Community Health Group	POLICY TYPE: ☒Corporate ☐ Divisional			
EFFECTIVE DATE: 01/01/08	INITIAL APPROVAL DATE: 01/01/07	NEXT REVIEW DATE: May 2017	POLICY NUMBER: 5509.2	
REVISION APPROVAL DATE: 03/01/07, 03/08, 03/09, 01/10, 12/10, 3/11, 3/12, 09/13, 5/14, 11/14, 3/15, 4/16		APPLIES TO PRODUCT TYPE: ☒Medi-Cal ☒ CMC		PAGE: 1 of 4
POLICY APPLIES TO: All CHG Employees		CLASSIFICATION SERIES: Compliance		

SUBJECT:

Managing Incidents of Suspected Fraud

Policy: Community Health Group (CHG) will investigate and respond appropriately to reports of suspected fraud.

Purpose: CHG recognizes that, unfortunately, fraud exists in the health care marketplace. Employees are trained in the prevention and detection of fraud, and to report suspected fraud to the appropriate CHG supervisory or management personnel. This policy provides guidelines for further investigation by CHG of suspected fraud, reporting to the appropriate law enforcement agency, assisting with law enforcement investigations, and taking appropriate response measures when fraud is found to have occurred.

Procedure:

1. Response to Suspected Employee Fraud (other than health care fraud)

Cases of suspected fraud, other than health care fraud, which may have been perpetrated by a CHG employee are reported immediately to the Human Resources Director, and are not necessarily subject to this Policy.

2. Compliance Committee

CHG maintains a Compliance Committee. CHG's Compliance Officer convenes the Compliance Committee on an as-needed basis, but not less than quarterly, for the purpose of overseeing implementation of the Compliance Plan, including determining and guiding appropriate responses to reported or suspected fraud. The Chief Regulatory & Legal Affairs and Compliance Officer shall serve as Chair. The Chief Financial Officer shall serve as Vice-Chair, and in the absence of the Chief Regulatory & Legal Affairs and Compliance Officer, shall convene the Compliance Committee as needed. In the event there is a matter being considered by the Compliance Committee that could involve a conflict of interest for a Committee member, that member shall excuse him- or herself from participation in Committee proceedings that involve the matter in question. Any member of the Committee may contact CHG's contracted legal counsel for advice on issues pertaining to conflict of interest.

The Compliance Officer shall report to the Chief Executive Officer (CEO) and Compliance Committee. To facilitate coordination of information flow within the company, the Compliance Committee will report on its proceedings, as appropriate, to the Quality Improvement Committee. The Board shall be generally kept apprised of implementation of the Compliance Plan, by CHG's CEO.

3. Handling of Reports of Suspected Fraud

A. Suspected fraud may be reported to CHG by employees, contractors (including FDRs), enrollees, or others.
B. Unless otherwise directed or required by law, reports of suspected fraud are treated as confidential, with contents shared with others only on a "need to know" basis.
C. When suspected FWA is reported, CHG's Compliance Officer will conduct the preliminary investigation. Incidents will be investigated as soon as possible and within two weeks of the date of noncompliance or report of suspected FWA. Compliance Officer maintains a log of receipt of all reports of suspected fraud.
D. After conducting a preliminary investigation, the Compliance Officer will determine whether further investigation is warranted. The following steps are carried out:
    a. If from the preliminary investigation it is determined no further investigation is needed, the Compliance Officer will:

- Provide a written report to the Compliance Committee and provide case status update to the Board and CEO, as appropriate; and
- Direct staff to continue business and remain vigilant for fraud.

b. If from preliminary investigation it is determined that further investigation is needed, the Compliance Officer will:

- Notify Compliance Committee
- Make determinations whether to:

a) Contact CHG legal counsel;
b) Initiate investigation by CHG staff;
c) Refer to antifraud consultant for investigation, if necessary; and
d) Take other appropriate action.

- In the event further investigation is undertaken, the Compliance Officer reconvenes the Compliance Committee as often as needed to provide oversight.
- In the event the investigation seems to substantiate that fraud may have occurred, the Compliance Committee, after consultation with CHG legal counsel, makes a determination whether to:
  a) Report case to appropriate law enforcement authorities;
  b) Take appropriate responsive action, which may include:
  - If the fraud involved a member, termination of coverage (may take the form of Plan-Initiated Disenrollment);
  - If the fraud involved a provider or other contractor, cancellation of provider contract in accordance with its terms;
  - If the fraud involved CHG staff, discipline of CHG staff as appropriate;
  - If the fraud involved claims, then denial, modification, or suspension of payment of such claims (to the extent allowed by law);
  - If disciplinary action or investigation has commenced by an agency, assisting authorities in the suspension or revocation of provider license, provider number or other discipline; and
  - If the fraud involved claims previously paid, seeking restitution.
  c) Other action as appropriate.
- In the event that investigation does not substantiate that fraud may have occurred, this finding is presented to the Compliance Officer and, upon his/her recommendation, to the Compliance Committee for concurrence.

e) The Compliance Officer will report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date it first becomes aware of, or is on notice of, such activity.

Compliance Officer maintains a written record of Compliance Committee activities, findings, reports, and communications, and may direct that personnel involved in the investigations provide written reports of those investigations to the Compliance Committee.

4. Importance of Obtaining Legal Consultation

In cases involving significant allegations or suspicion of fraud, the Compliance Officer and Compliance Committee will obtain legal consultation prior to conducting, or causing to be conducted, an investigation, and prior to taking, or causing to be taken, any responsive action with the supervisor. This is because:

- Action taken without a sound legal basis in response to suspected fraud may impair or compromise the investigation of, and response to, suspected fraud;
- Great care must be taken to preserve, to the extent possible, and as required by law, evidence, confidentiality, and continuity of care;
- Great care must also be taken in determining whether, when and how to notify suspected parties they are under investigation; and in taking appropriate measures to preserve evidence and confidentiality; and
- Legal consultation can be helpful in determining whether there are applicable fraud reporting opportunities and/or requirements arising from law or contract.

5. Referrals of Fraud Cases to Law Enforcement Authorities

CHG is committed to appropriate investigation, and referral for prosecution, of health care fraud committed by enrollees, providers, agents, and other individuals. The Compliance Officer in consultation with the Compliance Committee and with legal counsel, will coordinate referrals to law enforcement authorities. The Compliance Officer will work with the appropriate departments within the company to provide assistance to law enforcement officials, in compliance with state and federal laws. Referrals may be made to state fraud bureaus, the U.S. Postal Inspector, Federal Bureau of Investigation, U.S. Department of Health and Human Services, state and medical licensing and disciplinary boards, state insurance commissioners, federal, state, and county attorneys, local police departments, Immigration and Naturalization Service, Internal Revenue Services, the NBI MEDIC, the Centers for Medicare and Medicaid Services, or any other appropriate authority.

The Compliance Officer will report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date it first becomes aware of, or is on notice of, such activity.

6. Recordkeeping and Reports

1. CHG's Compliance Officer will maintain records of CHG's antifraud activities for ten (10) years, with the exception of personnel training records, which shall be maintained by CHG's Human Resources Department.
2. CHG's Compliance Officer will prepare an annual report of CHG's antifraud activities, for submission to the Department of Managed Care by January 31 of each year (covering activities in the preceding calendar year).
3. CHG's Compliance Officer will coordinate preparation of other reports as may be required from time to time by CHG's Board of Directors or senior management.
4. CHG's Compliance Officer will attempt to track the disposition of all cases of suspected health care fraud referred to a law enforcement agency by making a follow-up telephone inquiry at least quarterly. Such follow-up inquiries will be made to the law enforcement agency to which CHG initially made the referral, or to any other governmental entity to which that law enforcement agency refers CHG. CHG will continue to make such follow-up inquiries until the case is resolved, to the extent that this information is made available to CHG by the law enforcement agency or other governmental entity. CHG's Compliance Committee will consider all cases referred to law enforcement agencies to be standing agenda items at Compliance Committee meetings until each case's final resolution; again, to the extent the information is made available to CHG by the law enforcement agency or other governmental entity.

7. Corrective Action

CHG will design remedies to correct the underlying problem that results in program violations and to prevent future noncompliance. CHG will undertake a root cause analysis to determine what caused or allowed the FWA, problem or deficiency to occur and will tailor the corrective action to address the particular FWA, problem or deficiency identified, which includes timeframes for specific achievements. CHG will maintain thorough documentation of all deficiencies identified and corrective actions taken, both with respect to employees and FDRs.

ACCESS PRIVILEGES TO: ☐ All ☐ _____

REGULATORY: 42 C.F.R. § 422.5003 (b) (3) (vi); Manual Ch. 11 – Section 20.1

NCQA:

POLICY STATUS: ☒ Signed (Signature on File) ☐ Active Draft ☐ Policy In Development

Approved By: Signature: _____

Date: _____

Department Head: Chief Compliance & Regulatory Affairs Officer

Division Chief: Chief Executive Officer

Signature: _____

Date: _____