Orange County Health Authority
dba CalOptima Health

2026 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September 2025)

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I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies.

Inquiries regarding the Fraud, Waste, and Abuse Plan may be directed to the CalOptima Health Fraud, Waste, and Abuse Director, Fay Ho, who may be reached at (714) 246-8892.

CalOptima Health will submit its anti-fraud plan to the Department of Managed Health Care (DMHC). Any changes will be filed with DMHC pursuant to Health and Safety Code (HSC) § 1352. The submission will describe the manner in which the plan is complying with HSC § 1348(a), and the name and telephone number of the contact person to whom inquiries concerning the anti-fraud plan may be directed.

CalOptima Health will provide to the DMHC director an annual written report describing CalOptima Health's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by CalOptima Health, this report will include the number of cases prosecuted to the extent known by CalOptima Health. The report may also include recommendations by CalOptima Health to improve efforts to combat health care fraud.

The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- Applicable regulatory guidance
- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S. Code §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Health and Safety Codes (HSC) §§ 1348(a), and 1352
- Title 42, Code of Federal Regulations (CFR) 422, 423 and 438.608

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately

to such incidents of FWA.

Covered California:
In accordance with Covered California contractual requirements, the purpose of CalOptima Health's anti-fraud plan shall be to organize and implement an anti-fraud strategy to identify and reduce costs to CalOptima Health, providers, subscribers, members, 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.

II. DEFINITIONS

Medi-Cal:
Abuse ("Abuse") means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to a CalOptima Health 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 CalOptima Health Programs.

Fraud ("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. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Waste ("Waste") means the overutilization or inappropriate utilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Covered California:
Abuse - Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.

Fraud - Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (California (CA) Civil Code §3294 (c)(3), CA Penal Code §§470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered.

Waste - Intentional or unintentional, extravagant careless or needless expenditures,

consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.

III. FWA TRAINING

FWA training is provided to all CalOptima Health Board members, employees, and contractors as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA in accordance with CalOptima Health Policy HH.2023: Compliance Training. First-tier, downstream and related entities (FDRs) are also required to complete FWA training.

CalOptima Health's FWA training provides guidance to Board members, employees, contractors, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- ► The process for detection, prevention, and reporting of suspected or actual FWA;
- ► Common types of member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- ► Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, etc.);
- ► Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- ► How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- ► CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- ► Information on the False Claims Act and CalOptima Health's requirement to train employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima Health shall provide Board members, employees, contractors, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is

engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- ► CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- ► Claims data history;
- ► Encounter data;
- ► Medical record audits;
- ► Member and provider complaints, appeals, and grievance reviews;
- ► Utilization Management reports;
- ► Provider utilization profiles;
- ► Pharmacy data;
- ► Auditing and monitoring activities;
- ► Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- ► Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the Pharmacy Benefit Manager (PBM) will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- ► Overutilized services;
- ► Aberrant provider billing practices;

- ► Abnormal billing in relation to peers;
- ► Manipulation of modifiers;
- ► Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- ► Unbundling of services;
- ► Unusual Durable Medical Equipment (DME) billing; and/or
- ► Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- ► Average dollars paid per medical procedure;
- ► Average medical procedures per office visit;
- ► Average visits per member;
- ► Average distance a member travels to see a provider/pharmacy;
- ► Excessive patient levels of high-risk diagnoses;
- ► Peer to peer comparisons within specialties;
- ► Analysis of provider medical billing activity within their own peer group;
- ► Analysis of pharmacy billing and provider prescribing practices;
- ► Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- ► Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

- ► Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- ► Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- ► Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- ► Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- ► Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- ► Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA,

but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- ► Claims that show any altered information (dates, codes, names).
- ► Photocopies of claim forms and bills, or handwritten claims and bills.
- ► Provider's last name is the same as the member/patient's last name.
- ► The insured's address is the same as the servicing provider.
- ► Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- ► Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- ► The allegation is logged into the case management system;
- ► The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- ► SIU develops an investigative plan;
- ► SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- ► Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- ► Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- ► SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- ► SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- ► Review of FDR enrollment applications, history, and ownership
- ► Review of member enrollment applications and other documents, as necessary;
- ► Review of applicable contracts and/or All Plan Letters (APLs);
- ► Discuss allegation and evidence collected with subject matter experts;
- ► All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- ► After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- ► The FWA case report shall reflect all information gathered and documentation received to

ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods;

- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has repeated disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, DMHC, Covered California, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS, Covered California, DMHC, and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare program.

For the purposes of reporting FWA to Covered California:

- CalOptima Health shall communicate within ten (10) days to Covered California any material concerns identified by CalOptima Health or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by State and Federal Regulators related to regulatory compliance that may impact performance under the contract with Covered California following CalOptima Health's knowledge of such occurrence; provided, however, such notification shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California members. All notifications shall be made according to the "Contract Reporting Requirements" table posted on CalOptima Health's extranet website provided by Covered California.
- If CalOptima Health receives any preliminary or final reports, findings, or orders related to material concerns identified by State and Federal Regulators that may impact performance under the contract with Covered California pursuant to Section 1.15 of the 6.5. Qualified Health Plans (QHP) contract, CalOptima Health shall provide Covered California with copies of them within 48 hours of receiving them from State and Federal Regulators.
- CalOptima Health shall provide Covered California with a description of its FWA detection and prevention programs and report total monies recovered by CalOptima Health in the most recent 12-month period for CalOptima Health's total book of business as well as, total monies recovered for Covered California business only. This description shall be updated during each year that the contract with Covered California is in effect and shall include an overview of fraud and abuse detection and prevention program activities

conducted by CalOptima Health, Participating Providers, other Subcontractors and their authorized Agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.

- ► CalOptima Health maintains and enforces a written Code of Conduct publicly available on CalOptima Health's website.
- ► CalOptima Health shall refer potential fraud activities identified through fraud detection and response measures to Covered California. CalOptima Health shall follow the established Carrier Referral Process posted on the Contractor's extranet website provided by Covered California.

Potential cases that should be referred include, but are not limited to:

- ► Suspected, detected, or reported criminal, civil, or administrative law violations;
- ► Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- ► Allegations involving known patterns of FWA;
- ► Patterns of FWA threatening the life, or well-being, of CalOptima Health members; and/or
- ► Schemes with large financial risk to CalOptima Health, or its members.

b. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, prepayment claim review, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. The SIU will track and trend the FWA allegation and investigation, including, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board members, employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

CalOptima Health will not terminate Covered California member coverage for fraud without

prior review and approval from Covered California.

c. Cooperation with regulatory investigations or prosecutions
Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2007: Compliance Committee
- HH.2014: Compliance Program
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2023: Compliance Training
- HH.2028: Code of Conduct
- HH.3012: Non-Retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management