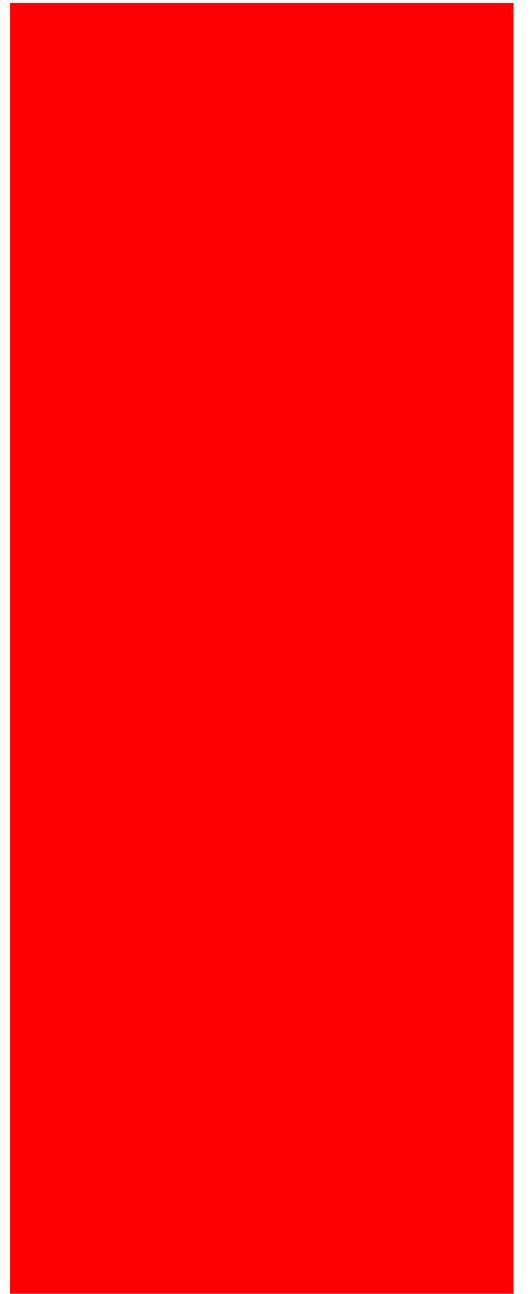


109 SECTION O – FRAUD  
AND ABUSE

110 O.1



## Section O: Fraud & Abuse (Section §15 of RFP)

**O.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.**

### **Aetna Better Health® Experience**

Aetna Better Health, with our affiliates, has 25 years of experience designing, developing, administering, and monitoring Medicaid Fraud and Abuse Plans (F&A Plans). We currently administer comprehensive F&A Plans that meet federal, state, and local laws and regulations in 10 states including Arizona, California, Connecticut, Delaware, Florida, Illinois, Maryland, Missouri, Pennsylvania, and Texas. The Aetna Better Health Board of Directors is our governing body and has ultimate accountability for the sufficient staffing and utilization of appropriate resources to achieve contractual compliance and meet federal, state, and local laws and regulations.

Aetna Better Health maintains a strict policy of “zero tolerance” toward any form of fraud and abuse by Aetna Better Health employees, members, providers, and contractors. Aetna Better Health has established written policies, procedures, standards of conduct, and processes designed to prevent, reduce, detect, correct, and report known or suspected fraud and abuse in the administration and delivery of Medicaid services. We have a variety of established mechanisms for our employees, members, providers, and contractors to report suspected or known fraud and abuse issues without fear of reporting diversion or retaliation.

#### ***Fraud and Abuse Plan Oversight***

The Aetna Better Health Board of Directors has delegated the design, administration, maintenance, monitoring, and daily functions of the F&A Plan to the Aetna Better Health Compliance Officer (CO). While ultimately accountable to the Board of Directors, the CO reports directly to the Aetna Better Health Chief Executive Officer (CEO). Our CO is located in Louisiana and has direct access to senior management and legal counsel at all times. Aetna Better Health has developed written criteria that outline the authority and responsibilities of the CO position as well as a job description that clearly defines required and essential skills and experience. The CO serves as the primary point of contact regarding suspected or known fraud and abuse issues.

#### ***Committee Involvement***

Our CO fosters open lines of communication across all levels of the organization by facilitating the compliance components and sections of new hire, annual, and ad hoc training, as well as numerous routine and ad hoc departmental meetings. Compliance including, but not limited to, fraud and abuse is a standing agenda item for the following operational and quality meetings:

#### **Quality Management Oversight Committee**

Aetna Better Health’s Quality Management Oversight Committee’s (QMOC’s) primary purpose is to integrate Quality Assurance and Performance Improvement (QAPI) activities throughout the health plan and the provider network. The committee is chaired by the health plan CEO and

designed to provide executive oversight of the QAPI and make decisions about Aetna Better Health's quality management and performance improvement activities. The committee reviews and approves the annual QAPI, work plan, and evaluation and works to make sure the QAPI is integrated throughout the organization, including among the appropriate and relevant departments, delegated organizations and network providers. A delegated organization is a major subcontractor that Aetna Better Health has assigned or delegated certain functions or responsibilities and Aetna Better Health reviews and approves this organization's performance and policies and procedures on an annual basis.

The QMOC's responsibilities include, but are not limited to, the following:

- Making sure that quality activities are designed to improve the quality of care and services provided to members
- Advising or making recommendations to improve our medical, operational and administrative performance
- Recommending pertinent policy decisions involving quality
- Reviewing and evaluating company-wide performance and compliance monitoring activities, including care management, customer service, credentialing, claims, grievance and appeals, prevention and wellness, provider service and quality and utilization management

#### **Compliance Committee**

The Aetna Better Health Compliance Committee answers directly to the QMOC and is responsible for reviewing, monitoring, and assessing the compliance program and advising our CO on interventions for improving program effectiveness. This committee is chaired by the CO and comprised of several Board members along with key Aetna Better Health executives. These executives include, but are not limited to, the Chief Operating Officer (COO), Chief Medical Officer (CMO) or designee, and representatives from key departments such as Quality Management, Utilization Management, Grievance and Appeals, Provider Relations, and Claims. The committee meets at least quarterly and minutes and summary reports are recorded, maintained, and provided to the Department of Health and Hospitals (DHH) as requested. The functions of the compliance committee include, but are not limited to, the following:

- Overseeing the development, maintenance, and revision of all compliance program policies and procedures and other related documents
- Recommending, reviewing, and monitoring internal controls such as compliance reports and corrective action plans resulting from audits
- Initiating and directing investigations related to any identified potential compliance gaps
- Reporting all compliance issues to the Board of Directors and subcommittees as appropriate

#### **Quality Management/Utilization Management Committee**

Aetna Better Health's Quality Management/Utilization Management (QM/UM) Committee's primary purpose is to advise and make recommendations to the CMO on matters pertaining to the quality of care and service provided to members including the oversight and maintenance of the QAPI and utilization management program. The QM/UM Committee will provide utilization review and monitoring of UM activities of both Aetna Better Health and its providers and is

directed by Aetna Better Health's Medical Director. This committee convenes quarterly and submits meeting minutes to DHH within five (5) business days of each meeting. The QM/UM Committee responsibilities include, but are not limited to, the following:

- Monitoring providers' requests for rendering healthcare services to its members
- Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed
- Approving policies and procedures for utilization management that conform to industry standards, including methods, timelines and individuals responsible for completing each task
- Monitoring over- and under-utilization
- Reviewing member medical records to monitor Primary Care Provider (PCP) provision of high quality health care that is documented according to established standards

#### **Service Improvement Committee**

Aetna Better Health's Service Improvement Committee (SIC) is an interdisciplinary team that includes senior management and employees from multiple departments across the organization. The SIC is our principal forum to systematically identify, discuss and resolve issues that impact both members and providers. This committee is chaired by the Aetna Better Health COO and its functions include, but are not limited to, the following:

- Review of trended data to identify for service improvement opportunities
- Approves recommended intervention activities
- Identifies additional improvement activities
- Assigns action plans and monitors the action plans to completion

The SIC also uses results from provider inquiries, complaints, requests for information, data analysis (trends) to develop recommendations regarding process and service improvements.

#### **Fraud and Abuse Plan**

Aetna Better Health's F&A Plan is an integral part of our overall compliance program and is designed to effectively guard against and respond to suspected or known fraud and abuse in compliance with federal, state, and local laws and regulations. Aetna Better Health will submit a copy of our compliance program, including our F&A Plan, to DHH for approval within 30 days from the Contract date. Any modifications, changes, or updates to our compliance will be submitted to DHH for approval 30 days in advance of the effective date.

#### ***Establishing Effective Lines of Communication***

In order to promote effective communication between the CO and all Aetna Better Health employees, the CO maintains an "open door" policy. Any Aetna Better Health employee is able to have direct communication (in person or electronically) with the CO. The CO has the authority to meet with any employee, member, provider or stakeholder in the course of fraud or abuse investigations. The CO serves as a resource to Aetna Better Health employees, members, providers, and other parties for issues, inquiries and requests. These requests may include providing information regarding the Aetna Better Health compliance program, compliance code

of conduct and interpretation of compliance policies. Aetna Better Health utilizes an array of communication mechanisms to promote open, two-way communication for the receipt of and dissemination of compliance information including:

- Dedicated toll-free hotline that is accessible to any individual (e.g., our employees, providers, members) to make confidential, anonymous and non-retaliatory reports of compliance issue/inquiries verbally or in writing
- Easy on-line access for Aetna Better Health employees to provide fraud and abuse reporting that can be confidentially, anonymously sent directly to DHH or the Aetna Better Health CO
- Written materials about the compliance program including, but not limited to, how to report suspected or known fraud and abuse and disciplinary guidelines for compliance violations and non-reporting are distributed through employee or provider training sessions, direct e-mails, or in Aetna Better Health publications (e.g., network and provider newsletters, provider manual, member handbook)
- Classroom and web-based training on the components, requirements, and specifications of our compliance policies, programs, disciplinary standards, and operational guidelines
- It is Aetna Better Health's standing operating procedure that all personnel shall have direct access to the CO at all times for both reporting of compliance issues and inquiries or for use as a resource regarding our compliance program.

#### ***Preventing, Reducing and Detecting Fraud and Abuse***

We have written policies, procedures, and standards of conduct that articulate Aetna Better Health's compliance with the fraud and abuse requirements of DHH, the Louisiana Office of the Inspector General (OIG), and Centers for Medicare & Medicaid Services (CMS). Our CO participates in the Aetna Better Health Operations Department personnel meetings to discuss potential fraud and abuse issues, identify resolution strategies, develop action plans, and determine follow up activities. In implementing the F&A Plan, Aetna Better Health requires the following activities to effectively prevent, reduce, and detect fraud and abuse as well as evaluate our system wide compliance with federal/state laws and regulations and contractual requirements:

#### ***Fraud and Abuse Training and Education***

Aetna Better Health promotes the importance of education and training as a method to be compliant with legal, contractual and fraud and abuse requirements. As a result, we have developed a training program designed to promote compliance at all levels of our organization and within our provider network as well as assisting and empowering our members in recognizing and reporting fraud and abuse.

#### **Employee Training and Education**

Aetna Better Health employees across all levels of the organization are trained, expected, and required to comply with all provisions of our compliance program including, but not limited to, fraud and abuse. Our employees must complete our compliance training program upon hire, annually, and on an ad hoc basis as needed.

Fraud and abuse training topics include, but are not limited to, the following:

- Aetna Better Health's commitment to the compliance including HIPAA requirements

- The Aetna Better Health Code of Conduct for employees in preventing, reducing, detecting, correcting, and reporting fraud and abuse violations
- Prevention, detection, and reporting of known or suspected fraud and abuse through the following:
  - a) Aetna Better Health’s Compliance Officer contact information
  - b) Aetna Better Health’s 24 hour, toll-free number for reporting
  - c) The Medicaid fraud hotline toll-free number for reporting
  - d) Louisiana’s Program Integrity Unit (PIU) for reporting via written correspondence
  - e) Louisiana’s fraud reporting fax line for reporting via written correspondence
  - f) DHH’s website reporting capability
- Corrective action guidelines
- Deficit Reduction Act of 2005 and Federal False Claim Act provisions
- Non-retaliation protections

Upon completion of initial and ongoing compliance training, our employees acknowledge they: 1) participated in the training; 2) understood the information provided; and 3) will adhere to compliance program requirements. Aetna Better Health maintains attendance and participation records in accordance with DHH record retention standards.

### **Member Education**

Our member handbook and our website serve as one of the main sources for communicating the details of the F&A Plan to our members. Our member handbook and website provide information on types of fraud and abuse including, but not limited to, identification (ID) card fraud, emergency room abuse, and prescription drug misuse/abuse. These also educate members on their responsibilities, the responsibilities of others, the definition of fraud and abuse, and how and where to report suspected or known fraud and abuse through the following:

- Aetna Better Health’s Compliance Officer contact information
- Aetna Better Health’s 24 hour, toll-free number for telephonic reporting
- The Medicaid fraud hotline toll-free number for telephonic reporting
- Louisiana’s PIU for reporting via written correspondence
- Louisiana’s fraud reporting fax line for reporting via written correspondence
- DHH’s website reporting capability

Aetna Better Health Case Managers have direct contact with our members and are responsible for providing information to our members and members’ families/caregivers regarding the process for detecting and reporting potential fraud and abuse as needed. Periodic articles on fraud and abuse including, but not limited to, ID card fraud are published in quarterly member newsletters, provide additional examples of behaviors to watch for and emphasize the responsibility of members’ to report potential fraud and abuse.

### **Provider Training and Education**

Aetna Better Health's Provider Services personnel, provider manual, and website educate providers on our F&A Plan including providers' respective responsibilities, the responsibilities of others, the definition of fraud and abuse, and how and where to report suspected or known fraud and abuse. Aetna Better Health Provider Services personnel schedules an orientation with each provider to review the health plan requirements within 30 days of contracting. This orientation includes an overview of the F&A Plan and specific examples of provider fraud, such as upcoding, billing for services not provided, and submitting false encounter data. Aetna Better Health's Claims Educator conducts ongoing telephonic and on-site communication with contracted and non-contracted providers. These communications include information on appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers. Our network providers can view or download the most up-to-date version of our provider manual and information on how to locate regular fraud and abuse updates on our website.

Our fraud and abuse provider training includes, but is not limited to, the following:

- Aetna Better Health's commitment to compliance including HIPAA requirements
- Standard of Conduct for providers in preventing, identifying, and reporting compliance violations
- Prevention, identification, and reporting of known or suspected fraud and abuse including the availability of the following:
  - a) Aetna Better Health's Compliance Officer contact information
  - b) Aetna Better Health's 24 hour, toll-free number for telephonic reporting
  - c) The Medicaid fraud hotline toll-free number for telephonic reporting
  - d) Louisiana's PIU for reporting via written correspondence
  - e) Louisiana's fraud reporting fax line for reporting via written correspondence
  - f) DHH's website reporting capability
- Corrective action guidelines
- Deficit Reduction Act of 2005 and Federal False Claim Act provisions
- Confidentiality and non-retaliation protections

Periodic articles on fraud and abuse are published in quarterly provider newsletters, providing additional examples of behaviors to watch for and emphasizing the responsibility of providers in preventing, detecting, and reporting potential suspected and known fraud and abuse.

### ***Confidentiality and Non-Retaliation Protections***

We understand that our employees, members, providers, and contractors are more likely to report suspected or known fraud and abuse issues if they feel it is a safe and confidential process. As a result, all complaints reported by employees, members, providers, contractors, or other persons will be kept confidential by Aetna Better Health to the extent that is possible during and following the investigation.

We have a zero-tolerance policy for any retaliation against employees, members, providers, contractors or other persons who make reports regarding known or suspected violations of

federal, state and local laws and regulations. Retaliation for reporting is prohibited and violators will be subject to disciplinary action. Aetna Better Health employees who retaliate against any employee, member, provider, contractor, or other person are subject to disciplinary action up to and including termination. Employees who believe they have been retaliated against are encouraged to inform their supervisor, but may also contact Aetna Better Health's CO or other executive, DHH, or the Louisiana OIG. Members, providers, and contractors who believe they have been retaliated against are encouraged to contact Aetna Better Health, DHH, or the OIG.

### ***Internal Monitoring and Auditing Procedures***

Aetna Better Health has established a variety of internal methods to detect possible fraud and abuse. The CO collects and analyzes information from various departments within our organization to monitor and identify potential compliance violations. In addition to the prevention and detection of fraud and abuse, our compliance team conducts internal monitoring of our system-wide compliance with federal, state, and local laws and regulations, as well as contract requirements. Aetna Better Health uses the following strategies to monitor and audit for fraud and abuse:

- Claims system edits are designed to prevent, reduce, and detect potential fraud. These edits include, but are not limited to, reviews for 1) member eligibility, 2) covered services, 3) medically unlikely services for age or gender, 4) duplication of services, 5) prior authorization, 6) invalid procedure codes and 7) duplicate claims. Claims edited through our automatic editing process that are identified as fraudulent in nature are denied.
- Medical management activities (e.g., prior authorization, concurrent review, discharge planning, retrospective review and provider profiling) serve as a first line of defense to prevent and detect fraud and abuse. These activities include: 1) verifying member eligibility, 2) reviewing the medical necessity of the service, 3) determining the appropriateness of the service being authorized; 4) verifying that the service is covered and 5) referring members to appropriate providers. Should the prior authorization process indicate fraud or abuse, the prior authorization will be denied, a notice of action will be sent to the provider and member, and a report will be sent to the CO. Our CO reviews, trends and will report findings to DHH as necessary. In addition, medical management reports allow the department to have multiple points of data to review and verify unusual patterns that may indicate potential fraud or abuse. Any unusual incident is documented and reported immediately as required by our policies and procedures.
- Provider Services and Quality Management personnel are trained to be aware of probable indicators of fraud and abuse so that issues may be identified during routine office visits. These employees report suspected fraud and abuse activities to our CO for review. For example, either the Provider Services Representative, during routine office visits, or the Quality Management employee during a provider ambulatory medical records review may, identify care rendered by an unlicensed person in a physician's office or a member obtaining DHH services illegally.
- Member complaints, grievances and appeals (including member survey results) are tracked and documented by the Member Services Department to identify potential trends or patterns of fraud.

- Provider credential validation is conducted to prevent contracting with providers previously convicted of fraud or abuse. Aetna Better Health validates the credentials of all providers at initial and for recredentialing in accordance with National Committee for Quality Assurance (NCQA) criteria, as well as state and federal standards. As part of this process, we collect and evaluate information about providers from a variety of sources (e.g., National Practitioners Data Bank, OIG list of Excluded Individuals or Entities, and applicable state professional licensure boards).
- Random Statistically Valid (RSV) audits are conducted on a routine and periodic basis. These audits identify and detect inappropriate claims and potential provider fraudulent billing. Audit findings are provided to the CO for review and action. At a minimum, the audit examines if: 1) the provider was contractually allowed to provide the service being billed; 2) the service provided is covered for the member; 3) the appropriate level of care was used for the presenting condition; 4) the provider billed correctly for the services rendered; 5) the charges for services are reasonable and 6) there was no evidence of excessive testing or referrals.

#### ***Responding to Fraud and Abuse***

Aetna Better Health trains, expects, and requires our employees to respond to and report suspected or known fraud and abuse. Our CO and Board of Directors provide oversight to all reports of suspected or know fraud and abuse. Our written P&Ps promote the timely response to suspected and detected fraud and abuse offenses. Aetna Better Health's CO reports all suspected and known fraud and abuse offenses to DHH's PIU. Aetna Better Health will coordinate and communicate with the PIU to review and investigate fraud and abuse issues including, but not limited to, fraud and abuse issues identified through our Utilization Management (UM) program.

#### ***Coordinating Fraud and Abuse Complaints and Referrals***

Aetna Better Health's CO provides and supports the PIU's access to all information including, but not limited to, documentation, electronic data, and preliminary investigations findings as follows:

- 1) Complaints received by Aetna Better Health regarding a member's eligibility are referred to the PIU in writing within three (3) business days of referral receipt for review and investigation.
- 2) Complaints received by Aetna Better Health regarding a member's utilization of benefits or against a healthcare provider are reviewed and investigated by Aetna Better Health. Should this investigation determine that a fraud and abuse offense may exist, Aetna Better Health reports this information to the PIU in writing within three (3) business days.
- 3) Complaints received by Aetna Better Health regarding a network provider or contractor are reviewed and investigated by Aetna Better Health. Should this investigation determine that a fraud and abuse offense may exist, Aetna Better Health reports this information to the PIU in writing within three (3) business days. All suspected or known provider fraud and abuse issues that warrant investigation referred to the PIU will include the following:

- Name, type, and contact information of the provider suspected of fraud and abuse
  - Source of the fraud and abuse complaint or allegation
  - Nature and type of complaint
  - Information regarding the suspected value of the violation
  - Investigation findings and/or disposition of the violation
- 4) Aetna Better Health immediately initiates an investigation upon receipt of a fraud and abuse complaint. Should the preliminary investigation indicate that a fraud or abuse incident may have occurred, Aetna Better Health refers this information to the PIU in writing within three (3) business days. We submit preliminary investigation findings and other relevant information and coordinate with the PIU during the investigation as needed.

***Correcting Fraud and Abuse***

Aetna Better Health takes compliance violations very seriously and is committed to enforcing our written policies, procedures, and standards of conduct through our comprehensive, well-publicized disciplinary guidelines. During initial and annual training, employees are educated on required adherence to our compliance program and the resulting discipline following compliance violations. Disciplinary guidelines are consistently made available to employees through our policies and procedures manual and the employee portal on our website. Aetna Better Health personnel in executive, managerial, and supervisory positions are responsible for understanding, enforcing, and holding employees accountable for compliance with federal and state standards in their respective areas of responsibility. These personnel are responsible for preventing, identifying, reporting, and administering corrective action for compliance violations.

Aetna Better Health will fully support DHH during the evidentiary and corrective action process for any employee, member, provider, contractor, or other party identified as violating fraud and abuse laws, regulations, or requirements. Should Aetna Better Health determine or be notified by DHH that an Aetna Better Health employee has committed a fraud and abuse violation, we will implement the following corrective action as appropriate:

- Retraining
- Written warning
- Performance improvement plan
- Termination
- Criminal prosecution

Upon determination that a provider is in violation of fraud and abuse laws, regulations, or requirements, Aetna Better Health will terminate the provider's contract. We will report the contract termination to DHH and the enrollment broker. We will report the violation to the National Practitioner Data Bank and Health Care Integrity and Protection Data Bank. Aetna Better Health will query the National Practitioner Data Bank and the Health Care Integrity and Protection Data Bank on a monthly basis to identify excluded providers.

***Reporting Fraud and Abuse***

Aetna Better Health takes fraud and abuse very seriously and we understand that reporting potential and suspected fraud and abuse issues to the appropriate entities is key to improving our processes. Our CO follows our established policies and procedures in reporting fraud and abuse complaints, investigation findings, and violations to the following entities in a timely manner:

- DHH Program Integrity Unit
- Aetna Better Health's Board of Directors
- Aetna Better Health's CEO
- Aetna Better Health's committees including the QMOC, QM/UM, and SIC
- Louisiana OIG as appropriate
- CMS

Aetna Better Health will provide a fraud and abuse activity report on a quarterly basis and an annual summary report to DHH. The Aetna Better Health CO will meet with the DHH PIU and the Louisiana Attorney General Medicaid Fraud Control Unit on a quarterly basis for the purpose of exchanging information, collaborating on suspected fraud and abuse activities, and identifying opportunities for improving our processes for preventing, reducing, detecting, correcting, and reporting suspected or known fraud and abuse.