South Country Health Alliance

Medicare	☒
Medicaid	☒

Policy & Procedure

Policy Name	**Fraud and Abuse Plan and Policy**
Policy Number	**AD 05**
Regulatory Requirement(s)	DHS Managed Care Contract, Article 9 31 U.S.C. § 3801, et. seq. 42 CFR § 405.370 42 CFR § 422.500 42 CFR § 422.222 42 CFR § 422.224 42 CFR § 423.4 42 CFR § 423.504 (b)(4)(vi)(G) 42 C.F.R. § 455.1 et seq. 42 C.F.R. §1001.1001 et seq. Managed Care Manual – Chapter 21 Prescription Drug Benefit Manual – Chapter 9 Minnesota Rules, Part 9505.2160 et seq.
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Policy

All employees, agents or entities performing services on behalf of South Country must comply with Fraud, Waste and Abuse prevention and detection requirements.

Definitions

"Abuse"
For purposes of Medicaid programs, "**Abuse**" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes enrollee practices that result in unnecessary cost to the Medicaid program. Abuse shall also include substantial failure to provide Medically Necessary items and services that are required to be provided to an enrollee under this Contract if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the enrollee.

For purposes of Medicare programs, "**Abuse**" includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

"Credible allegation of fraud" means an allegation which as been verified by South Country and which has an indicia of reliability. In determining whether there is a credible allegation of fraud, South Country will review all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis. An allegation from any source includes, but not limited to the following:

(1) Fraud hotline tips verified by further evidence

(2) Claims data mining.

(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability.

"Fraud"
For purposes of Medicaid programs, "**Fraud**" means the definition as set out in Minnesota Rules, Part 9505.2165, subpart 4, as follows:

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

(1) Theft in violation of Minnesota Statute, section 609.52;

(2) Perjury in violation of Minnesota Statute, section 609.48;

(3) Aggravated forgery and forgery in violation of Minnesota Statute, sections 609.625 and 609.63;

(4) Medical assistance fraud in violation of Minnesota Statute, section 609.466; and

(5) Financial transaction card fraud in violation of Minnesota Statute, section 609.821.

B. Making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status; and

C. A felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952.

For purposes of Medicare programs, "**Fraud**" means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.

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

"Inappropriate prescribing" means the definition as set out in 42 CFR §§ 422.500 and 423.4, as follows: after consideration of all the facts and circumstances of a particular situation identified through investigation or other information, there is an established pattern of potential fraud, waste, and abuse related to prescribing of opioids, as reported by the plan sponsors. Beneficiaries with cancer and sickle-cell disease, as well as those patients receiving hospice and long term care (LTC) services are excluded, when determining inappropriate prescribing.

"**Integrity program**" means the administrative and management arrangements or procedures required in Article 9 of South Country's contracts with DHS.

"**Medically necessary**" or "**Medical necessity**" means a health service that is consistent with the enrollee's diagnosis or condition and:

A. is recognized as the prevailing standard or current practice by the provider's peer group; and

B. is rendered in response to a life threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or

C. is a preventative health service defined under Minnesota Rules, part 9505.0355.

"Network Provider" means a healthcare provider who is appropriately licensed in the state or states where the provider renders health services and has contracted with South Country to be a participating provider.

"Overpayment" means any payment made to South Country or to a network provider by South Country, to which the network provider or South Country is not entitled to under Title XIX of the Social Security Act (42 USC 1396 et. Seq.) or Minnesota Statutes, Ch 256B and Minnesota

Rules, Ch9505. This includes any amount that is not authorized to be paid by the Medicaid program, whether paid as a result of improper claim submission, unacceptable practices, fraud, abuse, or error.

A. Overpayments include any amounts paid in excess of what is properly allowable under statutes and Minnesota Health Care Programs (MHCP) program rules, whether resulting from fraud, waste, abuse, billing errors, adjudication errors, eligibility discrepancies, coordination of benefits issues, or other payment inaccuracies, as identified through post-adjudication review.

B. Identified Overpayments include Overpayments that have been identified by South Country, the State, or the provider.

C. Recovered Overpayment means any amount that was previously paid by South Country to a provider or subcontractor and that has been identified as an Overpayment and has been recouped, refunded, or otherwise returned or credited to South Country through any mechanism.

D. An Overpayment is considered "due to potential Fraud" if South Country has determined, based on established investigative procedures, that the provider's billing activity raises a Credible Allegation of intentional misrepresentation or deceit. This classification does not imply a legal finding of fraud but supports further program integrity review and/or referral to the State, the Medicaid Fraud Control Unit (MFCU) or appropriate enforcement authority.

"Regulatory- Internal Audit and Delegation Entity (RIDE) Committee" means the internal South Country committee that reviews all regulatory audit and corrective action plans. The RIDE committee reports to the Compliance Committee, at least quarterly, a summary of the RIDE committee meetings.

"State" means the Minnesota Department of Human Services, its Commissioner or its agents.

"Substantiated or suspicious activities of fraud, waste, or abuse" means the definition as set out in 42 CFR §§ 422.500 and 423.4, as follows: includes, but is not limited to, allegations that a provider of services (including a prescriber) or supplier -

(1) Engaged in a pattern of improper billing;

(2) Submitted improper claims with suspected knowledge of their falsity;

(3) Submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity; or

(4) Is the subject of a fraud hotline tip verified by further evidence.

"**Waste**" means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Procedure

1. South Country's Integrity Program requirements will include:

    a. Administrative and management procedures, including a compliance plan designed to guard against Fraud, Abuse and Improper Payments.

    b. Written policies, procedures and standards of conduct that articulate a commitment to comply with all applicable federal and state standards.

    c. Designated Compliance Officer and a Compliance Committee (CC) accountable to the Joint Powers Board and senior management within the organization.

        i. The Compliance Officer will manage ongoing Fraud, Waste and Abuse detection and prevention activities and is responsible for the education and training of South Country employees and agents to enhance information sharing and referrals to the Compliance Department regarding potential FWA.

        ii. As needed, the CC will advise the Compliance Officer and assist in Fraud, Waste and Abuse detection and prevention activities.

    d. Effective training and education for the Compliance Officer and South Country employees. New employee and annual compliance training and education is required for all employees and agents. South Country will maintain records of training and education of employees and agents and will report results regularly to the CEO and CC.

    e. Maintaining open and effective lines of communication between the Compliance Officer and employees concerning the reporting of fraud and abuse issues or incidents. Any employee who makes a good faith report of a known or suspected instance of wrongdoing will not be subject to disciplinary action or punished for making the report. South Country also has an absolute policy against retaliation for bringing forward a good faith concern. Reports may be made in writing, in person, via telephone, or by mail or e-mail. Reports may also be made through the REPORT IT hotline and may remain anonymous.

    f. Enforcement of standards through well-publicized disciplinary guidelines that are published in such media as the employee handbook, new employee compliance orientation, Code of Conduct, policies and training.

g. Maintaining procedures for regular internal monitoring and auditing, including monitoring and auditing of contracted providers and subcontracted services to detect fraud, abuse and improper payments.

iii. South Country has several components of oversight and ongoing auditing and monitoring for delegates that provide third party administrator services.

iv. South Country reviews Integrity Programs, Fraud, Waste and Abuse programs, and policies and procedures at facilities that provide third party administrator services to ensure the programs meet South Country's expectations, as well as state and federal requirements. Annual review of third party administrator performance is documented in the annual delegation audit report.

v. South Country also performs pre-delegation and annual delegation audits as applicable for these contracted organizations. Specific audit tools are designed to assess compliance with Fraud, Waste and Abuse.

h. Maintaining procedures for prompt response in detecting offenses, and for the development of corrective action initiatives. South Country's Code of Conduct and associated policies and procedures reflect applicable DHS contract requirements for detection, resolution and reporting of offenses. Policies require prompt resolution of compliance issues and specify corrective actions that may include, but are not limited to training, policy revisions, operational changes and discipline.

i. Maintaining procedures for profiling provider services and enrollee utilization that identifies aberrant behavior and/or outliers.

vi. Claims data and certain utilization reports are reviewed to identify trends in costs and other possible abnormalities. This information is also used to identify enrollees who may need case management or restriction.

vii. A variety of pre-payment reviews are utilized to detect potential Fraud, Waste or Abuse prior to claims payment including:

1. Review of high dollar;

2. Review of claims submitted for services rendered without required prior authorization;

3. Review of member eligibility/entitlement, other insurance coverage, excluded services, and possible submission of duplicate claims; and

4. Pre-payment review edits – procedure to procedure, procedure to provider, procedure to gender, frequency to time, diagnosis to procedure, procedure to provider certification and others.

viii. A variety of retrospective reviews are also utilized to detect potential Fraud, Waste or Abuse including:

1. Data analysis, including both random and focused audits;

2. Complaints from members, employees and others;

3. Third party review of claims and billing practices;

4. Post-payment review edits – procedure to procedure, procedure to provider, procedure to gender, frequency to time, diagnosis to procedure, procedure to provider certification and others;

5. Monitor suspect providers and triage for review and further investigation; and

6. Provide billing and payment education to providers as appropriate.

j. Maintaining policies and procedures that safeguard against unnecessary or inappropriate use of services and against excess payments for services.

ix. South Country's and its delegates employ a wide variety of procedures to address over- and under-utilization and Overpayments. The Quality Assurance Committee reviews case management and utilization reports on a quarterly basis, monitors trends, and recommends action for areas of concern. Delegates' claims payment processes are audited to ensure that claims are not paid for unnecessary or inappropriate services.

x. South Country and its delegates also identify persons for possible restriction in the Restricted Recipient Program (RRP) in an effort to make sure members are utilizing services appropriately.

xi. Additionally, South Country, county, and TPA customer service staff are trained to identify and report members' communication that may be related to provider services that were felt to be inappropriate or inadequate.

k. Maintaining policies and procedures that safeguard against failure by subcontractors or network providers to render medically necessary items or services that are required to be provided to an enrollee covered under South Country contracts.

xii. South Country's delegates conduct delegation oversight audits of carved-out entities and care systems, including those relationships where they delegate utilization management responsibilities.

xiii. South Country performs prior authorization reviews for the determination of medical necessity. The Grievances and Appeals department also monitors this area. South Country monitors coverage criteria that delegated entities use to make sure the service requested meets medical necessity.

xiv. South Country's case management professionals ensure that members receive services for which they are eligible through delegated entities and counties. South Country also works with the state ombudsman to ensure that members receive benefits covered under their benefit plan.

l. Maintaining provisions for identifying, investigating, and taking corrective action against fraudulent and abusive practices by providers, subcontractors, enrollees, South Country employees, officers and agents.

xv. South Country has established internal controls to ensure that potential fraudulent and abusive practices are identified and investigated in a timely manner. The CEO and CFO approve all payments made by South Country. The controller and an outside CPA firm regularly review revenues and expenses and watch for trends in each area. The Compliance Officer monitors South Country executives and Board members for potential conflicts of interest and any ownership or control interests that appear suspect.

xvi. The Compliance Officer and designated compliance staff meet weekly to discuss fraudulent, wasteful and abusive activities and issues.

xvii. South Country staff maintain awareness of current efforts in the state to reduce Fraud, Waste, and Abuse. The Compliance Officer and designated compliance staff participate in the Minnesota Healthcare Fraud Taskforce quarterly meetings.

m. Maintaining a method to verify whether services paid for by South Country were actually furnished to the Enrollee as required in 42 CFR § 455.1(a)(2). These methods are described in detail in the Annual Integrity Program Report.

n. Maintaining a mechanism for network providers to report overpayments to South Country, to return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and to notify South Country of the reason for the overpayment. This process is outlined in Chapter 4 of the South Country Provider Manual.

2. South Country will submit an Annual Integrity Program Report to DHS by April 30th that details implementation processes, investigative activity, corrective actions, and Fraud and Abuse prevention efforts and results. The report will detail implementation of DHS requirements and will specifically describe the activities undertaken to safeguard against Fraud and Abuse as detailed in section 9.4.2 of the DHS Contract.

3. South Country will document all activities and corrective actions taken under its Integrity Program.

    a. South Country will report to the State, MFCU, CMS, NBI MEDIC and/or the OIG, credible information of violations of law by the State, South Country, contracted providers, subcontractors or enrollees, for a determination as to whether criminal, civil, or administrative action may be appropriate. If South Country has reason to believe that an enrollee has defrauded one of the programs, South Country will refer the case to the State, MFCU, CMS, NBI MEDIC and/or the OIG, and other appropriate law enforcement agencies, as necessary.

    b. Monthly Reporting of Adverse Action: South Country will report monthly to the State the name, specialty, address, and reason for adverse action (in a form approved by the State) of Providers whose participation have been denied at enrollment, credentialing or re-credentialing, and providers whose active participation status South Country or its' delegates has taken action to terminate or not renew during the previous month.

4. Upon request, South Country and its subcontractors will make available to the Minnesota MFCU and other required agencies all administrative, financial, medical and any other records that relate to the delivery of items or services under the contract.

5. South Country will cooperate with the State's OIG/PIO on joint investigations or audits regarding network providers or enrollees. South Country will follow the guidelines outlined in section 9.4.5 of the DHS Contract for requesting or participating in a joint investigation.

6. South Country will obtain approval from the State's OIG/PIO before recovering or withholding improper payments when more than one (1) year has passed since adjudication of the original claim submitted.

7. South Country will attempt to recover improper payments from contracted providers when South Country identifies improper payments in an audit or investigation that South Country solely conducts.

8. South Country will not take any action to recover or withhold improper payments already paid or due to a provider when the issues, services, or claims upon which the recovery or withhold meet one or more of the criteria listed in section 9.4.6.3 of the DHS Contract.

9. South Country will cooperate with the State's OIG/PIO for the recovery of overpayments identified in audits and investigations the State's OIG/PIO, CMS, or other agents solely conduct pursuant to section 9.4.6.4 of the DHS Contract.

10. South Country will void (or reverse) all encounter claims that are a result of Fraud or Abuse, that have been recovered as a result of South Country's Integrity Program. Reversal or void will occur within thirty (30) days of the recovery.

11. South Country will report to the State any Fraud related to Medicaid or MinnesotaCare funds that South Country knows or has reason to believe has been committed by a provider, vendor, employee, subcontractor or member within five (5) business days after South Country knows or has reason to believe such Fraud has been committed. South Country will cooperate fully in any investigation of the suspected Fraud or Abuse and in any subsequent legal action that may result from those investigations.

    a. South Country will maintain a detailed log (in a form approved by the State) of all reports of provider and enrollee Fraud and Abuse investigated by South Country or South Country's TPAs which will be submitted to the State on a monthly basis by the fifteenth (15^{th}) day following the end of the month.

    b. South Country will report in writing to the State any abusive billing by Providers that warrant investigation within ninety (90) days of identification of the problem. South Country will use the detailed log described above for this reporting.

12. South Country maintains detailed procedures regarding suspending payment to providers due to a payment suspension initiated by DHS or implemented by South Country due to a credible allegation of fraud. South Country follows the guidelines outlined in sections 9.4.6.7 through 9.4.6.10 of the DHS Contracts and 42 CFR § 455.23 (e) and (f).

13. South Country will notify the State within thirty (30) days when it becomes public that South Country joins or becomes a party to a class action, mass tort or *qui tam* litigation or if recoveries have been obtained as a result of a class action, mass tort or *qui tam* litigation.

14. South Country will retain any amounts recovered through its efforts, provided that:

    a. Total payments received do not exceed the total amount of South Country's financial liability for those services provided by South Country to its enrollees;

    b. The state has not duplicated this recovery; and

    c. Such recovery is not prohibited by Federal or State law.

15. South Country will report in writing to the State any suspected Fraud and/or patterns of Abuse by enrollees and beneficiaries in accordance with sections 9.4.3.1(1) and 9.4.10 of the DHS Contracts.

16. South Country will establish, implement and disseminate Fraud Enforcement and False Claims Act policies and procedures to educate employees and agents about procedures for detecting and preventing Fraud, Waste and Abuse.

    a. South Country will certify to the State by February 1 each year that it has complied with this requirement for the previous year.

    b. South Country will include in its written policies and procedures and in the employee handbook specific information on:

        i. The False Claims Act, 31 USC § § 3729 through 3733;

        ii. Administrative remedies for false claims and false statements established under 31 USC § § 3801, et seq.;

        iii. The Minnesota False Claims Act, Minnesota Statutes § 15C.02, and any state laws pertaining to civil or criminal penalties for false claims and statements;

        iv. The rights of employees to be protected as whistleblowers, including the employer restrictions in Minn. Stat. § 15C.14; and

        v. South Country's policies and procedures for detecting and preventing Fraud, Waste and Abuse.

17. South Country will have data certification guidelines.

    a. South Country will provide to applicable regulatory agencies a certification that accompanies its submission of certain data which identifies each data submission, the date submitted and certifies all data submitted, unless otherwise specified.

    b. South Country will also certify with applicable regulatory agencies that its annual statutory financial filing with the Minnesota Department of Health (MDH) represents only costs related to services covered under the State Plan or costs related to providing those services, such as administrative costs, and include an attestation as to the accuracy, completeness and truthfulness of the data or documents being submitted.

18. South Country will implement programs to monitor excluded individuals and entities pursuant to OIG guidance, 42 CFR § 1001.1901, and the Social Security Act. See *AD 25 Exclusion Review Policy* for information on exclusion monitoring.

19. South Country will implement a process to ensure that payments are not made to individuals and entities included on the preclusion list, defined in 42 CFR § 422.2, in accordance with the provisions in 42 CFR § 422.222 and 422.224.

20. South Country reports debarments, suspensions, or changes in circumstances to the State for itself and for its credentialed or contracted providers. South Country also reports when a provider is decredentialed, disenrolled, or denied credentialing due to Fraud, integrity or quality concerns.

    a. South Country and its delegates have a process in place to monitor monthly the OIG sanctions list to determine if any contracted providers, employees, delegates or agents are identified with any sanctions.

    b. All terminations, suspensions, debarments, decredentialing, disenrollments and credentialing denials are reported to MDH and DHS within 15 days. Where these instances involved issues of Fraud, integrity or quality concerns, South Country also reports this information to the OIG (HHS). These situations would also be reported through the Credentialing Committee, Compliance Committee and ultimately to the South Country Joint Powers Board.

    c. The Credentialing Department monitors quality complaints and grievances on a quarterly basis to identify any provider trends that may trigger a quality site visit or direct follow-up with a provider. This quality complaint process is tied into the recredentialing process which integrates with the primary source verification review that would identify any negative debarments or suspensions with a contracted provider. Any issues identified through this primary source verification process would be presented to the Medical Director and the Credentialing Committee for appropriate decision-making. A negative decision or outcome of the Credentialing Committee would then be reported to the State.

    d. South Country utilizes Prime West Health, our contracted third-party administrator, to identify potential issues of Fraud, Waste and Abuse that may be picked-up through the claim's adjudication process.

    e. South Country reports monthly to DHS the name, specialty, and address of each Provider that South Country has chosen to terminate or not renew during the previous month.

    f. South Country monitors itself as well as its credentialed and contracted providers through monthly OIG exclusion checks and internal audits. South Country immediately gives written notice to the State agencies should South Country or any of South Country's credentialed or contracted providers come under investigation for allegations of Fraud or a criminal offense in connection with: 1) obtaining, attempting to obtain, or performing a public (federal, state or local government) transaction; 2) violating any federal or state antitrust statutes; or 3) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

21. South Country takes appropriate action on a report of suspected Fraud, Waste or Abuse.

a. South Country will report to DHS (as detailed in section 11 above) and may report to CMS, NBI MEDIC, and/or the OIG any suspected Fraud.

b. South Country investigates vendors and providers to monitor compliance with program requirements for the purposes of identifying Fraud, Abuse, theft or error in the administration of the programs.

c. South Country will report enrollees responsible for fraud, waste, or abuse of controlled substances to DHS.

d. South Country's investigations include but are not limited to the following:

    i. Contacting the person(s) making the allegation, where appropriate;

    ii. Contacting appropriate agencies to assist in the investigation process (claims payors such as Prime West, Delta Dental and PerformRx);

    iii. Retrieving and comparing medical records to claims where appropriate;

    iv. Retrieving and comparing prescription drug records to claims where appropriate;

    v. Contacting the credentialed/contracted provider at issue, where appropriate;

    vi. Internal meeting(s) to discuss results, next steps; and

    vii. Conducting onsite audits or reviews at a provider's place of business, when appropriate.

e. During an investigation, if South Country staff believe that an onsite audit or review at a provider's place of business is warranted due to the nature of the allegations, staff will consult with the Compliance Officer to determine if an onsite visit is necessary. Provider Network or other internal departments may be consulted when making a determination.

f. After completion of an investigation, South Country takes one or more of the following actions:

    i. Close the investigation when no further action is warranted;

    ii. Impose administrative sanctions as appropriate – including suspension, termination, debarment, re-training, corrective action plans, lockouts;

    iii. Seek monetary recovery as appropriate;

iv. Refer/report the investigation findings to the appropriate state and federal regulatory agency, peer review mechanism or licensing board;

v. Refer the investigation to law enforcement or other attorney for possible civil or criminal legal action;

vi. Issue a warning letter to the enrollee;

vii. Issue a warning that states the practices are potentially in violation of program laws or regulation;

viii. Send a letter stating the review has been completed and indicating there were no findings; or

ix. Refer the investigation to another appropriate agency.

22. South Country will have a process in place to determine when a Corrective Action Plan (CAP) is required for Network Providers resulting from program integrity initiatives.
    a. After completion of the investigation, South Country will review the outcome of the investigation to determine if the findings of the investigation rise to the level requiring a CAP. A CAP may be implemented if any of the following are met:
        i. Repeat findings;
        ii. Network Provider has not complied with billing and performance requirements outlined in South Country's Provider Manual; or
        iii. Any other action that results in a program violation that requires action to correct the underlying problem to prevent future noncompliance, as determined by the Compliance Officer.
    b. The CAP will be developed to include the following elements: defining the problem, due dates, root cause, action items, stakeholders, metrics for completion, and progress updates. The Compliance Officer will review and approve all CAPs. The CAP may also be presented to the RIDE Committee or the Program Integrity Committee for discussion and monitoring.
    c. The status of all open CAPs will be monitored on an ongoing basis until it is completed to the satisfaction of the Compliance Officer. Monitoring will be done in the form of meetings, telephone or e-mail correspondence and will occur in accordance with the CAP timelines, or a minimum of every 90 days, until all requirements of the CAP are completely satisfied by the Network Provider. The Compliance Officer will approve the CAP closure, if appropriate, or may request a revision of the CAP with ongoing monitoring continuing until the CAP issue has been resolved to the satisfaction of the Compliance Officer.

23. South Country will meet compliance plan requirements as a Part D sponsor as described in 42 CFR § 423.504 (b)(4)(vi)(G) and Section 1860D-4(c)(1)(D), including having a program to control Fraud, Waste and Abuse.

    a. South Country will report and submit data, as specified in 42 CFR § 423.504 (b)(4)(vi)(G)(4) through (7), in the program integrity portal for all payment suspensions pending investigations of a credible allegation of fraud by pharmacies, information related to the inappropriate prescribing of opioids, and referrals of substantiated or suspicious activities of fraud, waste or abuse.

    b. PerformRx, South Country's Pharmacy Benefit Manager (PBM), also has a robust Fraud, Waste and Abuse program that meets Part D requirements.

    c. Periodically, CMS issues alerts to South Country concerning Fraud schemes identified by law enforcement officials. These notices describe activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes (e.g., prescribers receiving payment as an inducement or reward for writing prescriptions). CMS issues these notices so that contracting organizations can take appropriate steps to ensure that Medicare payments are not made for fraudulent claims for prescription drugs.

        i. South Country is obligated, per 42 C.F.R. § 423.504(b)(4)(vi), to adopt and implement an effective compliance program which includes measures designed to prevent, detect, and correct Fraud, Waste, and Abuse.

        ii. South Country may take action (including denying or reversing claims) in instances where South Country's own analysis of its claim's activity (prompted by its receipt of a CMS-issued Fraud alert) indicates that Fraud may be occurring. South Country's decisions to deny or reverse claims should be made on a claim-specific basis.

        iii. Upon receiving the alert, South Country should work with the PBM to review the contractual arrangements they may have with the identified pharmacies or prescribers.

        iv. South Country's PBM should have the system capability to establish edits on a given provider and use that edit to automatically deny or suspend payment for a script written by that specific provider or filled at a given pharmacy. The PBM should also utilize data analysis to identify trends and develop more focused audits. Again, the information in the alert allows the PBM to focus their data analysis tools on the claims submitted by the identified providers.

        v. South Country and the PBM are also obligated to review their past paid claims from these parties based on the Fraud alert information. The regulations at 42 C.F.R. § 423.505(k)(3) require Part D sponsors to certify

the accuracy of the claims data it submits to CMS. With the issuance of a Fraud alert, CMS has put sponsors on notice that they should review claims involving the identified providers. To meet the "best knowledge, information, and belief" standard of the certification, South Country should make their best efforts to identify claims that may have been part of the alleged Fraud scheme and remove them from their sets of prescription drug event (PDE) data submissions.

vi. Finally, all paid claims have an impact on the true out of pocket (TrOOP) and cumulative drug spend used to calculate each beneficiary's progression through the Part D benefit and into those phases (e.g., catastrophic) during which Medicare assumes greater responsibility for drug costs. To ensure that Medicare and the sponsors are not indirectly paying for fraudulent claims, South Country must reverse the affected claims with their pharmacies and reduce their members' TrOOP and drug spend amounts accordingly.

Violation of Policy

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

Signatures

Signature Approval: Signed by: Jeff Marks 989A80047C13427... Date: 12/19/2025

Compliance Officer

Joint Powers Board Approval Date: December 8, 2006