COMMUNITY FIRST
HEALTH PLANS

PLAN TO PREVENT
FRAUD, WASTE, AND ABUSE

September 1, 2024 through August 31, 2025

INTRODUCTION

This document summarizes the plan developed by Community First Health Plans, Inc. (Community First) in response to 1 TAC §353.501 (Medicaid) and 1 TAC §370.501 (CHIP) regarding the establishment and operation of a Special Investigation Unit (SIU) by Managed Care Organizations.

Items covered in this document include procedures for detecting, investigating and preventing possible acts of fraud, waste, or abuse by providers and members; procedures for referring possible acts of fraud, waste, or abuse for investigation to Community First's in-house Special Investigation Unit (SIU); reporting fraud, waste, and abuse to State of Texas and federal agencies; training company personnel and educating providers and members to prevent fraud, waste, and abuse; identification of designated personnel responsible for compliance with the rules; and advertising and marketing and other provisions of the plan.

Community First recognizes detection, investigation and prevention of fraud, waste, and abuse is vital to maintaining an affordable health care system. Community First has mounted a sincere effort to limit fraud, waste, and abuse through the efforts summarized in this document.

CORPORATE STATEMENT

SPECIAL INVESTIGATION UNIT

Community First is committed to protect and preserve the integrity and availability of health care resources to our members, our healthcare partners, and the general community. Community First performs several activities through its in-house Special Investigation Unit (SIU) to detect, prevent and identify fraud, waste and abuse at the provider, member, and health plan level. Activities include working together with code editing vendors to ensure claims are processed accurately and training employees, contractors, and agents to identify and report possible acts of fraud, waste, and abuse. When such acts are identified, Community First seeks effective remedies to identify overpayments, prevent future occurrences of fraud, waste, and abuse, and report offenses to the appropriate agencies.

FRAUD, WASTE AND ABUSE (FWA) COMMITTEE

Community First has established a FWA Committee consisting of Senior Leadership, Compliance Managers, and Manager of the SIU. The Executive Director of Compliance and Risk Management serves as the Chair of the FWA Committee. Members of the Board of Directors of Community First may, at their discretion, attend FWA Committee meetings.

The FWA Committee is viewed by Community First as an integral part of the corporate commitment to compliance. The fulfillment of the duties and responsibilities of each member of the FWA Committee will help ensure Community First adheres to its corporate commitment to abide by state and federal regulations governing legal and ethical business operations and interactions.

I. PROCEDURES FOR DETECTING POSSIBLE ACTS OF FRAUD, WASTE OR ABUSE BY PROVIDERS

The SIU's procedures for detecting possible acts of fraud, waste, or abuse by Community First providers include:

A. Audits

The SIU performs audits to monitor compliance and assist in detecting and identifying possible Medicaid and CHIP program violations and possible fraud, waste, and abuse overpayments through:

1. Data matching: Procedures, treatments, supplies, tests, other services, as well as diagnosis billed, are compared for reasonableness using available sources including the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). Comparisons include age, gender, and specialty when applicable.

2. Analysis: Inappropriate submissions of claims are evaluated using various forms of claim data analysis and software-automated analysis. A comparison of providers' activities lists outliers based on a particular specialty and across specialties and includes procedures, modifiers, and diagnosis.

3. Trending and Statistical Activities: The SIU uses software and claim data reports to analyze provider utilization and identifies unusual trends in weekly, monthly, and yearly patterns.

B. Monitoring

The SIU monitors claim billing patterns of providers, groups, pharmacies, subcontractors, and facilities. Using various reports, outliers may be monitored through claims submissions and utilization. Providers that are identified for specific payment patterns are also examined for other outliers to obtain an overall profile.

C. Hotline

Community First maintains an anti-fraud hotline at (210)358-6332 to allow reporting of potential or suspected violations of fraud, waste, and abuse by members, providers, and employees. Messages left on the hotline are reviewed by SIU personnel within two business days. The hotline number is accessible on appropriate member and provider communication and published on the Community First web site, as well as in Community First provider and member handbooks. A toll-free anonymous hotline is also available 24/7 for reporting suspected violations at (877)225-7152.

The SIU maintains a log of recorded calls, the nature of the investigation, and the disposition of the referral.

D. Random Payment Review

Random selections of paid claims are selected to detect potential overpayments. Various billing patterns are analyzed such as modifier misuse, unreasonable units of service, or overutilization of high-level Evaluation and Management Services. Flagged providers with aberrant patterns may be identified for compliance reviews and/or investigations.

E. Edits

Community First utilizes claim-editing software to prevent payment for fraudulent or abusive claims. It is an established and widely used clinical based auditing software that verifies coding accuracy of professional service claims. These edits include specific elements of a claim such as procedure, modifier, diagnosis, age, gender and/or dosage.

Additional edits published by the Center for Medicare and Medicaid Services (CMS) are also applied during claims processing to prevent payment of incorrect code pairing, units of service errors, and/or abusive claim submissions. These edits include the National Correct Coding Initiative (NCCI) and the Mutually Exclusive Edits (MUE).

F. Routine validation of Community First Data

Community First routinely validates data for applicable encounter data deliverables. The encounter data items reviewed to ensure accuracy include, but not limited to, inaccurate member identification numbers, inaccurate provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or medical procedure performed.

G. Verification of services received

On a monthly basis, Community First verifies that members received services that were billed. The SIU maintains a log of all outreach calls, questions, and member responses. Findings of inappropriate billing for services not received are investigated for possible fraud, waste, or abuse.

II. PROCEDURES FOR INVESTIGATING POSSIBLE ACTS OF FRAUD, WASTE OR ABUSE BY PROVIDERS

A. Preliminary Investigation

The SIU conducts preliminary investigations related to possible acts of fraud, waste, and abuse by providers within 15 working days of identification or report of the suspicion or allegation. Information and evidence are gathered from relevant internal and external sources as listed below:

B. Preliminary Investigation Includes:

The preliminary investigation includes the following activities:

1. Determines if Community First has received any previous reports of incidences of suspected fraud, waste, or abuse or conducted any previous investigations of the provider in question.

    a. If so, the investigation includes a review of all materials related to the previous investigations,

    b. Documents the outcome of the previous investigations,

    c. Determines whether the new allegations are the same or relate to the previous

investigation.

2. Determines if the service provider has received any educational training regarding the allegation.

3. Conducts a review of the provider's billing pattern to determine if there are any suspicious indicators.

4. Reviews the provider's payment history for the past three years to determine if there are any suspicious indicators.

5. Reviews the policies and procedures for the program type in question to determine if what has been alleged is a violation.

6. If the preliminary investigation determines suspicious indicators of possible fraud, waste, or abuse, within 15 working days from the conclusion of the preliminary investigation, the SIU selects a sample for further review and begins an extensive investigation.

C. Extensive Investigation

1. Within 15 working days from the conclusion of the preliminary investigation the SIU selects a sample for further review. The SUI will request medical records and encounter data for the same members. The sample consists of a minimum of 30 Medicaid members, 50 CHIP members or 15% of a provider's claims related to the suspected fraud, waste, and abuse to include a minimum of 30 Medicaid or 50 CHIP members.

2. If the requested records are not supplied within the specified time frame, SIU refers the case to OIG for failure to supply records.

3. Within 45 working days of receipt of the requested medical records, the SIU completes the review of medical records and claims data to:

   a. Validate the sufficiency of service delivery data and to assess utilization and quality of care,

   b. Ensure the claims data submitted by the provider is accurate.

   c. Evaluate if a review of other pertinent records is necessary to determine if fraud, waste, or abuse occurred. If the review of additional records is necessary, the SIU conducts such review.

III. PROCEDURES FOR DETECTING POSSIBLE ACTS OF FRAUD, WASTE OR ABUSE BY MEMBERS

A. Member Claims Review

Member claims are reviewed when fraud, waste, or abuse is suspected or reported to determine if:

1. Treatments and/or procedures appearing to be duplicative, excessive, or contraindicated by more than one provider, i.e., same patient, same date-of-service, same procedure code.

2. Medications appearing to be prescribed by more than one provider, i.e., same patient, same date-of-service, and same NDC code.

   Members appearing to receive excessive medications higher than average dosage for the medication.

3. Compare the Primary Care Provider (PCP) relationship code to the member to evaluate if other providers and not the PCP are treating the member for the same diagnosis.

4. Identify members with higher-than-average emergency room visits with a non-emergent diagnosis.

B. Medical Record Review

Medical records are reviewed for members in question when the claims review does not clearly determine if fraud, waste, or abuse occurred.

C. Edits and Other Techniques

Edits and other evaluation techniques are used to identify possible overuse and/or abuse of psychotropic and/or controlled medications by members who are allegedly treated at least monthly by two or more physicians. A physician includes but is not limited to psychiatrists, pain management specialists, anesthesiologists, physical medicine, and rehabilitation specialists.

IV. PROCEDURES FOR INVESTIGATING POSSIBLE ACTS OF FRAUD, WASTE OR ABUSE BY MEMBERS

A. Allegation

The SIU conducts preliminary investigations related to possible acts of fraud, waste, and abuse by members within 15 working days of identification or report of the suspicion or allegation.

B. Preliminary Investigation

Preliminary Investigation Includes:

1. Review of acute care and emergency room claims submitted by providers for the suspected member.

2. Analysis of the pharmacy claim data submitted by providers for the suspected member to determine possible abuse of controlled or non-controlled medications. If SIU does have the data necessary to conduct the pharmacy claims review, SIU will request the data within 15 working days of the initial identification and/or reporting of the suspected or potential waste, abuse, or fraud.

3. Analysis of the claims submitted by providers to determine if the diagnosis is appropriate for the medications prescribed.

V. INTERNAL PROCEDURES FOR REFERRING AND REPORTING POSSIBLE ACTS OF FRAUD, WASTE OR ABUSE

A. The Executive Director of Compliance and Risk Management

The Executive Director of Compliance and Risk Management serves as the Compliance Officer and has the responsibility and authority at Community First for reporting investigations resulting in a finding of possible acts of fraud, waste, and abuse to the Texas Health and Human Services Commission-Office of Inspector General (HHSC-OIG) and other appropriate agencies is:

Name:	Kethra Barnes
Title:	Executive Director, Compliance and Risk Management
Street Address:	12238 Silicon Drive, Suite 100
City State Zip	San Antonio, TX 78249
Office Phone:	210-510-2607
Office Fax:	210-358-6306
Email:	kbarnes@cfhp.com

B. Procedure for reporting possible FWA to the SIU

1. Annually during fraud, waste and abuse training, officers, directors, managers, and employees are educated on reporting all possible FWA to the above officer.

2. Additionally, the annual training educates officers, directors, managers, and employees to report all suspected FWA within 24 hours to the SIU.

3. Training includes guidance on the type of information to be included in the reporting of suspected FWA as well as examples of FWA.

4. Suspected FWA is reported utilizing the online Suspicious Activity Report form (SAR) located on the Community First website and or employee intranet along with other reporting options of phone, fax, hotline, regular mail, and email.

C. Procedures for reporting SIU findings of FWA to assigned officer

1. Findings for all investigations, which include the details of the preliminary and extensive investigation (if applicable) are reported to the FWA Committee which reports to the above assigned officer.

2. All possible acts of FWA are reported to the FWA Committee within 15 workings of making the determination.

D. Procedures for submitting referral to HHSC- OIG

1. Within 30 working days of the completion of the SIU investigation and receiving reports of possible acts of waste, abuse, or fraud from the SIU, the assigned officer or director must notify and refer all possible acts of waste, abuse, or fraud to the HHSC-OIG.

2. All reports and referrals of possible acts of FWA, except for an expedited referral, must include the following information related to the referrals:

    a. the provider's enrollment/credentialing documents.

    b. the complete SIU investigative file on the provider, which must include:

        i. an investigative report identifying the allegation, statutes, regulations, rules violated or considered, and the results of the investigation;

        ii. the estimated overpayment identified;

        iii. a summary of interviews conducted; and

        iv. a list of all claims and associated overpayments identified by the preliminary investigation.

    c. a summary of all past investigations of the provider conducted by Community First or the SIU. Upon request, Community First shall provide the complete investigative files or any other information regarding those past investigations to the HHSC-OIG investigator;

    d. copies of HHSC program and Community First policy, contract, and other requirements, as well as statutes/regulations/rules, alleged to be violated for the time period in question;

    e. all education letters (including education documents) and/or recoupment letters issued to the provider by Community First and/or the SIU at any time;

    f. all medical records;

g. all clinical review reports/summaries generated by Community First;

h. any and all correspondence and/or communications between Community First, the subcontractors, and any of their employees, contractors, or agents, and the provider related to the investigation. This should include but not be limited to agents, servants, and employees of Community First, regardless of whether those agents, servants and employees are part of the SIU who investigated the provider;

i. copies of all settlement agreements between Community First and its contractors and the provider;

j. and if the referral contains fewer members or claims than the minimum described in paragraph (2)(C) of this subsection, a written justification for the decision to substantiate the waste, abuse, or fraud with fewer members or claims. The justification will be subject to review and approval by HHSC-OIG, who may require Community First to provide further information.

E. Procedures for expedited referrals

An expedited referral is required when Community First has reason to believe that a delay may result in:

1. harm or death to patients
2. the loss, destruction, or alteration of valuable evidence; or
3. a potential for significant monetary loss that may not be recoverable; or
4. hindrance of an investigation or criminal prosecution of the alleged offense.

VI. PROCEDURES FOR EDUCATING MEMBERS AND PROVIDERS AND TRAINING PERSONNEL TO PREVENT WASTE, ABUSE AND FRAUD

A. On an annual basis, Community First provides waste, abuse and fraud training to each employee who is directly involved in any aspect of Medicaid/CHIP and is responsible for data collection, provider enrollment or dis-enrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance and marketing.

B. The training is specific to the area of responsibility of the staff and contains examples of waste, abuse or fraud in their particular area.

C. General training is provided to all Medicaid/CHIP managed care staff that is not directly involved with the areas listed in above. The general training provides information about the definition of waste, abuse and fraud; how to report suspected waste, abuse and fraud and to whom the suspected waste, abuse and fraud is reported.

D. All new staff directly involved with any aspect of Medicaid/CHIP receives training within 90 days of the employee's employment date.

E. Training updates are made to all affected areas when changes to policy and/or procedure may affect employee job responsibilities. The updates are provided within 20 working days of the changes occurring.

F. Members, providers, and employees are educated about their responsibilities, the responsibility of others, the definition of waste, abuse and fraud and how and where to report it. Methods of educating members, providers and employees may include but are not limited to newsletters, pamphlets, bulletins, and provider manuals.

G. Community First maintains a training log for all training pertaining to waste, abuse and/or fraud in Medicaid/CHIP. The log includes the name and title of the trainer, names of all staff attending the training and the date and length of the training. The log is provided immediately upon request to the HHSC-OIG, Office of the Attorney General's (OAG)-Medicaid Fraud Control Unit (MFCU) and OAG-Civil Medicaid Fraud Division (CMFD), and the United States Health and Human Services-Office of Inspector General (HHS-OIG).

H. Written standards of conduct and written policies and procedures includes a clearly delineated commitment from Community First for detecting, preventing, and investigating waste, abuse, and fraud.

VII. ASSIGNED OFFICER FOR CARRYING OUT THE PLAN

Name:	Kethra Barnes
Title:	Executive Director, Compliance and Risk Management
Street Address:	12238 Silicon Drive, Suite 100
City State Zip	San Antonio, TX 78249
Office Phone:	210-510-2607
Office Fax:	210-358-6306
Email:	kbarnes@cfhp.com

The above officer is responsible for carrying out the plan changes and the required information to be reported to HHSC OIG within 15 working days of the change.

VIII. COMMUNITY FIRST'S PERSONNEL RESPONSIBLE FOR INVESTIGATING AND REPORTING POSSIBLE ACTS OF WASTE, ABUSE OR FRAUD; AND,

- Executive Director, Compliance and Risk Management
- Manager, Special Investigation Unit
- Investigator, Special Investigation Unit
- Coding & Documentation Compliance Specialists

IX. ADVERTISING AND MARKETING MATERIALS

Advertising and marketing materials utilized by Community First accurately reflect information about Community First. Marketing and Advertising materials related to government lines of business are approved by HHSC prior to utilization. Community First understands marketing materials include any informational materials targeted to members.

Advertising and marketing materials related to fraud, waste, and abuse activities support the Texas Health and Human Services Commission's objective to bring the public and private sectors together to reach the mutual goals of reducing healthcare fraud and abuse; improving Community First's operational quality; improving the quality of healthcare; and reducing overall healthcare costs.

X. OTHER PROVISIONS

A. MCO Open Case Listing Report

On a monthly basis, the SIU submits to the HHSC-OIG a report listing status of all investigations opened. This includes SIU investigations opened on providers as a result of a determination that a provider's license is expired or cancelled or that the provider has been excluded, suspended, or terminated from participation in the Texas Medicaid program or CHIP. The report includes the allegation, the suspected members or provider's Medicaid number, the claim number, the source, the time period in question, and the date of receipt of the identification and or reporting of suspected and/or potential fraud, waste, or abuse, the identified overpayment amount and or any comments.

B. Incident Log

The SIU maintains a log of all incidences of suspected fraud, waste, and abuse, received by Community First regardless of the source. The log contains the subject of the complaint, the source, the allegation, the date the allegation was received, the member or providers Medicaid number, and the status of the investigation.

The SIU provides the incident log at a time of a reasonable request to the HHSC-OIG, OAG-MFCU, OAG-CMFD, and the HHS-OIG. A reasonable request means a request made during hours open for business.

C. Confidentiality

The SIU maintains the confidentiality of any patient information relevant to an investigation of fraud, waste, or abuse, in concert with HIPAA regulations concerning this type of investigation.

D. Record Retention

The SIU retains records obtained as the result of an investigation conducted by the SIU for a minimum period of ten years or until audit questions, appeal hearings, investigations, or court cases are resolved.

E. Failure to supply requested information

Failure of the provider or facility to provide requested information such as medical records, invoice receipts, itemized billings by Community First's SIU may result in the provider being reported to the HHSC-OIG as refusing to supply records upon request and the provider may be subject to sanction or immediate payment hold.