, sub. 2. Abuse also includes substantial failure to provide medically necessary items and services that are required to be provided to an enrollee if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the enrollee.

Fraud: the definition as set out in Minnesota Rules, Part 9505.2165, subpart 4, as follows:

- (A) Acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes, including the following:

- a. Theft in violation of Minnesota Statute, section 609.52;
 - b. Perjury in violation of Minnesota Statute, section 609.48;
 - c. Aggravated forgery and forgery in violation of Minnesota Statute, sections 609.625 and 609.63;
 - d. Medical assistance fraud in violation of Minnesota Statute, section 609.466; and
 - e. Financial transaction card fraud in violation of Minnesota Statute, section 609.821
- (B) Making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status; and
- (C) A felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952.

Improper Payment: means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes, but is not limited to: 1) any payment for an ineligible recipient; 2) any duplicate payment; 3) any payment for services not received; 4) any payment incorrectly denied; and 5) any payment that does not account for credits or applicable discounts.

Medically Necessary or Medical Necessity: a health service that is, pursuant to Minnesota Rules, Part 9505.0175, sub (25):

- 1) Consistent with the Enrollee's diagnosis or condition;
- 2) Is recognized as the prevailing standard or current practice by the Provider's peer group; and
- 3) Is rendered:
 - (A) In response to a life threatening condition or pain; or
 - (B) To treat an injury, illness or infection; or
 - (C) To care for the mother and child through the maternity period; or
 - (D) To achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or
 - (E) As a preventative health service defined under Minnesota Rules, part 9505.0355.

Standards

- 1. SCHA will have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against Fraud, Abuse and Improper Payments.
- 2. SCHA will document all activities and corrective actions taken under the integrity program.

3. SCHA will inform the Minnesota Department of Human Services (DHS) and other applicable regulatory agencies of the names of our integrity program officials.
4. SCHA will send a report annually to DHS by August 31st, detailing the integrity program and include investigative activity, corrective actions, fraud and abuse prevention efforts, and results consistent with DHS guidelines.
5. SCHA will report to DHS, CMS and/or the OIG credible information of violations of the law by regulatory agencies, SCHA, participating providers, subcontractors or enrollees for a determination of whether criminal, civil or administrative action may be appropriate.
 - a. If SCHA has reason to believe that an enrollee has defrauded a program, SCHA will refer the case to an appropriate law enforcement agency.
6. SCHA will report quarterly to applicable regulatory agencies the name, specialty and address of each provider whose participation status SCHA has taken action to terminate or not to renew during the previous quarter.
7. SCHA will appropriately handle fraud and abuse by SCHA and/or SCHA subcontractors and/or participating providers.
8. SCHA will appropriately handle fraud and abuse by SCHA recipients.
9. SCHA will appropriately handle fraud and abuse by PCA Providers.
10. SCHA will disseminate written policies and procedures for employees, contractors, and agents, as required, that include detailed information pertaining to the Fraud Enforcement & Recovery Act of 2009, the False Claims Act and other provisions of § 1902 of the Social Security Act.
11. As a condition for receiving payment, SCHA will certify its data and documents that are relied upon by regulatory agencies in determining payments made to SCHA.
12. SCHA will implement programs to monitor excluded individuals and entities pursuant to OIG guidance, 42 CFR § 1001.1901, and the Social Security Act.

Procedure

1. SCHA's integrity program requirements will include:
 - a. Administrative and management procedures, including a compliance plan designed to guard against fraud, abuse and improper payments.

- b. Written policies, procedures and standards of conduct that articulate a commitment to comply with all applicable federal and state standards.
- c. Designated Compliance Officer and a Compliance Committee (CC) accountable to senior management within the organization.
 - i. The Compliance Officer will manage ongoing fraud and abuse detection and prevention activities and is responsible for the education and training of SCHA employees and agents.
 - ii. As needed, the CC will advise the Compliance Officer and assist in fraud and abuse detection and prevention activities.
- d. Effective training and education for the compliance officer and SCHA employees:
 - i. New employee and annual compliance training and education that is required for all employees and agents. SCHA will maintain records of training and education of employees and agents and will report results regularly to the CEO and CC.
- e. Maintaining open and effective lines of communication between the Compliance department and employees concerning the reporting of fraud and abuse issues or incidents.
 - i. Any employee who makes a good faith report of a known or suspected instance of wrongdoing will not be subject to disciplinary action or punished for making the report. SCHA also has an absolute policy against retaliation for bringing forward a good faith concern. Reports may be made in writing, in person, via telephone, or by mail or e-mail. Reports may also be made through the REPORT IT hotline, and may remain anonymous.
- f. Enforcement of standards through well-publicized disciplinary guidelines:
 - i. Guidelines are published in such media as the employee handbook, new employee orientation, Code of Conduct, policies and training.
- g. Maintaining procedures for internal monitoring and auditing, including monitoring and auditing of subcontracted services to detect fraud, abuse and improper payments.
 - i. South Country has reviewed integrity programs, fraud and abuse programs, and policies and procedures at these facilities that provide third party administrator services to ensure the programs meet South Country expectations, as well as state and federal requirements.

- ii. South Country also performs pre-delegation or annual delegation audits as applicable for these contracted organizations. Specific audit tools are designed to assess compliance with fraud, waste and abuse, confidentiality and HIPAA standards, as well as other delegated responsibilities.
 - iii. South Country receives regular performance and service reports from selected delegates that measure operational functions such as grievance and appeals, utilization management decisions, claims payment timeliness and accuracy, customer service, and other reports that measure activities with regulatory implications.
 - iv. South Country's compliance department also monitors all vendor and TPA contracts and amendments to ensure that contract content and language complies with applicable NCQA standards and reflects current DHS, CMS and MDH requirements.
- h. Maintaining procedures for prompt response in detecting offenses, and for the development of corrective action initiatives.
- i. South Country's Code of Conduct and associated policies and procedures reflect applicable DHS contract requirements for detection, resolution and reporting of offenses. Policies require prompt resolution of compliance issues and specify corrective actions that could include training, policy revisions, operational changes and discipline.
- i. Maintaining procedures for profiling provider services and enrollee utilization that identifies aberrant behavior and/or outliers.
- i. Claims data and certain utilization reports are reviewed to identify trends in costs and other possible abnormalities. This information is also used to identify enrollees who may need case management or restriction.
 - ii. A variety of pre-payment reviews are utilized to detect potential fraud, waste or abuse prior to claims payment including:
 - 1. Review of claims over \$9,000;
 - 2. Review of claims submitted for services rendered without required prior authorization;
 - 3. Review of member eligibility/entitlement, other insurance coverage, excluded services, and possible submission of duplicate claims; and
 - 4. Pre-payment review edits – procedure to procedure, procedure to provider, procedure to gender, frequency to time, diagnosis to procedure, procedure to provider certification and others.

- iii. A variety of retrospective reviews are also utilized to detect potential fraud, waste or abuse including:
 - 1. Data analysis, including both random and focused audits;
 - 2. Complaints from members, employees and others;
 - 3. Third party review of claims and billing practices; and
 - 4. Post-payment review edits – procedure to procedure, procedure to provider, procedure to gender, frequency to time, diagnosis to procedure, procedure to provider certification and others.
- iv. South Country also contracts with MMSI to provide additional fraud, waste and abuse services in an effort to ramp up efforts to detect, coordinate, investigate, report and deter fraud, waste and abuse among our providers. Services include, but are not limited to:
 - 1. Provider, specialty and red flag reporting
 - 2. Trend reporting
 - 3. State and federal level reporting
 - 4. Monitor suspect providers and triage for review and further investigation
 - 5. Provide billing and payment education to providers as appropriate
 - 6. Conduct prepayment and retrospective report reviews
 - 7. Other services as appropriate, as needed
- j. Maintaining policies and procedures that safeguard against unnecessary or inappropriate use of services and against excess payments for services.
 - i. South Country’s delegates employ a wide variety of procedures to address over- and under-utilization and overpayments. The Utilization Management Committee reviews case management and utilization reports on a quarterly basis, monitors trends, and recommends action for areas of concern. Delegates’ claims payment processes are audited to ensure that claims are not paid for unnecessary or inappropriate services.
 - ii. South Country and its delegates also identify persons for possible restriction in the Restricted Recipient Program (RRP) in an effort to make sure members are receiving services appropriately.
 - iii. Additionally, South Country, county, and TPA customer service staff are trained to identify and report members’ communication that may be related to provider services that were felt to be inappropriate or inadequate.
- k. Maintaining policies and procedures that safeguard against failure by subcontractors or Participating Providers to render medically necessary items or

services that are required to be provided to an Enrollee covered under SCHA contracts.

- i. South Country's delegates conduct delegation oversight audits of carved-out entities and care systems, including those relationships where they delegate utilization management responsibilities.
 - ii. South Country performs prior authorization reviews for the determination of medical necessity. The appeals and grievances department also monitors this area. South Country monitors coverage criteria that delegated entities (MMSI) use to make sure the service requested meets medical necessity.
 - iii. South Country's case management professionals ensure that members receive services for which they are eligible through delegated entities and counties. South Country also works with the state ombudsman to ensure that members receive benefits covered under their benefit plan.
 - l. Maintaining provisions for identifying, investigating, and taking corrective action against fraudulent and abusive practices by providers, subcontractors, and enrollees, MCO employees, officers and agents.
 - i. South Country has established internal controls to ensure that potential fraudulent and abusive practices are identified and investigated in a timely manner. The CEO and CFO approve all payments made by South Country. The controller and an outside CPA firm regularly review revenues and expenses and watch for trends in each area. The Compliance Officer monitors South Country executives and Board members for potential conflicts of interest and any ownership or control interests that appear suspect.
 - ii. South Country and MMSI together have developed a fraud, waste and abuse workgroup where specific staff meet regularly to discuss fraudulent, wasteful and abusive activities and issues. This work group reviews and discusses new regulations and how best to meet industry standards.
 - iii. South Country and MMSI staff maintain awareness of current efforts in the state to reduce fraud, waste, and abuse. The Compliance Officer and designated MMSI SIU staff participate in the Minnesota Healthcare Fraud Taskforce quarterly meetings.
 - m. Maintaining a method to verify whether services paid for by SCHA were actually furnished to the Enrollee as required in 42 CFR 455.1(a)(2).
 - i. Chart Reviews/Risk Adjustment - South Country's provider education, coding manager and coding staff complete random chart reviews, based on

claims data, verifying whether services furnished to an enrollee were actually provided. The chart reviews are conducted onsite at facility locations or the records are requested and reviewed at South Country. If there are services in question, the medical records and claim information will be reviewed by another reviewer. After the second review, if there are still services in question, the information will be provided to the Compliance Department for further action.

- ii. HEDIS – During the HEDIS data collection process, medical record abstraction is completed for members who meet the specific measure criteria. The record location is identified from a claim received for a provider/clinic that a service was provided. When the abstractor finds no information on this member: “member was never seen at this office, member not in the office computer”, this information is placed in a report reviewed by the SCHA’s HEDIS Coordinator. All verification reports are monitored and trended by provider and service to identify possible trends in provider fraud or abuse. Internal analysis will be completed to identify that a claim really was received and not a data error; or verify that the provider did provide the service but sees patients at several locations and SCHA may not have identified the correct location. The member may be contacted to confirm receipt and location of the service.
- iii. Durable Medical Equipment – A report from IT of any DME item greater than \$1000.00 will be run, and will be routed to the UM Coordinator on a monthly basis. UM Coordinator will contact IT if report not received by 15th of the month. UM Coordinator will review claim and dollar amount, and will contact County CC, Connector or internal staff. Depending on the Medicare/Medicaid product the member is enrolled in, Care Coordinators, County connectors or SCHA staff will verify that the member received the item(s). If there is an incorrect item or inferior item. Provider Relations will be contacted to clarify and solve issue with Provider. If the item does not work for the member at the Care Coordination County meeting, the problem will be discussed and an alternative plan developed. If the member received the item, but no longer has it, a report will be filed for potential fraud and abuse. If the member never received the item, Connector/SCHA Staff or Care Coordinator will report to SCHA via CCM or by telephone, and Provider relations will contact vendor to follow up on item. If provider states item was delivered, it will be investigated and a fraud and abuse report will be sent depending on outcome.
- iv. Transportation – IT will produce a report that matches the transportation date of service with a medical/dental/chiropractic appointment on a quarterly basis. Reports will be sorted by vendor. A random review of claims will be done (one out of every ten). If more than three of ten are unmatched, Provider Relations will contact vendor and an audit of their

services will occur. A report of findings will go to the compliance Committee for recommended action. For a pattern of issues with a transportation vendor, a report for possible fraud or abuse will be sent.

- v. Chiropractic – Clinical Resource Group (CRG) will audit claims on a quarterly basis to verify that services paid by CRG were actually furnished to employees. A random list of enrollees with claims within the last 30 days will be generated monthly and contacted by phone to verify that the most current date of service was provided. A monthly summary will be included in the Quality Report to SCHA.
- vi. Pharmaceutical – Pharmacy Audit has several processes in place which are used to verify the validity of prescription claims. Prime’s contracts with participating pharmacies require that a signature log is maintained to document the member’s receipt of the prescription drug. Prime’s Provider Manual, which is an addendum to the pharmacy’s contract, requires participating pharmacies to reverse prescriptions and return them to stock if the patient does not pick up after 14 days. Prime requests a sample of signature logs during a desktop audit. If the pharmacy is unable to provide a requested signature log, this is noted as an audit finding. Prime requests a sample of signature logs during an on-site audit. If the pharmacy is unable to provide a requested signature log, it is noted as an audit finding. While on-site, the pharmacy auditor also reviews the pharmacy’s the return to stock process to verify that the requirement is being met. If the requirement is not met, this is noted and the pharmacy is educated on the proper procedure. When a pharmacy does not provide the requested signature logs, Pharmacy Audit contacts the prescriber to verify the legitimacy of prescription orders to support the validity of specific claims. Pharmacy Audit may also request wholesaler invoices from the pharmacy to support the claims billed. The following actions may be taken as a result of a pharmacy audit: financial chargeback; corrective action plan and follow up auditing; payment suspension; or network termination.
- vii. Health Promotions - Upon completing the healthcare service required for the respective reward program, the medical provider signs a voucher indicating the service was received by the member. The member then sends the voucher to SCHA to redeem a reward. Member reward program participation reports are matched with medical claims data to ensure the service noted on the voucher signed by the provider was completed by the member. For cases in which member participation in the reward program does not match a claim for the related medical service, internal analyses are completed to determine if the error occurred by the member or the medical provider signing the voucher. Voucher reward program validation reports are monitored for trends in member and provider compliance. Individual members or providers who appear to be repeatedly non-compliant receive more intensive outreach from SCHA provider

contracting staff. Providers who facilitate member fraud with the reward programs (i.e. sign vouchers despite knowing the service was not rendered) may be restricted from assisting members with the reward vouchers.

- viii. Member Surveys - A quarterly member survey will be sent to a random selection of members for which SCHA was billed a DME or home care service. Survey questions will be included that ask the member to confirm the equipment or home care service received as well as their satisfaction with the service/equipment. A follow-up survey will be sent to non-responders followed by a phone call to members who did not respond to both surveys. Returned surveys will be documented in a spreadsheet identifying any members responding that they did not receive the service or equipment at all or as expected. This will help identify members who may have received services or equipment at a lower quality than expected or as billed. Verification reports are monitored and trended by provider and service to identify possible trends in provider fraud or abuse.
2. The annual integrity program report provided to DHS will detail implementation processes, investigative activity, corrective actions, fraud and abuse prevention efforts, and results designed to meet the requirements of DHS Contract.
 3. SCHA will have a process for reporting to the State, MFCU, CMS and/or the OIG, credible information of violations of law by the State, SCHA, participating providers, subcontractors or enrollees, for a determination as to whether criminal, civil, or administrative action may be appropriate.
 - a. If SCHA has reason to believe that an enrollee has defrauded one of the programs, SCHA shall refer the case to the State, MFCU, CMS and/or the OIG, and other appropriate law enforcement agencies, as necessary.
 4. Upon request, SCHA will make available to the Minnesota Medicaid Fraud Control Unit (MFCU) and other required agencies all administrative, financial, medical and any other records that relate to the delivery of items or services under the contract.
 - a. SCHA will report to the State agency and the MFCU any suspected fraud and/or abuse by providers within twenty-four (24) hours after SCHA knows or has reason to believe of such suspected fraud and/or abuse. SCHA will cooperate fully in any investigation of the suspected fraud or abuse and in any subsequent legal action that may result from those investigations.
 5. SCHA will report to applicable regulatory agencies any suspected fraud or patterns of abuse by its recipients.
 6. SCHA will ensure that PCA providers not under continuous direct supervision have a background study completed prior to providing PCA services.

- a. SCHA may work with the State to utilize the state's licensing system, but any other process utilized by SCHA must review using the same standards as the State's licensing system.
 - b. SCHA will require that PCA provider agencies submit claims to SCHA using one date of service per claim line, per PCA.
7. SCHA will establish and disseminate Fraud Enforcement and False Claims Act policies and procedures to educate employees and agents about procedures for detecting and preventing fraud, waste and abuse.
 - a. SCHA will certify to the state by February 1 each year that it has complied with this requirement for the previous year.
 - b. SCHA will include in its written policies and procedures and in the employee handbook specific information on:
 - i. The False Claims Act;
 - ii. Administrative remedies for false claims and false statements;
 - iii. The Minnesota False Claims Act, Minnesota Statutes 15C.02 and any state laws pertaining to civil or criminal penalties for false claims and statements;
 - iv. The rights of employees to be protected as whistleblowers, including the employer restrictions in Minn. Stat. 15C.14; and
 - v. SCHA's policies and procedures for detecting and preventing fraud, waste and abuse.
8. SCHA will have data certification guidelines.
 - a. SCHA will provide to applicable regulatory agencies a certification that accompanies its submission of certain data which identifies each data submission, the date submitted and certifies all data submitted, unless otherwise specified.
 - b. SCHA will also certify with applicable regulatory agencies that its annual statutory financial filing with the Minnesota Department of Health (MDH) represents only costs related to services covered under the State Plan or costs related to providing those services, such as administrative costs, and include an attestation as to the accuracy, completeness and truthfulness of the data or documents being submitted.

9. SCHA will monitor the Medicare Exclusion Database (MED) or the OIG List of Excluded Individuals/entities (LEIE) database monthly and will require all subcontractors to search the MED and LEIE for providers, agents persons with an ownership or control interest and managing employees to verify that they are not excluded from Medicaid under 1128 or 1128A of the Social Security Act, and have not been convicted of a criminal offense related to involvement in Medicare, Medicaid or a Title XX services program.
 - a. SCHA will not pay for items or services furnished, ordered or prescribed by excluded individuals or entities.
 - b. SCHA will not include in our business entity a director, officer, partner or person with an ownership or control interest who is excluded from participation in a federal health care program under the Social Security Act.
 - c. SCHA will not make an employment, consulting or other agreement with an individual or entity for the provision of items or services that are significant or material to our obligations under contract with applicable regulatory agencies where the individual or entity is excluded from participation in a federal health care program under the Social Security Act.
 - d. SCHA will not have agents, managing employees or persons with an ownership or control interest who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XX services program.
 - e. SCHA will report to applicable regulatory agencies, within ten (10) working days of receipt of any information regarding excluded or convicted individuals or entities and any occurrence of an excluded, convicted or unlicensed entity or individual who applies to participate as a provider.
 - f. SCHA will promptly notify applicable regulatory agencies of any administrative action it takes to limit participation of a Provider in a federal health care program.
10. SCHA refers cases of suspected provider fraud or abuse appropriately (e.g., the State Agency, the State's Medicaid Fraud Control Unit, other law enforcement agencies).
 - a. South Country reports to DHS and the MFCU any suspected fraud and/or abuse by providers within twenty-four (24) hours after South Country knows or has reason to believe of such suspected fraud and/or abuse. South Country fully cooperates in any investigation of the suspected fraud and/or abuse by state agencies and MFCU and in any subsequent legal action that may result from those investigations.
 - b. South Country reports/refers to DHS, MFCU, CMS and/or the Office of Inspector General for the U.S. Department of Health and Human Services, credible

information of violations of law by State organizations, South Country, participating providers, subcontractors, or enrollees, for a determination as to whether criminal, civil, or administrative action may be appropriate.

11. SCHA reports debarments, suspensions, or changes in circumstances to the State for itself and for its credentialed or contracted providers. South Country also reports when a provider is decertified, disenrolled, or denied credentialing due to fraud, integrity or quality concerns.
 - a. South Country and its delegates have a process in place to monitor monthly the OIG sanctions list to determine if any contracted providers, employees, delegates or agents are identified with any sanctions.
 - b. All terminations, suspensions, debarments, decertification, disenrollments and credentialing denials are reported to MDH and DHS within 15 days. Where these instances involved issues of fraud, integrity or quality concerns, South Country also reports this information to the OIG (HHS). These situations would also be reported through the Credentialing Committee, Compliance Committee and ultimately to the South Country Joint Powers Board.
 - c. The credentialing department monitors quality complaints and grievances on a quarterly basis to identify any provider trends that may trigger a quality site visit or direct follow-up with a provider. This quality complaint process is tied into the recertification process which integrates with the primary source verification review that would identify any negative debarments or suspensions with a contracted provider. Any issues identified through this primary source verification process would be presented to the Medical Director and the Credentialing Committee for appropriate decision-making. A negative decision or outcome of the Credentialing Committee would then be reported to the State.
 - d. SCHA utilizes MMSI, our contracted third-party administrator, to identify potential issues of fraud, waste and abuse that may be picked-up through the claims adjudication process.
 - e. South Country reports quarterly to DHS the name, specialty, and address of each Provider that South Country has chosen to terminate or not renew during the previous quarter.
 - f. South Country monitors itself as well as its credentialed and contracted providers through monthly OIG exclusion checks and internal audits. South Country immediately gives written notice to the state agencies should South Country or any of South Country's credentialed or contracted providers come under investigation for allegations of fraud or a criminal offense in connection with: 1) obtaining, attempting to obtain, or performing a public (federal, state or local government) transaction; 2) violating any federal or state antitrust statutes; or 3)

committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

12. SCHA takes appropriate action on a report of suspected provider fraud or abuse.
 - a. South Country reports to DHS and the MFCU any suspected fraud and/or abuse by providers within twenty-four (24) hours after South Country knows or has reason to believe of such suspected fraud and/or abuse. South Country cooperates fully in any investigation of the suspected fraud and/or abuse by state agencies and MFCU and in any subsequent legal action that may result from those investigations.
 - b. South Country Health Alliance investigates vendors and providers to monitor compliance with program requirements for the purposes of identifying fraud, abuse, theft or error in the administration of the programs.
 - c. South Country's fraud, waste and abuse investigations include but are not limited to the following:
 - i. Contacting the person(s) making the fraud or abuse allegation, where appropriate;
 - ii. Contacting appropriate agencies to assist in the investigation process (claims payors such as MMSI, CRG, DentaQuest, Prime Therapeutics);
 - iii. Retrieving and comparing medical records to claims where appropriate;
 - iv. Retrieving and comparing prescription drug records to claims where appropriate;
 - v. Contacting the credentialed/contracted provider at issue, where appropriate;
 - vi. Internal meeting(s) to discuss results, next steps
 - d. After completion of an investigation, South Country determines whether (1) the vendor/provider is in compliance with the requirements of a program and program payments were properly made; (2) insufficient evidence exists that fraud, abuse theft or error has occurred, or (3) the evidence of fraud, abuse, theft or error supports administrative, civil or criminal action.
 - e. After completing the above determination, South Country takes one or more of the following actions:
 - i. Close the investigation when no further action is warranted;

- ii. Impose administrative sanctions as appropriate – including suspension, termination, debarment, re-training, corrective action plans, lockouts;
- iii. Seek monetary recovery as appropriate;
- iv. Refer/report the investigation findings to the appropriate state and federal regulatory agency, peer review mechanism or licensing board;
- v. Refer the investigation to law enforcement or other attorney for possible civil or criminal legal action;
- vi. Issue a warning letter to the enrollee;
- vii. Issue a warning that states the practices are potentially in violation of program laws or regulation;
- viii. Send a letter stating the review has been completed and indicating there were no findings; or
- ix. Refer the investigation to another appropriate agency.

13. SCHA will meet compliance plan requirements as a Part D sponsor as described in 42 CFR 423.504 (b)(4)(vi)(G) and Section 1860D-4(c)(1)(D), including having a program to control fraud, waste and abuse.

- a. Prime Therapeutics, a SCHA third party delegate, also has a robust fraud, waste and abuse program that meets Part D requirements.

Violation of Policy

A breach of this policy may result in noncompliance with regulatory requirements and potential penalty to SCHA. SCHA will investigate alleged violations and take disciplinary or other appropriate corrective action.

Signatures

Signature Approval: _____ Date: _____
Compliance Officer

Signature Approval: _____ Date: _____
Chief Executive Officer

Joint Powers Board Approval Date: December 8, 2006