

Policy and Standards

Product Applicability:

<input type="checkbox"/> Commercial	<input checked="" type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Part C	<input type="checkbox"/> Part D
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Business Division and Entity Applicability:

Magellan Healthcare							
<input checked="" type="checkbox"/> Magellan Healthcare(B)	<input checked="" type="checkbox"/> Magellan Complete Care(C)	<input checked="" type="checkbox"/> Magellan Healthcare Provider Group(G)	<input checked="" type="checkbox"/> AlphaCare of New York(L)				
NIA Magellan							
<input checked="" type="checkbox"/> National Imaging Associates(N)							
Magellan Rx Management							
<input checked="" type="checkbox"/> Magellan Rx Pharmacy(I)	<input checked="" type="checkbox"/> MMA(A)	<input checked="" type="checkbox"/> MPS(S)	<input checked="" type="checkbox"/> Partners Rx(X)	<input checked="" type="checkbox"/> CDMI(D)	<input checked="" type="checkbox"/> Magellan Rx Management(R)	<input checked="" type="checkbox"/> Magellan Administrative Services(O)	<input type="checkbox"/> Magellan Rx Medicare(K)

Corporate Policy:

Policy Number:	COM.MCD.1923.01-2015.B-C-G-L-N-I-A-S-X-D-R-O		
Policy Name:	Medicaid Compliance Program		
Date of Inception: January 1, 2007	Previous Annual Review Date: April 15, 2014	Current Annual Review Date: April 20, 2015	
Review Type:	<input type="checkbox"/> New Policy <input checked="" type="checkbox"/> No Changes <input type="checkbox"/> Non-substantive <input type="checkbox"/> Substantive (material changes or initial documentation of current processes)		
Previous Corporate Approval Date: April 17, 2014	Current Corporate Approval Date: April 20, 2015	Unit Effective Date: May 20, 2015	

Corporate Policy Approvals:

04 – 2015 changes were non-substantive; thus, full corporate approvals were not required.

John J. DiBernardi, Jr., Esq.	<i>Approval on file</i>	04-20-2015
Magellan Health, Senior Vice President & Corporate Compliance Officer		Date

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Cross Reference(s)

Magellan Code of Conduct; False Claims Laws and Whistleblower Protections

Policy Statement

Magellan Health, its subsidiaries and affiliates, (Magellan) are dedicated to conducting business in an ethical and legal manner. Magellan's Compliance Program describes our comprehensive plan for the prevention, detection and reporting of fraud, waste and abuse across various categories of health care related fraud (e.g., internal fraud, electronic data processing fraud, external fraud). Magellan has written policies, procedures and standards of conduct mandate that every employee comply with all applicable Federal and State standards. Magellan aggressively pursues allegations of health care fraud, waste, and abuse.

Purpose

To provide comprehensive prevention, detection and awareness training. The Fraud, Waste and Abuse Compliance Program helps employees understand and follow federal and state laws related to their jobs and demonstrates Magellan's commitment to conducting business honestly and responsibly to the Medicaid community and the community at large.

Scope

<input checked="" type="checkbox"/> Account Management	<input checked="" type="checkbox"/> Claims (Service Ops)	<input checked="" type="checkbox"/> Clinical Operations
<input checked="" type="checkbox"/> Compliance	<input checked="" type="checkbox"/> Credentialing/Re-cred	<input checked="" type="checkbox"/> EAP
<input checked="" type="checkbox"/> Federal and State Affairs	<input checked="" type="checkbox"/> Finance	<input checked="" type="checkbox"/> Human Resources
<input checked="" type="checkbox"/> Information Technology	<input checked="" type="checkbox"/> Legal	<input checked="" type="checkbox"/> Marketing/Comm/Sales
<input checked="" type="checkbox"/> Network	<input checked="" type="checkbox"/> Operations (Member Services)	<input checked="" type="checkbox"/> Quality Improvement
<input checked="" type="checkbox"/> Security	<input checked="" type="checkbox"/> Special Investigations Unit	

Key Terms

None

Policy Terms & Definitions are available should the reader need to inquire as to the definition of a term used in this policy.

To access the *Policy Terms & Definitions Glossary* in MagNet, click on the below link: *(internal link(s) available to Magellan Health employees only)*

[Policy Terms & Definitions Glossary](#)

Standards

- I. Corporate Compliance Program
 - A. Magellan's Corporate Compliance Program is overseen by the Corporate Compliance Department. The Corporate Compliance Officer (CCO), who reports to the General Counsel and has the authority to report compliance issues directly to the Board of Directors, leads the Compliance Department.

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- B. The primary components of the Corporate Compliance Program include:
1. Written Policies and Procedures;
 2. Designation of a Compliance Officer and a Compliance Committee;
 3. Conducting Effective Training and Education;
 4. Developing Effective Lines of Communication;
 5. Enforcement through Publicized Disciplinary Guidelines and Policies Dealing with Ineligible Persons;
 6. Auditing and Monitoring;
 7. Responding to Detected Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities; and
 8. Whistleblower Protection and Non-Retaliation policy.

II. Written Policies and Procedures and Standards of Conduct

- A. Magellan has corporate policies, procedures, and standards of conduct in place that address all aspects of its compliance program. These include policies concerning fraud, waste, and abuse including, but not limited to policies that address applicable federal and state false claims acts, and policies that outline Magellan's procedures for detecting and preventing fraud, waste and abuse ("FWA"), and whistleblower protections. All policies and procedures are available to the Federal Government and the State(s) for review and are provided any time they are requested. Specific policies related to handling FWA include, but are not limited to:
1. COM.MCD.1923.xx - Medicaid: Fraud and Abuse Compliance Program;
 2. COM.1916.xx - False Claims Laws and Whistleblower Protections;
 3. COM.1919.xx - Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers and Vendors);
 4. COM.1906.xx - Corporate Compliance Hotline;
 5. COM.1908.xx - Corporate Compliance Structure with Care Management Centers (CMCs), Business Divisions, and Corporate Departments;
 6. COM.1902.xx - Employee's Obligation to Report Potential Compliance Violations;
 7. COM.1900.xx - Corporate Compliance Committee;
 8. CR.1102.xx - Network Practitioner Credentialing; and
 9. CR.1104.xx - Network Practitioner Re-Credentialing.
- B. In compliance with the Deficit Reduction Act of 2005 FWA education requirements, Magellan has written policies regarding FWA including a grid, which provides information about applicable federal and state FWA laws. The State False Claims laws grid also contains information about the American Recovery and Reinvestment Act of 2009 (ARRA) and Whistleblower Protection laws.
- C. The State False Claims laws grid is available at <http://www.magellanhealth.com/our-company/compliance/dra-compliance-statement.aspx>
- D. Magellan's policies also contain detailed information regarding Magellan's procedures to detect, deter, monitor, and to report FWA. These policies are provided online to employees, providers, and subcontractors at <http://www.magellanhealth.com/our-company/compliance/dra-compliance-statement.aspx>.

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- E. Magellan’s Code of Conduct (“Code of Conduct”) outlines the written policies, procedures and standards of conduct that include the fundamental rules that Magellan employees are required to follow.
- F. The Code of Conduct is distributed to all employees when they start working at Magellan, and it is reviewed annually, so that employees are familiar with the ethical and legal standards with which they are required to comply. An electronic copy of the Code of Conduct is posted in the Onboarding (or New Hire) portal, which is used by all new employees to complete the necessary paperwork during new employee orientation. New employees can print copies of the Code of Conduct from the portal. Current employees can obtain copies of the Code of Conduct from Magellan’s intranet site or the web site at <http://www.magellanhealth.com/our-company-/compliance.aspx>.
- G. The Code of Conduct addresses but is not limited to the following topics:
 - 1. Confidentiality of Health Information;
 - 2. Licensure and Accreditation;
 - 3. Billing;
 - 4. Accounting;
 - 5. Sarbanes-Oxley Act;
 - 6. Conflict of Interest;
 - 7. Software Copyright Infringement;
 - 8. E-mail and other Computer and Network Usage;
 - 9. Business Development;
 - 10. Anti-trust Laws;
 - 11. Drugs, Narcotics, and Alcohol;
 - 12. Employment Reference Checks and Drug Screening (Background Checks);
 - 13. Securities Law;
 - 14. Litigation and Government Investigations;
 - 15. Record Retention;
 - 16. Federal Anti-Kickback Statute;
 - 17. Fraud, Waste, Abuse, and Overpayments;
 - 18. Federal False Claims Act; and
 - 19. State False Claims laws.
- H. In addition to the Code of Conduct, Magellan also has corporate policies and/or procedures in place to address the following areas:
 - 1. Compliance with Federal laws including, but not limited to:
 - a) Federal False Claims Act (31 U.S.C. § 3279);
 - b) Anti-Kickback Statute (42 U.S.C. § 1320a-7b);
 - c) The Deficit Reduction Act of 2005;
 - d) The American Recovery And Reinvestment Act of 2009;
 - e) The Patient Protection and Affordable Care Act of 2010;

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- f) The Health Care and Education Reconciliation Act of 2010;
 - g) Any other applicable Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse;
 - h) Health Insurance Portability and Accountability Act (45 CFR 160 and 164);
 - i) Title VI of the Civil Rights Act of 1964;
 - j) Age Discrimination Act of 1975;
 - k) Rehabilitation Act of 1973;
 - l) Titles II and III of the American with Disabilities Act;
 - m) Titles XVIII, XIX, XXI of the Social Security Act;
 - n) Federal Rehabilitation Act of 1973;
 - o) Davis Bacon Act (40 U.S.C. § 276a et seq.);
 - p) Copeland Anti-Kickback Act (40 U.S.C. § 276c);
 - q) Byrd Anti-Lobbying Amendment (31 U.S.C. 1352); and
 - r) Federal Debarment and Suspension regulations (45 CFR 74 Appendix A (8) and Executive Order 12549 and 12689).
2. Network and Credentialing;
 3. Overpayment and Underpayment identification;
 4. Process for identifying overpayments including auditing and refund processing procedures;
 5. Reviewing employees, board members and officers for OIG debarment or exclusion at hire and at least annually thereafter;
 6. Reviewing providers and subcontractors for OIG debarment or exclusion upon contract execution and on a monthly basis thereafter;
 7. Record Retention;
 8. Prescription Drug Fraud;
 9. Fraud, waste and abuse violation referrals to State Agencies and/or law enforcement; and
 10. Responding to data requests from CMS, State and Federal Agencies, and law enforcement.

III. Designation of a Compliance Officer and a Compliance Committee

A. Corporate Compliance Officer (CCO) Responsibilities

1. Magellan's Corporate Compliance Department is responsible for overseeing review and implementation of federal and state statutory and regulatory requirements and is led by the Corporate Compliance Officer (CCO).
2. The CCO ensures that policies and procedures relating to compliance, fraud, waste and abuse promote effective interdepartmental and external lines of communication.
3. Quarterly, the CCO or his designee reports to the Board of Directors Audit Committee, the Chief Executive Officer and the Chief Financial Officer, a summary of material violations of state and/or federal laws, the Code of Conduct including the

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nature of the alleged violation; the subsidiary or department involved; the findings of any investigation; and the action taken.

4. The Corporate Compliance Department staff includes Regulatory Compliance Attorneys, Compliance Directors, and Legislative Analysts.

B. Local Compliance Officer (LCO) Responsibilities

1. Magellan has a full time staff person who is designated as the Local Compliance Officer (LCO) at the Care Management Center (CMC). The LCO is responsible for helping to oversee the Compliance program at the CMC and ensuring compliance with the contractual obligations as it relates to the specific Medicaid contract.
2. Also to maintain the independence of the LCO, s/he has a reporting relationship with the CCO, who in turn, has the authority to report compliance issues directly to Magellan's CEO and/or its Board of Directors.
3. The LCOs attend the quarterly Compliance meeting with the CCO.

C. Corporate Compliance Committee

1. The Corporate Compliance Committee consists of representatives of executive management from various key operational areas and business units of the Company.
 - a) The CCO chairs the Corporate Compliance Committee.
 - b) The CCO also sits on the Enterprise Quality Council, which oversees quality improvement activities for the company.
2. The Corporate Compliance Committee oversees the implementation and operation of the Corporate Compliance Program including:
 - a) Reviewing reports and recommendations of the CCO regarding compliance activities. Based on these reports, the Committee makes recommendations regarding future compliance priorities and resources;
 - b) Reviewing reports from investigations when agreement upon disciplinary action and/or corrective action plans cannot otherwise be reached. In these cases, the Corporate Compliance Committee makes the final decision;
 - c) Approves the Annual Compliance Work Plan, which addresses areas of focus for the year; and
 - d) Reviewing and approving Compliance Department policies and procedures that describe the scope and authority for Compliance activities.

IV. Corporate Compliance Program Training and Education

- A. The CCO and the Human Resources Department are responsible for coordinating the training efforts for the Compliance Program. Compliance, and Security staff determines the content and requirements for the compliance trainings while working with the training department to develop the training for employees/contractors.
- B. Compliance training sessions are conducted and documented for all new employees (including full-time, part-time, contracted or temporary employees), physician advisors and health care professional advisors within thirty (30) days of their hire date.
 1. The initial training for all new employees and professional staff members includes, in- depth review of the Code of Conduct, the standards of conduct and the applicable policies and procedures, as well as a HIPAA Primer and Fraud, Waste, and Abuse Training.

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2. Annually all Magellan employees including the CCO and the LCO must complete three (3) Compliance trainings. The Compliance trainings are: Code of Conduct, HIPAA Privacy and Security and F.I.R.E. (Fraud Investigation Recognition and Education). These annual trainings include information consistent with Sections 6032 of the federal Deficit Reduction Act (DRA) of 2005 such as information about:
 - a) The False Claims Act;
 - b) Penalties for submitting false claims & statements;
 - c) Magellan's role in preventing and detecting fraud, waste and abuse;
 - d) Each person's responsibility relating to detection and prevention;
 - e) The toll-free state telephone numbers for reporting fraud, waste, and abuse; and
 - f) Applicable federal and state whistleblower protections.
 3. Trainings are offered through on-line modules and include a post-test that employees must pass with an eighty (80%) percent score or better. Magellan uses the Achieve online learning management system to administer the courses. The Achieve system records the complete/incomplete status for each employee/contractor who is assigned the course and the date that the employee/contractor completes a training course.
 4. The on-line training system records employee/contractor completion and sends reminders to employees if they have not completed the course(s). The system maintains logs of the employee/contractor, course and date of completion.
 5. Supervisors have the responsibility to ensure all employees complete the training in a timely manner. If an employee does not complete all three (3) of these mandatory training courses by the deadlines provided, the employee may be placed on an unpaid "leave of absence." After five (5) days of unpaid "leave", if the training(s) have not been completed, the employee may be terminated from employment.
 6. Throughout the calendar year, Magellan publishes numerous educational pieces and conducts various activities and programs designed to educate and raise awareness of compliance and compliance related issues, including fraud, waste and abuse. Training topics are reinforced through posters located in each site, print outs from the training systems, monthly articles in the Magellan employee electronic newsletter, and during special event weeks such as "International Fraud Awareness Week," Health Information Privacy Week, and National Ethics Week.
 7. Magellan conducts an annual "Compliance Awareness Week," which is a week-long series of activities and programs designed to educate and raise awareness of compliance and compliance related issues, including fraud waste and abuse.
- B. Within thirty (30) days of the implementation date of changes to the Corporate Compliance Program, current employees, physician advisors and behavioral health care professional advisors are advised of the changes through distribution of the revised Code of Conduct or via the corporate intranet.
- C. If the CCO or LCO determines that written materials are not sufficient to familiarize employees and advisors with the amendments to the Magellan Code of Conduct or Magellan's policies and procedures or changes in the applicable law, interim training sessions are conducted.
- D. Educational information for contracted health network providers regarding the detection of healthcare fraud, waste and abuse is provided through a series of provider newsletter

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articles and mailings to providers, which include examples of potential fraud, waste, abuse, and overpayments.

- E. Policies and procedures and contact information are also published on the Magellan website and in the Code of Conduct.
 - F. Providers are informed of the fraud and abuse program and practices, including the fact that reported allegations will be investigated. This information is included in the Provider Handbook and reviewed through provider meetings, notices, or provider focus alerts.
- V. Effective Lines of Communication
- A. To ensure that employees and agents are familiar with the Corporate Compliance Program, there is on-going communication from the Compliance Department to the CMC LCOs with regard to the Compliance Program.
 - 1. The LCO for each CMC attends the quarterly Compliance meeting with the CCO. The meeting is one of the mediums used to exchange information between the Corporate Compliance Department and the local Compliance Department. Other effective communication lines available to the Local Compliance Officer include working with the CCO and/or Regulatory Compliance Attorney assigned to the state and the Special Investigations Unit (SIU).
 - 2. Magellan maintains a Corporate Compliance Hotline and other compliance procedures to foster an open atmosphere for employees and others to report issues and concerns, free from retaliation.
 - 3. Employees, members, or subcontractors may report suspected cases of fraud, waste, or abuse and other compliance concerns anonymously.
 - 4. The Compliance Hotline is available twenty-four (24) hours a day, seven (7) days a week and is maintained by an outside vendor. Callers may choose to remain anonymous. All calls are investigated and remain confidential. *Magellan prohibits any employee from taking retribution against a Hotline caller.* Written confidentiality and non-retaliation policies have been developed to encourage open communication and the reporting of incidents of suspected fraud, waste, abuse, and other compliance concerns to Magellan and applicable regulatory agencies.
 - 5. Employees may also direct any questions or concerns to their Supervisor, LCO, or the CCO.
 - 6. The LCO distributes in writing, posts in a conspicuous places, and posts to the Compliance department webpage any modifications of, or amendments to the Compliance Plan, standards of conduct or policies at the state level.
 - 7. Employees, members, providers, and subcontractors have been informed through the employee training, posters, Enrollee Handbooks (to the extent delegated by the Customer), Provider Handbooks and Magellan's Deficit Reduction Act of 2005 Compliance Statement respectively, that they can report suspected cases of fraud, waste, abuse, and overpayments via any one of the following methods:
 - a) Special Investigations Unit Hotline: (800) 755-0850;
 - b) Special Investigations Unit E-mail: SIU@magellanhealth.com;
 - c) Corporate Compliance Hotline: (800) 915-2108; or
 - d) Compliance Unit Email: Compliance@magellanhealth.com.

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8. Employees, members, providers, and subcontractors are also notified that they can report suspected cases of fraud, waste, and abuse to the applicable federal and state regulatory agency as specified in the Medicaid contract and/or applicable law including but not limited to the U.S. Department of Health & Human Services Office of Inspector General.

- Contact the Office of the Inspector General by phone, fax, email, or by mail.

U.S. Department of Health & Human Services Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS

PO Box 23489

Washington, DC 20026

Telephone: 1-800-HHS-TIPS (1-800-447-8477)

Fax: 1-800-223-8164

TTY: 1-800-377-4950

Email: HHSTips@oig.hhs.gov

On-line: oig.hhs.gov/report-fraud

- B. The CCO coordinates with the following departments for all fraud, waste and abuse activities:

1. Special Investigations Unit

- a) Magellan's Special Investigations Unit (SIU) is responsible for protecting the assets of Magellan and its clients by detecting, identifying, and deterring fraud, waste, and abuse by conducting audits of internal and external sources of information.
- b) The SIU creates and maintains thorough and objective documentation of all findings.
- c) The SIU develops and recommends appropriate case strategies to bring cases to a timely and successful close.
- d) The SIU develops relationships with, and uses the resources of, other Magellan departments, law enforcement and government agencies, professional associations, and the SIU departments of Magellan customers.
- e) The SIU must comply with the fraud, waste and abuse reporting requirements under applicable state and federal laws.

2. Care Management Centers

- a) General Managers of CMCs are accountable for reducing fraud, waste and abuse within the lines of business for which they are responsible.
- b) General Managers of CMCs and LCOs are responsible for identifying and reporting all fraud, waste, and abuse issues that are specific to the region in which they operate and to contracts under their purview to the SIU.

3. Claims Department

- a) All claims personnel (claim supervisors, processors, cost containment personnel, managed care personnel, and enrollee relations representatives) involved in the initial review of the claim are trained to recognize fraud indicators or issues that may warrant additional investigation by the Magellan SIU.
- b) Objective reasons for requesting scrutiny of the claim by the Magellan SIU must be present to justify a referral. Each individual who subsequently participates in

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the evaluation of the claim (i.e., Supervisors, SIU Investigators, and Managers) shares this responsibility.

- VI. Enforcement of Standards through Well Publicized Disciplinary Guidelines and Policies Dealing With Ineligible Persons
- A. Employees who violate the Code of Conduct are subject to sanctions, including, but not limited to, termination of employment.
- Employee orientation training and processes include statements about disciplinary guidelines and the importance of enforcement standards.
- B. Disciplinary guidelines known as Corrective Action Guidelines are reviewed with all employees during initial orientation and are distributed in the Employee Handbook. This information is also available to all employees on the Magellan website.
- These guidelines are designed to encourage fair and impartial treatment of all employees. This policy is administered without discrimination and in full compliance with our Equal Employment Opportunity philosophy.
- C. Magellan employees are strictly prohibited from engaging in any activity that violates applicable state and/or federal law, the Code of Conduct, the standards of conduct, or the applicable policies and procedures.
- Violations may be grounds for termination or other disciplinary action, depending on the circumstances of each violation as determined by the Human Resources Department in consultation with the Corporate Compliance Officer or designee.
- D. Disciplinary action is taken against employees who authorize or participate directly in a violation of applicable state or federal law, the Code of Conduct, standards of conduct, or policies and procedures, and any employee who may have deliberately failed to report such a violation or who hinders an investigation.
1. Magellan disciplines any employee who has deliberately withheld relevant and material information concerning a violation of applicable state and/or federal law, the Code of Conduct, the standards of conduct, or the applicable policies and procedures and takes appropriate actions to prevent reoccurrence.
 2. In cases in which disciplinary action may be appropriate, the CCO (or delegate) will work with the Human Resources Department and the relevant supervisor to implement such actions. If agreement cannot be reached on a disciplinary action, the matter will be discussed with the relevant senior and/or executive management, as applicable. If agreement cannot be reached at the executive manager level, the matter may be referred to the Corporate Compliance Committee for resolution.
- E. The Corporate Compliance Committee, in consultation with the Legal Department as necessary, recommends any appropriate remedial or other action as warranted under the circumstances if agreement cannot be reached between the appropriate business owner, Corporate Compliance Officer and Human Resources Department.
- F. Posters and other communication materials are used throughout the local CMC and are available through the internal website as well as through HR representatives at the local CMC and corporate level. Posters include information regarding how to report fraud, waste, and abuse including submitting anonymous reports; the posters also include information that the report and their identity are kept confidential.
- G. Policies Dealing With Ineligible Persons:
1. All prospective employees are required to undergo a pre-employment background check and mandatory drug screens prior to employment with Magellan.

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2. Magellan also conducts checks to screen-out those who have engaged in fraudulent acts via routine checks/screening to include, but is not limited to, criminal background checks as required by law or contract, employment verification checks, and primary source verifications during the credentialing and re-credentialing of providers as outlined in the following policies respectively:
 - a) HR. 1502.xx - Employment Background Investigations Policy;
 - b) CR. 1100.xx - Credentialing Program Description Policy;
 - c) CR. 1102.xx - Network Practitioner Credentialing Policy;
 - d) CR. 1104.xx - Network Practitioner Re-credentialing Policy;
 - e) COM. 1919.xx - Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers and Vendors) policy; and
 - f) NE.1318.xx - Provider Network: Ongoing Monitoring Policy.
3. Magellan checks the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database, U.S. Treasury Department Office of Foreign Assets List of Specially Designated Nationals and Blocked Persons and applicable state exclusion lists for names of excluded employees, contractors, providers, subcontractors, and vendors barred from participation in Medicare, Medicaid, other federal health care programs, federal contracts, and state health care programs.
4. Magellan also checks the exclusion lists during credentialing, re-credentialing, prior to the employment of any prospective Magellan employee, and prior to contracting with any vendor, and monthly thereafter.
5. The provider credentialing and re-credentialing process includes a review of applicable state exclusion/termination/sanctions lists. Providers who are excluded/terminated/debarred from participating in state Medicaid programs are not allowed to participate in Magellan's Provider Network for government funded health care programs. Magellan notifies the customer and/or applicable regulatory agency (as outlined in the customer contract) when a provider has disclosed information regarding a criminal conviction related to Medicare, Medicaid, and Title XX during the credentialing/contracting/ re-credentialing process. Magellan also notifies the applicable regulatory agencies and/or customer of adverse actions such as convictions, exclusions, revocations, and suspensions taken on provider applications including program integrity related denials for participation in Magellan's Medicaid Provider Network.
6. Magellan created the *Medicaid Disclosure Form* and interactive web application to comply with the Medicaid disclosure requirements pursuant to 42 CFR 455.104, 105, and 106. These federal regulations require Medicaid providers to disclose information regarding (1) the identity of all persons with an ownership or control interest of 5% or greater in the provider, including the identity of managing employees and agents; (2) certain business transactions between the provider and subcontractors/wholly owned suppliers; and (3) the identity of any person with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider or disclosing entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs.

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- a) Providers are contractually obligated to disclose this information during the credentialing/re-credentialing/contracting process. Providers are also obligated to update Magellan, if there are any changes.
- b) Upon receipt of the required disclosure, Magellan will review the disclosed information and run the names of all the entities/individuals disclosed through the *Medicaid Disclosure Form*/interactive web application against the *Federal Database Check* process.
 - The *Federal Database Check* process includes a review and comparison of the disclosed information against the following lists: List of Excluded Individuals/Entities (LEIE) database (<http://exclusions.oig.hhs.gov/>), the General Services Administration's System for Award Management (SAM) Exclusion Database (<http://www.sam.gov/>), and any other applicable State exclusion list including other state Medicaid programs.
7. Any adverse information obtained as a result of the disclosure referenced above is submitted to the health plan customer and/or the applicable regulatory agency in compliance with the Medicaid contract and applicable regulations.
8. Excluded/terminated/suspended individuals/entities are not hired, employed, or contracted by Magellan to provide services for Magellan's federal and state government funded health care benefit plan contracts including but not limited to contracts issued under Medicaid (Title XIX), Medicare (Title XVIII), or Social Services Block Grants (Title XX programs), or the State Children's Health Insurance Program (Title XXI).

VII. Monitoring and Auditing

- A. The foundation for monitoring and auditing is Magellan's SIU. The SIU is responsible for protecting the assets of Magellan and its clients by detecting, identifying, and deterring fraud, waste, and abuse.
- B. Magellan uses the Perspective Case Management System from PPM 2000, Inc. to capture and track investigations. Procedures for investigation, documentation, evidence handling, and reporting exist to guide investigators in creating an accurate work product.
- C. The SIU works closely with other departments to adjudicate investigative findings including Provider Networks, Legal, Cost Containment, and other departments as needed.
- D. Magellan is a corporate member of the National Health Care Anti-Fraud Association (NHCAA). Magellan maximizes quality referrals of fraud, waste, and abuse by utilizing the resources available in the NHCAA Special Investigations Resource and Information System (SIRIS), Requests for Investigation Assistance (RIAs) from Law Enforcement, distribution of published news articles, and other information sharing initiatives.
- E. Magellan also has internal controls related to claims processing. Our claims processors are assessed and tested each year by the Company's Internal Audit Department as part of the annual Sarbanes Oxley compliance. Areas covered include provider credentialing and rate loading, claims receipt, adjudication and payment, enrollment and benefit loading, and information systems. The claim processing systems used by Magellan have extensive controls that limit individuals' access to specific functions as well as ensuring processing based on contracts, legislation, etc.
- F. Magellan's Claims system also has edits that deny claims for items such as duplicate claim, unknown service, unknown member, member ineligible to receive service, improper coding, and provider not eligible to provide service. During post-processing

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review of claims, Magellan produces reports that show overlapping dates of service to determine if any claims have been submitted and were adjudicated for services that did not fail the claim edit logic.

- G. To prevent improper payments when incorrect code combinations are reported, Magellan implemented the National Correct Coding Initiative (NCCI edits) as part of its claims pre-payment review process. The customer delegation agreement and the product type (NIA, BH, Magellan Rx Pharmacy) are used to determine which of the claim edits should be applied to the benefit plan.
- H. NCCI edits are used during the pre-payment claims review to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes listed on claims submitted by Medicaid providers. These edits are intended to reduce coding errors because of clerical mistakes or fraud, and incorrect use of codes or their units of service.
- I. The use of NCCI edits would also decrease the number of overpayments and fraud, waste and abuse. Reports are generated and reviewed on a weekly basis by the Claims Department. A list of all claims that were denied for NCCI edits during the claims pre-payment review process in the prior month are sent to the SIU. The SIU is responsible for analyzing the claims data and for selecting the providers with a high volume of denials or other patterns for further review. Based on the results of this analysis, this may or may not result in a full investigation.
- J. In addition to the claims system edits described above, to the extent delegated, Magellan also conducts the following audits listed below as part of its fraud, waste, and abuse detection, prevention, and monitoring tools. The customer delegation agreement and the product type (NIA, BH, Magellan Rx Pharmacy) are used to determine which of the audits described below should be applied to the benefit plan.
 - 1. Verification of Services Provided to Members Audit

The purpose of this review is to determine and to verify whether services billed by providers were actually received by members. Magellan randomly selects paid claims for member service verification. On a quarterly basis, Magellan will send the "Member Service Verification" questionnaire to members that are selected from a random sample of paid claims. The criteria used in the selection process are described below:

- a) On a quarterly basis, the Reporting Department selects claims for member verification applying the following criteria:
 - i) Select all claims paid within the last thirty (30) calendar days excluding the following:
 - a. No-shows; and
 - b. Services defined as confidential by the applicable State Medicaid Agency.
 - ii) Randomly select one hundred (100) members for member service verification. In order to avoid overly burdening members, once a member has been selected for one report, the member is excluded from selection in subsequent reports for the period of one (1) year.
- b) Except for the services excluded under Standard VII.J.1.a) i) above, the selected sample report lists up to five (5) paid services for each member within the thirty (30) day time period referenced above.
- c) Magellan will review each copy of the questionnaire that is returned by the member and results are recorded in the Member Service Verification Log (MSVL).

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If a member indicates that he or she never received the services outlined in the questionnaire, the LCO will contact the member to verify the member understands the procedure billed. If the member still indicates the service was not received, the CMC will forward those cases to the Special Investigations Unit (SIU), and will comply with the applicable Medicaid Contract reporting requirements.

2. Provider Chart Audits & On-site Reviews

To monitor provider billing practices, a selection of charts may be audited for compliance with clinical treatment record review standards and also against corresponding claims paid reports. If findings from a claims audit indicate that there are potential fraud and/or quality of care concerns, the clinical reviewer notifies the LCO for the CMC. The LCO completes a Special Investigations Unit (SIU) referral form and sends the completed form to SIU via interoffice mail. Furthermore, the LCO is responsible for notifying the customer in compliance with Magellan's contractual obligations.

3. Post Pay Audits

Magellan audits a minimum of 2% of completed claims for each account. This includes manually processed and auto-adjudicated claims. A daily-automated report of finalized claims is utilized for this 2% random audit sample selection process. The random sample size is based upon 2% of the Claim Processors finalized claims. Selecting a sample size at the Claim Processor level ensures that Magellan is selecting enough claim audits at the Group level in order to satisfy contractual obligations.

4. Pre-pay High Dollar Audits

In addition to post pay audits, pre-pay audits are conducted on all high dollar claims. For this purpose, high dollar claims are defined as those claims with a paid or denied amount of \$5,000 or more. These claims will be audited and released by the auditor if there are no errors noted. If errors are noted the claim will be expedited to the supervisor of the individual for review, corrective action and release of the claim.

5. Trainee Audits

All claims processed by trainees are audited. This ensures the trainee receives immediate audit feedback. While trainees are in class, the trainee is held to a maximum of fifty (50) claims production per day with focus on quality before targeting production. When errors are identified, the trainee should not continue to process new claims until the errors can be resolved. The trainee and trainer must review the audited claims and correct any errors. The trainer will ensure that all errors are corrected prior to release of payment or denial. At the end of class, each trainee will be assessed to determine his/her status before moving onto the unit. Trainee audits will gradually be reduced from 100% to the daily average of 2% audit based upon quality results and agreement upon by the unit supervisor and trainer.

6. Second Level Audit

Magellan's auditing program includes a second level audit to validate the integrity audit methods and results. Magellan pulls a monthly sample of each Auditor's work and performs a second level audit of that claim to measure auditor accuracy and reliability. The goal of this process is to validate that the proper decision was made, that all Auditors would audit the claim the same way, and that any discrepancies should be surfaced for review and discussion. A secondary goal of the second level audit is to identify potential Auditor training and performance improvement

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opportunities and to address them in a timely fashion. Auditors are held accountable for errors identified through the rebuttal process. Claims reviewed for the second level audit process focus on those with no errors in order to provide a full spectrum of auditor performance.

7. Focused and Ad hoc Audits

Magellan Quality Management will provide ad hoc and focused audits at the request of Claims Management staff or the Care Management Center. In addition, the auditing staff will work to provide trend and root-cause analysis based on findings and reports via the database. It is also the responsibility of Claims Management to assess the errors identified through routine and external audits and to request ad hoc analysis of specific problems.

8. Cost Containment Department (CCD) Audits

The CCD performs standard audits over the claims systems on a monthly basis to identify opportunities for recoveries. Standard reports include (but are not limited to) duplicate claims payment, terminated members, and claims with COB.

- Magellan's Recovery Unit (a section of the CCD) responds to overpayment leads identified through various methods and/or departments including but not limited to, claims and resolution units, contracts & rates department, legal, internal audits, SIU and various reports. Magellan pursues recovery of overpayment for identified core risks, with exceptions based on contractual and/or regulatory requirements. Overpayments are reported pursuant to the Medicaid contractual obligations.

K. Pursuant to Section 6402[d] of the Patient Protection and Affordable Care Act (PPACA) of 2010, based on the latter of the date which is sixty (60) days after the date on which the overpayment was identified or the date any corresponding cost report is due, (if applicable), overpayments are reported and returned to the applicable regulatory agency specified in the Medicaid contract or to the Health Plan customer to forward to the applicable regulatory agency. The notice of overpayment also outlines the reason for the overpayment. The reporting time frame may be shorter if required by the customer contract.

L. Magellan's prior authorization system will determine if a covered service requires prior authorization, and if there is a prior authorization in the system for the service in question. During Utilization/Quality Management, Magellan monitors over/under utilization for covered services.

VIII. Responding to Detected Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities

- A. Magellan cooperates with law enforcement authorities in the prosecution of health care and insurance fraud cases and reports fraud related data as specified by Federal and State laws and regulations and self-reports to the State Departments of Insurance, State Agencies, and Federal Agencies as may be required by law and/or customer contract.
- B. The SIU is responsible for ensuring Magellan's compliance with all Federal and State laws and regulations that apply to the reporting of fraud, waste and abuse.
- C. Magellan supports and utilizes the services of the National Health Care Anti-Fraud Association.
- D. The Magellan SIU refers cases as follows:

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1. Customer cases are referred to the plan sponsor where appropriate, for their review and possible action. We advise them that we may be required to report our findings to the appropriate agency;
 2. Health care provider case information is submitted to the appropriate law enforcement and/or administrative agency, including the appropriate state licensing board;
 3. The prosecution of individuals who present fraudulent insurance claims is a strong deterrent to future fraudulent claims. Referral directly to law enforcement agencies may be instituted by the Magellan SIU if:
 - a) A state insurance fraud bureau or other agency (e.g., State Attorney General) has been designated by law to investigate suspected/fraudulent insurance claims;
 - b) A law enforcement agency has directly subpoenaed the claim file and requests information directly from the Magellan SIU;
 - c) A state law allows for law enforcement to directly request, with proper identification, copies of the claim file and Magellan SIU information regarding a suspect claim; or
 - d) Other situations arise which may require direct referral of a suspect or fraudulent claim to law enforcement agencies. If those situations are outside of the normal established procedures for referral as outlined above, then prior approval from the Magellan SIU management or their Legal Counsel must be obtained.
- E. Specific Company procedures do not allow, without prior approval of the CCO, the following situations:
1. Participation in law enforcement operations (e.g., sting operations); or
 2. Lawsuits initiated on Magellan's behalf where damages are being sought from an insured or third party claimant.
- F. Disciplinary action is taken against employees who authorize or participate directly in a violation of applicable state or federal law, the Code of Conduct, standards of conduct, or policies and procedures, and any employee who may have deliberately failed to report such a violation, or who hinders an investigation by destroying evidence or by misrepresentation.
- G. Magellan conducts appropriate discipline, including termination, of any employee who has deliberately withheld relevant and material information concerning a violation of applicable state and/or federal law, the Code of Conduct, the standards of conduct, or the applicable policies and procedures and takes appropriate actions to prevent reoccurrence.
- H. Magellan self-reports to the State Department of Insurance, and other state and federal agencies as may be required by law and/or contract.
- IX. Whistleblower Protection and Non-Retaliation Policy
- A. Magellan complies with all state and federal requirements for government-sponsored programs, including the Federal False Claims Act, the Deficit Reduction Act of 2005, the American Recovery, and Reinvestment Act of 2009, applicable Whistleblower Protection laws, and any state false claims statutes. To the extent permitted by law, Magellan protects the identity of individuals, who report in good faith alleged acts of fraud, waste, abuse, and overpayments.

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- B. Magellan does not retaliate against an employee for reporting or bringing a civil suit for a possible False Claims Act violation. Magellan does not discriminate against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a False Claims Act action.
- C. Magellan does not retaliate against any of its employees, agents and contractors for lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under the False Claims Act or other efforts to stop 1 or more violations of the False Claims Act, or for reporting suspected cases of fraud, waste, or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority.
- D. Federal and state law also prohibits Magellan from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a False Claims Act action.
- E. Additional information regarding whistleblower protection is available in the *False Claims Laws and Whistleblower Protections Policy* and the state false claims grid available online at: <http://www.magellanhealth.com/our-company-/compliance/dra-compliance-statement.aspx>

Associated Corporate Forms & Attachments (internal link(s) available to Magellan Health employees only)

Special Investigations Unit Referral Form: [SIU Referral Form.doc](#)

Special Investigations Unit Anti Fraud Plan ([see SIU webpage](#))

[Magellan Code of Conduct](#)

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