COMPLIANCE AND OVERSIGHT MONITORING

The contract between HCA and Molina Healthcare defines a number of performance requirements that must be satisfied by Molina Healthcare subcontracted Providers to provide services to eligible and enrolled Molina Healthcare Members. Among these are:

- The Provider's agreement to participate in medical audits and/or other mandated audits required by HCA and other regulatory agencies
- The Provider's agreement to maintain books and records for a period of at least ten years and make such documents available to regulatory agencies
- The Provider's agreement to furnish Molina Healthcare with encounter data in a format mutually agreed upon

Providers are encouraged to review their contracts with Molina Healthcare to become thoroughly familiar with these and additional performance requirements.

QUALITY OVERSIGHT MONITORING

Under the terms of its contract with HCA, Molina Healthcare conducts ongoing reviews of Provider performance. The outcomes and findings of elements listed and other performance indicators will be reviewed by Molina Healthcare's Quality Improvement (QI) Department and, as necessary, by Molina Healthcare's Executive Quality Improvement Committee (EQIC).

Among the elements reviewed are the following:

- Access Standards - Molina Healthcare reviews the time it takes Members to access emergency, urgent, non-urgent (routine) and preventive care as listed in Section 5 of this manual. Periodic and random telephone surveys are conducted to obtain current access information. Providers who fail to meet the timely access requirements will receive written notification and be re-surveyed within three to six months.
- Medical Records - Molina Healthcare will review medical records to ensure they are being appropriately maintained and reflect the care and follow-up provided to Molina Healthcare Members. Providers will be notified in advance of review dates.
- Medical Facilities - Molina Healthcare must ensure care is provided at service sites that meet licensing, contractual and other requirements intended to support the delivery and management of high-quality medical care. Facility reviews are conducted by Molina Healthcare representatives using an approved facility checklist and review tools. Providers are informed in advance of selected review dates.
- Member Complaint and Grievance Indicators - Member concerns regarding the care and services of specific Providers are collected and acted upon by Molina Healthcare

1. Quality of Care – Member concerns about specific care received from Molina Healthcare's contracted Providers are reviewed by the QI Department. Member medical records are often requested as part of this review process.
2. Quality of Service - Member concerns about service received from Molina Healthcare's contracted Providers are reviewed by the QI Department. Providers may be engaged in the review of these concerns and will be asked to assist in resolution, as needed.

QUALITY IMPROVEMENT CORRECTIVE ACTION PLANS

When it is found Providers do not meet the terms of their contracts, applicable policies and procedures, licensing and related requirements, and the provisions of this manual, they will be notified in writing of deficiencies. Quality Improvement Corrective Action Plans are forwarded to Providers and include corrective actions and dates by which corrective actions are to be achieved.

Molina Healthcare representatives work with and offer support to Providers to ensure the timely resolution of corrective action plan requirements. Providers who fail to respond to an initial corrective action plan by the date specified will be provided a second notice and may be assigned an extended action plan due date.

Failure to comply with the terms of Molina Healthcare's Quality Improvement Corrective Action Plan may result in one or more of the following actions:

- Closing the Provider's panel to new Member assignments
- Moving current Members to another Provider
- Formal contract termination

FRAUD AND ABUSE

Molina Healthcare seeks to uphold the highest ethical standards for the provision of health care benefits and services to its Members, and supports the efforts of Federal and State authorities in their enforcement of prohibitions of fraudulent practices by Providers or other entities dealing with the provision of health care services.

Definitions:

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services not medically necessary or failing to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR §455.2)

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR§ 455.2)

Federal False Claims Act, 31 USC Section 3279

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean a person with respect to information:

- Has actual knowledge of falsity of information in the claim
- Acts in deliberate ignorance of the truth or falsity of the information in a claim or
- Acts in reckless disregard of the truth or falsity of the information in a claim

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

On February 8, 2006, President Bush signed into law the Deficit Reduction Act (DRA). The law, which became effective on January 1, 2007, aims to cut fraud, waste and abuse from the Medicare and Medicaid programs over the next five years.

As a Provider to Molina Healthcare Members, you are either a covered entity or contractor/agent, as a contractor/agent you are required to follow Molina Healthcare's policy and procedures on the DRA, fraud and abuse. Health care entities like Molina Healthcare who receive or pay out at least $5 million in Medicaid funds per year must comply with DRA. These entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims
- How Providers will detect and prevent fraud, waste, and abuse
- Employee protected rights as whistleblowers

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as whistleblower provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole, including:

- Employment reinstatement at the same level of seniority
- Two times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor contracted Providers to ensure compliance with the law.

Health Care Fraud:

Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

What is health care fraud, waste and abuse?

Health care fraud and abuse occurs in every area of health care. Health care fraud is the intentional falsification of a fact on a healthcare claim in order to receive payment or services not owed to them. Health care waste and abuse describes practices that directly or indirectly result in unnecessary costs to a healthcare program and its members.

Who commits health care fraud, waste or abuse?

Providers can commit health care fraud, waste or abuse by:

- Billing incorrectly
- Billing for: services never rendered, inappropriate/unnecessary services, or "free services"

- Make false claims about qualifications, licensure and/or education
- Falsify records to suggest ongoing medical services
- Forge a physician's signature on plans of care
- Alter information on care plans, prescriptions, and/ or other medical documentation
- Billing for multiple family members when only one family member received service(s) and/or supplies
- Change or incorrectly code a claim to receive maximum payment
- Falsify the diagnosis or procedure to maximize payments
- Change dates of service for double billing

Patients can commit healthcare fraud, waste and abuse by:

- Share health plan ID cards
- Claim non-covered dependents
- Participate in doctor shopping ("Doctor Shopping" is a term commonly used to refer to a patient who may or may not have a real physical illness, but goes from doctor to doctor with the objective of improperly obtaining multiple prescriptions for narcotic painkillers)
- Consent with doctors to submit claims for services not received or not necessary
- Fabricate claims
- Alter submitted medical documentation of any type
- Use a stolen health plan ID card to obtain healthcare services
- Use a deceased member's health plan ID card to obtain healthcare services
- Ineligible persons using an eligible person's health plan ID card to obtain medical services or benefits

How can I help stop health care fraud?

Healthcare fraud takes money from healthcare programs and leaves less money for real medical care.

Here are some ways you can help stop fraud:

- Do not give your Molina Healthcare ID card, ProviderOne Services Card or ID number to anyone other than a health care provider, a clinic, or hospital and only when receiving care
- Do not let anyone borrow your Molina Healthcare ID Card or ProviderOne Services Card
- Do not sign a blank insurance form
- Be careful about giving out your Social Security number
- Be careful of anyone who offers you "free" tests and services in exchange for your Medical/Molina Healthcare card number.

You can report fraud by:

- Phone: Toll-free to Member Services (800) 869-7165
- Fax: (425) 424-7156 or Toll-free (800) 282-9929
- Email: mhwcompliance@molinahealthcare.com

You can report fraud, without giving us your name, by:

- Phone: Toll-free (866) 702-0404 (Confidential Compliance Voicemail Box)

- Fax: Compliance Director (425) 424-7156 or toll free (800) 282-9929
- Mail:
  Attn: Compliance Director (CONFIDENTIAL)
  Molina Healthcare of Washington, Inc.
  PO Box 4004
  Bothell, WA 98041-4004
- Email: mhwcompliance@molinahealthcare.com

If you think fraud has taken place, call DSHS at:

- (800) 562-6906 to report Medicaid client fraud
- (360) 586-8888 to report Medicaid provider fraud

Additional Health Care Compliance and Anti-Fraud & Abuse Information may be accessed by visiting any of the following websites:

Office of the Attorney General
Washington State Medicaid Fraud Control Unit
P.O. Box 40116
Olympia, WA 98504-0116
http://www.atg.wa.gov/MedicaidFraud/default.aspx
Tel. (360) 586-8888
Fax (360) 586-8877

Division of Fraud Investigations at DSHS
http://www1.dshs.wa.gov/Fraud/index.html
(800) 562-6906

For those who do not have access to computers in your home, Internet access is available at your local public library.