Section V – Program Integrity

V.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. Include other best practices, you have utilized in other contracts that could be utilized in this contract.

Program Integrity Approach

Louisiana Healthcare Connections (LHCC) is well positioned to enhance our Fraud and Abuse Detection and Prevention program to meet DHH's new Program Integrity contract requirements. We will enhance operations of our Fraud, Waste, and Abuse Compliance Plan (FWACP) for the prevention, detection, reporting, and corrective action of suspected cases of Fraud and Abuse in the administration and delivery of services. LHCC will adopt proven best practices for the Medicaid program from our affiliate health plans in 18 other states, and may utilize such best practices as conducting desk audits with in-state staff, and implementing more assertive approaches when providers do not initially respond to medical record request letters.

LHCC's parent company, Centene Corporation (Centene), will continue to provide guidance and technological and clinical support to augment our staff expertise and infrastructure. This support will ensure that LHCC's robust Fraud, Waste and Abuse (FWA) Program meets federal and new State requirements, as well as DHH's expectations. We discuss in our response to V.2, that LHCC will create a Program Integrity Division located in the State of Louisiana led by our Program Integrity Officer and staffed with Fraud, Waste and Abuse (FWA) Investigators.

Our approach to Program Integrity takes advantage of both prospective and retrospective methods for addressing FWA. We use prepayment review to:

- Identify providers engaging in fraudulent and/or abusive behavior early
- Quickly engage identified providers in education, effectively stopping incorrect or illegal payments more quickly.

We found that when providers understand that we conduct prepayment reviews on physician office-based and hospital outpatient facility claims, they are less tempted to file fraudulent and/or abusive claims.

LHCC's Fraud and Abuse Detection and Prevention program and FWACP will comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812, Sections 1128, 1156, 1902(a)(68) of the Social Security Act, La.R.S. 46:437.1-437.14; LAC 50:I.4101-4235, and all relevant RFP requirements, including Section 15.

We describe our approach to meeting the Program Integrity requirements under two categories:

1. Our Fraud, Waste, and Abuse Compliance Plan and
2. Our Detection, Investigation, Corrective Action, and Reporting Processes

We discuss our adoption of prepayment review to identify improper payments before they are paid, reducing the outflow of improperly paid State and federal dollars. Our approach further saves money by eliminating the need to pay for the cost involved in recovering funds that were improperly paid. In addition, we discuss our close working relationship we have with our Provider Relations team. Finally, we describe the best practices we adopted from other contracts that could be utilized in this contract, including medical record request processes used by other states that have improved provider response rates.

LHCC Fraud, Waste, and Abuse Compliance Plan

The LHCC Fraud, Waste, and Abuse Compliance Plan (FWACP) will focus on prevention, reduction, detection, correction and reporting of known or suspected FWA (while preventing potential health risks to members), and will comply with the requirements of RFP Section 15.2.3. LHCC will cooperate and assist DHH, State and federal agencies in the investigation and prosecution of any suspected fraud by a providers, members, or subcontractors, in accordance with RFP Sections 15.1.3 through 15.1.5. LHCC will fully comply with all State and federal laws and regulations relating to FWA in the Medicaid and CHIP programs.

LHCC will submit our FWACP to DHH within 30 days from the date of contract signing and annually thereafter, and will submit all updates and modifications to DHH for approval at least 30 days in advance of their effective date. We will review and update our FWACP, following DHH approval, at least annually to make sure that we incorporate the results of previous year's activities, "lessons learned", best practices of our affiliate health plans, and any DHH requested or required additions or revisions. We will include in the FWACP citations to all applicable State and federal laws and document the commitment of all LHCC staff to compliance.

Program Goals and Objectives. LHCC documents compliance goals, objectives, and activities in the FWACP, developed by adhering to State and federal laws, rules and regulations from the Office of Inspector General (OIG); direction from DHH; issues identified by Centene's Special Investigation Unit (SIU) or affiliate plans; and issues identified by the LHCC staff in their interactions with members, providers and subcontractors. We address all required components in the FWACP including Section 15.2.3 requirements such as:

1. ***FWACP Leader***: A designated Program Integrity Officer and Program Integrity Committee to oversee internal and external monitoring activities. The Program Integrity Officer must have the authority and responsibility to carry out the provisions of the FWACP and communicate directly with LHCC's Board of Directors, regulatory authorities and DHH agents.
2. ***FWACP Resources:*** A Program Integrity Division that supports the Program Integrity Officer in developing and implementing the FWACP.
3. ***Written Policies and Procedures***: Written policies, procedures, and standards of conduct that articulate LHCC's commitment to comply with all applicable federal and State standards.
4. ***Administrative Provisions:*** A systematic method for identifying, investigating, and taking corrective action against any person found in violation of items related to Medicaid Program Integrity.
5. ***Effective Lines of Communication and Education and Training***: Effective lines of communication that are established and maintained between the Program Integrity Officer and all LHCC providers, subcontractors, officers, directors, managers, employees and members. A systematic program of effective training and education to ensure that all understand the FWACP, their role in the compliance process, and the consequences of noncompliance.
6. ***Disciplinary Procedures:*** Well-publicized disciplinary procedures that address employee violations of the Integrity/Compliance Program.
7. ***Confidential Reporting Mechanisms***: Confidential reporting of FWA issues through hotlines and other well-publicized means, and processes in place to prevent retaliation against providers, members, and staff for reporting incidents.
8. ***Timely Reporting to Authorities***. Methods for reporting suspected and/or investigated cases of FWA to the appropriate State or federal authorities, with the right information at the right point in the process.
9. ***Ongoing Monitoring***: Developed policies and processes for internal monitoring and auditing, including timelines for development and completion of corrective action plans, and prompt

responses to reported FWA. Monitoring and auditing of LHCC's systems will include, but not be limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities and provider activities.

LHCC develops each goal, objective, and activity so that responsibility and accountability for the steps involved, the documentation required, and the oversight is clear. LHCC documents all FWA activities, including correspondence with providers, recoupment if applicable, receipts of voluntary repayments, and education activities conducted.

FWACP Leader and Resources. The LHCC Program Integrity Division will be the focal point of LHCC's Program Integrity and FWA activities. As described in more detail in our response to V.2, LHCC's staff expertise and infrastructure; and Centene's guidance, clinical, and technology support will combine to ensure that LHCC develops and manages a robust FWA Program that meets federal and State requirements and DHH expectations. LHCC's Program Integrity Officer will lead the Division, oversee the in-state FWA Investigators, and Chair the LHCC Program Integrity Committee. The Program Integrity Officer will also regularly coordinate activities with other LHCC departments as well as with Centene's senior executives responsible for Program Integrity. Centene executives will share best practices from affiliate health plan staff for inclusion in the LHCC FWACP.

The LHCC Program Integrity Officer and other designated LHCC representatives will attend all meetings set by DHH to collaborate on FWACP policies and operations, including procedural updates or training sessions. The LHCC Program Integrity Officer will be LHCC's primary point of contact for the FWA program and the FWACP. The Program Integrity Officer and the CEO or COO will meet quarterly, annually, and at DHH's request, to discuss fraud, abuse, waste, neglect and overpayment issues with DHH and the State's Office of Attorney General Medicaid Fraud Control Unit (MFCU).

Written Policies and Procedures. The LHCC FWACP will include policies and procedures specific to fraud and abuse detection, prevention, investigation and reporting. LHCC will adopt those fraud and abuse policies and procedures that are consistent with RFP Section 15 and that Centene has implemented through its Special Investigative Unit (SIU) for affiliate health plans. LHCC is committed to complying with all State and federal standards regarding fraud and abuse prevention and detection and shares the same definition of Fraud presented by DHH in the RFP. In addition to adopting the policies and procedures in Appendix EE of the RFP, LHCC will develop additional policies and procedures as may be required by DHH or to comply with relevant State and federal laws, CMS, HHS, the OIG or any such standards established or adopted by the State of Louisiana or its Departments.

Education and Training Regarding Fraud and Abuse. LHCC believes that the key to preventing, deterring, detecting and stopping FWA lies in providing effective training and education for the Program Integrity Officer, FWA Investigators, managers, employees, providers, members and subcontractors. Training should ensure all parties know and understand LHCC's commitment to supporting and enforcing federal and State laws and regulations governing FWA, ethical behavior and the provisions of LHCC's FWACP.

Training for LHCC Program Integrity Division Staff. LHCC will ensure that the Program Integrity Officer and the FWA Investigators receive appropriate training and education that will assure that they can effectively carry out their roles and responsibilities. Twice annually the LHCC Program Integrity Officer will attend a Centene Corporate Compliance Conference with Program Integrity Officers from other Centene affiliate health plans where each attendee receives updated training materials on how to improve compliance planning, implementation and monitoring, and FWA activities.

In addition to initial and annual specialized training, the FWA Investigators will also receive training on CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks, and specialized training that will help them to carry out their responsibilities for

helping to develop and implement the LHCC FWACP. LHCC will also afford the FWA Investigators the opportunity to attend training sessions and conferences hosted by the American Academy of Professional Coders and other local and national organizations.

Training for LHCC Employees. LHCC requires all employees, subcontractors, temporary staff and consultants to annually attend Fraud and Abuse training sessions led by trained staff from the LHCC Program Integrity Division. We document each session through attendance logs and the training materials, which are scanned and saved to show completion in Compliance 360©, our comprehensive compliance program management tool. The latest PowerPoint training deck is available for DHH's review.

The goals of our FWACP and extensive training initiatives are to:

- Uphold LHCC's commitment to business ethics and compliance
- Educate our employees on identifying and preventing occurrences of FWA
- Provide discipline or additional education, as appropriate
- Provide reporting mechanisms and complete any necessary reporting

LHCC's goal is to maintain transparency and continue to build on Centene's reputation as an organization that strives for the highest level of ethical behavior and compliance and proactively identifies and mitigates any potential instances of noncompliance. LHCC focuses our training on the FWACP and the LHCC and Centene Code of Conduct. The Code of Conduct clearly states that all employees, officers, and directors are responsible for complying with our compliance policies and procedures; and all applicable State, federal and local laws and regulations at all times and for reporting any possible noncompliance.

LHCC trains employees to notify the Program Integrity Officer, Program Integrity Division staff, the Centene SIU or to call the toll-free hotlines to report any suspected FWA. In line with our organizational value of integrity, LHCC considers failure to report a violation as a violation of our code of conduct. In addition to all State and federal FWA requirements, LHCC includes in our training modules requirements to not use or disclose confidential information, engage or assist with insider trading, and not provide monetary business courtesies to government employees. We also train staff on the requirements of the False Claims Act and Anti-Kickback statute and LA RS 14:133, the Louisiana False Public Records statute. We educate and remind employees of our obligations under the federal HIPAA and HITECH privacy rules and State privacy laws.

We conclude training sessions with a reminder of the consequences for violating or failing to report violations of LHCC policies and the applicable laws and regulations, which include personal, civil and criminal consequences, as well as consequences under our disciplinary guidelines up to and including termination of employment.

Intranet Training for Employees**.** In addition to the annual training, LHCC and Centene provide required, computer based training modules on topics such as "Speaking Up: How and When to Speak Up with a Concern." This online course takes employees through a scenario of speaking up to a manager about a potential conflict of interest, including the proper way to make a report; how the manager should handle the situation; our zero tolerance non-retaliation policy for a report submitted in good faith; and what to expect from an investigation and follow up. Other online sessions related to maintaining Program Integrity have included:

- Identification, Reporting, and Resolving Conflicts of Interest
- Avoiding Insider Trading
- Centene 101 – Compliance, HIPAA and Fraud and Abuse

LHCC monitors employee participation in these sessions and tests attendees to determine that they have successfully mastered the subject matter.

Training for New Employees**.** LHCC requires that new employees complete and attest to having completed fraud and abuse training within 30 days of the beginning date of their employment.

The LHCC Program Integrity Division will conduct the training, which will address:

- The LHCC and Centene Code of Conduct
- Privacy and Security - Health Insurance Portability and Accountability Act
- Fraud, waste, and abuse
- Procedures for timely consistent exchange of information and collaboration with DHH
- LHCC organizational chart including the Program Integrity Officer and FWA Investigators
- Provisions that comply with 42 CFR §438.610 and relevant State and federal laws, regulations, policies, procedures, guidance and standards, including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks, as required by RFP Section 15.2.3.11.

Provider and Subcontractor Training. During orientation sessions, LHCC educates providers about our FWACP, which includes information about their obligations and how to report any concern directly to the health plan or via our FWA hotline. We also disseminate this information in our Provider Manual, through articles in LHCC's quarterly Provider Newsletter, (also available on the web to both contracted and non-contracted providers), in letters, in classes, and during onsite visits to individual providers. These visits may be routine, the result of a random audit, an issue focused audit, or an inquiry generated by some reported concern.

LHCC educates our subcontractors and consultants, including personnel who work onsite, during their initial orientation and mandatory annual trainings. LHCC contractually requires subcontractors and consultants to comply with all relevant laws, regulations, DHH mandates, and our Provider Manual. We also contractually obligate subcontractors to immediately report any concerns about noncompliance within their organization; or that they may have observed at LHCC, at a provider's office, by a member, or by another subcontractor.

At a minimum, LHCC meets quarterly with each of its subcontractors or more frequently based on volume of business, criticality, sensitivity of responsibilities, or historical performance. During these delegated vendor oversight meetings, we review operational reports and reports on compliance and our Program Integrity efforts.

Member Training. We educate our members about FWA prevention through the Member Handbook, quarterly Member Newsletters, the Member Portal, and new member orientation Welcome Calls. LHCC provides these resources to all new members, including those who lose eligibility and re-enroll with LHCC. Our materials provide guidance to members about proper use of the Emergency Room (ER), utilization issues, and how to report persons suspected of fraud or abuse. In addition, our interactive voice response systems will include a DHH approved message that encourages members and providers to be alert for FWA. The message will provide callers with a toll free number to report instances of suspected FWA, and will allow callers to connect to the toll free number or speak to someone immediately.

Effective Communication and Confidential Reporting. Our Program Integrity Division has established effective lines of communication between the Program Integrity Officer; FWA Investigators; and LHCC's employees, providers, and contractors; enforced through well publicized disciplinary guidelines in compliance with RFP Section 15.2.3.2.

The Program Integrity Division uses several methods of communication to address employee concerns, questions, and reports of potential noncompliance. The combination of new hire orientation and ongoing employee training, along with participation of Program Integrity Division staff in the Quality Assessment Performance Improvement Committee (QAPI Committee) and workgroup meetings encourages our employees to approach our Program Integrity Division staff members with any questions or concerns.

In addition, we provide an internal and external toll-free FWA Helpline for employees, providers, members, subcontractors, or others to anonymously report their noncompliance concerns. LHCC contracts with a third party that specializes in providing confidential assistance to corporations to operate these phone lines 24 hours a day, 365 days a year. LHCC uses a hotline administered by a third party to enhance the potential for reporting FWA issues and allows callers to report their concerns anonymously. The hotline administrator logs all suspected FWA issues and forwards them immediately to the Centene Vice President for Ethics and Compliance for substantiation. If Centene's Vice President for Ethics and Compliance agrees that there is a problem related to LHCC, the Vice President will forward the information immediately to LHCC's Program Integrity Officer for action. LHCC will report this information to DHH and MFCU, or DHH and local law enforcement in accordance with the requirements of 15.1.16.4 of the RFP.

LHCC includes instruction in staff training on the variety of resources staff can use to report a FWA issue or concern, including the employee's supervisor, the Program Integrity Division, the toll free FWA Helpline, or Centene's Program Integrity Committee representatives. We stress during our training that the most important thing is to report any and all suspected instances of FWA or noncompliance without fear of retaliation. LHCC lists all reporting resources, including telephone and e-mail contact information, in training materials and the Employee Handbook. LHCC ensures that the written policies and trainings described above emphasize that any willful violation or failure to report will result in discipline up to and including termination of employment.

Prohibited Affiliations. LHCC will comply with the requirements of RFP Section 15.3 and applicable provisions of 42 CFR §438.610. We address the prohibition against inappropriate affiliations as an integral part of the Program Integrity training for new and existing employees, providers, subcontractors and consultants. In addition, on LHCC's behalf, Centene screens all LHCC employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, CHIP, and/or any federal health care program in compliance with the requirements of 42 CFR §455.436.

In conducting these screens Centene will search the following websites monthly and agrees to report all exclusion information discovered to DHH within three business days.

- OIG List of Excluded Individuals/Entities (LEIE)
- The Health Integrity and Protection Data Bank (HIPDB)
- The Louisiana Adverse Actions List Search (LAALS)
- The System for Award Management.
- Other applicable sites as may be determined by DHH

As required by RFP Sections 15.3.4.2 and 15.5.1, LHCC further agrees to notify DHH, within three business days of receipt, in the event LHCC receives notice that action is being taken against LHCC or any person defined in 15.3.4.1 of the RFP; or defined under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7); or any contractor which could result in exclusion, debarment, or suspension of LHCC or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

Rights of Recovery. LHCC will comply with the requirements of RFP Section 15.7. We acknowledge our responsibility for investigating possible acts of provider FWA for all services, including

subcontracted services. We further acknowledge that LHCC has the exclusive right of review and recovery for 365 days from a claim's original service date to initiate a "complex" review (as defined in RFP Section 15.7.2), to determine a potential overpayment or underpayment, by providing a written notice of the review initiation to the provider. LHCC also acknowledges that notice to the provider is prohibited in instances of suspected fraud, which LHCC has identified and referred to DHH, MFCU, or other law enforcement agency, unless approved by DHH. LHCC will complete all complex reviews within 120 days of the date of notice to a provider, unless DHH authorizes an extension. Monthly, LHCC will notify DHH of the results of "complex" reviews in accordance with the requirements of RFP Section 15.7.3.

We further acknowledge that if LHCC does not initiate a complex claim review within 365 days from the claim's original service date, DHH or its agent may recover any overpayments they identify from the provider. However, LHCC may conduct audits of providers' claims for a five-year period from the date of service and must report results of the audit reviews to DHH at least monthly in instances of suspected fraud or requiring collection. The funds collected from these reviews will remain with LHCC. We will not retain the exclusive right of review and/or recovery from the initial claim service date when DHH or its agent identifies improper payments as a result of "automated" claims reviews, as defined in RFP Section15.7.6. LHCC will return any overpayments that DHH identifies through an "automated" review.

When DHH or its agent notifies LHCC of potential improper payments from a complex or automated review, LHCC has 30 calendar days from the notification date to indicate whether the payments were corrected or adjusted prior to the notification date. We will not correct the claims nor initiate an audit upon notification unless directed to do so by DHH. In the event LHCC is notified by DHH or its agent that a provider has not timely refunded identified overpayments or arranged for an acceptable payment plan, LHCC will initiate a payment withhold on the provider in the amount due to DHH and will collect and refund any amount collected to the Department. LHCC and/or DHH will sustain any instance of a credit balance until resolved or dismissed under DHH rules.

LHCC Detection, Investigation, Corrective Action, and Reporting Processes

LHCC Detection Processes. LHCC, in partnership with Centene, has developed a two-pillar approach similar to that used by the Centers for Medicare and Medicaid Services (CMS), which takes advantage of both prospective and retrospective methods. This two-pillar approach allows LHCC the flexibility to stop payment for potentially wasteful or abusive claims. By employing a robust prepayment editing system combined with clinician reviews, LHCC is able to stop payment on every potentially miscoded claim versus paying providers and then recouping or entering into a settlement. This includes those claims that present upcoding, modifier misuse/abuse, unbundling, and age/gender issues.

In our experience, retrospective review settlements typically range between 50%-70% of the actual loss, whereas LHCC's robust prepayment review process stops 100% of the overpayment.

Prepayment review or prospective review is widely recognized as the most effective way in which to identify potential FWA and use of this approach is spreading. For example, the Patient Protection and Affordable Care Act (PPACA) requires state Medicaid agencies to use certain specific prepayment edits, and the Government Accounting Office (GAO) periodically recommends more widespread use of prepayment reviews in Medicaid. Beginning with claims submitted on October 1, 2010, PPACA required states to incorporate into their Medicaid Management Information System (MMIS) compatible National Correct Coding Initiative (NCCI) methodologies in order to promote correct coding and to control improper coding leading to inappropriate payment.

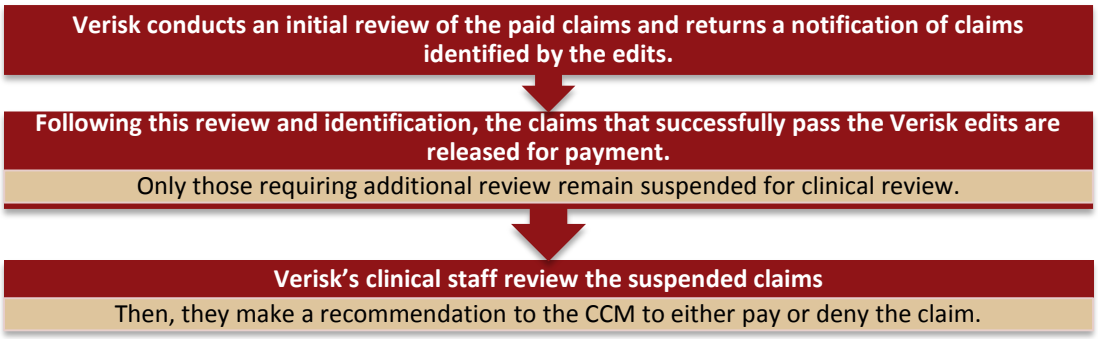
LHCC saved approximately $700,000 from January 2013 to December 2013 from avoiding paying incorrect claims identified through this prepayment review methodology for modifiers alone.

CMS is conducting prepayment demonstration projects in several states and some state Medicaid programs like Pennsylvania routinely use prepayment reviews. Finally, Governor Jindal advocated for wider use of prepayment methodologies in Medicaid in *The Freedom and Empowerment Plan: The Prescription for Conservative Consumer-Focused Health Reform*, April, 2014. Here Governor Jindal stating "Louisiana's new Bayou Health managed care model built in robust savings from fraud detection, requiring plans participating in Bayou Health to crack down on suspicious transactions or face financial penalties. But Congress should do more to end the current "pay and chase" model, which attempts to track down fraud after the-fact …"

Inappropriate modifier usage is one of the most common misused and abused billing practices detected by an investigative unit. Most state/federal agencies and other health plans allow providers to bill with modifiers and monitor for a high pattern of usage before opening an investigation or conducting a review. LHCC, in partnership with ***Verisk Health***, reviews every claim submitted with a modifier for proper usage. By reviewing the patient's claim history and diagnosis code, a clinician is able to create a clear picture of the services provided that day and determine whether the modifier was appropriate. Following this approach, LHCC does not need to wait for a reoccurring billing pattern to detect and avoid overpayments.

***Proactive FWA Detection Processes*.** AMISYS Advance, LHCC's claims processing system, has system edits that verify provider participation, member eligibility, benefit determination, and duplicate submissions prior to payment. LHCC proactively detects potential FWA using the prepayment editing/claims system edit methods described below. In total, all of LHCC's proactive FWA services combined saved approximately $6.3 million, or $3.40 per member per year (PMPY) in 2013.

- ClaimsXten Claims Software Editing. Centene's Coding Management (CCM) Department utilizes a McKesson product called ClaimsXten (CXT), as our primary code editing software. The CCM regularly reviews edit results and reports concerns to LHCC and Centene's SIU. The CCM provides LHCC with reports that assist with educating providers on appropriate coding practices. CXT reviews claims against common coding standards established by the American Medical Association (AMA), CMS, and various medical specialty societies. CXT identifies such potential FWA triggers as unbundling, mutually exclusive codes, procedure frequency-by-day, and age/gender discrepancies. During 2013, LHCC saved approximately $2.6 million, or $1.41 PMPY, by utilizing CXT.
- Physician Claim Clinical Review. Centene contracts with Verisk Health (Verisk) to enhance the claims software editing by adding a clinical review component. Clinical review enables an additional screening of clinical billing discrepancies on a prepayment basis, without disrupting claims turnaround time. Verisk uses thousands of edits to help reduce wasteful billing and can assess claims that cannot be identified by pure code editing software alone. Verisk can determine when modifiers are appropriately used, when procedures appear to be medically unlikely, or when two different providers are billing for the same service.



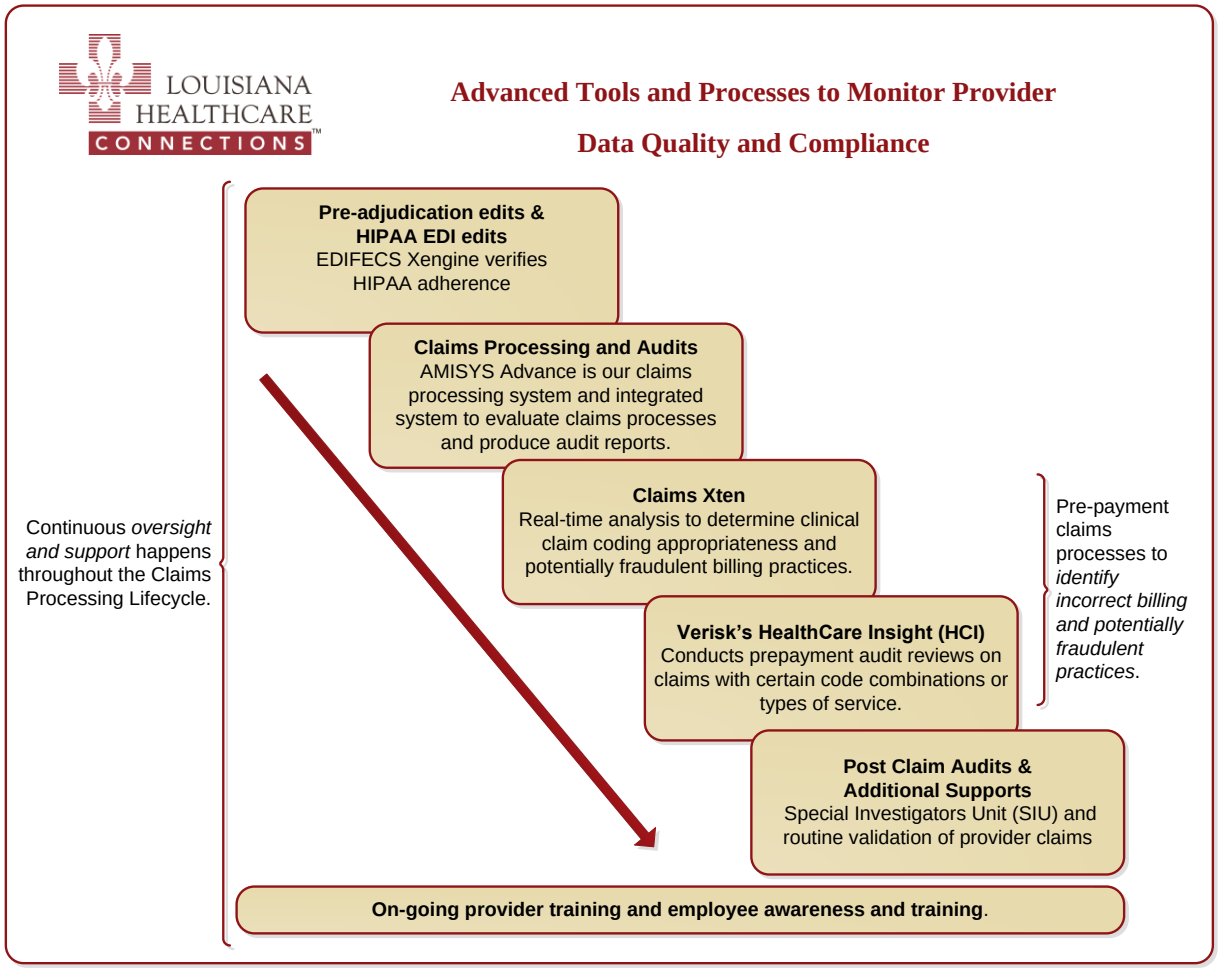
Clinician review is one of the most powerful tools LHCC employs to prevent FWA. By adding the clinician review, LHCC does not have to wait for a substantial loss before reviewing the provider's billing habits and opening a case. This process allows LHCC to review each claim before payment, avoiding excessive expense. LHCC saved an additional estimated $2.0 million in 2013 ($2.7 million when including the $700,000 saved through modifier reviews discussed above). During 2013, approximately 90% of the denials resulting from these reviews were never appealed by providers. Of those appealed, 50% were overturned resulting in an overall uphold rate of 95%. LHCC reviews reports semiannually to determine where edits should be modified to avoid providers who consistently code correctly from submitting appeals.

- Fraud Finder Pro Predictive Modeling**.** Centene's SIU also uses Fraud Finder Pro (FFP), a predictive modeling tool offered by Verisk that allows the SIU to identify aberrant provider patterns prior to payment. FFP compares provider billing habits by specialty, and flags providers with payments that vary by more than two standard deviations from the norm. Once a provider is flagged, LHCC is notified and the provider's claims are held to allow LHCC Program Integrity staff to conduct a mini preliminary investigation.
- The Investigator typically reviews the provider's contract, the provider's specialty, the State regulations, and health plan bulletins. If no reason can be found for the aberrant billing, a sample of claims will be denied and medical records requested. Once the Investigator reviews the sample records, they prepare and review a clinical summary. If the provider is billing appropriately, the case is closed with no further action. If the provider could benefit from education, the Investigator will prepare an educational letter for review by the LHCC Program Integrity Officer. If the provider consistently demonstrates inappropriate coding, the LHCC Investigator may open a retrospective case and place the provider on prepayment review for misused codes. This approach allows LHCC to quantify the loss on a larger scale and avoid additional losses while the investigation is completed. The Investigator will inform our Program Integrity Officer of the findings. Once informed, she will decide whether to immediately initiate recoupment and/or to report the potential violation to DHH, MFCU and/or local law enforcement (if it is a case of suspected member fraud). This practice saved LHCC approximately $1.0 million during 2013.

Reactive FWA Detection Processes. With the assistance of Centene's SIU, LHCC will utilize a variety of data mining tools to help identify providers who may be billing inappropriately. In addition to prepayment reviews, LHCC's Fraud Investigator will be responsible for data mining LHCC's paid claims, utilizing the following tools to identify at least one provider per month per Investigator for further investigation.

Tool	Description
EDIWatch Intelligent Investigator	LHCC's post-payment fraud and abuse provider profiling software. This innovative FWA detection software uses complex algorithms to identify suspicious billing trends, and contains hundreds of edits that identify outliers such as diagnoses or procedures incompatible with age/gender, mutually exclusive codes billed together, upcoding, add-on codes without primary CPT codes, and non-emergency procedures billed on Sundays or holidays.
Enterprise Data Warehouse (EDW)	The SIU analysts create ad-hoc reports using information from the EDW, which stores a variety of information including payment, provider, member, claims, and other insurance and forwards the report to the LHCC Program Integrity Officer. This tool has enabled and will continue to enable LHCC to develop reports that help identify members engaged in doctor shopping activities as well as frequent users of emergency rooms.
Claims Payment Audit	Centene's Internal Audit Department (Internal Audit) completes periodic, comprehensive audits on statistically valid samples of all processed claims, and validates whether a claim was authorized, entered and processed correctly, paid timely and to the correct provider. Internal Audit staff refer any suspicious claims to the LHCC Program Integrity Officer for further investigation.
Hotline Referrals	The SIU maintains a Fraud Waste and Abuse Hotline (1-866-685-8664) that is available to LHCC employees, members and providers. LHCC publishes this number in Member Handbooks, Provider Manuals, Newsletters, on the web portals, and discusses during provider orientations. All referrals are investigated and remain confidential. Members have called the hotline to report stolen ID cards, quality of care issues, falsified benefit determinations and family members abusing their privileges. Provider and Customer Services staff often identify and report suspicious activities identified when processing a provider or member complaint.
Member Fraud	Centene's SIU continuously analyzes claims data to detect member fraud, such as when members frequent different hospital emergency rooms to inappropriately obtain multiple prescriptions for controlled substances. Member, provider and Medical Management staff, and SIU Hotline staff also identify and report potential member fraud. If an instance of suspected member fraud is identified, staff report it immediately to the LHCC Program Integrity Officer, who in turn reports it immediately to DHH and local law enforcement.
Explanation of Benefits (EOBs)	Using RAT-STATs, a free statistical software package offered by the OIG, we send random EOB mailings to members to verify services provided. The sample size is enough to produce accurate results up to a 95% confidence interval with an anticipated error rate of 10%. We ask Members who receive an EOB but believe they have not received the service to call the LHCC's Customer Service Department. Customer Service staff gather the appropriate information and forward validated concerns to the LHCC Program Integrity Officer who will assign the case to an LHCC FWA Investigator for further review. The Investigator will conduct a preliminary investigation and, if needed, submit additional requests for member surveys via telephone. To ensure member privacy, sensitive and confidential treatment services are excluded from the random paid claims selection criteria that generate the EOBs.

The diagram on the following page illustrates the different filters through which claims are subjected to monitor claims quality and provider compliance as they move through the claims processing lifecycle:



LHCC Investigation Processes. Following detection of FWA, LHCC's investigative processes involve LHCC preliminary investigations, State conducted investigations after reporting to the State, and clinical and medical record review. The LHCC Investigators will maintain the confidentiality of all FWA referrals, including those received through the Fraud Hotline.

When an LHCC Investigator is notified of potential fraud or abuse, after timely reporting to the Program Integrity Officer and applicable State agencies, s/he will use Trail Tracker (a SIU case tracking system) to assign a case number, and then conduct a preliminary investigation to determine if the case is credible. If the Investigator detects no irregularity, s/he will close the case, file it for future reference, and inform the Program Integrity Officer of the results. LHCC notifies DHH in accordance with the requirements of 15.1.16.4.

If the Investigator determines the initial evidence suggests a billing irregularity, s/he will select a sample of claims for medical record review and send the request to the LHCC's Program Integrity Officer for approval. Once approved, the Investigator will send a certified letter to the provider requesting medical records. Once the medical records are received, the Investigator will inform the Centene Clinical Team, located within the SIU, that the medical records are available for review. The Clinical Team will review the records, prepare a clinical findings summary and discuss the results with Centene's Chief Medical Officer. Our Investigator will review the clinical findings and prepare the final investigation report.

If the Investigator identifies fraud or abuse, the Investigator will work closely with Centene's SIU and the LHCC Program Integrity Officer to determine the appropriate next steps, including required reporting to the State and appropriate corrective action.

Preliminary Investigation. Once we report a concern to the State, LHCC's Program Integrity Division will assign a case number and conduct a preliminary investigation in accordance with the requirements of RFP 15.1.16.7. LHCC will conduct a preliminary investigation on every suspected and/or confirmed fraud and abuse case unless we receive notification from a State or federal agency indicating that no action should be taken. We will complete the preliminary investigation within 30 working days of receipt of the allegation.

The Program Integrity Division will consult with Centene's SIU to determine historical information. For providers and delegated subcontractors, we will assess the following:

- Whether LHCC has received previous reports of potential billing issues pertaining to the provider or subcontractor. If so, we will collect the previous investigation documentation to determine whether the current allegation is related or unrelated.
- Whether and when the provider or subcontractor previously received training on issues relating to the allegation
- The provider's billing and payment history for other suspicious indicators (usually covering a one- to three-year time period)
- The provider's prescribing habits (if available) to determine if a potential quality of care issue exists
- Which, if any, State regulations or program policies and procedures have been violated

For members, the following circumstances may trigger an investigation:

- Review of encounter data reflecting treatments and/or medications that have been prescribed by more than one provider; and appear to be duplicative, excessive or contraindicated
- Review of the member's prescription history indicates insufficient office visits to support the medications received
- Patient encounter data reflects that a provider other than the assigned PCP is treating the member, and there is no evidence that the member was treated by the assigned PCP for a similar or related condition
- Claims history indicates that the member has a high volume of Emergency Room visits with non-emergent diagnoses

Investigations Conducted by the State. Once we report a case of suspected fraud to the State, LHCC will suspend all plan efforts to investigate, resolve, or take further action, if directed to do so by the DHH, to avoid interfering with any ongoing State investigation or enforcement process. Neither LHCC nor Centene will disclose the existence of any investigation conducted by DHH or a federal law enforcement agency. If the State directs us to suspend our investigation, our Program Integrity Officer will suspend the investigation.

Clinical Review. If our Investigator determines a clinical record review is required, s/he will select a random sample of services for review using RAT-STATs. The sample will represent a 95% confidence interval. Once a sample is selected, the Investigator will prepare and send the medical record request to the provider by certified mail. The letter, which will contain an Attachment A that lists the record submission requirements, will also request return of the records within 14 days to LHCC. If we do not receive the records, the LHCC Program Integrity Officer will coordinate with Provider Relations staff to go onsite to the provider's office to obtain the records.

Once LHCC receives the medical records, the LHCC Investigator will prepare a spreadsheet for review by Centene's Clinical Review Unit. The spreadsheet contains a list of all the CPT Codes by member and date of service. The Investigator reviews the medical records and flags any abnormalities that should be identified for clinical staff who compare the claim history to the medical records to determine medical necessity, appropriateness and completeness. If applicable, CPT codes incorrectly billed will be flagged and marked with the appropriate code. For all codes flagged as incorrect, the Clinical Review Unit will indicate why they are inappropriate.

If we determine that fraud, waste, or abuse may have occurred, our Program Integrity Officer will report the investigative findings immediately to DHH and MCFU, or other appropriate agency in accordance with the requirements of 15.1.16.4 of the RFP. The Integrity Officer will use a Fraud Reporting Form deemed satisfactory by the agency to which the report is to be made in accordance with the requirements of 15.1.16.5 of the RFP.

Medical Record Review. Anytime LHCC receives records requested as part of preliminary investigation or sample review, the Investigator will utilize Centene's Clinical Review Unit to review the records to ensure the services billed are appropriately documented. The review team is comprised of RN's, LPN's and certified coders. Clinical Review Unit will review all clinical findings with LHCC's and Centene's Chief Medical Officers or physician designees, and provide a report detailing their review, and the LHCC FWA Investigator will use the report to calculate potential overpayments. They also provide key information when developing the provider education letter. When the Clinical Review Unit team reviews medical records, they will, at a minimum, ensure that the medical records meet the requirements at 15.6 of the RFP.

Prior to the medical record review, our Investigator will ensure that the medical records are scanned and stored securely. We also will ensure that we maintain an electronic copy of the medical records for at least six calendar years after the last date of service has been provided to a member or authorized agent. When we are notified that the records are subject to a review, audit investigation or judicial action by a State or federal agency, we will retain those records until the matter is resolved. LHCC will provide to the member one free copy of the member's medical record, upon the member's request.

LHCC Corrective Action Processes. Upon completion of the investigation, LHCC will respond promptly. The following are some of the actions we may take in response to an investigation:

Provider/Subcontractor Education. If LHCC determines a billing error exists, but not abuse or fraud, the LHCC Program Integrity Division will work with Provider Relations (PR) staff to prepare appropriate educational materials. Our Investigator will prepare and send an education letter to the provider, and a PR Specialist will coordinate a meeting with the provider, the Investigator, and the Clinical Review Unit team to review the results of the investigation. We also will facilitate education/training of provider office staff related to correct billing guidelines, and work out the details for repayment of any funds owed. The education letter will describe the errors found during the review and the regulations violated. The letter also will include a notice of intent to recoup the overpayment and whether any services will be placed on prepayment review. Providers have the right to appeal any planned recoupment.

Corrective Action Plans (CAP). Our Program Integrity Division, working in conjunction with PR staff and with the Chief Medical Officer, will develop with the provider a corrective action plan to resolve billing or service issues. Corrective measures vary but normally must be completed within six weeks of agreement. The Program Integrity Division, working with Quality Improvement and Provider Relations staff, will monitor progress and compliance, usually up to 180 days after CAP completion. The Program Integrity Officer will oversee the CAP implementation and completion.

Member Education and Other Actions. For members who waste or misuse health benefits and services, the Program Integrity Officer, our Chief Medical Officer, and VP of Medical Management will jointly determine the most appropriate member education and outreach. Such education may include a phone call

by a Customer Services Representative to further explain health benefits and to remind the member about the availability of NurseWise. We may refer the member to Case Management for a health risk assessment and education. We will also contact the member's PCP to be sure he or she is coordinating the member's care appropriately. For members whose wasteful activities involve drug seeking or drug abuse behaviors, the Program Integrity Officer immediately refers the member to our Pharmacy Lock-in Program and notifies Case Management for member referral into our substance abuse program. If we suspect the member of fraudulent activities, the Program Integrity Officer will immediately report the suspected fraud and abuse to DHH and local law enforcement and will work cooperatively with them to determine appropriate next steps.

Enforcement of Standards. As described above, we use a number of different methods to notify and educate internal staff and providers about our FWACP. This includes how LHCC will enforce the program requirements. LHCC will ensure that the written policies and training programs described in this response will also be included in provider agreements and provider manuals and emphasize that any willful violation or failure to report suspected fraud and abuse will result in discipline up to and including termination of employment.

We will also ensure that our provider agreements include a provision requiring that the provider comply with Section 15 of the RFP as a condition of receiving any Medicaid payment. Similarly, LHCC will enforce compliance by subcontractors with corrective action clauses and the inclusion of a provision requiring that the subcontractor comply with Section 15 of the RFP as a condition of receiving payment. Should we find an issue or receive a report of a concern, we notify DHH and the MCFU, discuss it with the subcontractor, and implement a corrective action plan. Severe or repeated issues may result in termination of the subcontract and if warranted, a report to the appropriate authorities.

Recoupment. The LHCC Program Integrity Officer will determine, based on investigation results and medical records/clinical review, when an overpayment has occurred and recoupment procedures should be initiated. LHCC will collect overpayments in accordance with our recoupment policies and procedures and applicable federal and State laws. The recoupment figure will be based on the dollar value error rate identified during the clinical review. Providers will have the right to appeal any planned recoupment.

LHCC Reporting Processes. LHCC complies with all RFP reporting requirements, including Sections 15.1.16 and 15.5, and all applicable federal and State laws and regulations. LHCC acknowledges that DHH may impose a civil penalty for willful failure to report fraud and abuse by recipients, applicants, members or providers to DHH or MFCU as appropriate. LHCC will promptly report to DHH all instances of suspected fraud, abuse, waste, neglect, and overpayment upon discovery, including all internal and external tips as required by RFP Section 15.1.16.3 and in accordance with RFP Section 15.5.1. If any situation is believed to be fraud or abuse after review by the FWA Investigator, LHCC's Program Integrity Officer will be notified immediately. The LHCC Program Integrity Officer will immediately notify the appropriate State offices in accordance with the requirements at RFP Sections 15.1.16 and 15.5 and initiate a preliminary investigation.

Reporting Suspected Provider Fraud. A crucial part of our FWACP is to report any provider whose billing activity appears to be more than erroneous or even abusive to the State. While LHCC educates providers and their office billing staff about errors, LHCC will report any provider to DHH. We also will report any credible report of fraud, or any case in which we have not received requested recoupment. Our LHCC Program Integrity Officer, or designee, will forward the following information to DHH and the appropriate State agencies, using an approved Fraud Reporting Form, in accordance with RFP Sections 15.1.16.4, 15.1.16.5, and 15.5. The Program Integrity Officer, or designee, shall provide, at a minimum, the following information:

- Provider name and ID number
- Source of the potential compliance issue (if known)

- Type of provider
- Nature of the potential compliance issue
- Approximate dollars involved
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant

LHCC recognizes and will provide documentation to any of the State identified resources below:

- Louisiana Medicaid Office of Program Integrity
- The Louisiana Medicaid fraud hotline toll free number, 1-800-488-2917
- DHH website www.dhh.state.la.us
- The Attorney General's Medicaid Fraud Control Unit
- The Louisiana Department of Insurance

Reporting Suspected Member Fraud. LHCC monitors our program, including critical case management data, member calls, and claims data to deter, detect, and resolve any issue with member fraud. Some of the indicators we train our staff to detect include:

- Similar medications prescribed by more than one doctor
- Members receiving similar treatment by more than one doctor
- Excessive doctor visits to providers other than the member's PCP
- High volume of ER visits

LHCC does not consider these indicators proof of member fraud but rather indications that a member's chronic condition is not under control or the member has a condition that has not been properly diagnosed and requires plan intervention. If LHCC has suspicions or knowledge of member fraud or abuse, we will report it immediately to DHH and local law enforcement.

***Reporting Compliance Activity to the State*.** LHCC reports FWA activities progress, including meeting goals and objectives, quarterly to DHH in accordance with the requirements of RFP Section 15. We also report provider educational initiatives related to billing and medical records. We will keep DHH informed of important findings of our investigations, such as trends in a certain type of billing error in one part of the State or an identifiable health system, or a group of providers that appeared to be billing members inappropriately. LHCC will also include a list of recoupments from providers in its quarterly report. In addition, LHCC reports complaint numbers and information required by RFP Sections 15.5.2 and 15.1.16 and attests monthly to DHH that records searches to capture exclusions have been completed as required by RFP Section 15.5.3.

Best Practices Identified by Affiliate Plans

LHCC's Program Integrity Division draws upon Centene's significant clinical experience, expertise, and cutting edge analytical tools, as well as our 18 Medicaid affiliate plans to discuss program integrity trends and to seek advice on best practices to prevent, detect, and eliminate FWA. In addition to numerous instances of smaller scale improvements resulting from the adoption of best practices from other contracts, LHCC has identified three best practices from four affiliate health plans in other states that could have a significant positive impact on our program integrity efforts:

1. **Peach State Health Plan (Peach State), our affiliate in Georgia**. Peach State has instituted a more assertive approach to a second medical record request letter. Peach State sends a letter informing providers undergoing a claims review by program integrity staff that records were previously requested and not received. The letter instructs the provider to submit records within 14 days or Peach State will assume that the services for which claims were submitted were not rendered, and recoupment of the funds will be initiated within 45 days of the date of the letter. In the past, many providers (undergoing claims reviews) from whom LHCC has requested records have not responded timely. Changing our procedures to include a more assertive approach that clearly explains the consequences of not timely submitting the requested records should improve the response rate as it has for Peach State. In addition, this change would also help us to move more quickly to recoupment.
2. **Superior Health Plan (Superior), our affiliate in Texas**. Superior experienced difficulty obtaining requested records timely from providers undergoing a validation of irregularities found in a prepayment review. Like Peach State, Superior decided a change in their procedures was warranted but decided to take a slightly different approach. Superior recently approved sending a demand letter to providers from whom records were requested to validate their prepayment review, if the provider doesn't submit the records timely. The letter explains that Superior previously requested records that have not been received and informs the provider that failure to comply with this second request may result in a full audit of 50 member records, and/or a referral to the OIG, if the records are not received within 30 days of the date of the letter. We view this approach as another option we may consider to improve the provider response rate for record requests.
3. **IlliniCare Health (IlliniCare) and Granite State Health Plan (Granite State), our affiliates in Illinois and New Hampshire.** Both IlliniCare and Granite State changed their policies regarding desk audits of personal care cases to conduct the desk audits by in-state plan staff rather than by Centene's SIU staff. IlliniCare and Granite State both view taking responsibility for the desk audits as more efficient and more effective because in-state staff have a better grasp of the issues and know the providers better than staff from another state. With the addition of in-state FWA Investigators, LHCC will assume responsibility for desk audits and apply as a best practice what IlliniCare and Granite State have learned about conducting audit processes.

We will continue our practice of communicating regularly with our affiliate health plans, seeking best practices to improve our program integrity efforts. We will consider adopting those that are consistent with the requirements of section 15 of the RFP. In addition, prior to implementation we will work with Customer Service staff to ensure that we explain changes clearly and effectively to members and providers, and provide proper notice of any changes that might affect member and provider rights and responsibilities.

V.2 Provide a description your Corporate Program Integrity Division including the Program Integrity Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart D in your response) involved in compliance along with staff levels of authority.

LHCC is well positioned to enhance our Fraud and Abuse Detection and Prevention program to meet DHH's new Program Integrity contract requirements. LHCC will quickly deploy an effective Program Integrity Division team, led by the Program Integrity Officer and supported by LHCC's parent company, Centene Corporation (Centene). Our "best of breed" corporate structure for program integrity combines LHCC's experience leading program integrity efforts with Centene's technological and clinical review support and experience using in-state investigators in two affiliated health plans in other states. We are also well positioned to review and enhance our existing program on an ongoing basis to ensure we meet the DHH goal of developing and implementing the "best of breed" Medicaid Program Integrity operation.

LHCC and Centene's Corporate Program Integrity Division will fully comply with all regulatory and statutory requirements including RFP Section 4.2.7, Program Integrity Officer; Section 15, Fraud, Abuse, and Waste Prevention, including Sections 15.1.2, 15.1.12, 15.1.23, 15.2.3.2, 15.5.2.2; and all other applicable RFP sections, and federal and state law requirements.

Corporate Program Integrity Division

LHCC will draw upon Centene's well-defined, "best of breed" corporate structure for program integrity to help DHH achieve the desired outcome of decreased fraud, abuse, and wasteful spending in the Medicaid program. The Program Integrity corporate structure consists of LHCC's Program Integrity Division, Centene's Special Investigation Unit (SIU) and Centene's Compliance Coding and Cost Recovery Unit. In addition Centene manages a Compliance Committee and LHCC manages a Program Integrity Committee.

The LHCC Program Integrity Division is the focal point of LHCC's program integrity and fraud, waste, and abuse prevention, detection, investigation, corrective action, and reporting activities. The LHCC Program Integrity Division will operate independently from the program integrity infrastructure of Centene but will receive support from the SIU, Compliance Coding and Cost Recovery, and Centene's technology infrastructure. LHCC's staff expertise and infrastructure and Centene's clinical and technology support will combine to ensure that LHCC develops and manages a robust fraud, waste and abuse (FWA) program that meets federal and state requirements and the expectations of DHH.

In addition, LHCC will coordinate activities with other LHCC department executives, including LHCC's Vice President of Network Contracting and Provider Relations, Vice President of Operations, Director of Member and Provider Services, and Chief Medical Director; and with Centene's Vice President for Program Integrity, Vice President for Ethics and Compliance and, as previously stated, Centene's SIU and Compliance Coding and Cost Recovery staff. LHCC's Fraud, Waste, and Abuse Compliance Plan (FWACP) establishes effective lines of communication between the Program Integrity Officer and LHCC employees, providers, and contractors enforced through well publicized disciplinary guidelines.

LHCC Program Integrity Division. In accordance with the requirements of Section 15.1.12, LHCC will establish and operate a Program Integrity Division with adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist in preventing and detecting potential fraud, waste, and abuse. A Program Integrity Officer experienced and trained in program integrity, health care, and risk management will head the Division. LHCC will build upon successful compliance activities directed by the LHCC Vice President of Compliance, who will take on the role of Program Integrity Officer.

With the creation of the Program Integrity Division, LHCC will take on program integrity responsibilities that were previously performed for LHCC by Centene, including monitoring and sampling paid claims

data for discrepancies and investigating any discrepancies found. In addition, LHCC will continue current activities, including developing and implementing the LHCC FWACP; planning and providing program integrity training for LHCC employees; and developing, implementing, and monitoring corrective action plans. Centene will continue to provide policy guidance, claims analysis support, and clinical review support. The Division will continue to carry out LHCC's responsibility for compiling and submitting reports to DHH, the Office of Attorney General Medicaid Fraud Control Unit (MFCU), and other appropriate agencies and for meeting with and maintaining effective lines of communication with DHH and the MFCU, LHCC employees, providers, and contractors.

LHCC Program Integrity Officer. LHCC's current Vice President of Compliance, located in Louisiana, will serve as LHCC's Program Integrity Officer and will report directly to LHCC's President and Chief Executive Officer. The Program Integrity Officer will also have direct access to the LHCC Board of Directors, and will have the authority to assess records; investigate suspected instances of fraud and abuse; and independently refer suspected member fraud, provider fraud, and member abuse cases to DHH and other duly authorized enforcement agencies.

The Program Integrity Officer will serve as the Chair of the LHCC Program Integrity Committee, and as LHCC's authority on fraud, waste, and abuse. She also will serve as the LHCC's primary point of contact for communicating with regulatory authorities, including the MFCU and DHH, regarding the LHCC FWACP and other fraud, waste and abuse prevention and detection activities. The Program Integrity Officer and CEO or COO will meet with DHH and the MFCU quarterly, annually, and at DHH's request, to discuss fraud, abuse, waste, neglect, and overpayment issues.

The Program Integrity Officer will also communicate regularly with Centene's Vice President for Ethics and Compliance; Vice President of Payment Integrity and SIU; as well as with colleagues at affiliate health plans on common issues, best practices, and training initiatives. Finally, the Program Integrity Officer will direct the operations of LHCC's Program Integrity Division, overseeing the development, monitoring, and enforcement of LHCC's Fraud, Waste and Abuse Compliance Program and, in conjunction with the Program Integrity Committee, the implementation of LHCC's state approved FWACP.

LHCC Program Integrity Committee. The LHCC Program Integrity Committee, led by the Program Integrity Officer, advises and assists the Program Integrity Officer in developing program integrity policy and in overseeing program implementation. The Program Integrity Committee is comprised of LHCC staff from key operational areas that have the authority to commit resources to address noncompliance with program integrity requirements. The Committee's membership will include, but not be limited to staff from Medical Management, Quality, Provider Relations and Customer Service. The Program Integrity Committee reports to the LHCC Board of Directors and its functions include, but are not limited to:

- Analyzing LHCC's environment, regulatory requirements and risks for noncompliance
- Assessing and revising existing policies and procedures to more effectively address state and federal requirements and goals
- Recommend and monitor, in conjunction with the relevant LHCC departments, improved processes and procedures for carrying out LHCC's program integrity responsibilities
- Determining the appropriate methods for promoting program integrity and for detecting potential areas of noncompliance
- Maintain a system to solicit, evaluate and respond to program integrity concerns, including oversight of investigations resulting from reports made to anonymous hotlines

Centene Program Integrity Structure. Centene's Vice President for Ethics and Compliance and Vice President for Payment Integrity lead the Program Integrity function at Centene. The Vice President for Ethics and Compliance oversees Centene's SIU, which provides investigative guidance and technological support, in conjunction with other Centene departments; and clinical review support to the Program Integrity Divisions of LHCC's affiliate health plans and LHCC. The Vice President for Payment Integrity oversees Compliance Coding and Cost Recovery, which provides guidance and support on clinical coding and cost recovery to LHCC's Program Integrity Division, as well as to other affiliate health plans. The Vice President for Payment Integrity is also at the focal point of a Centene effort to use analytics to develop payment policies designed to limit or eliminate wasteful billing.

Centene's **Internal Audit Department** (Internal Audit) supports the investigative functions of the SIU. Internal Audit completes periodic, comprehensive audits on statistically valid samples of all processed claims to validate whether a claim was authorized, entered, and processed correctly, paid timely, and to the correct Provider. Internal Audit currently refers any suspicious claims to the SIU for further investigation and will, in the new contract period, refer suspicious claims from LHCC providers to the LHCC Program Integrity Division for investigation.

The SIU also maintains a **Fraud Waste and Abuse Hotline** (1-866-685-8664) that is available to LHCC employees, members, and providers. LHCC publishes this number in Member Handbooks, Provider Manuals, Newsletters, and on our web portals. We also discuss the Hotline in provider orientations. Members have called the Hotline to report stolen ID cards, quality of care issues, falsified benefit determinations and family members abusing their privileges.

Provider and Customer Services staff often identify and report suspicious activities discovered when processing a provider or member complaint. SIU will report and refer suspicious activity involving LHCC providers, subcontractors and members to the LHCC Program Integrity Division for investigation. Centene and LHCC will protect the confidentiality of all Hotline referrals and tips received through Customer and Provider Services and all related follow-up.

The SIU continuously analyzes claims data to detect member fraud, waste or abuse such as when members frequent different hospital emergency rooms to inappropriately obtain multiple prescriptions for controlled substances. Member, Provider and Medical Management staff also identify and report potential member fraud. When Centene staff identify instances of potential fraud, waste or abuse involving LHCC members, they will report these instances to the LHCC Program Integrity Division, which will follow up in accordance with the requirements of RFP Section 15.

Centene's Compliance Committee. The Vice President for Ethics and Compliance leads the Centene Compliance Committee, which reports directly to Centene's Board of Directors. The Committee, which meets at least every calendar quarter, evaluates Centene's adherence to compliance requirements, including fraud, waste and abuse requirements, and establishes and oversees the implementation of any corrective action plans. The Committee is supported by compliance analysts and key subject matter experts and is composed of senior level staff including:

- Vice President for Ethics and Compliance
- Vice President for Payment Integrity
- Senior Vice Presidents for Health Plans and Internal Audit
- Director, Medicare Compliance
- Senior Vice Presidents/Vice Presidents for Medical Management
- Vice Presidents for Specialty Company, and Payment Integrity
- Vice Presidents/Directors for Finance, Claims Operations, Legal, IT Security and Systems, Member and Provider Services, and Human Resources

Centene Technology System Resources. LHCC uses Centene's robust technology resources with clinical review services to support a two pillar, prospective and retrospective approach similar to that employed by the federal Centers for Medicare and Medicaid Services (CMS). By employing a robust prepayment editing system combined with clinician reviews, LHCC stops payment on every potentially miscoded claim, including those with upcoding, modifier misuse/abuse, unbundling and age/gender issues, rather than paying providers and then recouping or entering into a settlement. LHCC saved approximately $1.0 million from January to December 2013 with this approach.

Systems and Services Supporting Proactive Fraud Detection. AMISYS Advance, LHCC's claims processing system, edits verify provider participation, member eligibility, benefit determination and duplicate submissions prior to payment. LHCC uses Centene's robust technology systems, some of which are highlighted below, to proactively detect potential FWA. In total, LHCC's proactive FWA services saved approximately $6.3 million or $3.40 per member per year (PMPY) in 2013.

- ClaimsXten Claims Software Editing. Centene's Coding Management (CCM) Department utilizes a McKesson product called ClaimsXten (CXT), as the primary code editing software. CXT reviews claims against common coding standards established by the American Medical Association (AMA), CMS and various medical specialty societies. CXT identifies potential FWA triggers such as unbundling, mutually exclusive codes, procedure frequency-by-day, and age/gender discrepancies.
- Physician Claim Clinical Review. Centene contracts with Verisk Health (Verisk) to enhance the claims software editing by adding a clinical review component. Clinical review enables an additional screening of clinical billing discrepancies on a pre-payment basis, without disrupting claims turnaround time. Verisk uses thousands of edits to help reduce wasteful billing and can assess claims that cannot be identified by pure code editing software alone. Verisk can determine when modifiers are appropriately used, when procedures appear to be medically unlikely, or when two different providers bill for the same service.
- Fraud Finder Pro Predictive Modeling**.** SIU also uses Fraud Finder Pro (FFP), a predictive modeling tool offered by Verisk that allows the SIU to identify aberrant provider billing patterns prior to payment. FFP compares provider billing habits by specialty and flags providers with payments that vary by more than two standard deviations from the norm.

Systems Supporting Reactive Fraud, Waste and Abuse Detection**.** With the assistance of Centene's SIU, LHCC will utilize a variety of data mining tools to help identify providers who may be billing inappropriately. In addition to prepayment reviews, LHCC's Fraud Waste and Abuse Investigators (FWA Investigator) will be responsible for data mining LHCC's paid claims, utilizing the following tools to identify at least one provider per month per investigator for further investigation.

- Enterprise Data Warehouse (EDW). The SIU analysts create ad-hoc reports using information from this warehouse, which stores a variety of data including payment, provider, member, claims, and other insurance and forwards the report to the LHCC Program Integrity Officer. LHCC will continue to use this tool to develop reports that help identify members engaged in doctor shopping activities as well as frequent users of emergency rooms.
- Explanation of Benefits (EOBs). Using RAT-STATs, a free statistical software package offered by the Office of Inspector General, LHCC sends random EOB mailings to members to verify services provided. LHCC uses a sample size sufficient to produce accurate results up to a 95% confidence interval with an anticipated error rate of 10%. LHCC asks members who receive an EOB, but believe they have not received the service, to call the LHCC Customer Service Department.
- Customer Service staff gather the appropriate information and forward validated concerns to the LHCC Program Integrity Officer who will assign the case to an LHCC FWA Investigator for further review. The FWA Investigator will conduct a preliminary investigation and, if needed, submit

additional requests for member surveys via telephone. To ensure member privacy, LHCC excludes sensitive and confidential treatment services from the random paid claims selection criteria that generate the EOBs.

- EDIWatch Intelligent Investigator. EDIWatch is LHCC's post-payment fraud and abuse provider profiling software. This innovative fraud and abuse detection software uses complex algorithms to identify suspicious billing trends, and contains hundreds of edits that identify outliers such as diagnoses or procedures incompatible with age/gender, mutually exclusive codes billed together, upcoding, add-on codes without primary CPT codes, and non-emergency procedures billed on Sundays or holidays.

Staff Levels of Authority and Functions

LHCC Program Integrity Staff. A team of full-time FWA Investigators located in Louisiana will support the Program Integrity Officer, who will report directly to the LHCC CEO. As previously discussed, the LHCC Program Integrity Officer will have the authority to assess records; investigate suspected instances of fraud and abuse; independently refer suspected fraud and abuse cases to DHH and other duly authorized enforcement agencies; chair the LHCC Program Integrity Committee; act as LHCC's authority on waste, fraud, and abuse; and be the primary point of contact for communicating with regulatory authorities.

LHCC will draw on the experience of Centene's affiliate health plan in Kansas, Sunflower Health Plan (Sunflower), to design Program Integrity Division staffing and functions, as this plan has significant experience operating a Program Integrity Division with in-state investigators. For example, Sunflower has learned how to take full advantage of the investigative, technological, clinical and coding resources available to them through the Centene Program Integrity infrastructure. Sunflower received assistance from Centene in developing its Program Integrity infrastructure, designing the FWA Investigator job description, and designing the Investigator's training program, including training on Program Integrity technological tools.

Initially LHCC will employ 4 full-time FWA Investigators as required by the RFP for an estimated enrollment in excess of 300,000. Within 30 days of the start of the new contract period, we will review LHCC enrollment and expeditiously hire additional FWA Investigators, as needed, to meet contractual requirements. We will use the staffing formula found at RFP Sections 15.1.12 and 15.1.23 to determine the appropriate number of investigators; 1 full-time investigator physically located within Louisiana for every 100,000 members or fraction thereof. LHCC will review enrollment quarterly and hire additional investigators as needed to meet requirements.

The LHCC FWA Investigators will report to the LHCC Program Integrity Officer and will, under the direction of the Program Integrity Officer, monitor and sample paid claims data for discrepancies; investigate any discrepancies found; assist in the development and implementation of the FWACP; plan and provide Program Integrity training for LHCC employees; and develop, implement, and monitor corrective action plans.

Centene Program Integrity Staff. The LHCC Program Integrity Division will have at its disposal Centene's FWA policy expertise and considerable clinical and technological resources Centene deploys to prevent and detect fraud, waste, and abuse. The LHCC Program Integrity Officer will have access for FWA policy guidance and advice to Centene's Vice President for Ethics and Compliance, and Vice President for Payment Integrity. Centene's SIU staff provides, and will continue to provide assistance to LHCC's Program Integrity Division through training, providing guidance and advice on investigations, and conducting clinical review support.

The SIU team supporting LHCC's Program Integrity Division includes well educated associates with Bachelor's and Master's Degrees in relevant specialties including Criminal Justice, Health

Administration, Healthcare Management, Finance, Communications, and Nursing. Their combined experience includes working with fraud, waste, and abuse requirements related to Medicaid, Medicare, Commercial Insurance, Workers Compensation, Property and Casualty, Underwriting, Claims Configuration, Consumer Funds, Investigations, and Dental Claims.

In addition to relevant education, the SIU team also possesses significant professional experience in their fields. The SIU team includes AHFIs, LPNs, RNs, a Certified Fraud Examiner, an attorney, Certified Pharmacy Techs, Certified Professional Coders, a BLS certified instructor, an ACLS certified instructor, PALS, Trauma Nurse Core Certified, a Nationally Board Certified Emergency Nurse, a Certified Professional Compliance Officer, a Certified Professional Code – Payer, and a Certified Healthcare Chart Auditor. SIU staff are active in national and state associations concerned with compliance and fraud, waste and abuse including the Health Care Compliance Association (HCCA) and the National Health Care Anti-Fraud Association (NHCAA). They regularly attend conferences and training sessions sponsored by both organizations.

Centene staff will perform the following major functions in support of LHCC:

- Reference and background checks for all LHCC employees, to verify each applicant's Social Security number, national criminal history, previous employment, education and exclusions at LEIE, EPLS/SAM.gov and Debarment List Status
- Screening employees for ownership or controlling interest relationships and exclusions upon hire and monthly thereafter to identify any conflicts and potential criminal offenses involving Medicaid, Medicare or Children's Health Insurance Program
- Screening subcontractors against LEIE, EPLS/SAM.gov and Louisiana exclusions lists
- Screening provider credentials and criminal activity to determine if exclusion is warranted

Organizational Chart of Staff

Please see the Program Integrity Division Organizational Chart on the following page.

Program Integrity Division Organizational Chart. The Program Integrity Organizational Chart depicts LHCC's Program Integrity Division including the Program Integrity Officer's levels of authority and reporting relationships. The Chart also illustrates the organizational structure of the Centene Program Integrity functions, and staff involved in Centene's FWA and Compliance activities.

LHCC's Vice President, Compliance, who also serves as LHCC's Program Integrity Officer, leads the Program Integrity Division. The Program Integrity Officer reports directly to the LHCC Chief Executive Officer, and is also responsible to the LHCC Board of Directors. The Program Integrity Officer chairs the LHCC Program Integrity Committee, which is responsible to the LHCC CEO and Board of Directors. The Program Integrity Officer supervises a staff of FWA Investigators located within Louisiana.

As indicated by the dotted line on the chart, the Program Integrity Officer also maintains relationships with the Centene Vice Presidents for Ethics and Compliance and for Program Integrity, as well as the Centene Compliance Committee.

The Centene Vice President for Ethics and Compliance leads Centene's Compliance Committee, which reports to the Centene Board of Directors. As indicated by the dotted line on the chart, the Centene Vice President for Program Integrity is a member of and maintains a relationship with the Centene Compliance Committee.

Although LHCC's Program Integrity Officer will receive policy advice and technological, clinical and coding support from Centene's Program Integrity infrastructure, she will have the authority to, and responsibility for, independently operating LHCC's Program Integrity Division and Program.

LOUISIANA HEALTHCARE CONNECTIONS™

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