Program Integrity Program

FY 2024-2025

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A. BACKGROUND

1. GOAL

The goal of San Francisco Health Plan's (SFHP) Program Integrity program is to ensure that all SFHP members receive appropriate and quality health care services. Prevention of health care fraud, abuse, and identify theft are a major focus of state and federal government entities, as well as health plans. The California Department of Health Care Services ("DHCS") contracts with managed care plans, which it holds accountable to maintain administrative and management policies and procedures which are designed to prevent and detect fraud, waste, and abuse (FWA). In furtherance of this goal, SFHP maintains a Program Integrity Program in compliance with the DHCS Program Integrity and Compliance Program requirements and requirements of 42 Code of Federal Regulations (CFR) section 438.608.

According to the DHCS, 42 CFR, and U.S. Federal Sentencing Guidelines, adoption and implementation of an effective program integrity program to detect and prevent fraudulent and abusive actions is instrumental in alleviating potential criminal, civil and administrative liabilities. This program integrity program demonstrates SFHP's commitment to integrity and high ethical standards. The Board of Governors and management of SFHP are committed to maintaining an effective program integrity program. SFHP ensures the adequate allocation of the time, resources and leadership needed to assure that effective systems are in place to implement this program.

The goals and standards set forth in this program integrity program are achieved and sustained through the actions and conduct of all SFHP employees and providers. SFHP employees are obligated to conduct themselves in a manner that adheres to the goals and standards described in this program. Such actions and conduct will be important factors in evaluating an employee's judgment and competence, and an important element in the evaluation of an employee's performance. Employees who are non-compliant with the content and principles set forth in this compliance program will also be subject to the appropriate disciplinary actions, as stated in the Employee Handbook.

2. MEDI-CAL RELATED FRAUD

As a public agency and Medi-Cal managed care plan, one of the primary responsibilities of SFHP is cooperation with state and federal agencies to prevent and report Medi-Cal related fraud. DHCS has established a separate division called Audits and Investigations ("A&I"), whose role is to investigate and prosecute fraud as it relates to Medi-Cal members, plans and providers. A&I is the designated Program Integrity Unit for Medi-Cal and its mission is to protect and enhance the integrity of the health programs administered by DHCS. A&I is tasked to perform audits of Medi-Cal providers and plans and investigate any reported fraud and abuse cases. Medi-Cal has the authority under California law to impose administrative sanctions on Medi-Cal providers and plans. SFHP's program integrity policies and procedures ensure prompt referral of any potential fraud, waste, or abuse that SFHP, members, or providers identify to the DHCS' A&I unit. Through quarterly meetings with the Department of Justice (DOJ) and the A&I unit, SFHP maintains a productive partnership with the Medi-Cal A&I unit and DOJ to identify, report and investigate potential cases.

B. DEFINITIONS

Abuse -Abuse means any activities or practices that are inconsistent with sound fiscal, business or medical practices and either directly or indirectly result in unnecessary costs to State and Federal health care programs.

Fraud - Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to himself or some other person.

Waste - Waste means the extravagant, careless or needless expenditure of funds that results from deficient practices, system controls or decisions and results in increased costs to State and Federal Medicaid/Medi-Cal and Medicare programs.

Common types of fraud within managed care include submission of false claims for services not performed (or for more expensive services than actually provided), denial of medically necessary services, deceptive enrollment practices, and receipt of services an individual is not entitled to receive. A listing of some common fraud and abuse indicators is attached as Exhibit A.

C. COMPLIANCE AND FRAUD AND ABUSE PREVENTION AND DETECTION PROGRAM

In an effort to comply with applicable regulations, ensure proper business practices and to deter fraudulent activities, SFHP has developed this Compliance and Fraud and Abuse Prevention and Detection Program ("the Program"). The Program is comprised of the following required components:

1. Code of Conduct
2. Policies and Procedures
3. Program Integrity (PI) Committee
4. Roles and Responsibilities
5. Training and Education Program
6. Reporting, Detection and Investigation of Allegations
7. Response and Investigations of Suspected Allegations
8. Disciplinary Actions
9. Monitoring and Auditing
10. Prevention of Fraud and Abuse
11. Delegate Oversight

This Program is designed to (i) establish clear guidelines to ensure staff observe pertinent laws, regulations and policies; (ii) prevent, detect and correct wrongdoing, (iii) to discipline those involved in non-compliant behavior and (iv) to prevent further noncompliance. This Program is not static but rather will be continually modified and updated to reflect current developments in the law and accepted practices.

1. CODE OF CONDUCT

The following Code of Conduct is intended to be a general statement of the standards to which all officers, directors, employees and agents are expected to conform. It is also found in the section of the SFHP Employee Handbook, "Standards of Conduct."

The Plan believes that a reputation for integrity and honesty is a highly valued asset -- one which must be constantly maintained and enhanced. Each employee has a personal responsibility to uphold the Plan's reputation above all other considerations. In every decision we make, that principle cannot be compromised. The employees of the Plan are expected to demonstrate the highest standards of public trust by:

- Being honest and ethical;
- Adhering to all Federal, State and local laws and regulations;
- Protecting the Plan's reputation and assets;
- Maintaining complete confidentiality of health plan and health plan members' confidential information such as demographics, medical information, eligibility, etc.; and
- Maintaining complete confidentiality of Plan and provider information, including rates, credentials, claims for services rendered, resolution of patient complaints, etc.

Each employee has an obligation to observe and follow the Plan's policies and to always maintain proper standards of conduct. It is not possible to provide employees with a complete list of every possible offense that will, like unsatisfactory job performance, result in discipline, including discharge. However, in order to give employees some guidance, examples of unacceptable conduct are listed below. Employees should be aware that conduct that is not listed, but that is unprofessional or potentially embarrassing, adversely affects or is otherwise detrimental to the Plan's interests, or the interests of its employees, customers, providers, or the public at large, may also result in disciplinary action, up to and including immediate termination.

- Malicious or willful destruction or damage to Plan property or supplies, or to the property of another employee, a customer, a provider, or a visitor;
- Theft or unauthorized removal from Plan premises of any Plan property, or the property of another employee, a customer, a provider, or a visitor;
- Obtaining employment or employee benefits by giving false or misleading information; falsifying or omitting any material information on employment documents or records, including your or a co-worker's time records;
- Dishonesty of any kind in relations with the Plan, its employees, customers, or providers;
- Bringing or possessing firearms, weapons, or other hazardous or dangerous devices or substances on Plan property without proper authorization;
- Possession, use, sale, manufacture of or distribution of controlled substances on Plan property or while conducting Plan business, or reporting for work or working under the influence of alcohol or illegal drugs;
- Insubordination, including improper conduct toward a supervisor or refusal to perform tasks assigned by a supervisor;
- Fighting on Plan property, or "horseplay" or any other action that is dangerous to others or to Plan property, or that disrupts work;
- Harassing, threatening, intimidating or coercing another employee, a customer, a provider, or members of the public who do business with the Plan, at any time, including off-duty periods;
- Being convicted of any crime other than a minor traffic violation (to the extent permitted by law);
- Unauthorized disclosure or use of any confidential information about the Plan, its customers, its providers, or its employees or any trade secrets that you have learned through your employment with the Plan;

- Failure to follow all safety rules, to cooperate in safety inspections, or to promptly report all unsafe conditions encountered during work to the appropriate person;
- Unsatisfactory attendance, chronic lateness, or unreported absence of three (3) consecutive scheduled workdays;
- Failure to observe the terms and conditions of all software agreements and licenses to which the Plan may be a party;
- Unauthorized use of Plan equipment; and
- Violation of any Plan policy, including any of the policies described in the handbook as revised from time to time.

Nothing in the above listing alters the at-will nature of employment with the Plan. Nothing in the above listing is intended to deter or punish lawful concerted protected activity protected under the National Labor Relations Act (NLRA) or any other law.

2. POLICIES AND PROCEDURES

Policies and Procedures provide structure and guidance to the operations of the organization and ensure SFHP remains compliant with contractual, statutory, and regulatory requirements. SFHP employees are responsible for ensuring that they comply with the policies and procedures pertaining to their positions. At least bi-annually (every two years), SFHP staff reviews and updates policies and procedures. SFHP's Policy and Compliance Committee (PCC) reviews and approves proposed changes and additions to SFHP's policies and procedures as presented by the Department leads at monthly PCC meetings. SFHP policies and procedures are posted in SFHP's Square One intranet page. Program Integrity-related policies and procedures include but are not limited to the following:

- Compliance with state and federal standards
- Reporting compliance-related issues
- Description of how potential compliance issues are investigated, resolved and reported
- Non-retaliation for good faith participation in the Program Integrity Program.

3. PROGRAM INTEGRITY COMMITTEE

The SFHP Program Integrity Committee (the "PI Committee") oversees the compliance, fraud and abuse prevention and detection process and is comprised of SFHP management representing the following areas:

- Compliance and Regulatory Affairs
- ITS
- Pharmacy
- Medical Coding
- Provider Network Operations
- Finance
- Member Eligibility Management
- Coverage Programs
- Clinical Operations
- Claims

The activities of the PI Committee are led by the SFHP Chief Compliance Officer who reports to the Chief Executive Officer of the Plan, as well as an indirect reporting relationship to the

Governing Board. With assistance of PI Committee members, the Chief Compliance Officer is responsible for the coordination of all aspects of the Program, including development, implementation and review of policies and procedures related to the Program and reporting fraudulent or other suspected activities.

The PI Committee is responsible for reviewing, and if warranted, investigating suspected incidents of fraud, abuse, HIPAA violations, or other wrongdoing. Suspected incidents of fraud or abuse are reported to the Chief Compliance Officer or Director, Compliance and Oversight, who, if necessary, will consult with the PI Committee to determine how to proceed with the investigation.

Other duties of the PI Committee include:

- Revising existing or creating new policies and procedures that address identified risk areas.
- Determining the appropriate strategies to promote company-wide compliance with this Program.
- Reviewing results of internal and external audits and investigations to help decide on the proper course of action to take to ameliorate any uncovered problems.

In addition to ongoing monitoring and investigations of suspected activities, the PI Committee is actively involved in staff education and awareness programs for SFHP employees, members, and providers. The PI Committee will meet at least every quarter to discuss the effectiveness and potential revisions to the Program. Additionally, the PI Committee will review and discuss potential compliance-related issues, as needed.

4. EFFECTIVE LINES OF COMMUNICATION AND ROLES AND RESPONSIBILITIES

The Chief Officer, Compliance and Regulatory Affairs, ("Chief Compliance Officer") and Director, Compliance and Oversight, ensure the provision of education and training programs for employees, responds to inquiries from any employee regarding appropriate questions relating to this Program Integrity Program and ensures implementation of best business practices for program integrity and investigates any allegations of possible fraud, waste and abuse.

The duties and responsibilities of the Chief Compliance Officer include the following:

- Submits annual reports regarding the Plan's anti-fraud and abuse activities and findings to DMHC and the Plan's Finance Committee, Board of Governors and Executive Team (ET).
- Inform the Board and ET of suspected and investigated fraud and abuse activities on an ongoing basis.
- Maintain open lines of communication with SFHP employees and Board.
- Provides ongoing industry specific information to continually educate managers and staff of potentially fraudulent activities.
- Provides support for SFHP employees, including monitoring calls into the Compliance Hotline (described below) and protecting employee's anonymity if requested.
- Ensures that SFHP employees receive annual training and periodic education, as needed.
- Coordinates staff training with the Plan's Human Resources department and Provider Relations Department to ensure that all employees, providers and independent contractors have undergone the proper background check and understand SFHP's commitment to the principles and requirements set forth in this Program.

- Cooperates and communicates with law enforcement and regulatory authorities as needed.
- Updates or develops new policies and procedures.
- Makes program-related documents readily available to SFHP staff on SFHP's intranet.
- Plans and oversees audits and monitoring of the Plan's operations in order to identify and rectify any possible barriers to the efficacy of this Program
- Performs such other duties and responsibilities as the Board, Chief Executive Officer or ET of SFHP may request in furtherance of the goals of the Program.

Executive Team and Governing Board

The Chief Compliance Officer provides at least a semi-annual report to the Board and Regulatory Compliance and Oversight Committee (Finance Committee) to provide information necessary to support the goals of the Program Integrity Program. Program details and progress are discussed at both Board and ET meetings. For each fiscal year, the Chief Compliance Officer is responsible to budget for adequate funds to ensure that the Program can function effectively.

5. TRAINING AND EDUCATION PROGRAMS

Purpose of Educational Program

The Program Integrity Program promotes the Plan's policy of adherence to professional and ethical standards, as well as all applicable laws and regulations. This Program Integrity Program includes a mandatory annual educational and training program required of all employees in an effort to ensure that all SFHP employees are familiar with all areas of law, regulation and policy that apply to and impact upon the conduct of their respective duties. Contracted providers are required per their contract to provide compliance training to their staff. In addition to an annual and other periodic training, all employees have access to a copy of this Program Integrity Program on the organization's intranet. All updates to the Program Integrity Program are provided to all Plan employees in a timely manner.

Training Program

The Chief Compliance Officer is responsible to ensure all employees receive proper compliance-related training and education. The Program is intended to provide each employee of the Plan with an appropriate level of information and instruction regarding the Program Integrity Program. Education and training of all employees is conducted on an annual basis, upon hire and, if needed, on a periodic basis. Training sessions are provided online and in-person when feasible. Completion of the annual compliance training is mandatory and documented through the learning system platform. Specialized or focused training, e.g., HIPAA best practices, is provided as needed. Focused training may focus on complex areas or on areas that pose a high risk to SFHP.

As new developments, requirements or concerns arise, the Compliance Officer may require additional training sessions for some or all Plan employees. From time to time, the Plan may require that certain employees attend outside seminars or professional educational courses, e.g., sponsored by the Center for Medicare and Medicaid Services (CMS), DOJ, DHCS or Department of Managed Health Care (DMHC).

Training Methods

While the Plan will make every effort to provide appropriate compliance information to all employees, and to respond to all inquiries, no educational and training program, however comprehensive, can anticipate every situation that may present compliance issues. Responsibility for compliance with this Program, including the duty to seek guidance when in doubt, rests with each employee of the Plan. Additionally, all employee ideas on modifying the Program or facilitating the educational aspects of the Program are welcomed. Contact the Chief Compliance Officer or your supervisor with your ideas. Compliance education materials are made readily available to all employees, providers and members upon request, and are also available on the SFHP intranet.

6. REPORTING AND DETECTION OF SUSPECTED ALLEGATIONS

Detection and reporting of allegations may come from all areas of the organization. Each staff member receives mandatory training on what types of activities and/or actions constitute fraud and the proper channels for reporting suspect activities or actions to the Chief Compliance Officer. Additionally, Plan providers and members will be notified through presentations and/or plan materials on the prevalence of health care fraud and how to contact the Plan in the event of suspect activities or actions.

Compliance Hotline

The Chief Compliance Officer and designees have an "open door" policy with respect to receiving reports of violations, or suspected violations of the Program and with respect to answering employee questions concerning adherence to the law and to this Program. In addition, the Plan has established a hotline (the “Compliance Hotline”) with Convercent. The hotline is accessible through Web or a toll-free number, www.convercent.com and 1-800-461-9330. Callers may wish to remain anonymous. All information reported to the Compliance Hotline will be kept confidential by the Plan to the extent that confidentiality is possible throughout any resulting investigation; however, there may be a point where an employee's identity may become known or may have to be revealed in certain instances.

Other Reporting Mechanisms

Every Plan employee, member or provider who has concerns or questions regarding unethical practices, improper employee conduct or other improper practices described throughout this Compliance Program, is encouraged to report such concern directly to his or her supervisor or to the Chief Compliance Officer (via the Hotline, Referral Form, email or in person). All Plan employees must fully cooperate and assist the Chief Compliance Officer during the course of the investigation. If a Plan employee is uncertain whether specified conduct is prohibited, then he or she should contact the Chief Compliance Officer for guidance prior to engaging in such conduct or call the Chief Compliance Hotline. However, any person who makes an intentionally false

statement or otherwise intentionally misuses the Compliance Hotline or any of the compliance processes will be subject to disciplinary action.

7. RESPONSE TO AND INVESTIGATION OF ALLEGATIONS

The Chief Compliance Officer shall lead the investigation and work with other subject matter experts and staff as appropriate. The Chief Compliance Officer has twenty years of experience as a Compliance Officer, which includes investigation of allegations of fraud, waste and abuse. The Chief Compliance Officer is certified through the Health Care Compliance Association for over 15 years. The Chief Compliance Officer and designees review and confidentially investigate all suspected compliance-related incidents, including those related to fraud and abuse, to determine the appropriate course of action the Plan should pursue concerning each incident. Whenever a suspected incident is detected by or reported to any individual within SFHP, it is that individual's responsibility to notify their supervisor or Chief Compliance Officer, including using the Case Referral Form, the Compliance Hotline or email. The Chief Compliance Officer or designee conducts an initial assessment of the incident and will notify the PI Committee when a valid concern has been raised.

The Chief Compliance Officer and designees lead the investigation process. Information to be reviewed includes referral documentation, eligibility history, explanation of benefits, claim history, encounter data, experience reports and all other relevant documents. The appropriate departments within the organization cooperate in the fact gathering process as needed. These departments are required to cooperate with the research and investigation as necessary to confirm or negate the suspicions of fraudulent or abusive activities. Outside sources, e.g., providers or members, are included as necessary.

Once the fact gathering process is completed, the results are presented to the PI Committee. The PI Committee reviews the investigation results and makes recommendations as needed including the following actions:

- Closure of the investigation.
- Administrative action including suspension or termination if necessary
- Law enforcement or government agency referral
- Continue investigation
- Report findings to the proper professional association and regulatory agencies as required
- Demand for repayment
- Civil action

If the PI Committee determines outside investigation is appropriate for a particular case, the case will be referred to the DHCS A&I Unit, CMS, or DOJ. In addition, the Chief Compliance Officer and the PI Committee continue to provide any necessary assistance to the A&I and to the designated fraud and abuse investigator assigned by DHCS to SFHP.

During the investigation process, SFHP staff and providers must not conceal, destroy, or alter any documents, lie, or make misleading statements. Each staff member should not cause another to fail to provide accurate information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of law. SFHP protects the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and

legal requirements but also to ensure that records are available to defend our business practices and actions. No one may alter or falsify information on any official record or document related to the investigation. Medical and business documents and records are retained in accordance with the law and the SFHP record retention policy. Medical and business documents include paper documents such as letters and memos, computer-based information such as e-mail or computer files. Employees of SFHP must not tamper with records, nor remove or destroy records.

In the event an investigation proves fraudulent activities have been committed, the appropriate law enforcement agencies will be notified. Additionally, reports may be made to the state fraud bureau, Federal Bureau of Investigations, DMHC, the state medical licensing and disciplinary boards, the state insurance commissioner, Internal Revenue Service or any other appropriate agency. Cases under review or turned over to law enforcement or other agencies for prosecution will be documented and reported to the Governing Board and Regulatory Compliance and Oversight Committee (Finance Committee) on a semi-annual basis. The Plan will also evaluate the effectiveness of its anti-fraud and abuse efforts on an annual basis.

In addition to reporting any specific incidents of fraud and abuse to DHCS and DMHC, SFHP must also disclose to DMHC an annual written report which describes the plan's efforts to detect and prevent fraud and abuse (Health & Safety Code Section 1348(c). The annual plan may also include any specific recommendations by SFHP to improve its efforts to combat health care fraud.

8. DISCIPLINARY ACTIONS

Compliance-related violations of conduct, including fraudulent or abusive practices, may result in the following actions, sanctions and disciplinary actions, according to SFHP Human Resources policies and procedures:

- Re-training;
- Revision of policies and procedures;
- Root cause analysis to identify improvements necessary to prevent the problem from recurring;
- Providers: disciplinary actions as described in the contract, provider manual and policies and procedures;
- Plan Employees: disciplinary actions as described in the SFHP Employee Handbook;
- Members: regulatory agencies notified of inappropriate activities, disenrollment through the appropriate agencies, and referral to law enforcement agencies; and
- In cases where sufficient evidence is gathered to indicate that fraudulent or abusive activities have in fact occurred, the SFHP Chief Compliance Officer reports cases to law enforcement agencies and external counsel.

Appropriate disciplinary measures will be taken on a case-by-case basis in accordance with this Program, SFHP Employee Handbook, and related policies and procedures.

9. MONITORING AND AUDITING

<u>Regular Audits and Monitoring Activities</u>
Regular audits and monitoring activities are scheduled in the Program Integrity Workplan and Oversight program and conducted as outlined in the annual Program Integrity Workplan. Such

audits are used to determine the level of compliance with the Program and determine what, if any, compliance issues exist.

Audits and monitoring activities are conducted in accordance with the comprehensive audit procedures established by the PI Committee and Provider Network Operations Committee (PNOC) and include, at a minimum:

(i) high-risk or priority areas as identified by the PI Committee;
(ii) interviews with personnel involved in management, operations and other related activities;
(iii) reviews, at least annually, of whether the Program's main elements have been satisfied (e.g. whether there has been appropriate dissemination of the Program's standards, training, disciplinary actions, etc.);
(iv) review of Provider contracts and the credentialing process to make sure that none of the compliance standards have been violated, such contracts promote the goals of this Program and that none of the Plan Providers have lost their credentials or have been convicted of engaging in health care related fraudulent conduct; and
(v) assess the effectiveness of the Compliance Hotline including responsiveness and clarity of information exchanged.

Compliance audit procedures will be conducted following the Program Integrity Workplan and the results thereof are confidential to the extent necessary. All individuals involved in the auditing and monitoring process must: (i) have the qualifications and experience necessary to adequately identify potential issues with the subject matter that is reviewed; (ii) be objective and not feel threatened for uncovering potential violations (e.g. will not be fired for uncovering non-compliant behavior by supervisor); and (iii) have access to sufficient resources, relevant personnel, and all relevant areas of operation.

Audit Reports

Audit reports are prepared by Director, Compliance and Oversight, or other designees. These reports are submitted to the PI Committee and PNOC for review and approval as needed. Semi-annual reports are presented to the Board and Regulatory Compliance and Oversight Committee (Finance Committee) which can take steps or recommend actions as necessary. The audit report and other analytical reports identify non-compliance, areas where corrective actions are needed**,** and in which cases, if any, subsequent audits or studies would be advisable to ensure that the recommended corrective actions have been implemented and are successful.

Compliance with Applicable Fraud Alerts

The Chief Compliance Officer and Director of Compliance and Oversight regularly and periodically monitor the issuance of special fraud alerts issued by OIG, DHCS and other applicable governmental bodies. Any and all fraud alerts so issued will be carefully considered by the Compliance staff. SFHP will revise and amend this Program Integrity Program as needed, in accordance with such fraud alerts and any other relevant information coming from regulatory bodies.

Retention of Records and Reports

SFHP documents its efforts to comply with applicable statutes, regulations and Medi-Cal and Medicare program requirements. Records and reports created in conjunction with the SFHP's

adherence to the Program are confidential and will be maintained by SFHP. Consultation with the SFHP's counsel will be incorporated as needed, including determination of when destruction of such documentation is appropriate.

10. PREVENTION OF FRAUD AND ABUSE

SFHP maintains a system of internal and external processes designed to prevent fraudulent and abusive activities. These processes include:

- An organizational structure which segregates various business functions of the plan, e.g., Finance, Claims and Clinical Operations
- Audit of provider claims and encounter data
- Oversight of contracted providers by the SFHP's Compliance, Provider Relations and Health Services Departments
- Verification of patient eligibility and plan coverage
- Grievance staff responsible for investigation of all member grievances
- On-going education of employees, members and providers of SFHP's fraud and abuse activities

In addition to the processes listed above, departments within SFHP implement processes that support the Program.

Provider Fraud and Abuse

As part of the provider review process, claims that SFHP pays on a fee-for-service basis are reviewed for, but not limited to, the following indicators:

1. Possible third-party liability/workers' compensation coverage
2. Claims for excessive services, especially claims for physical and occupational therapy
3. Surgery or other treatment inconsistent with standards
4. Excessive single visit charge and other outlier characteristics

To assure consistency in claims payments the following processes are followed:

1. All company checks are held and released by the Finance Department. Check stock is held by Finance for internal control.
2. The Claims Manager is responsible for processing claims and requesting batches of checks from Finance to be used for paying eligible claims.
3. Once the Claims Manager has completed the information necessary to complete the claim checks, they are sent to the Finance. After the checks are reviewed and approved, they are submitted to the Chief Financial Officer for signature and disbursement.

In addition to claims-related fraud, other key departments are trained to recognize situations that could potentially signify other fraudulent or abusive activities. In the event of suspected fraudulent or abusive activities, such as denial of medically necessary services, or fraudulent representative of medical licensure, staff make reports of suspected activity to the Compliance department. If warranted, the case will be forwarded to the PI Committee for review and investigation.

Contractual arrangements with SFHP providers address SFHP's commitment to program integrity and protection against provider health care fraud. The following elements are incorporated into SFHP provider contracts:

(i) requires providers to supply SFHP with all data needed to investigate potential cases of fraud and abuse;
(ii) permits SFHP and government agencies with access to provider's (and provider's subcontractors') books and records and facilities in order to complete fraud investigations;
(iii) requires providers to represent and warrant that all claims, encounter data and other reports represents truthful and accurate information;
(iv) prohibits any incentive programs with providers or any downstream arrangements which can be construed as an inducement to limit medically necessary services provided.
(v) requires disclosure of any sanctions for a health care related offense of provider or its subcontractors; and
(vi) defines services to be provided, quality of services, accessibility of services, qualifications of all personnel rendering services and when supervision is required as required by regulatory authorities or in conformance with industry standards.

Employee Fraud and Abuse

All SFHP employees receive a copy of SFHP Employee Handbook and are required to sign an acknowledgement on an annual basis. Additionally, each year, there is a mandatory compliance training to provide education on fraud, abuse, waste and HIPAA privacy and security. The training affirms SFHP's commitment to investigating instances of potential fraud and abuse. Every SFHP employee has the duty to report suspected fraudulent activities to their supervisor and/or Compliance. If appropriate, the supervisor may also report cases of suspected employee fraud to Human Resources for confidential investigation. The Human Resources Director coordinates his or her investigative activities with the Chief Compliance Officer, if appropriate. In addition to all the confidentiality, privacy and other standards provided to each employee during their new hire process, every employee will also be expected to promptly report any violation of this Program to their supervisor or to the Compliance department (through the Compliance Hotline if desired).

SFHP requires that every employee comply with applicable laws and regulations. All SFHP employees must be knowledgeable about and ensure compliance with applicable laws and regulations related to their responsibilities and must immediately report suspected violations to their supervisor or the Compliance department (including through the Compliance Hotline). The Chief Compliance Officer provides all SFHP staff with the information and education to ensure compliance with applicable laws and regulations.

Under no circumstances will the good faith reporting of any potential violation of this Program by an SFHP employee serve result in any retaliatory actions to be taken against the employee making the report. No SFHP employee who reports suspected misconduct will be retaliated against or otherwise be disciplined by the SFHP for making such report. The Chief Compliance Officer will work with the Human Resources Director to ensure that those who report suspected misconduct are not the victims of retaliation or other improper conduct.

Employees are offered the opportunity to consult, in a variety of manners, with their supervisor rather than directly going to the Chief Compliance Officer or Compliance department. Supervisors must make themselves fully available to employees. Questions, problems, suggestions or other information related to potential violations of this Program provided to the supervisor must be immediately reported to the Chief Compliance Officer. Failure to do so may result in disciplinary action for such supervisor.

Member Fraud and Abuse

For all SFHP lines of business, once a member has been enrolled in the plan and services are being accessed, the SFHP staff is in a position to detect abuse of the system or plan benefits or fraudulent activity. Eligibility and capitation reports are reviewed on a monthly basis for accuracy and completeness. Additionally, eligibility information is available to SFHP providers 24 hours a day, seven days a week through a voice response system.

In the event that Customer Services (CS) is contacted about member-related fraudulent activities, the CS representative must report such suspected fraud to his or her supervisor. If the supervisor believes that an issue exists, he or she must report the issue to the Chief Compliance Officer or other staff in Compliance. If a contracted provider has a report to make, they should be directed to the Provider Relations Department. If warranted and appropriate, Provider Relations will take down the provider's report and then report to the Chief Compliance Officer or Compliance staff. When appropriate, law enforcement agencies will be notified for additional investigation and prosecution.

Pharmacy Fraud

The most likely type of health care fraud for SFHP may involve prescriptions. SFHP Pharmacy department is responsible for addressing and researching all potential cases of member pharmacy-related fraud. Suspected incidents of fraud or abuse should be documented by SFHP Pharmacist and immediately forwarded to the Medical Director who will coordinate the assessment of the case with the Chief Compliance Officer. If an investigation is warranted, the case will be forwarded to the PI Committee. The Pharmacist will be made available to assist in any investigation.

Follow-up and Reporting to State Agencies
Cases of suspected fraud and abuse are followed up, investigated and reported appropriately, according to SFHP policy and procedure, C&RA-08 Fraud and Abuse Prevention and Investigation.

11. DELEGATE OVERSIGHT AND COMPLIANCE

SFHP delegates certain functions and/or processes certain medical groups and subcontractors such as, but not limited to, the following:

- Credentialing and re-credentialing
- Claims processing
- Utilization management
- Case management

SFHP maintains a delegate oversight program and policies and procedures approved by DHCS to ensure that its Network Providers, Subcontractors, and Downstream Subcontractors fully comply with all applicable terms and conditions of the DHCS contract and responsibilities delegated to Subcontractors and Downstream Subcontractors. SFHP evaluates each prospective Network Provider's, Subcontractor's, and Downstream Subcontractor's ability to perform the contracted services or functions through pre-delegation audits as appropriate. SFHP oversees and remains responsible and accountable for services or functions undertaken by a Network Provider, Subcontractor, or Downstream Subcontractor.

EXHIBIT A

Examples of Indicators of Fraud and Abuse

Billing Related Indicators

- Duplicate billing
- Double billing
- Payments issued to P.O. Box numbers
- Same payee name but checks issued to different addresses
- Misspelled or misapplication of medical terminology unbundling of codes
- Excessive single visit charges
- Surgeries/Other treatment inconsistent with patient diagnosis, age or sex
- Split billing, particular as related to claims paid all inclusively under per diem or outpatient surgery global rates.

Provider Related Indicators

- Underutilization and Access Problems
- Falsifying credentials
- Addition of fictitious providers to network
- Providing inferior services or supplies (can be measured via grievances)
- Balance billing of patients
- Unusually high diagnosis frequency
- Patient dumping/refusal to treat (via grievances and member satisfaction surveys)
- Complaints from patients regarding billing practices
- Practice patterns that differ between capitated and non-capitated Members (analyze fee for service and encounter data to compare differences)
- Subcontracting out work that a Provider claims they are providing. Contracts should restrict such behavior.

Member-Related Indicators

- Accessing relatives unused health benefits after patient exhausts their own
- Selling or allowing others to use their Medi-Cal card and associated benefits.
- Home address outside of covered service/coverage area
- Enrolling in plan under another individual's personal information
- Falsifying familial relationships or other eligibility information in order to gain health benefit coverage
- Submitting false claims
- High pharmaceutical usage/inappropriate pharmaceutical usage

EXHIBIT B

SFHP Program Integrity Committee Team Members

The following individuals are members of the Program Integrity Committee:

- Chief Officer, Compliance and Regulatory Affairs
- Director, Compliance and Oversight
- Controller
- Pharmacy Services
- Director, Infrastructure and Technology Services
- Director, Human Resources
- Director, Provider Network Operations
- Director, Claims, or designee
- Manager, Member Eligibility
- Director, Clinical Operations, or designee

The above Committee members are all located at San Francisco Health Plan, 50 Beale Street, San Francisco, CA 94105, (415) 547-7818.

EXHIBIT C
Case Referral Form

SAN FRANCISCO HEALTH PLAN
COMPLIANCE, FRAUD AND ABUSE INVESTIGATION CASE REFERRAL FORM

Please complete all fields regarding the potential fraudulent or abusive incident to the best of your knowledge. You may choose to anonymously submit a report by not completing the first three fields.

Name: _____

Contact Phone: (____)_____

Department: _____

Case Type: _____ Provider _____ Member _____ Employee _____ Other

Information about the Suspected Individual/Entity:

Name of Individual or Group: _____

Address: _____
Street Address City State Zip Phone Number

Date of Birth (if member): _____

Member or Plan ID Number: _____

Tax ID Number: _____

How were you informed about this incident? _____ Self _____ Member _____ Provider _____ Other

If someone other than you detected this incident, please provide the following information:

Name: _____

Address: _____
Street City State Zip Phone Number

Provide a description of the suspect incident:

_____

_____

The completed form should be turned into your supervisor or the Chief Compliance Officer.