

SECTION V: PROGRAM INTEGRITY

V.1 Approach for Meeting Program Integrity Requirements

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.

Amerigroup honors our role as stewards of State and federal funds in identifying, preventing, and responding to suspected fraud, waste, and abuse in Louisiana. Our established and proven integrity program and compliance plan reflects the local culture and nuances of Louisiana's health care landscape and provider community. We deploy a wide-range of strategies and tactics that stretch from "feet on the ground" local insight to industry-leading high-tech systems and analyses to combat fraud, waste, and abuse.

We understand Louisiana's Medicaid program, the provider community, and program recipients—key to operating a successful fraud, waste, and abuse program. We cast a wide net to detect fraud, waste, and abuse and aggressively pursue leads. Through our integrated approach, our teams work in parallel to address fraud, waste, and abuse rather than in a linear or sequential manner. This allows us to continually fine-tune and adjust our strategies to address the fluid nature of fraud, waste, and abuse.

Program integrity is embedded throughout Amerigroup. We educate every employee, subcontractor, provider, and member on fraud, waste, and abuse, including how to identify and report allegations or suspicions. All new Amerigroup employees must pass our comprehensive compliance training—which includes modules related to fraud, waste, and abuse—within 30 days of hire as part of their orientation. The initial training is reinforced through annual refresher training and mechanisms such as banners on our company intranet and targeted email announcements. Our experienced investigations team collaborates with local Louisiana and national resources in areas such as provider relations, medical management, and health care analytics to identify and manage suspected fraud, waste, and abuse cases in a holistic manner.

Our fraud, waste, and abuse program, operational in Louisiana and 18 affiliate health plans supporting State-sponsored programs, has robust policies and processes and is staffed locally and nationally with experienced personnel from various backgrounds, including health care, State agencies, and law enforcement. As a partner to Louisiana since the initial launch of the Bayou Health program in 2012, we bring a unique level of understanding and expertise on DHH's program integrity initiatives, goals, and priority areas that is based on our hands-on experience with DHH and the Louisiana provider and member communities. We are committed to meeting our contractual obligations for Fraud, Abuse, and Waste Prevention activities and programs, as outlined in Section 15 of the RFP, and we look forward to continued collaboration with DHH under the new Contract.

\$295,290

Potential false claims.

\$68,407

Total Recoveries.

\$502,512

Savings from Changes
in Provider Behavior. 

(2014 Year to Date: 1/1/14 – 9/12/14)

For ease of review, we have organized our response as follows:

- **Amerigroup’s Fraud, Waste, and Abuse Compliance Plan.** Here, we discuss leadership and staffing.
- **Preventing and Detecting Fraud, Waste, and Abuse.** Our tools and systems to prevent and detect FWA are described, as well as various reporting mechanisms.
- **Prohibited Affiliations and Exclusions.** This describes our actions to screen employees and contractors (subcontractors and providers).
- **Investigating Fraud, Waste, and Abuse Allegations.** Includes our processes to investigate potential cases involving fraud, waste, and abuse.
- **Determining and Implementing Corrective Actions.** The potential actions Amerigroup will take, once a case of fraud or abuse is confirmed, are described here.
- **Fraud and Abuse Training.** Includes a description of the training we provide to our employees and providers.
- **Collaborating with DHH.** This describes how we work with DHH, including assisting with investigations and reporting.
- **Collaborating with Other Regulatory Agencies.** Amerigroup’s partnerships with other agencies, including the Medicaid Fraud Control Unit, are described here.
- **Program Effectiveness and Implementing Best Practices.** Included here are examples of fraud and abuse that Amerigroup has successfully addressed in Louisiana and affiliate health plans.

Amerigroup’s Fraud, Waste, and Abuse Compliance Plan

Amerigroup’s plan is a “living” document that is regularly reviewed and modified to address changes in the industry and changing fraud schemes and patterns. 🌸

Amerigroup maintains written policies, procedures, and standards of conduct that articulate our commitment to prevent, reduce, detect, correct, and report known or suspected fraud, waste, and abuse in the Bayou Health program. Our Fraud, Waste, and Abuse Compliance Plan details the manner in which we perform these functions and outlines our goals, objectives, and planned activities. The plan is a “living” document that is reviewed at least semi-annually to address changes in the industry and changing fraud

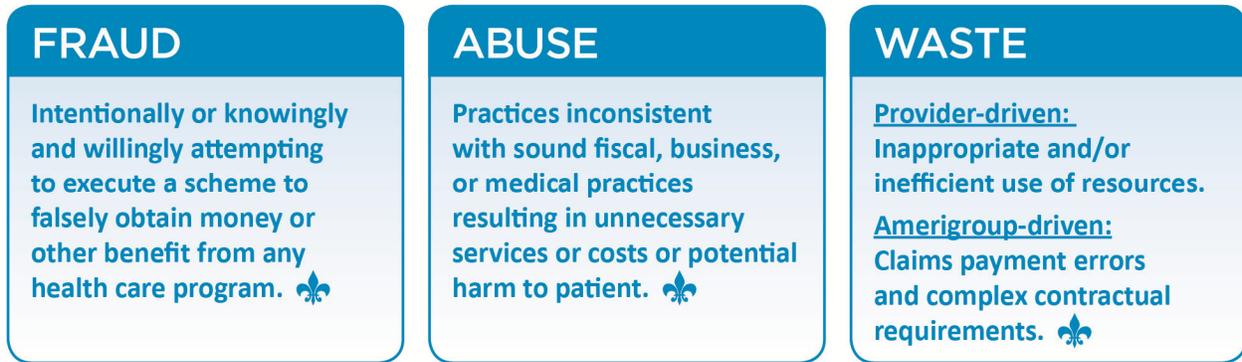
schemes and patterns. As a current Bayou Health MCO, we developed our Fraud, Waste, and Abuse Compliance Plan to address Louisiana’s specific goals and requirements and it contains all of the required elements, including the following:

- Written policies and procedures
- Effective and open lines of communication between program integrity staff, employees, providers, DHH, and other stakeholders
- On-going monitoring and auditing of Amerigroup’s systems
- Reporting processes for the identification of potential or confirmed fraud, waste, and abuse
- Effective and on-going training and education for program integrity staff, employees, providers, and members, including disciplinary procedures and repercussions

We will submit our Fraud, Waste, and Abuse Compliance Plan to DHH for review and approval within 30 days of Contract signing.

Our Fraud, Waste, and Abuse Compliance Plan includes a system of processes and controls to prevent, detect, report, and implement corrective action for fraud, abuse, and waste, as defined in Figure V.1-1.

Figure-V.1-1. Categorizing Fraud, Abuse, and Waste



Program Integrity Leadership and Staffing

Louisiana Dedicated Local Resources

Since the inception of the program, Amerigroup has executed a coordinated and consistent approach to fraud, waste, and abuse that meets or exceeds mandated regulatory requirements for Louisiana. Identification, investigation, and follow-up of fraud, waste, and abuse will be led locally by our Program Integrity Officer and Louisiana-dedicated investigators. Our Louisiana team has access to the resources of our national Medicaid Special Investigations Unit (MSIU). The MSIU supports our program integrity functions across Louisiana and our affiliate health plans operating State-sponsored programs. This national support facilitates the identification and sharing of best practices, trends, and industry-leading program integrity data analysis and mining.

To date, our Administrator/Chief Executive Officer, Sonya Nelson, has acted as the designated “Fraud Officer.” Upon award of the new Contract, Amerigroup will appoint a Louisiana-based Program Integrity Officer who will convene a Louisiana Program Integrity Committee. This individual will be accountable to Amerigroup’s Board of Directors and will report directly to Ms. Nelson.

In accordance with new requirements, Amerigroup will hire in-state investigative staff to work with our national MSIU resources. The investigators who currently support our Louisiana program, David Ross and Stephen Ballew, have developed a strong partnership with DHH through collaboration on continued improvements and enhancements to the investigative process used throughout the program. One such example is the suggestion to DHH by Mr. Ross and Mr. Ballew to hold quarterly meetings with all MCOs in attendance, instead of individual meetings, to better facilitate case information sharing.

Mr. Ross and Mr. Ballew will assist in identifying, hiring, and training our Louisiana-based program integrity staff and facilitate a smooth transition, including sharing of historical program information, and will continue to be involved in our fraud, waste, and abuse activities in the State. The qualifications of the investigative staff will be in keeping with Amerigroup’s professional standards and include possession of a BA/BS degree and 3–5 years’ experience in health care, white-collar crime investigation or related area, or any combination of education and experience that would provide an

COLLABORATING WITH BAYOU HEALTH MCOs

Amerigroup recently suggested that DHH hold quarterly meetings with all MCOs to facilitate the sharing of case information and best practices. 🌸

equivalent background. Professional certification of Certified Fraud Examiner (CFE), Accredited Healthcare Fraud Investigator (AHFI), or other job-related designation is preferred. Through this on-going partnership with the MSIU, our local program integrity resources will continue to enhance the efficiency and effectiveness of our Louisiana fraud, waste, and abuse activities.

National Medicaid Special Investigations Unit

Our Louisiana-based investigators are part of our larger national MSIU. The MSIU mission is to prevent, identify, and investigate all facets of fraud and abuse, and research and monitor fraud detection activities and resources.

The MSIU is a multi-disciplinary team of investigative staff that includes nurses, retired law enforcement officers, health care investigators, auditors, and programmers. Many MSIU employees maintain professional certifications from such organizations as the Association of Certified Fraud Examiners, National Health Care Anti-Fraud Association, the Association of Certified Fraud Specialists, and America's Health Insurance Plan's Health Care Anti-Fraud Associate Program. The investigative staff members research and monitor fraud detection resources. The MSIU has systems in place to detect and investigate any suspected provider or member fraudulent claims or activities.

The MSIU team also includes an expert team of data analysts who are skilled in applying coding, clinical, and payment methodologies to analyze data to determine potential instances of fraud, waste and abuse. Data Analysts help identify providers who qualify as outliers in their billing patterns and warrant further review. In our experience, data analysis is an essential part of identifying aberrancies or patterns in claims. Data analysis allows us to compare various claims and other related information to identify potential errors, identify areas of risk, and establish a baseline to recognize trends. The MSIU maintains a substantial inventory of investigative tools to combat fraud and waste.

Integral to our program integrity program are the close relationships the MSIU maintains with our Louisiana leadership team and functional departments, including Medical Management, Quality Management, and Provider Relations. Staff in these departments have routine and on-going interactions with contracted providers and members, and these relationships play an important role in our processes for avoiding, preventing, and detecting fraud, waste, and abuse. If staff members have an allegation or suspicion of fraud, waste or abuse, they report this information to the MSIU and provide information to support the investigative process.

Preventing and Detecting Fraud, Waste, and Abuse

Encouraging Reporting through Multiple Avenues

Anyone, including members, providers, employees, subcontractors, and law enforcement officials, can report suspicions of fraud, waste, and abuse, through the mail, in person, through e-mail, from our toll-free national compliance hotline, or through the fraud, waste, and abuse reporting links on our website. We use newsletters to remind members and providers of the mechanisms to report suspicions of fraud, waste, and abuse. Employees and providers can also use our Fraud Referral Form.

Individuals reporting suspected fraud and waste may remain anonymous. If reporters elect to provide identifying information, Amerigroup maintains a strict non-retribution policy. We do not tolerate any form of retribution or retaliation from any Amerigroup employee or network provider against individuals who report potential fraud or abuse or a program integrity violation.

Tools and Systems

Amerigroup maintains detection tools and systems that we apply prior to claim payment; during post-payment claim review, data mining, and referral follow-up; and when monitoring new fraud schemes identified by various organizations.

We use industry-leading fraud, waste, and abuse algorithms (EDIWatch) and predictive modeling tools (FICO Insurance Fraud Manager) to support our ability to address changing trends in patterns of fraud, waste, and abuse. These tools surpass the capabilities of rules-based systems in their ability to detect instances of fraud, waste, and abuse. Using these tools, we are able to identify previously-unknown patterns of fraud and suspicious behavior and more high-risk claims with low false-positives. Using this information, we are then able to prioritize and allocate the right resources to the right claims based on the level of fraud risk and the potential for savings.

Amerigroup has systems in place to detect and investigate any suspected provider and member fraudulent claims and/or activities. 🌸

The maturity of our claims database enables us to implement a comprehensive fraud and abuse plan benefitting Louisiana. For example, from 2012 to 2013, our Louisiana claims volume increased substantially and our analytics captured instances of medically unlikely billing. We have tools that allow us to proactively identify and evaluate providers with aberrant claims data through on-going monitoring activities and initiate investigations as appropriate.

Prevention

Recovering inappropriate provider reimbursement and referring suspected fraud and abuse to investigators is important, but our philosophy is driven by prevention. Prepayment review is highly effective in stopping suspect claim payments.

The MSIU recently tracked a large Louisiana provider group in which 80 percent of its Evaluation/Management claims were billed at a higher level, resulting in an inappropriate reimbursement. We placed the provider on prepayment review, requiring the provider to submit paper claims with the medical records to substantiate the services being billed. As part of prepayment review process, medical records are reviewed by a Certified Professional Coder (CPC) within MSIU to verify that the documentation supports the services as billed. If services billed are denied, we send the provider a letter with the results of the prepayment review and include education about documentation requirements. After a period of time on prepayment review, the Louisiana provider's behavior changed. The result of this change of

behavior resulted in 50 percent of its Evaluation/Management claims submitted and subsequently paid at a more appropriate level of reimbursement, thus averting an estimated \$48,000 in future Medicaid costs.

In addition to prepayment review, prevention tools and processes include the following:

- McKesson’s ClaimCheck software to automatically and comprehensively audit codes before claims are paid. The Policy Administration Module addresses claims editing based on published national reimbursement policies and national coding standards not currently available in ClaimCheck.
- FICO Insurance Fraud Manager, which uses predictive models, pre- and post- payment, to score claims and providers for the likelihood of fraud and abuse and the level of financial risk.
- Credentialing information.
- Provider licensing information.
- Information from our Utilization, Quality, and Care Management departments.

Detection

Although Amerigroup focuses heavily on prepayment activities, we use proactive postpayment review to identify erroneously billed claims and behaviors that cannot be detected by up-front edits.

For example, a review of paid claims billed by a Louisiana community health center identified multiple instances where a provider was billing ancillary codes in addition to the inclusive code. The claims system did not identify the aberrant billing because the provider used multiple place of service codes. During postpayment review, we analyzed a sample of the provider’s claims to look for unbundling of claims. As a result, erroneously billed claims were recouped, and the provider was placed on prepayment review and educated on appropriate billing practices. In addition, we notified other MCOs for appropriate action within their networks.

Amerigroup detection systems and resources include the following:

- EDIWatch, a retrospective, rules-based system that detects anomalies in data using thousands of statistics, rules, and patterns
- Trend reports to identify outliers and overutilization patterns
- Louisiana-based and national medical management staff available for training and analysis
- Facility site information
- Membership information
- Medical record reviews
- Field staff information
- Information databases, such as the following:
 - Lexis Nexis
 - Accurint for Insurance (Public Records)
 - CPT-Inquiry Services
 - SIRIS (NHCAA’s Special Investigations Resource and Intelligence System)

Prohibited Affiliations and Exclusions

Amerigroup will adhere to all federal requirements found in 42 C.F.R 1002 and the Bayou Health Contract with respect to excluded or disbarred providers and employees. We screen entities against the following entities:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- Louisiana Exclusion Database (LED)
- The System of Award Management (SAM)
- Other applicable sites as may be determined by DHH

Monthly protocols are in place to process exclusions and disbarments that occur after the initial screening or credentialing and before mandatory periodic screenings or credentialing. Exclusion information discovered is reported with three business days and a listing is included in the required monthly reporting.

Watch Lists

Amerigroup establishes “Watch Lists” based on recurrent themes our MSIU has identified through trending and analysis of our affiliates’ state-sponsored business across the country. The Watch Lists identify common schemes that are pervasive in all markets and aberrancies not yet seen in Louisiana, giving us the opportunity to monitor issues that may appear in the future. Using advanced analytics and the experience of our entire investigative team, we extract multiple data sets periodically and match them with paid claims across all of our Medicaid affiliate health plans. For example, our Texas affiliate has seen issues with the abuse of high-dollar ambulance codes. While aberrant billing of basic life support transport codes is not currently a problem in Louisiana, it may easily become so, given Louisiana’s proximity to Texas, and the MSIU is prepared to act if Louisiana experiences an uptick in aberrant transportation claims.

Medical Record Requirements

The basis for the majority of fraud detection systems is the medical record. Amerigroup has policies and procedures to maintain, or require providers and contractors to maintain, an individual medical record for each member that meets the specifications outlined in Section 15.6 of the RFP.

Investigating Fraud, Abuse, and Waste Allegations

Our Program Integrity Officer will have primary responsibility for the investigative process, serving as the primary contact for identified issues and leading all investigative efforts, in conjunction with the MSIU, for any potentially fraudulent or abusive claim or issue.

When a referral is received for investigation by our investigators or other staff within the MSIU, it is entered into the Case Information Management System (CIMS) database, where it is assigned an MSIU case or lead number.

Our investigators follow a formal process for investigating all possible fraud and abuse, as outlined in Table V.1-1.

Table V.1-1. Investigators Follow a Formal Process to Evaluate Potential Fraud and Abuse

Step	Activities
Detection and Referral	In this stage, suspected fraud and abuse is detected and the MSIU is notified.
Initial Assessment	The primary goal of assessing the lead is to firmly establish predication and the need for additional investigation. The investigator reviews the information gathered to date and accumulates any additional information needed in the initial screening process.
Investigative Strategy	If the need for additional investigation is established, an investigative plan is created and case prioritization is assessed. During this vital stage, the logical and appropriate investigative measures are mapped out.
Information Gathering	<p>The investigator uses all available, legal, and appropriate measures to gather information. At this time, data is analyzed, interviews are conducted, records are obtained and reviewed, and utilization histories are scrutinized.</p> <p>Investigations are in-depth and can include contract and credentialing reviews; licensure validation; data analysis; medical record audits; interviews with members, providers, and office staff; on-site office visits; Internet research; or collaboration with other MCOs.</p>
Evaluation of Evidence	All of the evidence that has been collected is evaluated to determine if there is reasonable evidence that fraud or abuse has occurred.
Determination of Action	At this point, the investigator, possibly in conjunction with legal counsel, must determine if and how to pursue with the case.
Civil/Criminal Proceedings	Finally, if appropriate, the investigator will meet with the attorney responsible for litigation of the case. Typically, this stage of the investigation is worked in tandem with the law enforcement agency prosecuting the case. The investigator often becomes the expert on the case, as he or she is familiar with all details and evidence, and assists with analysis, evidence gathering, and testimony, if requested.

The results of these investigations will be shared with the Program Integrity Officer, the Program Integrity Committee, Plan Compliance Officer, and other senior-level executives who review the findings and determine next steps. The Program Integrity Officer and MSIU will meet regularly to discuss matters of potential fraud, waste, and abuse.

Determining and Implementing Corrective Actions

Once confirmed, Amerigroup, in partnership with DHH and Louisiana's Medicaid Fraud Control Unit (MFCU), takes appropriate action to address reports of potential fraud, waste, and abuse depending on the scope and severity of the situation. We design each corrective action plan specific to the provider and nature of allegation. In doing so, we tap into our knowledge of and experience with Louisiana's provider community, setting Amerigroup apart from other health plans that apply a rigid, inflexible approach.

Based on the results of the investigation, we take appropriate action, which may include the following:

- **Provider letter.** Upon review by the Program Integrity Officer and MSIU Management, we send certified letters to providers that document the findings and the need for improvement and request a timely response. Further action is based on the provider's response or lack thereof.
- **Education.** Depending on the nature of the case, additional and targeted education may be directed at staff, providers, and members.
- **Medical record audits.** Our team, including clinicians, may review medical records to validate claims submissions.
- **Member lock-in.** Restricting a member to a single pharmacy and/or PCP to prevent duplicate and inappropriate drug therapies or assigning a member who sees multiple providers to a single primary care provider tends to result in reduced instances of fraud, waste, and abuse.
- **Prepayment review.** When billing issues are egregious or a provider fails to comply despite intervention, the provider may be placed on prepayment for further monitoring and evaluation. Certified Professional Coders within the MSIU review submitted medical records to verify that the services documented support the services billed on the claim forms.
- **Terminating the provider.** We may terminate from our network any providers who fail to comply with program policy and procedures or who violate the Contract in any way.
- **Recouping overpayments.** Amerigroup may seek recoveries through either direct reimbursement by the provider to Amerigroup or through a recovery process.
- **Reporting the provider.** Amerigroup may report the provider to the appropriate legal or regulatory agency and medical board.
- **Corrective Action Plans.** Amerigroup prepares and requests providers sign a Corrective Action Plan, confirming the understanding of the changes they need to make to come into compliance.

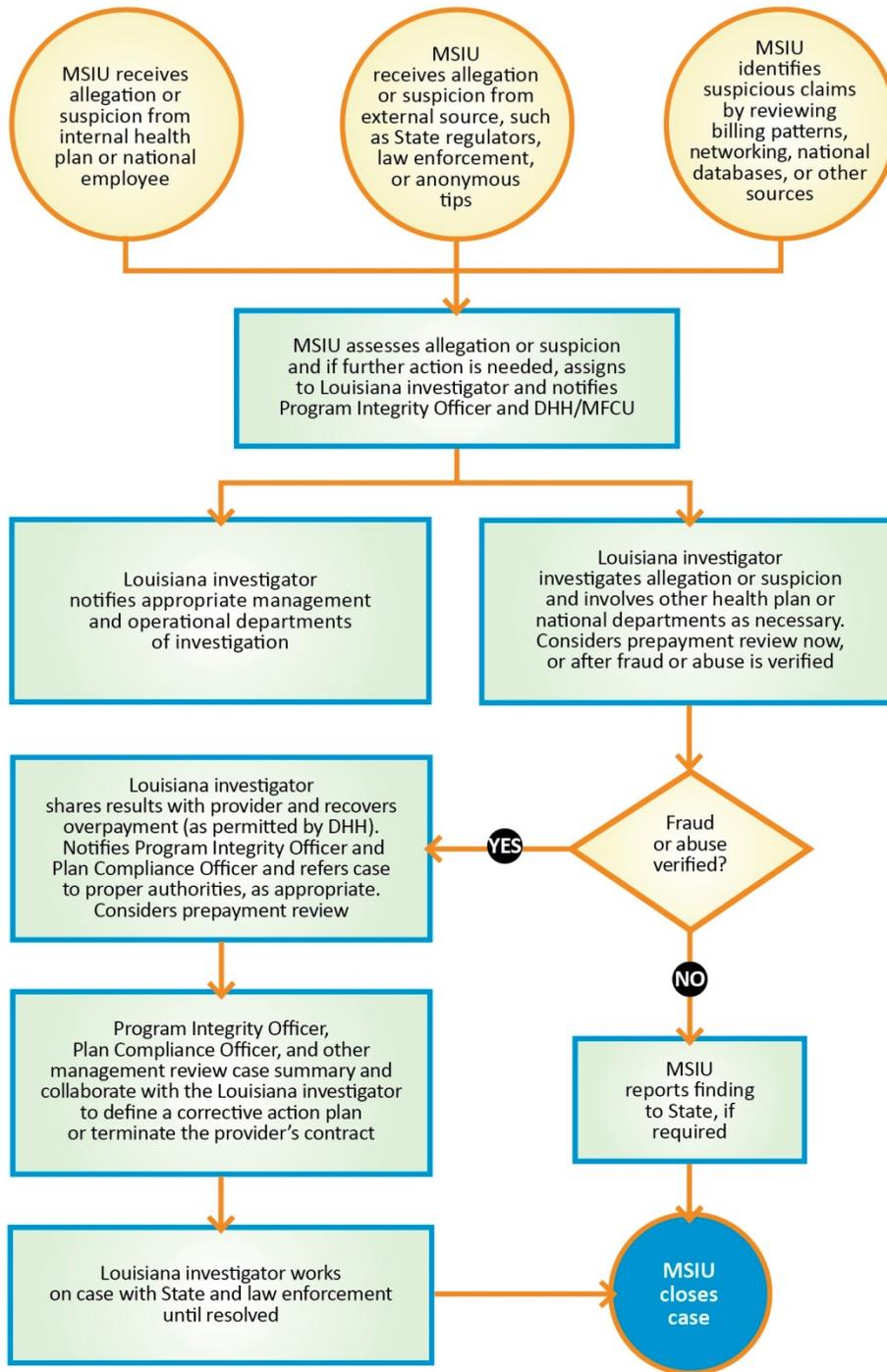
The Medical Director may also present a provider to the Peer Review Subcommittee for quality of care disciplinary action. Our ultimate goal is to educate providers, not penalize them, for aberrant practice patterns. We perform a follow-up review on these providers after six months and report any savings resulting from the action or education. When a situation arises that may lead to provider termination from our network, we terminate the provider if such a measure is in the best interest of our members and the State.

As summarized in Figure V.1-2, Amerigroup follows a documented process that begins with receipt of an allegation or suspicion or identification of suspicious activity through investigation and ends with case closure.

ENROLLEE CHOICE, PROTECTIONS, AND ACCESS

Amerigroup responds to investigation results by taking actions that protect our members and are in the best interest of the State. 

Figure V.1-2. Process Flow from Allegations or Suspicions through Investigation and Case Closure



Fraud and Abuse Training

Appropriate training is key to avoiding fraud and abuse. We educate our employees, our providers, and our members on signs of fraud and abuse and how to report suspected cases. Providers receive fraud and abuse education through our provider relations staff during orientation and in-service trainings and through the provider manual, e-mail alerts, newsletters, and our website. We educate members on identifying and reporting fraud through the member handbook, member newsletters, and our website. Additionally, the MSIU publishes monthly tips, available on our website and in provider publications, on how to identify and report fraud, waste, and abuse. We use these same mechanisms to widely publicize our disciplinary guidelines and how we enforce standards.

Amerigroup requires employees to complete two hours of general compliance training within 30 days of hire. Training modules include the following:

- Standards of Ethical Business Conduct
- Privacy and Security
- HIPAA mandates
- CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks
- 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance
- Policies and procedures, including reporting requirements, for working with DHH

All employees are required to complete annual refresher training that addresses compliance generally, and includes specific modules on the identification, prevention, and reporting of fraud, waste, and abuse and other topics, including the False Claims Act, as directed by the Centers for Medicare and Medicaid Services (CMS). Our Program Integrity Officer, local investigators, and MSIU employees must complete an additional 40 hours of fraud, abuse, and waste training annually.

Amerigroup further reinforces compliance with fraud and abuse standards through our online training program, which helps claims processors, customer service representatives, medical review personnel, and other employees identify patterns and trends indicating potential fraud. We use the term "red flags" to identify actions that may indicate the potential for fraud. Red flags may include the following:

- Pressure to adjudicate or process claims quickly
- Threats of legal action for delay in making payments
- Frequent telephone inquiries on claims status
- Assertive providers demanding same-day claim payment and special handling
- Charges submitted with no supporting documentation, such as X-rays or laboratory results
- An individual provider using a post office box as a return address
- Unusual charges for a service
- Unassigned bills that are normally assigned, such as large hospital or surgical bills
- Erasures or alterations
- Helping providers who abuse the system

Collaborating with DHH

Amerigroup believes that the success we have had combatting fraud and abuse is largely due to the successful partnership we have formed with DHH. Our MSIU, supported by the commitment and diligence of David Ross and Stephen Ballew, has worked closely with DHH staff since the start of the program to establish a collaborative and effective working relationship. We take seriously our role as a sentinel for the State and diligently pursue all suspected cases, regardless of size. When the evidence supports the allegation of fraud or abuse, our Program Integrity Officer will promptly report the case to DHH for further handling and will deliver timely reports highlighting activities and results. All confirmed or suspected enrollee fraud and abuse is reported immediately to DHH and local law enforcement.

Amerigroup will continue to assist the State in its investigations. We will also continue to work with DHH's Medicaid Surveillance and Utilization Review Department and their designated vendor to complement our internal data mining activities.

To date, Amerigroup has notified DHH of 81 investigations—with 12 resulting in referrals for suspected fraud and abuse. 🌸

Our staff will continue to meet with DHH staff on a quarterly basis to review outstanding cases and future focused efforts. To date, in addition to the dollar savings, Amerigroup has notified DHH of 81 investigations, resulting in 12 referrals for suspected fraud and abuse.

Operational Reporting of Activities

Continued, timely, and open reporting of allegations, investigations and outcomes is necessary. Current reporting requirements will be updated to include the following:

- Review of fraud and abuse activities
- Program Integrity cases opened within the previous two weeks, including the following information:
 - Provider Name and ID number
 - Source of complaint
 - Type of provider
 - Nature of complaint
 - Approximate range of dollars involved if applicable
- Suspected fraud and abuse in the administration of the program
- Internal monitoring and auditing activities
- Disposition of closed cases including corrective action plans
- Outcomes

Collaborating with Other Regulatory Agencies

Amerigroup understands the importance of collaborating with other regulatory entities. In Louisiana, we have established strong partnerships with regulatory agencies, the MFCU, and law enforcement. We also participate in regional task forces aimed at reducing health care fraud, including FBI-sponsored task forces in many states. Through these relationships, we share information and best practices in avoiding and detecting fraud and abuse, allowing us to continuously enhance our program.

Our MSIU staff regularly participates in CMS-sponsored fraud, abuse, and waste outreach and education events to provide us with information and insight on the most current trends and tools in health care fraud prevention. CMS currently hosts educational clinics in cities known by federal and state law enforcement agencies as Health Care Fraud Prevention and Enforcement Action Team (HEAT) areas. There are nine HEAT cities, including one in Louisiana, that law enforcement has determined to be significant outliers in instances of health care fraud. Amerigroup understands the tremendous value of these clinics and most recently attended the clinic held in Baton Rouge. Clinic attendees actively discuss trends, schemes, and on-going investigations. These meetings give Amerigroup a unique perspective on Medicare and Medicaid fraud cross-over investigations.

Through our strong partnerships with regulatory agencies, the Medicaid Fraud Control Unit, and law enforcement, Amerigroup shares information and best practices in avoiding and detecting fraud and abuse, allowing us to continuously enhance our program. 🌸

Collaboration with Industry

In Louisiana, Amerigroup works with other MCOs to share information, resources, and best practices for combatting fraud. Our activities include educational activities, case and scheme sharing, and networking to identify issues and methods to reduce fraud, abuse, and waste. This collaboration has optimized the State's efforts, minimized redundancy, and expanded the State's efforts to reduce increased costs associated with fraud and abuse.

State and Federal Assistance and Cooperation

Amerigroup understands that DHH has a Memorandum of Understanding with the Louisiana Attorney General's MFCU, which establishes the process for investigations and referrals for potential fraud cases. Since 2012, Amerigroup has worked with DHH, the Louisiana Office of the Attorney General, and the United States Attorneys' Offices in the prosecution of Medicaid fraud in Louisiana.

Amerigroup understands the importance of open and continuous communication. We hold quarterly, annual, and as-needed meetings to discuss fraud, abuse, waste, neglect, and overpayment issues. Meetings include DHH and the Louisiana MFCU, as well our CEO or COO, our Program Integrity Officer and investigators, and the MSIU.

Amerigroup and its subcontractors will make all program and financial records and service delivery sites open to the representative or any designees of HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, or the designees of any of the above with timely and reasonable access as specified in the RFP. As requested, Amerigroup will provide originals or copies (at no charge) of all records and information requested in the form and the language requested.

Amerigroup understands and accepts the rights and recovery requirements specified in the RFP, including requirements to provide timely access to program and financial records and information. We will promote continued adherence to these requirements through our internal policies and procedures.

Program Effectiveness and Implementing Best Practices

We monitor and measure our compliance program, including fraud, abuse, and waste, on a routine basis to make sure that activities and initiatives are conducted in a manner and within a framework that supports an effective compliance plan. We also use these monitors and measures to validate that controls are in place to mitigate targeted compliance risks, including those that may arise in connection with operations areas across our health plan: medical management (utilization, case and care management); marketing and enrollment; payments from federal and State regulatory agencies; data submissions and other reporting; quality management; accreditation and access to care; complaints, appeals, and grievances; claims payment; relationships with providers and contractors; subcontractor oversight; and privacy of protected information.

The oversight and support from our national MSIU provides our Louisiana program integrity efforts with systems and best practices developed from the experiences of all 19 affiliate health plans. As we identify new processes, tools, and best practices, we adjust our program accordingly. This collaboration also provides our Louisiana investigators with a backup network of experienced investigators to further support Louisiana activities.

Examples of Fraud or Abuse Detected by our Monitoring Program

The examples below detail fraud and abuse specifically detected and pursued in Louisiana and from one of our affiliate Medicaid health plans. These examples help illustrate the different methods of detection, types of investigations, and the actions taken.

Federally Qualified Health Center. Using data analytics, including EDIWatch, Amerigroup discovered that one of our Louisiana providers billed for duplication of services for a clinic using an all-inclusive code, T1015. The duplication of services was not immediately detected by the claims processing system because the provider used numerous place of service codes.

- **How Detected**—Proactive advanced data analytics
- **Actions Taken**—Referred the allegations to DHH and the Louisiana MFCU. Amerigroup placed the provider on prepayment review where all claims are reviewed prior to payment. We recovered all duplicate claim payments. We notified the other Bayou Health MCOs of our investigation so they could review their claims data for this scheme.

Hospital. Using data analytics, Amerigroup discovered that a Louisiana hospital provider billed for identical services for the same patients and the same dates of service using separate and distinct tax identification numbers. The duplication of services was not immediately detected by the claims processing system because the provider used different identification numbers. Amerigroup determined that the provider was overpaid \$27,421.81.

- **How Detected**—Proactive advanced data analytics
- **Actions Taken**—Referred the allegations to DHH and the Louisiana MFCU. Using system offsets on future claims payments, Amerigroup recouped the funds from all duplicate claims. We notified the other Medicaid MCOs about the investigation.

Ambulance/Behavioral Health. Using data analytics and cooperation from employees in our Texas affiliate health plan, we identified a significant number of Basic Life Support ambulance services that had no corresponding medical service claims. A review of transportation logs from a sample of ambulance providers identified common destinations and behavioral health providers. During surveillance, MSIU investigators observed a number of issues: up to five members being transported at the same time and in

the same ambulance; transportation provided in vans; and members transported to facilities with unsafe conditions.

- **How Detected**—Referral from health plan and advanced data analytics
- **Actions Taken**—Eleven ambulance providers and six behavioral health providers were terminated from the network. Adult Protective Services was contacted. To date, 40 ambulance providers and six behavioral health providers have been referred to the state for credible allegations of fraud. This investigation is ongoing.

Psychologist. After receiving an allegation that a provider was billing under another provider's name, data mining revealed a provider in our Texas affiliate health plan was billing psychotherapy services for members as young as 18 months old. The review filtered data by name to reveal excessive billing of services for a core group of about 17 members, some who were seen six days per week. The investigation found that the provider was unbundling psychotherapy services and billing for individual therapy when the provider actually was seeing members as a group.

- **How Detected**—Allegation submitted via email
- **Actions Taken**—An overpayment was identified and recovered, and the provider was placed on prepayment review with all claims reviewed prior to payment.

V.2 Description of Corporate Program Integrity Division

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.

Amerigroup is committed to fraud, abuse, and waste identification and prevention at the highest levels of our organization. We hold ourselves, our employees, our providers, and our members to a high standard. Having the necessary and appropriate resources throughout our organization is but one way we honor our commitment to protecting the State's resources.

Our Louisiana fraud, waste, and abuse activities will be led locally by our Program Integrity Officer and Louisiana-dedicated investigators. As mentioned in the previous section, Amerigroup will appoint a Louisiana-based Program Integrity Officer who will convene a Louisiana Program Integrity Committee. The Program Integrity Officer will be accountable to Amerigroup's Board of Directors and will report directly to our Executive/CEO, Sonya Nelson. The Program Integrity Officer will oversee the appointed Program Integrity Committee and will work closely with our CEO, local investigators, national MSIU, and DHH. Internally, the Program Integrity Officer and MSIU will meet at least quarterly to facilitate understanding and awareness of all current investigations.

Our Louisiana-based employees are supported by compliance resources and staff, including the following:

- Louisiana Contract Compliance Coordinator
- Louisiana Plan Compliance Officer and Louisiana Compliance Committee
- National MSIU
- National Medicaid Compliance Officer and the Medicaid Compliance Program Services Department

National Medicaid Special Investigations Unit Resources

Our MSIU was developed to establish controls, develop a coordinated and consistent approach to state-sponsored program fraud and abuse efforts, and promote compliance with mandated regulatory requirements. The MSIU is an internal proprietary function, fully dedicated to the detection, prevention, investigation, and prosecution of fraud and abuse in Amerigroup and its affiliate health plans' State-sponsored program business. The unit is physically separate from the Claims and Operations Departments, administratively reporting to the national Medicaid Compliance Officer.

The MSIU maintains strong working relationships across our national support functions and with our local Louisiana leadership, allowing it to effectively detect, prevent, investigate, and report fraud, waste and abuse.

Philip Mann is the Staff Vice President for the MSIU and reports directly to our national Medicaid Compliance Officer. Mr. Mann retired from the FBI as a Supervisory Special Agent and Chief Division Counsel of the Norfolk FBI Office. In his 28 years of service in five FBI Offices, including FBI Headquarters, he gained extensive firsthand expertise and success in both conducting investigative operations and providing legal counsel relating to such operations. Mr. Mann also played a critical role in revising key portions of the FBI's Domestic Investigations and Operations Guide. Before he joined Amerigroup, he served as the Chief Magistrate of Chesapeake, Virginia.

Mary Beach is the Director of the MSIU, a role she has served since 2007. Ms. Beach has more than 25 years of health care fraud investigation experience and is an Accredited HealthCare Fraud Investigator (AHFI), a Certified Fraud Examiner (CFE), and a Health Care Anti-Fraud Associate (HCAFA). She served on the Board of Directors for the National Health Care Anti-fraud Association and currently represents Amerigroup on the CMS Public Private Fraud Prevention Partnership.

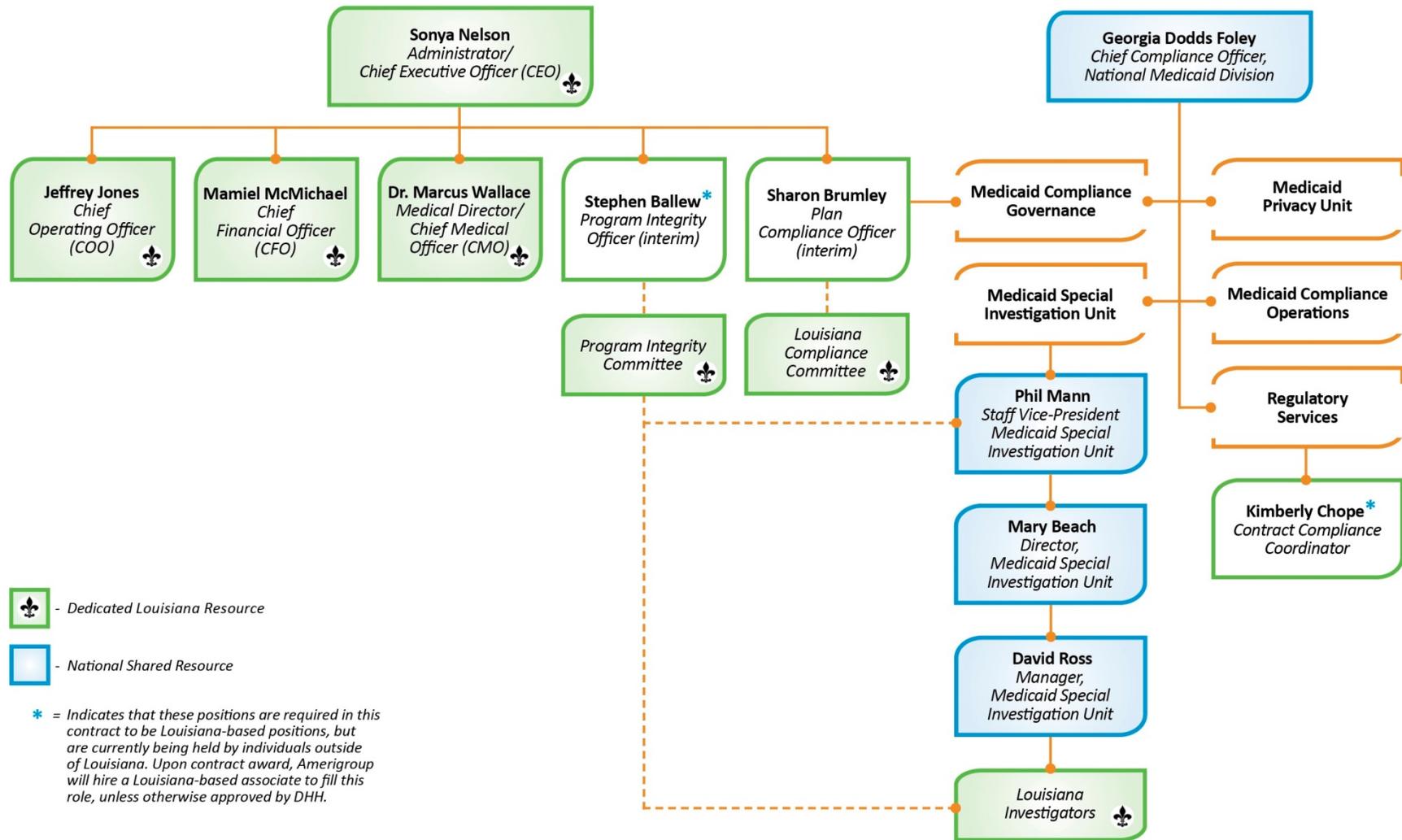
David Ross is a Manager in the MSIU and has many years of investigation experience in both health care and public assistance fraud. He worked in the law enforcement and Medicare sectors conducting investigations and research in the financial fraud and white collar crime arenas. He has been with Amerigroup for seven years and has had oversight for the Louisiana market since Amerigroup entered in 2012. Mr. Ross is a graduate of Florida State University with a BS in Criminology and is an AHFI and a CFE.

Steve Ballew is a Senior Investigator in the MSIU and has extensive experience in the investigation of Medicare, Medicaid, and Public Assistance fraud. He has been with Amerigroup for seven years and has been the lead investigator for Louisiana for the past year. Prior to Amerigroup, he worked for a CMS Program Safeguard Company where he investigated home health and hospice providers in a 10-state region which included Louisiana. Steve is a graduate of Florida State University with a BS in Criminology and is an AHFI.

Organizational Chart for Compliance

Figure V.2-1, submitted as Chart D, shows the staff involved in compliance.

Figure V.2-1. Chart D—Amerigroup Louisiana Program Integrity and Compliance Resources



Other Aspects of Amerigroup's Commitment to Compliance

In addition to our robust program integrity systems and resources as described earlier in this response, Amerigroup has one of the most proactive overall regulatory compliance programs in the industry. Founded in the principles of the U.S. Department of Justice's (USDOJ) Seven Fundamental Elements of an Effective Compliance Program, we maintain a robust system of processes and controls to prevent, identify, and mitigate potential risks. Our commitment to compliance and establishing a culture that encourages our employees to embrace this commitment is reflected in one of our company's core values: **Trustworthy**. At Amerigroup, we believe that being **trustworthy** and fostering open communication and dialogue across our health plan and with DHH are at the core of our ability to meet the expectations and goals of DHH, our providers, and our members.



Trustworthy

- We do the right thing.
- We keep our commitments.
- We are transparent in words and deeds. 

In support of our commitment to being *trustworthy*, our Louisiana health plan invests in dedicated compliance resources that maintain a singular focus on education, monitoring and oversight, and risk identification and mitigation. Our Louisiana compliance resources are supported by national compliance resources who provide oversight, guidance, and the sharing of best practices across all affiliate health plans. The components of our Louisiana compliance program and national support resources are outlined below, using the USDOJ framework.

1. Implementing Written Policies, Procedures, and Standards of Conduct

Policies and Procedures. Amerigroup maintains a robust library of policies and procedures that address our regulatory, contractual, and other program obligations and requirements. Policies are developed by functional managers throughout the organization, in consultation with our dedicated Contract Compliance Coordinator and the Louisiana Plan Compliance Officer. These policies play a major role in guiding health plan activities and operations. We monitor and review policies and procedures regularly and publish them on an internal SharePoint site accessible to all employees.

Standards of Ethical Business Conduct (Code). All Amerigroup employees must acknowledge and agree to comply with the Code as a condition of employment. The Code is applicable to Amerigroup and all of its affiliates and is designed to help employees understand and comply with our legal, regulatory, and contractual responsibilities and act in a way that supports our national principles.

2. Designating a Compliance Officer and Compliance Committee

Louisiana Plan Compliance Officer. Amerigroup maintains a full-time, dedicated Plan Compliance Officer. This individual partners with our health plan leadership to provide more extensive and focused engagement across the Louisiana health plan on issues, including compliance education and training, risk identification and mitigation, and the development and oversight of corrective actions. The Plan Compliance Officer provides Amerigroup with executive-level compliance oversight and management and works collaboratively across all functional areas to infuse compliance into everything we do.

Louisiana Contract Compliance Coordinator. We maintain a dedicated Contract Compliance Coordinator for the Bayou Health program. This individual serves as our primary liaison with DHH for day-to-day contract management and oversight issues, manages the submission of all required regulatory

reporting, and is our internal subject matter expert and resource regarding Amerigroup's contractual and regulatory obligations under the Bayou Health program.

Louisiana Medicaid Health Plan Compliance Committee. Chaired by our Plan Compliance Officer, our local Louisiana Medicaid Compliance Committee includes our executive-level leadership, including our Administrator/CEO, Sonya Nelson; COO, Jeffrey Jones; and Medical Director/Chief Medical Officer, Dr. Marcus Wallace. Additional members include the Contract Compliance Coordinator and a management representative from our Government Relations, Medical Management, Quality Management, Provider Relations, Operations, Marketing, and Finance departments. The Compliance Committee meets monthly and provides a forum for health plan leadership to review and discuss emerging issues and upcoming activities, assess potential compliance risks, and provide input into mitigation activities and corrective action plans. The Compliance Committee receives and reviews reporting about compliance monitoring activities and provides necessary oversight for our Louisiana Compliance Program.

3. Conducting Effective Training and Education

Extensive Compliance Training. All employees within the WellPoint family of companies receive mandatory compliance training—including two hours of initial compliance training and annual required compliance training—which incorporate education on the requirements of any current agreements or corrective action; fraud, abuse, and waste; HIPAA; and other aspects of the compliance program (including the Code and policies and procedures). Additionally, Louisiana health plan employees must participate in annual Medicaid-specific compliance training. We track and monitor completion of all required training through our online learning systems.

On-going Education and Awareness. We conduct additional education and awareness activities throughout the year to reinforce the role that all Louisiana health plan employees play in compliance. Our “Did You Know?” program delivers information directly to employees’ e-mail and is posted to our internal intranet site and in break rooms and copy rooms. Our Plan Compliance Officer participates in our regular Town Hall meetings to provide on-going education on compliance and contractual requirements, often by using scenarios and a “Jeopardy”-like answer and question format to gain interactive participation. Additionally, we participated in the “Ethics and Compliance Week” celebration held in June 2014, sponsored by our national Medicaid Compliance Department. Activities and information highlighted how employee commitment to compliance supports our overall success.

4. Conducting Internal Monitoring and Auditing

Louisiana Medicaid Compliance Program and Work Plan. Our Plan Compliance Officer develops and maintains a Louisiana Medicaid Compliance Program and Work Plan. The Compliance Committee reviews and approves the Work Plan each year and receives regular progress updates. The core functions of the Work Plan track the seven elements of an effective compliance program: written standards, structured compliance program, training and education, auditing and monitoring, reporting and investigation, enforcement and discipline, and response and prevention.

National Medicaid Compliance Officer. As part of WellPoint's National Medicaid Division, Amerigroup has access to the resources of our national Medicaid Compliance Officer and the Medicaid Compliance Program Services department. Collectively, this team manages and ensures the on-going operation and effectiveness of national Medicaid Compliance Program initiatives, including compliance program effectiveness reviews, standardized risk identification, prioritization and mitigation framework, and providing overall direction and guidance through the sharing of best practices to local Medicaid health plan compliance officers and committees.

Partnership with Internal Audit. Our compliance resources partner with our national Internal Audit department to ensure that master audit plans include key compliance issues and risks for detailed review, evaluation, monitoring, and corrective action as needed.

5. Reporting and Investigating

Speaking Up. In our Louisiana health plan and nationally across our affiliate companies, we work to establish a culture of compliance that encourages employees to “speak up” to identify any potential compliance concerns or issues through multiple reporting avenues. We maintain a strict and highly publicized policy of non-retaliation for any employee who proactively comes forward to identify potential compliance risks and/or concerns.

Confidential Compliance Hotline. Our national compliance hotline supports confidential (and anonymous as requested) and secure reporting of potential violations. All hotline reports are investigated and results reported to the National Medicaid Compliance Officer.

6. Enforcing Standards through Well-publicized Disciplinary Guidelines

National Ethics and Compliance Office. The national Ethics and Compliance Office administers and advises employees on the Standards of Ethical Business Conduct (described previously), serves as an independent resource to receive and investigate allegations of employee misconduct, provides employees with training on ethics and compliance issues, and provides high-level oversight of compliance programs across the WellPoint enterprise.

7. Responding Promptly to Detected Offenses and Undertaking Corrective Action

Corrective Action. When we learn of any deficiency, whether identified by the State, a provider, or internally, our Plan Compliance Officer, in collaboration with other internal stakeholders and business owners, investigates the root cause of the problem and develops an action plan to prevent a recurrence.

Taken together, these components represent a comprehensive and proactive approach to program monitoring and enforcement that helps promote full compliance with all State and federal requirements, provides the fullest protection of our members’ rights, and fully supports the goals and objectives of DHH’s mission in providing high-quality health care services at a reasonable and predictable cost.

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