Policy and Standards

Policy Number:	**COM.MCD.1923.03-2020**
Policy Name:	**Medicaid: Program Integrity and Compliance Program**
Review Type:	No Changes
Contract or Regulatory Reference: (include citation if applicable)	*N/A*

Corporate Policy Approvals

04 – 2020 had no changes or the changes were non-substantive; thus, full corporate approvals were not required.

John J. DiBernardi, Jr., Esq.	*Approval on file*	April 10, 2020
Magellan Health, Senior Vice President & Chief Compliance Officer		

Product Applicability: *(For Health Insurance Marketplaces, policies and procedures are the same, unless contractual requirements dictate a more stringent variation in which case customized documents are created.)*

Medicaid

Business Division and Entity Applicability:

Magellan Healthcare

Magellan Complete Care of Arizona
Magellan Complete Care Florida
Magellan Complete Care The Management Group
Magellan Complete Care Virginia
Magellan Healthcare (Behavioral)
National Imaging Associates
Senior Whole Health of New York
Senior Whole Health

Magellan Rx Management

4D Pharmacy Management Systems
Magellan Medicaid Administration
Magellan Method (formerly CDMI)
Magellan Pharmacy Solutions
Magellan Rx Management
Magellan Rx Pharmacy
VRx Pharmacy
VRx

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Policy Statement

Magellan Health, its subsidiaries and affiliates, (Magellan) are dedicated to conducting business in an ethical and legal manner. Magellan's Medicaid Program Integrity & 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 which 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 Medicaid Program Integrity & 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.

Policy Terms & Definitions Glossary

Key Terms *(as used in this policy)*

Abuse

Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)

Affiliates (48 CFR 2.101)

Means associated business concerns or individuals if, directly or indirectly
(1) Either one controls or can control the other; or
(2) A third party controls or can control both.

Credible allegation of fraud

Means a credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

(1) Fraud hotline complaints.
(2) Claims data mining.
(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. (42 CFR 455.2)

Exclusion

Means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid. (42 CFR 455.2)

Fraud

Means 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.

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It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2)

Network provider

Means any provider, group of providers, or entity that has a network provider agreement with a Managed Care Organization ("MCO), or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO. A network provider is not a subcontractor by virtue of the network provider agreement. (42 CFR 438.2)

Overpayment

Means any payment made to a network provider by a MCO to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO by a State to which the MCO is not entitled to under Title XIX of the Act. (42 CFR 438.2)

Provider

Means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services. (42 CFR 438.2)

Secretary

Means the Secretary of the U.S. Department of Health and Human Services.

Subcontractor

Means an individual or entity that has a contract with an MCO that relates directly or indirectly to the performance of the MCO's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO. (42 CFR 438.2)

Suspension

Means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid. (42 CFR 455.2)

Additional *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 C360, click on the below link: *(internal link(s) available to Magellan Health employees only)*

Policy Terms & Definitions Glossary

Standards

I. Magellan's Medicaid Compliance Program and Medicaid Program Integrity Plan for both Medicaid and State Children's Health Insurance Program (SCHIP) contracts in compliance with 42 CFR 438.608 and 42 CFR 457.1285 are addressed in this policy respectively.

- II. Magellan's Corporate Medicaid 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.

  B. The primary components of the Corporate Compliance Program include:

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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.

C. Written Policies and Procedures and Standards of Conduct

42 CFR 438.608(a)(1)(i)

1. Magellan has corporate policies, procedures, and standards of conduct in place that articulates Magellan's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements and also 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:
   a) COM.MCD.1923.xx - Medicaid: Program Integrity and Compliance Program;
   b) COM.1916.xx - False Claims Laws and Whistleblower Protections;
   c) COM.1919.xx - Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers and Vendors);
   d) COM.1906.xx - Corporate Compliance Hotline;
   e) COM.1908.xx - Corporate Compliance Structure with Care Management Centers (CMCs), Business Divisions, and Corporate Departments;
   f) COM.1902.xx - Obligation to Report Potential Compliance Violations;
   g) COM.1900.xx - Corporate Compliance Committee; and
   h) CR.1102.xx - Network Practitioner Credentialing and Recredentialing.

42 CFR 438.608(a)(6)

2. In compliance with Section 6032 of 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.
3. The State False Claims laws grid is available at: http://www.magellanhealth.com/mh/about/compliance/dra.aspx

42 CFR 438.608(a)(6)

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4. Magellan's policies also contain detailed information regarding Magellan's procedures to detect, deter, monitor, and to report FWA. These policies and the Compliance Statement regarding Section 6032 of the Deficit Reduction Act of 2005

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are provided online to employees, providers, and subcontractors at: http://www.magellanhealth.com/mh/about/compliance/dra.aspx .

5. Magellan's Code of Conduct outlines the written policies, procedures and standards of conduct that include the fundamental rules that Magellan employees are required to follow.

   a) 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/mh/about/compliance/dra.aspx.

   b) The Code of Conduct addresses but is not limited to the following topics:

      i. Confidentiality of Health Information;

      ii. Licensure and Accreditation;

      iii. Billing;

      iv. Accounting;

      v. Sarbanes-Oxley Act;

      vi. Conflict of Interest;

      vii. Software Copyright Infringement;

      viii. E-mail and other Computer and Network Usage;

      ix. Business Development;

      x. Anti-trust Laws;

      xi. Drugs, Narcotics, and Alcohol;

      xii. Employment Reference Checks and Drug Screening (Background Checks);

      xiii. Securities Law;

      xiv. Litigation and Government Investigations;

      xv. Record Retention;

      xvi. Federal Anti-Kickback Statute;

      xvii. Fraud, Waste, Abuse, and Overpayments;

      xviii. Federal False Claims Act; and

      xix. State False Claims laws.

D. In addition to the Code of Conduct, Magellan also has procedures in place to address the following laws and regulations:

   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);

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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;

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) Title IX of the Education Amendments of 1972 (regarding education programs and activities);

n) Age Discrimination Act of 1975;

42 CFR 438.3(f)(1)

o) Section 1557 of the Patient Protection and Affordable Care Act;

p) Titles XVIII, XIX, XXI of the Social Security Act;

q) Federal Rehabilitation Act of 1973;

r) Davis Bacon Act (40 U.S.C. § 276a et seq.);

s) Copeland Anti-Kickback Act (40 U.S.C. § 276c);

t) Byrd Anti-Lobbying Amendment (31 U.S.C. 1352); and

u) 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.

42 CFR 438.608(a)

- E. Magellan has policies in place to ensure that, to the extent that any Magellan subcontractor is delegated responsibility by Magellan for coverage of services and payment of claims under the Medicaid contract between the State and the Managed Care

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Organization (MCO), the Magellan subcontractor is contractually obligated to also implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.

F. Designation of a Compliance Officer and a Compliance Committee

1. Corporate Compliance Officer (CCO) Responsibilities

42 CFR 438.608(a)(1)(ii)

a) 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).

b) The CCO ensures that policies and procedures relating to compliance, fraud, waste and abuse promote effective interdepartmental and external lines of communication.

c) 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 and the Code of Conduct.

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

e) The CCO has the authority to report compliance related issues directly to the Chief Executive Officer and the board of directors.

2. Local Compliance Officer (LCO) Responsibilities

42 CFR 438.608(a)(1)(ii)

a) Magellan has a full time staff person who is designated as the Local Compliance Officer (LCO) at the Strategic Business Unit (SBU) or Care Management Center (CMC). The LCO is responsible for helping to oversee the Compliance program at the SBU/CMC and ensuring compliance with the contractual obligations as it relates to the specific Medicaid contract.

b) The LCO is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and has the authority to report compliance related issues directly to the CCO, the Chief Executive Officer and the board of directors.

c) The LCOs attend the quarterly Compliance meeting with the CCO and may meet with the CCO more frequently, if necessary.

d) The LCO chairs the Local Compliance Committee.

e) The LCO sits on the QI Committee, which oversees quality improvement activities for the company.

3. Corporate Compliance Committee

42 CFR 438.608(a)(1)(iii)

a) The Corporate Compliance Committee consists of representatives of executive management from various key operational areas and business units of the Company.

i. The CCO chairs the Corporate Compliance Committee.

ii. The CCO also sits on the Enterprise Quality Council, which oversees quality improvement activities for the company.

b) The Corporate Compliance Committee oversees the implementation and operation of the Corporate Compliance Program including:

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c) Reviewing reports and recommendations of the CCO regarding compliance activities. Based on these reports, the Committee makes recommendations regarding future compliance priorities and resources;

d) 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;

e) Approves the Annual Compliance Work Plan, which addresses areas of focus for the year; and

f) Reviewing and approving Compliance Department policies and procedures that describe the scope and authority for Compliance activities.

4. Designation of a Local Compliance Committee | 42 CFR 438.608(a)(1)(iii)

a) The Local Compliance Committee consists of representatives of management from various key operational areas and business units of the Company.

b) The LCO is the chair of the Local Compliance Committee. The LCO 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. This information is disseminated to Department Heads through the Local Compliance Committee.

c) Functions of the Local Compliance Committee

i. Overseeing the implementation and operation of Compliance activities.

ii. Reviewing reports and recommendations of the LCO regarding compliance activities. Based on these reports, the Committee makes recommendations regarding future compliance priorities and resources;

iii. The LCO provides information to the committee about any changes in policies, and contractual and/or regulatory requirements. The content and/or type of change will determine whether or not the LCO will conduct employee training or delegate the training to the corresponding Department Head/member of the Committee.

iv. The LCO is responsible for sharing the results of internal audits and external reviews with the Committee. A CAP may be required to address any deficiency identified as a result of an internal or external audit. The LCO is responsible for ensuring that all CAPs are completed in a timely manner. The issues addressed in the CAP will determine which Department Head/member of the Committee will play a key role in the development of the CAP with input from the LCO. The LCO also follows up with the Department/Committee member to ensure ongoing compliance with the CAP.

d) The Local Compliance Committee meets, at a minimum, quarterly.

G. Corporate Compliance Program Training and Education | 42 CFR 438.608(a)(1)(iv)

1. Magellan has a system for training and providing education for the Compliance Officer, Magellan's senior management, and all Magellan employees regarding the Federal and State standards.

2. The CCO and the Human Resources Department are responsible for coordinating the training efforts for the Compliance Program. Compliance, Internal Audit/SIU, and Security staff determines the content and requirements for the compliance trainings

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while working with the training department to develop the training for employees/contractors.

3. 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.

   a) 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.

   b) 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:

42 CFR 438.608(a)(6)

      i. The False Claims Act;

      ii. Penalties for submitting false claims & statements;

      iii. Magellan's role in preventing and detecting fraud, waste and abuse;

      iv. Each person's responsibility relating to detection and prevention;

      v. The toll-free state telephone numbers for reporting fraud, waste, and abuse; and

      vi. Applicable federal and state whistleblower protections.

   c) 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 online learning management system (SABA) to administer the courses. The SABA 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.

   d) 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.

   e) 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.

   f) 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

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Fraud Awareness Week," Health Information Privacy Week, and National Ethics Week.

4. 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.
5. 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.
6. 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.
7. Educational information for contracted health network providers regarding the detection of healthcare fraud, waste and abuse is provided through a series of provider newsletter articles and mailings to providers, which include examples of potential fraud, waste, abuse, and overpayments.
8. Policies and procedures and contact information are also published on the Magellan website and in the Code of Conduct.
9. 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.

H. Effective Lines of Communication | 42 CFR 438.608(a)(1)(v)

1. To ensure that that there are effective lines of communication between the compliance officer and all Magellan employees, Magellan implemented the procedures and tools described below. In addition, 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 and all employees with regard to the Compliance Program.
   a) 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).
   b) 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.
   c) Employees, members, providers, or subcontractors may report suspected cases of fraud, waste, or abuse, overpayments, and other compliance concerns anonymously.
   d) 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

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open communication and the reporting of incidents of suspected fraud, waste, abuse, and other compliance concerns to Magellan and applicable regulatory agencies.

e) Employees may also direct any questions or concerns to their Supervisor, LCO, or the CCO.

f) The LCO distributes in writing, posts in a conspicuous place, 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.

g) 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:

i. Special Investigations Unit Hotline: (800) 755-0850;

ii. Special Investigations Unit E-mail: SIU@magellanhealth.com;

iii. Corporate Compliance Hotline: (800) 915-2108; or

iv. Compliance Unit Email: Compliance@magellanhealth.com.

h) Employees, members, providers, and subcontractors are also notified that there are several options to report suspected cases of fraud, waste, abuse, and overpayments to the health plan customer (if applicable) and to the designated federal and state regulatory agency as specified in the Medicaid contract and/or applicable law including but not limited to the state Medicaid agency, state Medicaid Program Integrity Unit, state Medicaid Fraud Control Unit, state Insurance Agency or 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: http://oig.hhs.gov/fraud/report-fraud/index.asp

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

a) Special Investigations Unit

i. 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.

ii. The SIU creates and maintains thorough and objective documentation of all findings.

iii. The SIU develops and recommends appropriate case strategies to bring cases to a timely and successful close.

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iv. 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.

v. The SIU must comply with the fraud, waste and abuse reporting requirements under applicable state and federal laws.

b) Care Management Centers

i. General Managers of CMCs are accountable for reducing fraud, waste and abuse within the lines of business for which they are responsible.

ii. 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.

c) Claims Department

i. 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.

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

I. Enforcement of Standards through Well Publicized Disciplinary Guidelines

42 CFR 438.608(a)(1)(vi)

1. 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.

2. 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.

3. 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.

4. 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.

   a) Magellan disciplines any employee who has deliberately withheld relevant and material information concerning a violation of applicable state and/or federal law,

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the Code of Conduct, the standards of conduct, or the applicable policies and procedures and takes appropriate actions to prevent reoccurrence.

b) 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.

5. 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.

J. Monitoring and Auditing

42 CFR 438.608(a)(1)(vii)

1. Magellan has established and implemented procedures and a system for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

2. 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.

   a) 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.

   b) The SIU works closely with other departments to adjudicate investigative findings including Provider Networks, Legal, Cost Containment, and other departments as needed.

   c) 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.

3. 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.

   a) 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.

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During post-processing 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.

b) 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.

c) 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.

d) 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.

4. 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.

a) 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.

b) 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.

c) 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

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claim will be expedited to the supervisor of the individual for review, corrective action and release of the claim.

d) 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.

e) 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 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.

f) 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.

g) Cost Containment Department (CCD) Audits

i. The CCD performs standard audits over the claims systems on a monthly basis to identify opportunities for recoveries.

ii. Standard reports include (but are not limited to) duplicate claims payment, terminated members, and claims with COB.

iii. 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.

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5. 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.

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

42 CFR 438.608(a)(1)(vii)

42 CFR 438.608(a)(7)

1. Magellan has established and implemented procedures and a system for prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.
2. 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.
3. Magellan self-reports to the State Department of Insurance, and other state and federal agencies as may be required by law and/or contract.
4. 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. The LCO is responsible for ensuring Magellan's compliance with the customer contract requirement that applies to the reporting of fraud, waste, and abuse and overpayment.
5. Magellan supports and utilizes the services of the National Health Care Anti-Fraud Association.
6. The Magellan SIU refers cases as follows:
   a) 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;
   b) Health care provider case information is submitted to the appropriate law enforcement and/or administrative agency, including the appropriate state licensing board;
   c) 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:
      i. A state insurance fraud bureau or other agency (e.g., State Attorney General) has been designated by law to investigate suspected/fraudulent insurance claims;
      ii. A law enforcement agency has directly subpoenaed the claim file and requests information directly from the Magellan SIU;
      iii. 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
      iv. Other situations arise which may require direct referral of a suspect or fraudulent claim to law enforcement agencies. If those situations are outside

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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.

- L. 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.

M. Disciplinary Action

1. 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.
2. 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.

N. Corrective Action Plans are developed and reviewed through the Local Compliance Committee as described in *Standard II.F.4.c.iv., on page 9* in this policy.

O. Whistleblower Protection and Non-Retaliation Policy | 42 CFR 438.608(a)(6)

1. Magellan prohibits retaliation or intimidation against any employee who, in good faith, reports an ethical or legal concern, even if investigation of the concern does not result in a confirmed violation. Magellan believes non-retaliation for good faith reporting encourages internal reporting of potential violations, allows Magellan to enforce the appropriate disciplinary action for confirmed violations, and enables Magellan to proactively implement business policies, processes, and training that prevent reoccurrence.
2. 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.
3. 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.
4. 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 one (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.

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5. 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.
6. 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/mh/about/compliance/dra.aspx.

III. Magellan's Medicaid Program Integrity Plan

A. Magellan's Program Integrity Plan outlines Magellan's procedures and policies for implementing and maintaining arrangements or procedures that are designed to detect and prevent fraud, waste, abuse and overpayments in compliance with 42 CFR 438.608(a) including the following:

1. A Compliance Program; 42 CFR 438.608(a)(1)
   - Please see *Standard II.,* above *which starts on page 4* for a detailed description of Magellan's Compliance Program.
2. Policies and procedures for handling Overpayments (42 CFR 438.608(a)(2)); 42 CFR 438.608(c)(3)
   a) Magellan reports to the State within sixty (60) calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract. 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.

   42 CFR 438.608(a)(2)

   b) Magellan complies with the reporting time frame outlined in the Medicaid Contract to promptly (as specified in the contract) report all overpayments identified or recovered, and specifies the overpayments due to potential fraud, in the report to the State or health plan customer.
3. Procedures for reporting information that may impact an enrollee's eligibility status;

   42 CFR 438.608(a)(3)

   - Magellan provides prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including changes in the enrollee's residence; and the death of an enrollee.
4. Procedures for reporting information that may impact a provider's eligibility status to participate as a network provider;

   42 CFR 438.608(a)(4)

   - Please *see Standards III.C.1.e., and III.C.1.f.iii., below on pages 23 and 24 respectively,* for information regarding Magellan's process for reporting issues that may impact provider eligibility that are identified during the credentialing, re-credentialing and ongoing monitoring of providers.
5. Methods for verifying whether or not a member received the services Magellan paid for during the claims process; 42 CFR 438.608(a)(5)
   a) 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:

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i. The Reporting Department selects claims for member verification on a quarterly basis; and

ii. The selected claims will be 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.

b) 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.

c) Except for the services excluded under Standard III.A.5.a) i) a., above, the selected sample report lists up to five (5) paid service*s* for each member within the thirty (30) day time period referenced above.

d) 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). 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.

e) Additional information is outlined in the *Verification of Services Provided to Members Policy*.

6. Policies and procedures for ensuring ongoing compliance with the requirement to provide education about False Claims Act in Section 6032 of the Deficit Reduction Act of 2005;

42 CFR 438.608(a)(6)

- Magellan's policies contain detailed information regarding Magellan's procedures to detect, deter, monitor, and to report FWA. These policies and the Compliance Statement regarding Section 6032 of the Deficit Reduction Act of 2005 are provided online to employees, providers, and subcontractors at http://www.magellanhealth.com/mh/about/compliance/dra.aspx including a False Claims Grid that provides detailed information about federal and state false claims laws, anti-retaliation provisions, and the protections provided to whistleblowers.

7. Procedures for ensuring the referral of suspected cases of fraud, waste, and abuse in a timely manner to the designated regulatory authority specified in the state Medicaid Contract;

42 CFR 438.608(a)(7)

a) In compliance with the reporting requirements outlined in the Medicaid Contract, the Local Compliance Officer (LCO) promptly refers any potential fraud, waste, or abuse that Magellan identifies to either the State Medicaid program integrity unit and/or directly to the State Medicaid Fraud Control Unit as specified in the Medicaid Contract.

b) Initial identification of suspicious activity may occur through any of the following avenues:

i. Treatment record reviews conducted as part of the QI process;

ii. Member and/or customer complaints;

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iii. Suspicion raised by Magellan personnel (i.e., Member Service, Network, Clinical or Quality Improvement);

iv. An external source (i.e., database, PPRC referral, government agencies or other insurers);

v. Complaints filed with Magellan; or

vi. Case record audits/onsite provider reviews.

c) All Magellan staff are required to report suspected provider fraud or abuse immediately. This report is documented on a Special Investigation Unit (SIU) Referral Form and is submitted to the Local Compliance Officer and the Magellan SIU.

42 CFR 438.608(a)(7)

d) Written confidentiality and non-retaliation policies have been reaffirmed in this policy to encourage open communication and the reporting of incidents of suspected fraud, waste, and abuse to external regulatory authorities and Magellan.

- A copy of Magellan's corporate Compliance Handbook and the *False Claims Laws and Whistleblower Protections Policy* is available on Magellan's intranet site for employees, and it is also available to employees, providers, members, and subcontractors through Magellan's web site at: Magellan Health | DRA

e) The Local Compliance Officer (LCO) shall promptly report to the external regulatory authorities within the timeframe outlined in the customer contract any suspicion or knowledge of fraud and abuse including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return reimbursement for claims known to be fraudulent. The LCO's report shall also include:

i) Number of complaints of fraud and abuse made to State that warrant preliminary investigation; and

ii) For each which warrants investigation, supply the:

a. Name and ID number;

b. Source of complaint;

c. Type of provider;

d. Nature of complaint;

e. Approximate dollar; and

f. Legal & administrative disposition of the case.

f) Special Investigations Unit (SIU) Investigation Process and Actions

i) Upon receiving a referral regarding suspected fraud and/or abuse, the SIU conducts an assessment.

ii) SIU assessments may include:

42 CFR 438.608(a)(7)

a. Review of available provider claim history, contracting and credentialing information seeking potential patterns and outliers of claim submission;

b. Stopping the payment of claims as permitted by state and /or federal law;

c. Review of external documents and databases;

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d. Communication with the provider and/or member to confirm information; and

e. Conducting an on-site audit to review a claim sample.

iii) Findings of fraud and abuse investigations are communicated to the Department by Magellan's Local Compliance Officer (under guidance of Magellan's Legal Department).

iv) Concerns regarding fraud, integrity and quality are reported to the Quality Improvement Committee and to the RNCC for consideration during the credentialing and re-credentialing process.

v) The Local Compliance Officer notifies the Medicaid agency of suspected/confirmed cases of fraud, waste, and abuse in accordance with the customer contract as outlined in this policy.

g) Employees, members, providers, or subcontractors are informed through employee training, posters, Enrollee Handbooks, Provider Handbooks and Magellan's Deficit Reduction Act of 2005 Compliance Statement respectively that they can report suspected cases of fraud, waste and abuse through any of the following methods:

i) Internal Reports:

a. Special Investigations Unit Hotline: (800) 755-0850;

b. Special Investigations Unit E-mail: SIU@magellanhealth.com;

c. Corporate Compliance Hotline: (800) 915-2108; and/or

d. Reports to the Corporate Compliance Hotline may be made 24 hours a day/7 days a week and is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

e. Compliance Unit Email: Compliance@magellanhealth.com.

ii) External Reports:

a. State Medicaid Agency

b. State Medicaid Program Integrity Unit

c. State Medicaid Fraud Control Unit

d. State Insurance Agency

e. State Office of Inspector General or Attorney General

f. U.S. Department of Health & Human Services Office of Inspector General:

Contact the Office of the Inspector General at 1-800-447-8477 or by e-mail to HHSTips@oig.hhs.gov or by mail to the address below.

Office of Inspector General
U.S. Department of Health & Human Services
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026

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42 CFR 438.608(a)(8)

8. Procedures to ensure that Magellan is compliant by responding in a timely manner to all suspension of payments imposed by the Medicaid agency pursuant to 42 CFR 455.23.
   a) Magellan complies and implements the instructions specified in the state's Notice of Suspension of Payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23.
   b) Magellan withholds payments, in whole or in part, upon a determination made by a State Medicaid Agency or other regulatory body that there is a credible allegation of fraud against the provider as specified in 42 CFR Section 455.23 and/or the equivalent state law/regulation.
   c) Magellan relies on the determination made by a State Medicaid Agency or other regulatory body with respect to payment suspensions under 42 CFR 455.23 and/or the equivalent state law/regulation.
   d) Magellan documents the State Medicaid Agency or other regulatory body determination notice it relied on.
   e) Unless prohibited by the state from notifying a provider in compliance with 42 CFR 455.23(a)(2), Magellan provides written notice to the provider with a copy of the state issued Notice of Suspension to inform the provider that payments will be suspended in compliance with the terms, conditions and time frame outlined in the state issued Notice of Suspension.
   f) Payments will resume upon Magellan's receipt of written notification from the sanctioning state agency that the payment suspension has been removed.

B. Policies and procedures in place to ensure ongoing compliance with the provider screening and enrollment requirements. 42 CFR 438.608(b)
   1. As a condition of participating in Magellan's Medicaid Provider network, providers must be enrolled in the State's Medicaid program as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 CFR 455, subparts B and E.

42 CFR 438.608(b)

   2. Magellan does not contract with providers that are not enrolled in the state's Medicaid program.

C. Policies and procedures in place to ensure compliance with the disclosure requirements. 42 CFR 438.608(c)

42 CFR 438.608(c)(1)

   1. Policies Dealing With Ineligible Persons:

42 CFR 438.608(c)(1)

      a) All prospective employees are required to undergo a pre-employment background check and mandatory drug screens prior to employment with Magellan.
      b) 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:
         i. HR.1502.xx - Employment Background Investigations Policy;
         ii. CR.1100.xx - Credentialing Program Description Policy;
         iii. CR.1102.xx - Network Practitioner Credentialing Policy;
         iv. CR.1104.xx - Network Practitioner Re-credentialing Policy;

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v. COM.1919.xx - Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers and Vendors) policy; and

vi. NE.1318.xx - Provider Network: Ongoing Monitoring Policy.

c) 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 sanctioned employees, contractors, providers, subcontractors, and vendors barred from participation in Medicare, Medicaid, other federal health care programs, federal contracts, and state health care programs.

d) 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.

42 CFR 438.608(a)(4)

42 CFR 438.608(c)(1)

e) 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 taken on provider applications for reasons including but not limited to convictions, exclusions, revocations, suspensions and program integrity related denials for participation in Magellan's Medicaid Provider Network.

42 CFR 438.608(c)(2)

42 CFR 438.608(c)(2)

f) 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.

i. 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.

ii. 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.

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- The *Federal Database Check* process includes a review and comparison of the disclosed information against the following lists: List of Excluded Individuals/Entitles (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.

42 CFR 438.608(c)(1)

iii. 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.

42 CFR 438.608(a)(4)

iv. 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).

42 CFR 438.608(c)(2)

2. Disclosures Regarding Magellan - Upon receipt of a request for a disclosure regarding information about the ownership and control of Magellan pursuant to 42 CFR 455.104 – 106, Magellan responds in a timely manner in providing the required disclosure to a Medicaid agency or health plan customer.

42 CFR 438.608(c)(1)

a) Magellan provides disclosures regarding any prohibited affiliation in compliance with 42 CFR 438.610 as outlined below.

42 CFR 438.610(c)

i. Magellan may not knowingly have a relationship with any of the following individuals or entities (i) a director, officer, or partner of Magellan; (ii) a subcontractor of Magellan; (iii) a person with beneficial ownership of five (5%) percent or more in Magellan; (iv) a network provider or person with an employment, consulting or other arrangement with Magellan for the provision of items and services that are significant and material to Magellan's obligations under its contract with the State.

IF

42 CFR 438.610(a)(1)

a. The individual or entity is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549: or

42 CFR 438.610(a)(2)

b. The individual or entity is an affiliate, as defined in this policy consistent with the Federal Acquisition Regulation at 48 CFR 2.101 of a person described in paragraph (a)(1) of this section.

- Magellan checks the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion; *see Standard III.C.1.c., above on page 23 for* a description of the other lists checked by Magellan.

42 CFR 438.610(b)

b) Magellan may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

- Magellan checks the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities

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(LEIE); *see Standard III.C.1.c., above on page 23* for a description of the other lists checked by Magellan.

c) Potential Consequences for Failure to Comply With The Prohibited Affiliations Disclosures Described Above:

42 CFR 438.610(d)

i. The state must notify the Secretary of the noncompliance.

ii. The state may continue an existing agreement with Magellan unless the Secretary directs otherwise.

iii. The state may not renew or otherwise extend the duration of an existing agreement with Magellan unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

D. Policies and procedures in place for the handling and reporting of overpayments made by Magellan to Providers. 42 CFR 438.608(d)

42 CFR 438.608(d)(1)

1. Treatment of recoveries made by Magellan of overpayments to providers.

a) Magellan complies with the state Medicaid retention policy for the treatment of recoveries of all overpayments from Magellan to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

b) Magellan complies with the process, timeframes, and documentation required for reporting the recovery of all overpayments in accordance with the state Medicaid Contract.

c) Magellan complies with the process, timeframes, and documentation required for payment of recoveries of overpayments to the State in situations where Magellan is not permitted to retain some or all of the recoveries of overpayments.

d) This section does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

42 CFR 438.608(d)(2)

2. When a provider determines that it has received an overpayment from Magellan, network providers are contractually obligated to report the overpayment and to return the overpayment to Magellan within sixty (60) calendar days after the date on which the overpayment was identified. The provider must also notify Magellan in writing of the reason for the overpayment.

3. Magellan reports annually to the State on the recoveries of overpayments as specified in the Medicaid Contract. 42 CFR 438.608(d)(3)

4. The State must use the results of the information and documentation collected in paragraph (D)(1) of this section and the report in paragraph (D)(3) of this section for setting actuarially sound capitation rates for Magellan consistent with the requirements in 42 CFR § 438.4. 42 CFR 438.608(d)(4)

Cross Reference(s)

Magellan Code of Conduct; False Claims Laws and Whistleblower Protections; Nondiscrimination and Language Access; Verification of Services Provided to Members; Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers & Vendors)

Magellan Health policies apply to all subsidiaries where applicable to the subsidiaries' business.

Magellan HEALTH SM

Corporate Policy Life History

Date of Inception: January 1, 2007	**Previous Review Date:** March 15, 2019	**Current Review Date:** March 09, 2020
Previous Corporate Approval Date: March 16, 2019	**Current Corporate Approval Date:** April 10, 2020	**Unit Effective Date:** May 10, 2020

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

Special Investigations Unit Referral Form

Special Investigations Unit Anti-Fraud Plan

Magellan Code of Conduct

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