ANTI-FRAUD PLAN

In accordance with California Health and Safety Code Section 1348, Kern Health Systems (KHS) establishes and maintains an antifraud plan. The purpose of the antifraud plan outlines KHS strategies and efforts to identify and reduce costs to the plan, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud.

1. Definitions:

- **Abuse** is defined as practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal 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 Member practices that result in unnecessary cost to the Medi-Cal program.

- **Fraud** is defined as an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).

- **Waste** includes the overutilization or inappropriate utilization of services and misuse of resources.

2. Structure:

Under the leadership of the Chief Compliance and Fraud Prevention Officer (CCFPO), the KHS Compliance Department is responsible for implementation of the Anti-Fraud Plan (AFP). The Compliance Department is responsible for Anti-Fraud Plan oversight, and it has full authority to review all documents and other information that are relevant to the exercise of position duties. In addition, the Chief Compliance and Fraud Prevention Officer is copied on internal reports and work with Directors to identify opportunities for process improvement. The Chief Compliance and Fraud Prevention Officer annually reviews and updates the Anti-Fraud Plan as necessary to address KHS operational, legislation, or federal/state policies changes.

The Chief Compliance and Fraud Prevention Officer reports to the Chief Executive Officer and has access KHS legal counsel, and dotted reporting authority to the KHS Board of

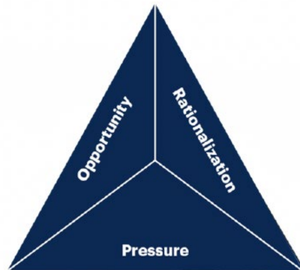
Directors. The attached Fraud Reporting Structure[i] demonstrates the relationship of the Compliance Department to senior management and KHS Board of Directors (see attachment A).

- KHS employees, providers, members, vendors, and sub-contractors shall abide by all parts of this plan.

- KHS serves Medi-Cal beneficiaries and coordinates care with local programs.

- KHS does not delegate program integrity and compliance plan functions to any Subcontractor or Downstream Contractor.

The KHS Compliance Department regularly reviews strategies to strengthen its Anti-Fraud Plan[1]. Key elements include ensuring enhanced fraud risk awareness and facilitating increased coordination and collaboration across the organization are essential to improving its fraud risk assessment processes.



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Fraud, Waste, and Abuse (FWA) Committee:

The Compliance Department chairs a Fraud, Waste, and Abuse Committee, which reviews and discusses potential fraud, waste, and abuse activities. The Committee meets at least quarterly, and more often as needed based on FWA activities and investigations.

3. Policies and Procedures:

KHS maintains an anti-fraud strategy to identify fraud, waste, or abuse and reduce costs associated with such activities. This includes the protection of the members during the delivery of health care services by providers.

The Compliance Department is responsible for the development and implementation of policies and procedures to prevent and detect fraud, waste, or abuse, which address specific areas of suspected fraud, waste, or abuse and the initiation of corrective action to prevent similar offenses. KHS has an established policy, *14.04-P Preventing, Detecting, and*

Reporting Fraud, Waste, or Abuse, which is submitted and approved by both the Department of Healthcare Services (DHCS) and the Department of Managed Health Care (DMHC) (see Attachment B).

In accordance with 42 USC section 1396b(i)(2), KHS will not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider as defined in Exhibit A, Attachment III, Subsection 1.3.4.A, (*Tracking Suspended, Excluded, and Ineligible Providers*) of DHCS Contract. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had a reason to know of the exclusion or prescribed by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of Fraud.

- Compliance with the Anti-Fraud Plan and related policies and procedures may be a factor in evaluating the performance of employees. KHS may take disciplinary action, up to and including termination, for violation of these requirements.

- Contracted providers are by virtue of their contract are obligated to adhere to all KHS' policies and procedures including regulatory requirements related to Fraud, Waste, or Abuse. Providers access relevant policy and procedures via KHS' website. Additionally, contracted providers periodically receive provider awareness bulletins.

4. Anti-Fraud Awareness Training Program:

Noncompliance and misconduct stem from many factors, and organizational culture remains a leading cause of both. Fraud-awareness training creates a culture of fraud awareness, helping prevent fraud and increase the likelihood of incident reporting. Comprehensive fraud-awareness training programs help address the conditions that lead to fraud — rationalization, pressure, and opportunity — by educating employees about common fraud scenarios and communicating consequences for fraudulent activity and behavior. A strong code of conduct provides the foundation for a fraud-aware culture.

KHS provides an effective training program for all KHS employees and Board of Directors. Providers, vendors, subcontractors, and enrollees also receive information to educate and improve their awareness of various forms of fraud, waste, or abuse and how they can detect, prevent, and report suspected fraud, waste, or abuse. This training highlights KHS' commitment to compliance with federal and state regulations regarding fraud, waste, or abuse.

- New employees receive Anti-Fraud Awareness training as part of the New Employee Orientation Program within 90 days from their hire date.

- FWA training is also conducted for all employees annually, which requires all employees to participate in the training and pass quizzes presented throughout the training.

- Employee attendance and participation in training programs are a condition of continued

employment, and failure to comply with training requirements may result in disciplinary action, up to and including termination.

- The Compliance Department maintains adequate training records, including attendance logs and material distributed during the training sessions.

- If an employee is unclear as to their obligations regarding anti-fraud matters, the employee may seek clarification from the Fraud Team, Director of Compliance, or the Chief Compliance and Fraud Prevention Officer.

- The Chief Compliance and Fraud Prevention Officer, Director of Compliance and members of the Compliance Department attend anti-fraud training, workshops, and seminars to enhance their knowledge and awareness of fraud investigation, detection, and prevention.

- New providers contracting with Kern Health Systems (KHS) are educated through our new provider orientation training, which includes a specific section on fraud, waste, and abuse.

5. Communication:

Employees may report suspected fraud, waste, or abuse or any anti-fraud compliance issue to the Anti-Fraud Team, Chief Compliance and Fraud Prevention Officer or designee, or by calling the Ethics Hotline. After making the report, the employee should refrain from additional discussion of the matter, except with the Chief Compliance and Fraud Prevention Officer or designee. All reports directed to the Compliance Department will be reviewed within the standards set by contract or law.

KHS acknowledges that information shared by DHCS, other State and federal agencies, and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral must be considered confidential, until formal criminal proceedings are made public. All reports of suspected fraud, waste, or abuse will be treated confidentially. However, contingent upon circumstances, KHS may be required to reveal such information to comply with governmental authorities or law enforcement.

In accordance with Policy 14.04-P *Preventing, Detecting, and Reporting Fraud, Waste, or Abuse Prohibition of Retaliation*, KHS prohibits retaliation against any employee who makes a good faith report of suspected fraud, waste, or abuse. No employee will be subject to disciplinary action solely because they reported what they reasonably believe to be an act of wrongdoing. However, an employee whose report of wrongdoing contains an admission of personal wrongdoing cannot be guaranteed protection against disciplinary action. The fact that the employee volunteered the information will be considered as a favorable act in any disciplinary action concerning that employee. An employee may be subject to discipline if KHS determines they knowingly fabricated, in whole or in part, a report of wrongdoing.

In addition to published policies and training, KHS supports ongoing communication and resources related to fraud, waste, and abuse, some of which are outlined below:

- The Compliance Department hosts an annual company-wide Compliance Awareness week event during the month of November. Materials are created internally and cover a variety of Compliance-related topics, including fraud, waste, and abuse.

- The KHS Code of Conduct also provides education on fraud, waste, and abuse. The code of Conduct is reviewed during New Employee Orientation and is also referenced during Compliance Week Activities. It is also available on the website (internal and external) for reference as needed.

- Additional provider education and resources include our Provider Manual and policies, which includes information on detection and reporting of fraud, waste, and abuse.

- The Member Handbook (Evidence of Coverage) describes examples of fraud, waste, and abuse and encourages members to report any allegations of fraud related to providers or members suspected of misusing his or her benefits or the benefits of others.

- The KHS website provides instructions for reporting fraud. A KHS FWA Reporting Form is available online at the KHS website for providers, members, and the public to use to report suspected fraud.

- Reports of suspected fraud, including those provided anonymously, are also accepted orally by telephone, via email to a dedicated Fraud Team email address, in person, or in writing from any source including employees, members, subcontractors, downstream subcontractors, providers and the public.

- The annual FWA training includes reminders on the internal processes for referring potential FWA to Compliance and the importance of timely referrals, including job aids and tutorials.

- The Compliance Team issues a monthly Compliance Capsule on a variety of topics, with at least one monthly capsule dedicated to potential fraud, waste, and abuse. The Compliance Capsule is distributed to all employees via email and also posted to the KHS internal employee dayforce hub.

- The Anti-Fraud Plan is submitted annually to the KHS Board of Directors (BOD). Regular reporting on the KHS FWA activities is also reported to the BOD.

6. Fraud Investigations:

The Chief Compliance and Fraud Prevention Officer, in collaboration with the Director of Compliance, oversees fraud, waste, or abuse investigations. The Compliance Manager of Audits and Investigations assists in managing the day-to-day operations regarding fraud, waste, and abuse.

The Compliance Department has dedicated team members responsible for researching and gathering information, including supporting documentation, for allegations of fraud, waste, or abuse received by the department.

Allegations may be identified and/or received from enrollees, providers, KHS employees, subcontractors, government regulatory agents, the public, or a variety of other sources.

The Compliance department also serves as the primary point of contact in the coordination of KHS resources in response to external auditor, regulator, or law enforcement requests, including but not limited to the California Department of Justice Special Investigators and DHCS Medi-Cal investigators.

Compliance Department activities may involve the submission of the results of the preliminary investigation to the Department of Health Care Services (DHCS) Program Integrity Unit, and possibly law enforcement. KHS is committed to comply with any investigation or a prosecution conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and/or the United States Department of Justice (US DOJ), including communicating requirements with Subcontractors and Downstream Subcontractors.

- All allegations or suspicions of potential fraud, waste, and abuse received or identified are submitted to the Compliance Department for investigation.

- All allegations of fraud, waste, or abuse are entered in a Fraud Log to control and track the status of investigations.

- Compliance conducts investigations, which may include, but are not limited to reviews and/or analysis of claims, medical records, accounting records, and utilization management prior authorizations; telephone interviews; provider responses; and/or other applicable investigation techniques.

- Cases may be determined to be unsubstantiated if the act committed was due to an honest and unintentional mistake, and/or where there is no evidence of potential fraud, waste, and abuse upon the completion of the investigation.

- Actions taken as a result of investigations may include but are not limited to: referring to criminal and/or civi11aw enforcement authorities as appropriate; education; issuing formal corrective action plans and monitoring through closure; disciplinary action, provider termination, or no additional action being taken, dependent on the nature of the allegation and outcome of the investigation.

- All investigations are documented utilizing an internal investigation form, with the allegation, investigation form, reporting, and all communications maintained in individual case files.

- The Director of Compliance, Manager of Audits and Investigations, Compliance Auditor, and Compliance Analysts meet weekly to review newly received cases, the status of open cases, and determine next steps.

- The CCFPO meets with the Director of Compliance, Manager of Audits & Investigations, and lead Compliance Analyst bi-weekly for oversight and additional direction on specific cases as needed.

- The FWA Committee also provides oversight and direction related to the FWA investigations.

- Compliance submits credible allegations of potential fraud, waste, or abuse to the Department of Health Care Services (DHCS) Program Integrity Unit, and law enforcement as required and outlined within our policies.

7. **Auditing and Monitoring:**

- The Compliance Department submits an Annual Audit and Monitoring Plan to the Chief Executive Officer and Board of Directors for review and approval annually. The Annual Audit Plan contains intended areas of focus and outlines audit objectives for a calendar year. KHS regularly audits and monitors its internal departments, providers, subcontractors, and vendors.

- Compliance coordinates internal reviews and monitoring activities, including periodic reviews of departments based upon the annual audit plan or requests for a special audits, which may be triggered through other monitoring activities or reviews.

- The Claims Department also conducts ad hoc audits related to potential fraud, waste, and abuse, reporting results up to Compliance and the Fraud, Waste, and Abuse Committee.

- In addition to the FWA specific investigations, additional monitoring activities occur to detect possible provider or member fraud. Some examples are outlined at a high level below and reported up through the FWA Committee:

Monitoring Activity	Description	Department
Verification of Services	Quarterly mailing to at least 150 members to validate claims processed by KHS were actually received by the member	Compliance
Transportation Misuse	Member Transportation reports are reviewed for potential misuse; members found to be abusing the use of the transportation services may be restricted in the types of transportation services provided	Member Services

Monitoring Activity	Description	Department
Grievance	Report of possible fraud when a member has filed a grievance is investigated.	Member Services
Provider Monitoring	Monthly review of multiple ineligible provider and suspensions lists (OIG, DHCS, etc).	Provider Credentialing

8. **Reporting:**

KHS complies with all reporting requirements as outlined within the DHCS contract and state and federal requirements.

- KHS reports FWA activity status regularly to the KHS Board of Directors and the quarterly FWA Committee.
- KHS reports relevant allegations to the DHCS Program Integrity Unit within ten (10) business days of initial identification and within ten (10) business days of completion.
- KHS provides a quarterly states report on FWA investigations to the DHCS Program Integrity unit within ten (10) calendar days of the end of each reporting quarter.
- KHS reports to other agencies and/or law enforcement as required based on the individual investigation.
- KHS provides an annual anti-fraud report to the Department of Managed Health Care Services by 12/31 of each year.
- KHS complies with the DHCS Contract, State and Federal laws, and the guidelines issued by DHCS pertaining to reporting and retention policies for the treatment of recoveries of all Overpayments to Providers, including for the treatment of recoveries of overpayments due to Fraud, Waste, and Abuse, as outlined in KHS Policy 6.01-P, Claims Submission and Reimbursement.

References:

i Attachment A – Fraud Reporting Structure
ii Attachment B – KHS Policy*14.04-P, Preventing, Detecting, and Reporting Fraud, Waste, or Abuse*
[1] 2022 Gartner Audit Key Priorities and Risks Survey.