

**CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
CARESOURCE**

I. PREAMBLE

CareSource hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, CareSource is entering into a Settlement Agreement with the United States.

Prior to the execution of this CIA, CareSource established a Corporate Compliance Plan (CCP). The CCP includes, among other things, Standards of Conduct, an employee hiring and training program, a mechanism for individuals to report incidents of non-compliance, a Compliance Committee, and a Compliance Officer. CareSource and OIG agree that CareSource may utilize and adapt any component of the CCP existing at the time of the execution of this CIA as necessary to be in compliance with the integrity obligations created by this CIA. To the extent that CareSource's existing CCP cannot be modified or maintained to meet corporate integrity obligations created by this CIA, CareSource shall adopt new components to its CCP or create a new compliance program, so that CareSource shall meet the corporate integrity obligations created by this CIA.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by CareSource under this CIA shall be five years from the effective date of this CIA, unless otherwise specified. The "Effective Date" shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

B. Sections VII, X, and XI shall expire no later than 120 days after OIG's receipt of: (1) CareSource's final annual report; or (2) any additional materials submitted by CareSource pursuant to OIG's request, whichever is later.

C. The scope of this CIA shall be governed by the following definitions:

1. "Care Management" means the coordination and monitoring of treatment rendered to CareSource's Medicaid Managed Care Plan (MCP) members with specific diagnoses or who require high-cost or extensive services (e.g. "Member with Special Health Care Needs" or "MSHCN"). Care Management services include:

- a. notification to all CareSource MCP members of the Care Management services they may be eligible to receive;
- b. documentation of the identification of members who potentially meet the criteria for Care Management;
- c. assessment of the member's health conditions to determine the need for Care Management;
- d. assignment of the member to a risk stratification level;
- e. notification to the member and his or her Primary Care Physician (PCP) of the member's enrollment in CareSource's Care Management program;
- f. development, implementation, and ongoing monitoring of a care treatment plan for members in Care Management;
- g. assignment of an accountable point of contact; and
- h. reporting Care Management program-related data to Ohio Department of Job and Family Services (ODJFS), as required.

2. "Covered Persons" includes:

- a. all owners, officers, directors, and employees of CareSource; and

- b. all contractors, subcontractors, agents, and other persons who provide Care Management and related services on behalf of CareSource, excluding (i) hospitals, health care facilities, physicians, dentists, pharmacies, or otherwise licensed, certified, or other appropriate individuals or entities, that are authorized to or may be entitled to reimbursement for health care services rendered to a Managed Care Plan member, and (ii) vendors whose sole connection with CareSource is selling or otherwise providing medical supplies or equipment to CareSource and who do not bill the Federal health care programs for such medical supplies or equipment.

Notwithstanding the above, this term does not include part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than 160 hours per year, except that any such individuals shall become “Covered Persons” at the point when they work more than 160 hours during the calendar year.

3. “Relevant Covered Persons” includes Covered Persons involved in the provision of Care Management; and Covered Persons involved in the collection, assembly, and submission of data relating to CareSource’s Care Management.

III. CORPORATE INTEGRITY OBLIGATIONS

CareSource shall establish and maintain a Compliance Program that includes the following elements:

A. Compliance Officer and Committee

1. *Compliance Officer.* Within 90 days after the Effective Date, CareSource shall appoint an individual to serve as its Compliance Officer and shall maintain a Compliance Officer for the term of the CIA. The Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Compliance Officer shall be a member of senior management of CareSource, shall report directly to the Chief Executive Officer of CareSource, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Audit Committee of the Board of Directors of CareSource, and shall be

authorized to report on such matters to the Board of Directors at any time. The Compliance Officer shall not be or be subordinate to the General Counsel or Chief Financial Officer. The Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by CareSource as well as for any reporting obligations created under this CIA. Any noncompliance job responsibilities of the Compliance Officer shall be limited and must not interfere with the Compliance Officer's ability to perform the duties outlined in this CIA.

CareSource shall report to OIG, in writing, any change in the identity of the Compliance Officer, or any actions or changes that would affect the Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, within five days after such a change.

2. *Compliance Committee.* Within 90 days after the Effective Date, CareSource shall appoint a Compliance Committee. The Compliance Committee shall, at a minimum, include the Compliance Officer and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as clinical, case management, human resources, data processing, audit, and operations). The Compliance Officer shall chair the Compliance Committee and the Committee shall support the Compliance Officer in fulfilling his/her responsibilities (e.g., shall assist in the analysis of CareSource's risk areas and shall oversee monitoring of internal and external audits and investigations). The Compliance Committee shall meet at least quarterly.

CareSource shall report to OIG, in writing, any changes in the composition of the Compliance Committee, or any actions or changes that would affect the Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

3. *Board of Directors Compliance Obligations.* The Audit Committee of the Board of Directors (Board Committee) shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements and the obligations of this CIA. The Board Committee shall comprise at least three members of the Board of Directors who are not officers or employees of CareSource.

The Board Committee shall, at a minimum, be responsible for the following:

- a. meeting at least quarterly to review and oversee CareSource's Compliance Program, including but not limited to the

performance of the Compliance Officer and Compliance Committee;

- b. ensuring that CareSource adopts and implements policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and Federal health care program requirements; and
- c. for each Reporting Period of the CIA, adopting a resolution, signed by each member of the Board Committee summarizing its review and oversight of CareSource's compliance with Federal health care program requirements and the obligations of this CIA.

At minimum, the resolution shall include the following language:

“The Board Committee has made a reasonable inquiry into the operations of CareSource’s Compliance Program including the performance of the Compliance Officer and the Compliance Committee. Based on its inquiry and review, the Board Committee has concluded that, to the best of its knowledge, CareSource is in compliance with the CIA and Federal health care program requirements.”

If the Board Committee is unable to provide such a conclusion in the resolution, the Board Committee shall include in the resolution a written explanation of the reasons why it is unable to provide the conclusion and the steps it is taking to implement an effective Compliance Program at CareSource.

CareSource shall report to OIG, in writing, any changes in the composition of the Board Committee, or any actions or changes that would affect the Board Committee’s ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

B. Written Standards

1. *Code of Conduct.* Within 90 days after the Effective Date, CareSource shall distribute a copy of its written Code of Conduct to each Covered Person. CareSource shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. The Code of Conduct shall, at a minimum, set forth:

- a. CareSource's commitment to full compliance with all Federal health care program requirements;
- b. CareSource's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with CareSource's own Policies and Procedures;
- c. the requirement that all of CareSource's Covered Persons shall be expected to report to the Compliance Officer, or other appropriate individual designated by CareSource, suspected violations of any Federal health care program requirements or of CareSource's own Policies and Procedures; and
- d. the right of all individuals to use the Disclosure Program described in Section III.E, and CareSource's commitment to nonretaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures.

Within 90 days after the Effective Date, each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by CareSource's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within 30 days after becoming a Covered Person or within 90 days after the Effective Date, whichever is later.

CareSource shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such review. Any revised Code of Conduct shall be distributed within 30 days after any revisions are finalized. Each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by the revised Code of Conduct within 30 days after the distribution of the revised Code of Conduct.

2. *Policies and Procedures.* Within 90 days after the Effective Date, CareSource shall implement written Policies and Procedures regarding the operation of its compliance program, including the compliance program requirements outlined in this CIA. In particular, CareSource shall develop and implement policies and procedures that will promote compliance with the Performance Standards set forth in CareSource's Medicaid Managed Care Provider Agreement; ensure accuracy of data submission

relating to CareSource's Medicaid Care Management; and promote compliance with all Federal health care program requirements.

Within 90 days after the Effective Date, the Policies and Procedures shall be distributed to all Covered Persons. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures.

At least annually (and more frequently, if appropriate), CareSource shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, any such revised Policies and Procedures shall be distributed to all Covered Persons.

C. Training and Education

1. *General Training.* Within 90 days after the Effective Date, CareSource shall provide at least two hours of General Training to each Covered Person. This training, at a minimum, shall explain CareSource's:

- a. CIA requirements; and
- b. Compliance Program, including the Code of Conduct.

New Covered Persons shall receive the General Training described above within 30 days after becoming a Covered Person or within 90 days after the Effective Date, whichever is later. After receiving the initial General Training described above, each Covered Person shall receive at least one hour of General Training in each subsequent Reporting Period.

2. *Specific Training.* Within 90 days after the Effective Date, each Relevant Covered Person shall receive at least three hours of Specific Training in addition to the General Training required above. This Specific Training shall include a discussion of:

- a. policies, procedures, and other requirements applicable to the provision of Care Management, and the documentation and submission of Care Management related information to the ODJFS and other Federal health care program payors;
- b. the personal obligation of each individual involved in the Care Management and reporting process to ensure that

information, files and data compiled pursuant to CareSource's Provider Agreement with ODJFS are accurate;

- c. applicable statutes, regulations, and Federal health care program requirements and directives;
- d. the legal sanctions for violations of the Federal health care program requirements; and
- e. examples of proper and improper Care Management, and Care Management reporting practices.

New Relevant Covered Persons shall receive this training within 30 days after the beginning of their employment or becoming Relevant Covered Persons, or within 90 days after the Effective Date, whichever is later.

After receiving the initial Specific Training described in this section, each Relevant Covered Person shall receive at least two hours of Specific Training, in addition to the General Training, in each subsequent Reporting Period.

3. *Board Member Training.* Within the period commencing 90 days prior to, and ending 90 days after the Effective Date, CareSource shall provide to each member of the Board of Directors at least two hours of training that addresses the responsibilities of board members and corporate governance. This training shall be in addition to the General Training described in Section III.C.1. of this CIA.

New members of the Board of Directors shall receive the Board Member Training described above within 30 days after becoming a member or within 90 days after the Effective Date, whichever is later.

4. *Certification.* Each individual who is required to attend training shall certify, in writing, or in electronic form, if applicable, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Compliance Officer (or designee) shall retain the certifications, along with all course materials.

5. *Qualifications of Trainer.* Persons providing the training shall be knowledgeable about the subject area.

6. *Update of Training.* CareSource shall review the training annually, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or the Performance Review, and any other relevant information.

7. *Computer-Based Training.* CareSource may provide the training required under this CIA through appropriate computer-based training approaches. If CareSource chooses to provide computer-based training, it shall make available appropriately qualified and knowledgeable staff or trainers to answer questions or provide additional information to the individuals receiving such training.

D. Review Procedures

1. *General Description*

- a. *Engagement of Independent Review Organization.* Within 120 days after the Effective Date, CareSource shall engage an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter “Independent Review Organization” or “IRO”), to perform reviews to assist CareSource in assessing and evaluating its compliance with Federal health care programs and CareSource’s Provider Agreement as it relates to CareSource’s provision of Medicaid Care Management. The applicable requirements relating to the IRO are outlined in Appendix A to this CIA, which is incorporated by reference.
- b. *Retention of Records.* The IRO and CareSource shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and CareSource) related to the reviews.

2. *Performance Review.* The IRO shall review and evaluate CareSource’s performance of its Medicaid Care Management obligations under the terms of the Provider Agreement with ODJFS (Performance Review). The IRO shall prepare a Performance Review Report, as outlined in Appendix B to this CIA, which is incorporated by reference.

3. *Validation Review.* In the event OIG has reason to believe that: (a) CareSource's Performance Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Performance Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Performance Review complied with the requirements of the CIA and/or the findings or Performance Review results are inaccurate (Validation Review). CareSource shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents. Any Validation Review of Reports submitted as part of CareSource's final Annual Report shall be initiated no later than one year after CareSource's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify CareSource of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, CareSource may request a meeting with OIG to: (a) discuss the results of any Performance Review submissions or findings; (b) present any additional information to clarify the results of the Performance Review or to correct the inaccuracy of the Performance Review; and/or (c) propose alternatives to the proposed Validation Review. CareSource agrees to provide any additional information as may be requested by OIG under this Section III.D.3 in an expedited manner. OIG will attempt in good faith to resolve any Performance Review issues with CareSource prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

4. *Independence and Objectivity Certification.* The IRO shall include in its report(s) to CareSource a certification or sworn affidavit that it has evaluated its professional independence and objectivity and has concluded that it is, in fact, independent and objective.

E. Disclosure Program

Within 90 days after the Effective Date, CareSource shall establish a Disclosure Program that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with CareSource's policies, conduct, practices, or procedures with respect to a Federal health care program believed by the individual to be a potential violation of criminal, civil, or administrative law. CareSource shall appropriately publicize the existence of the disclosure mechanism (e.g., via periodic e-mails to employees or by posting the information in prominent common areas).

The Disclosure Program shall emphasize a nonretaliation policy, and shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Compliance Officer (or designee) shall gather all relevant information from the disclosing individual. The Compliance Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, CareSource shall conduct an internal review of the allegations set forth in the disclosure and ensure that proper follow-up is conducted.

The Compliance Officer (or designee) shall maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews.

F. Ineligible Persons

1. *Definitions.* For purposes of this CIA:

- a. an "Ineligible Person" shall include an individual or entity who:
 - i. is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or
 - ii. has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

- b. "Exclusion Lists" include:
 - i. the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at <http://www.oig.hhs.gov>); and
 - ii. the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at <http://www.epls.gov>).

2. *Screening Requirements.* CareSource shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements:

- a. CareSource shall screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process, shall require such Covered Persons to disclose whether they are Ineligible Persons.
- b. CareSource shall screen all current Covered Persons against the Exclusion Lists within 90 days after the Effective Date and on an annual basis thereafter.
- c. CareSource shall implement a policy requiring all Covered Persons to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

Nothing in Section III.F affects CareSource's responsibility to refrain from (or liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by excluded persons. CareSource understands that items or services furnished by excluded persons are not payable by Federal health care programs and that CareSource may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether CareSource meets the requirements of Section III.F.

3. *Removal Requirement.* If CareSource has actual notice that a Covered Person has become an Ineligible Person, CareSource shall remove such Covered

Person from responsibility for, or involvement with, CareSource's business operations related to the Federal health care programs and shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the Covered Person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions.* If CareSource has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), or is proposed for exclusion during the Covered Person's employment or contract term, CareSource shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the Care Management provided by CareSource to any beneficiary under any Federal health care program.

G. Notification of Government Investigation or Legal Proceedings

Within 30 days after discovery, CareSource shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to CareSource conducted or brought by a governmental entity or its agents involving an allegation that CareSource has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. CareSource shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the investigation or proceedings, if any.

H. Repayment of Overpayments

1. *Definition of Overpayments.* For purposes of this CIA, an "Overpayment" shall mean the amount of money CareSource has received in excess of the amount due and payable under:

- a. any Federal health care program, or
- b. any Medicaid Managed Care Provider Agreement between CareSource and ODJFS, or another state payor.

2. *Repayment of Overpayments*

- a. If, at any time, CareSource identifies any Overpayment, CareSource shall repay the Overpayment to the appropriate payor (e.g., ODJFS, or other Federal health care payor) within 30 days after identification of the Overpayment and take remedial steps within 60 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. If not yet quantified, within 30 days after identification, CareSource shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor's policies.
- b. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

I. Reportable Events

1. *Definition of Reportable Event.* For purposes of this CIA, a "Reportable Event" means anything that involves:
 - a. a substantial Overpayment;
 - b. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;
 - c. the employment of or contracting with a Covered Person who is an Ineligible Person as defined by Section III.F.1.a; or

- d. the filing of a bankruptcy petition by CareSource.

A Reportable Event may be the result of an isolated event or a series of occurrences.

2. *Reporting of Reportable Events.* If CareSource determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, CareSource shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists.

3. *Reportable Events under Section III.I.1.a.* For Reportable Events under Section III.I.1.a, the report to OIG shall be made at the same time as the repayment to the payor required in Section III.H, and shall include:

- a. a copy of the notification and repayment to the payor required in Section III.H.2;
- b. a description of the steps taken by CareSource to identify and quantify the Overpayment;
- c. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;
- d. a description of CareSource's actions taken to correct the Reportable Event; and
- e. any further steps CareSource plans to take to address the Reportable Event and prevent it from recurring.

4. *Reportable Events under Section III.I.1.b or c.* For Reportable Events under Section III.I.1.b or c, the report to OIG shall include:

- a. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;
- b. a description of CareSource's actions taken to correct the Reportable Event;

- c. any further steps CareSource plans to take to address the Reportable Event and prevent it from recurring; and
- d. if the Reportable Event has resulted in an Overpayment, a description of the steps taken by CareSource to identify and quantify the Overpayment.

5. *Reportable Events under Section III.I.1.d.* For Reportable Events under Section III.I.1.d, the report to the OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program authorities implicated.

IV. CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Change or Closure of Unit or Location. In the event that, after the Effective Date, CareSource changes locations or closes a business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, CareSource shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change or closure of the location.

B. Purchase or Establishment of New Unit or Location. In the event that, after the Effective Date, CareSource purchases or establishes a new business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, CareSource shall notify OIG at least 30 days prior to such purchase or the operation of the new business unit or location. This notification shall include the address of the new business unit or location, phone number, fax number, the location's tax identification number(s); and the name and address of each Medicare and state Medicaid program contractor with which CareSource currently contracts. Each new business unit or location and all Covered Persons at each new business unit or location shall be subject to the applicable requirements of this CIA.

C. Sale of Unit or Location. In the event that, after the Effective Date, CareSource proposes to sell any or all of its business units or locations that are subject to this CIA, CareSource shall notify OIG of the proposed sale at least 30 days prior to the sale of such business unit or location. This notification shall include a description of the business unit or location to be sold, a brief description of the terms of the sale, and the name and contact information of the prospective purchaser. This CIA shall be binding on

the purchaser of such business unit or location, unless otherwise determined and agreed to in writing by the OIG.

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within 120 days after the Effective Date, CareSource shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (Implementation Report). The Implementation Report shall, at a minimum, include:

1. the name, address, phone number, and position description of the Compliance Officer required by Section III.A, and a summary of other noncompliance job responsibilities the Compliance Officer may have;
2. the names and positions of the members of the Compliance Committee required by Section III.A;
3. a copy of CareSource's Code of Conduct required by Section III.B.1;
4. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be available to OIG upon request);
5. a summary of all Policies and Procedures required by Section III.B (copies of the Policies and Procedures shall be made available to OIG upon request);
6. the following information regarding each type of training required by Section III.C:
 - a. a description of such training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions; and
 - b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions.

A copy of all training materials and the documentation supporting this information shall be made available to OIG upon request.

7. a description of the Disclosure Program required by Section III.E;
8. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this CIA; (d) a summary and description of any and all current and prior engagements and agreements between CareSource and the IRO; and (e) a certification from the IRO regarding its professional independence and objectivity with respect to CareSource;
9. a description of the process by which CareSource fulfills the requirements of Section III.F regarding Ineligible Persons;
10. a list of all of CareSource's locations (including locations and mailing addresses); the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's tax identification number(s); and the name and address of each Medicare and state Medicaid program contractor with which CareSource currently contracts;
11. a description of CareSource's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business; and
12. the certifications required by Section V.C.

B. Annual Reports. CareSource shall submit to OIG annually a report with respect to the status of, and findings regarding, CareSource's compliance activities for each of the five Reporting Periods (Annual Report).

Each Annual Report shall include, at a minimum:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Compliance Officer and any change in the membership of the Compliance Committee described in Section III.A;
2. the Board Committee resolution required by Section III.A.3;

3. a summary of any changes or amendments to CareSource's Code of Conduct required by Section III.B.1 and the reason for such changes, along with a copy of the revised Code of Conduct;

4. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be made available to OIG upon request);

5. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B and the reasons for such changes (e.g., change in contractor policy);

6. the following information regarding each type of training required by Section III.C:

- a. a description of the initial and annual training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions; and
- b. the number of individuals required to complete the initial and annual training, the percentage of individuals who actually completed the initial and annual training, and an explanation of any exceptions.

A copy of all training materials and the documentation to support this information shall be made available to OIG upon request.

7. a complete copy of all reports prepared pursuant to Section III.D, along with a copy of the IRO's engagement letter;

8. CareSource's response to the reports prepared pursuant to Section III.D, along with corrective action plan(s) related to any issues raised by the reports;

9. a summary and description of any and all current and prior engagements and agreements between CareSource and the IRO (if different from what was submitted as part of the Implementation Report);

10. a certification from the IRO regarding its professional independence and objectivity with respect to CareSource;

11. a summary of Reportable Events (as defined in Section III.H) identified during the Reporting Period and the status of any corrective action relating to all such Reportable Events;

12. a report of the aggregate Overpayments that have been returned to the Federal health care programs. Overpayment amounts shall be broken down into the following categories: Medicare, Medicaid (report each applicable State separately, if applicable), and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted pursuant to policies and procedures established by the payor do not need to be included in this aggregate Overpayment report;

13. a summary of the disclosures in the disclosure log required by Section III.E that relate to Federal health care programs (the complete disclosure log shall be made available to OIG upon request);

14. any changes to the process by which CareSource fulfills the requirements of Section III.F regarding Ineligible Persons;

15. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.G. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

16. a description of all changes to the most recently provided list of CareSource's locations (including addresses) as required by Section V.A.10; the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's tax identification number(s); and the name and address of each Medicare and state Medicaid program with which CareSource contracts; and

17. the certifications required by Section V.C.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications. The Implementation Report and each Annual Report shall include a certification by the Compliance Officer that:

1. to the best of his or her knowledge, except as otherwise described in the report, CareSource is in compliance with all of the requirements of this CIA;

2. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful; and

3. to the best of his or her knowledge, CareSource has complied with its obligations under the Settlement Agreement: (a) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (b) not to charge to or otherwise seek payment from federal or state payors for unallowable costs (as defined in the Settlement Agreement); and (c) to identify and adjust any past charges or claims for unallowable costs.

D. Designation of Information. CareSource shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. CareSource shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201

Telephone: 202.619.2078
Facsimile: 202.205.0604

CareSource:

Janet Grant
Executive Vice President and Corporate Compliance Officer
230 North Main Street
Dayton, OH 45402

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt. Upon request by OIG, CareSource may be required to provide OIG with an electronic copy of each notification or report required by this CIA in searchable portable document format (pdf), either instead of or in addition to, a paper copy.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request copies of CareSource's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of CareSource's locations for the purpose of verifying and evaluating: (a) CareSource's compliance with the terms of this CIA; and (b) CareSource's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by CareSource to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of CareSource's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. CareSource shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. CareSource's employees may elect to be interviewed with or without a representative of CareSource present.

VIII. DOCUMENT AND RECORD RETENTION

CareSource shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs and to compliance with this CIA for six years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify CareSource prior to any release by OIG of information submitted by CareSource pursuant to its obligations under this CIA (or otherwise obtained by OIG pursuant to Section VII) and identified upon submission by CareSource as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, CareSource shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

CareSource is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, CareSource and OIG hereby agree that failure to comply with certain obligations as set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CareSource fails to establish and implement any of the following obligations as described in Section III:

- a. a Compliance Officer;
- b. a Compliance Committee;
- c. a written Code of Conduct;
- d. written Policies and Procedures;

- e. the training of Covered Persons, Relevant Covered Persons, and Board Members;
- f. a Disclosure Program;
- g. Ineligible Persons screening and removal requirements;
- h. notification of Government investigations or legal proceedings, and;
- i. reporting of Reportable Events.

2. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CareSource fails to engage and use an IRO, as required in Section III.D, Appendix A, and Appendix B.

3. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CareSource fails to submit the Implementation Report or any Annual Reports to OIG in accordance with the requirements of Section V by the deadlines for submission.

4. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CareSource fails to submit any Performance Review Report in accordance with the requirements of Section III.D and Appendix B.

5. A Stipulated Penalty of \$1,500 for each day CareSource fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date CareSource fails to grant access.)

6. A Stipulated Penalty of \$5,000 for each false certification submitted by or on behalf of CareSource as part of its Implementation Report, Annual Report, additional documentation to a report (as requested by the OIG), or otherwise required by this CIA.

7. A Stipulated Penalty of \$1,000 for each day CareSource fails to comply fully and adequately with any obligation of this CIA. OIG shall provide notice to CareSource stating the specific grounds for its determination that CareSource has failed to comply fully and adequately with the CIA obligation(s) at issue and steps CareSource

shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after CareSource receives this notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1- 6 of this Section.

B. Timely Written Requests for Extensions. CareSource may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after CareSource fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after CareSource receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties

1. *Demand Letter.* Upon a finding that CareSource has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify CareSource of: (a) CareSource's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, CareSource shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event CareSource elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until CareSource cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.d, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that CareSource has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA

1. *Definition of Material Breach.* A material breach of this CIA means:

- a. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A;
- b. a failure by CareSource to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section III.H;
- c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C; or
- d. a failure to engage and use an IRO in accordance with Section III.D, Appendix A, and Appendix B.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by CareSource constitutes an independent basis for CareSource's exclusion from participation in the Federal health care programs. Upon a determination by OIG that CareSource has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify CareSource of: (a) CareSource's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion. (This notification shall be referred to as the "Notice of Material Breach and Intent to Exclude.")

3. *Opportunity to Cure.* CareSource shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

- a. CareSource is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;
- b. the alleged material breach has been cured; or
- c. the alleged material breach cannot be cured within the 30 day period, but that: (i) CareSource has begun to take action to cure the material breach; (ii) CareSource is pursuing such action with due diligence; and (iii) CareSource has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30 day period, CareSource fails to satisfy the requirements of Section X.D.3, OIG may exclude CareSource from participation in the Federal health care programs. OIG shall notify CareSource in writing of its determination to exclude CareSource. (This letter shall be referred to as the "Exclusion Letter.") Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of CareSource's receipt of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and nonprocurement programs. Reinstatement to program participation is not automatic. After the end of the period of exclusion, CareSource may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights.* Upon OIG's delivery to CareSource of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, CareSource shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (DAB), in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within

10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether CareSource was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. CareSource shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders CareSource to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless CareSource requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

- a. whether CareSource was in material breach of this CIA;
- b. whether such breach was continuing on the date of the Exclusion Letter; and
- c. whether the alleged material breach could not have been cured within the 30-day period, but that: (i) CareSource had begun to take action to cure the material breach within that period; (ii) CareSource has pursued and is pursuing such action with due diligence; and (iii) CareSource provided to OIG within that period a reasonable timetable for curing the material breach and CareSource has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for CareSource, only after a DAB decision in favor of OIG. CareSource's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude CareSource upon the issuance of an ALJ's

decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that CareSource may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. CareSource shall waive its right to any notice of such exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of CareSource, CareSource shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

CareSource and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of CareSource.

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA.

C. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

D. OIG may agree to a suspension of CareSource's obligations under this CIA based on a certification by CareSource that it is no longer providing Care Management to any Federal health care program and that it does not have any ownership or control interest, as defined in 42 U.S.C. §1320a-3, in any entity that bills any Federal health care program. If CareSource is relieved of its CIA obligations, CareSource will be required to notify OIG in writing at least 30 days in advance if CareSource plans to resume providing Care Management to any Federal health care program or to obtain an ownership or control interest in any entity that bills any Federal health care program. At such time, OIG shall evaluate whether the CIA will be reactivated or modified.

E. The undersigned CareSource signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

F. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF CARESOURCE

/Pamela B. Morris/

PAMELA B. MORRIS
President and Chief Executive Officer
CareSource

1-31-11

DATE

/Mark R. Chilson/

MARK R. CHILSON
Executive Vice President and General Counsel
CareSource

January 31, 2011

DATE

**ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

/Gregory E. Demske/

1/24/11
DATE

GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.D of the CIA.

A. IRO Engagement

1. CareSource shall engage an IRO that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph D. Within 30 days after OIG receives the information identified in Section V.A.8 of the CIA or any additional information submitted by CareSource in response to a request by OIG, whichever is later, OIG will notify CareSource if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, CareSource may continue to engage the IRO.

2. If CareSource engages a new IRO during the term of the CIA, this IRO shall also meet the requirements of this Appendix. If a new IRO is engaged, CareSource shall submit the information identified in Section V.A.8 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information or any additional information submitted by CareSource at the request of OIG, whichever is later, OIG will notify CareSource if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, CareSource may continue to engage the IRO.

B. IRO Qualifications

The IRO shall:

1. assign individuals to conduct the Performance Review who have expertise in the Medicaid Managed Care guidelines, and the Medicaid Care Management process;

2. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities

The IRO shall:

1. perform each Performance Review in accordance with the specific requirements of the CIA;
2. follow all applicable Medicaid rules, CareSource's Provider Agreement with ODJFS, and managed care guidelines in conducting the Performance Review;
3. if in doubt of the application of a particular Medicaid policy or regulation, request clarification from the appropriate authority;
4. respond to all OIG inquiries in a prompt, objective, and factual manner; and
5. prepare timely, clear, well-written reports that include all the information required by Appendix B to the CIA.

D. IRO Independence and Objectivity

The IRO must perform the Performance Review in a professionally independent and objective fashion, as appropriate to the nature of the engagement, taking into account any other business relationships or engagements that may exist between the IRO and CareSource.

E. IRO Removal/Termination

1. *Provider and IRO.* If CareSource terminates its IRO or if the IRO withdraws from the engagement during the term of the CIA, CareSource must submit a notice explaining its reasons for termination or the reason for withdrawal to OIG no later than 30 days after termination or withdrawal. CareSource must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of the prior IRO or at least 60 days prior to the end of the current Reporting Period, whichever is earlier.

2. *OIG Removal of IRO.* In the event OIG has reason to believe the IRO does not possess the qualifications described in Paragraph B, is not independent and

objective as set forth in Paragraph D, or has failed to carry out its responsibilities as described in Paragraph C, OIG may, at its sole discretion, require CareSource to engage a new IRO in accordance with Paragraph A of this Appendix. CareSource must engage a new IRO within 60 days of termination of the prior IRO or at least 60 days prior to the end of the current Reporting Period, whichever is earlier.

Prior to requiring CareSource to engage a new IRO, OIG shall notify CareSource of its intent to do so and provide a written explanation of why OIG believes such a step is necessary. To resolve any concerns raised by OIG, CareSource may present additional information regarding the IRO's qualifications, independence or performance of its responsibilities. OIG will attempt in good faith to resolve any differences regarding the IRO with CareSource prior to requiring CareSource to terminate the IRO. However, the final determination as to whether or not to require CareSource to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

PERFORMANCE REVIEW

A. Performance Review. The IRO shall conduct the Performance Review annually to cover each of the five Reporting Periods. The IRO shall conduct all components of each Performance Review.

1. *Definitions*. For the purposes of the Performance Review, the following definitions shall be used:

- a. Performance Report: A report or computer systems entry submitted by CareSource to ODJFS manually or electronically through the Care Management System (CAMS), to support CareSource's receipt of monthly Capitation, Maternity, and Incentive (Pay for Performance) payments for Medicaid Care Management services.
- b. Case File: A collection of medical, social, and psychological information and material pertaining to a CareSource Medicaid Managed Care Plan enrollee.
- c. Screening: The process of identifying CareSource Medicaid Managed Care Plan (MCP) members with specific diagnoses or who require high-cost or extensive services (e.g., "Member with Special Health Care Needs" or "MSHCN").
- d. Assessment: The process of determining CareSource Medicaid MCP members' eligibility for Care Management services.
- e. Care Management Services: The coordination and monitoring of treatment rendered to CareSource's Medicaid MCP members with specific diagnoses or who require high-cost or extensive services (e.g., "Member with Special Health Care Needs" or "MSHCN").
- f. Performance Standards: As set forth in the applicable

Medicaid Managed Care Provider Agreement between the ODJFS and CareSource, the performance standards in key program areas (Quality of Care, Access, Consumer Satisfaction and Administrative Capacity) relating to CareSource's provision of Medicaid Care Management.

- g. Data Quality Standards: As set forth in the applicable Provider Agreement between ODJFS and CareSource, standards to ensure completeness and accuracy of CareSource's submissions (e.g., case files, reports, and data entries) to ODJFS regarding CareSource's Medicaid Care Management.
- h. Population: The Population shall be defined as all case files pertaining to persons for whom CareSource claims to have provided Care Management and for which CareSource claimed reimbursement during each 12-month period covered by the Performance Review.
- i. Error Rate: The Error Rate shall be the percentage of case files that do not support CareSource's receipt of monthly Capitation, Maternity, and Incentive (Pay for Performance) payments for Medicaid Care Management services.

2. *Case File Review*. The IRO shall review:

- i. case files;
- ii. reports that CareSource submits to ODJFS; and
- iii. entries CareSource makes into ODJFS's Care Management System (CAMS).

3. *Discovery Sample*. The IRO shall randomly select and review a sample of 75 Case Files (Discovery Sample), along with CareSource's data submissions (Performance Report) pertaining to those files. The Case Files shall be reviewed based on the supporting documentation available at CareSource's offices or under CareSource's control, applicable Medicaid managed care guidelines, and the Performance Standards to determine whether CareSource correctly complied with its Provider Agreement with

ODJFS to provide Care Management.

If the Error Rate (as defined above) for the Discovery Sample is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The guidelines listed above do not imply that this is an acceptable error rate. Accordingly, CareSource should, as appropriate, further analyze any errors identified in the Discovery Sample. CareSource recognizes that OIG or other HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority may also analyze or review Case Files included, or errors identified, in the Discovery Sample or any other segment of the universe.)

4. *Full Sample.* If the Discovery Sample indicates that the Error Rate is 5% or greater, the IRO shall select an additional sample of Case Files (Full Sample) using commonly accepted sampling methods. The Full Sample shall be designed to: (1) estimate the actual Overpayment in the population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate; and (2) conform with the Centers for Medicare and Medicaid Services' statistical sampling for overpayment estimation guidelines. The Case Files selected for the Full Sample shall be reviewed based on supporting documentation available at CareSource or under CareSource's control and applicable Medicaid Care Management regulations and guidance to determine whether payments received under CareSource's Medicaid Provider Agreement with ODJFS were appropriate. For purposes of calculating the size of the Full Sample, the Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, the IRO may use the Case Files sampled as part of the Discovery Sample, and the corresponding findings for those Case Files, as part of its Full Sample, if: (1) statistically appropriate and (2) the IRO selects the Full Sample Case Files using the seed number generated by the Discovery Sample. OIG, in its sole discretion, may refer the findings of the Full Sample (and any related workpapers) received from CareSource to the appropriate Federal health care program payor for appropriate follow-up by that payor.

5. *Systems Review.* If CareSource's Discovery Sample identifies an Error Rate of 5% or greater, CareSource's IRO shall also conduct a Systems Review. The Systems Review shall consist of the following:

- a. a review of CareSource's Care Management in order to evaluate CareSource's compliance with the applicable Performance Standards as they relate to the coordination and monitoring of treatment rendered to CareSource's Medicaid

MCP members with specific diagnoses or who require high-cost or extensive services (e.g., “Member with Special Health Care Needs” or “MSHCN”); and to verify the completeness and accuracy of CareSource’s submissions to ODJFS.

- b. for each Case File in the Discovery Sample and Full Sample that resulted in an Overpayment, the IRO shall review the system(s) and process(es) that generated the error and identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the error.

6. *Other Requirements*

- a. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the Case Files selected as part of the Discovery Sample or Full Sample (if applicable), and CareSource shall furnish such documentation and materials to the IRO prior to the IRO initiating its review of the Discovery Sample or Full Sample (if applicable). If the IRO accepts any supplemental documentation or materials from CareSource after the IRO has completed its initial review of the Discovery Sample or Full Sample (if applicable) (Supplemental Materials), the IRO shall identify in the Performance Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the IRO gave to the Supplemental Materials in its review. In addition, the IRO shall include a narrative in the Performance Review Report describing the process by which the Supplemental Materials were accepted and the IRO’s reasons for accepting the Supplemental Materials.
- b. Case Files without Supporting Documentation. Any Case Files for which CareSource cannot produce documentation sufficient to support CareSource’s Performance Report, shall be considered an error and the total amount of payments received by

CareSource for Medicaid Care Management services, including Capitation, Maternity and Incentive payments, based on such Performance Report shall be deemed an Overpayment. Replacement sampling for Case Files with missing documentation is not permitted.

- c. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Case Files selected in each first sample shall be used (i.e., it is not permissible to generate more than one list of random samples and then select one for use with the Discovery Sample or Full Sample).

7. *Repayment of Identified Overpayments.* CareSource shall repay within 30 days any Overpayment(s) identified in the Discovery Sample or the Full Sample (if applicable), regardless of the Error Rate, to the appropriate payor and in accordance with payor refund policies. CareSource shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor.

B. Performance Review Report. The IRO shall prepare a Performance Review Report as described in this Appendix for each Performance Review performed. The following information shall be included in the Performance Review Report:

1. *Performance Review Methodology*
 - a. Performance Review Population. A description of the Population subject to the Performance Review.
 - b. Performance Review Objective. A clear statement of the objective intended to be achieved by the Performance Review.
 - c. Source of Data. A description of the specific documentation relied upon by the IRO when performing the Performance Review (e.g., case files; medical records, Queue Nurses' questionnaires and notes, physician orders "white sheets," "Missed Queue Call Buckets," monthly purges, computer system entries); Medicaid Managed Care and ODJFS manuals or bulletins (including issue and date); and other policies,

regulations, or directives.

- d. Review Protocol. A narrative description of how the Performance Review was conducted and what was evaluated.
- e. Supplemental Materials. A description of any Supplemental Materials as required by A.6.a., above.

2. *Statistical Sampling Documentation*

- a. A copy of the printout of the random numbers generated by the “Random Numbers” function of the statistical sampling software used by the IRO.
- b. A copy of the statistical software printout(s) estimating how many case files are to be included in the Full Sample, if applicable.
- c. A description or identification of the statistical sampling software package used to select the sample and determine the Full Sample size, if applicable.

3. *Performance Review Findings*

- a. Narrative Results
 - i. A description of CareSource’s Care Management, including the identification, by position description, of the personnel involved CareSource’s Care Management, and the submission of Medicaid Care Management related data and/or reports to ODJFS.
 - ii. A narrative explanation of the IRO’s findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Performance Review, including the results of the Discovery Sample, and the results of the Full Sample (if any).

b. Quantitative Results

- i. Total number and percentage of instances in which the IRO determined that the Performance Report submitted by CareSource differed from what should have been the correct Performance Report (total number and percentage of instances in which the IRO determined that CareSource's failed to meet the Performance Standards set forth in its Provider Agreement with ODJFS) regardless of the effect on the payment.
- ii. Total number and percentage of instances in which the Performance Report Submitted differed from the Correct Performance Report (total number and percentage of instances in which the IRO determined that CareSource's failed to meet the Performance Standards set forth in its Provider Agreement with ODJFS) and in which such difference resulted in an Overpayment to CareSource.
- iii. Total dollar amount of all Overpayments in the sample.
- iv. Total dollar amount of Capitation, Maternity Payments, and Incentive Payments involved in the sample and the net Overpayment associated with the sample.
- v. Error Rate in the sample.
- vi. A spreadsheet of the Performance Review results that includes the following information for each Capitation, Maternity, and Incentive Payments involved: Federal health care program billed, beneficiary health insurance claim number, date of service, allowed amount reimbursed by payor, correct amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct

amount due under the applicable Provider Agreement and Performance Standards.

- d. Recommendations. The IRO's report shall include any recommendations for improvements to CareSource's Medicaid Care Management based on the findings of the Performance Review.

4. *Systems Review Findings*. The IRO shall prepare a Systems Review Report based on the Systems Review performed (if applicable) that shall include the IRO's observations, findings, and recommendations regarding:

- a. the strengths and weaknesses in CareSource's Medicaid Care Management;
- b. the strengths and weaknesses in CareSource's Medicaid Care Management data submissions processes; and
- c. possible improvements to CareSource's Medicaid Care Management and data submissions systems and processes to address the specific problems or weaknesses that resulted in the identified Overpayments.

5. *Credentials*. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Performance Review and (2) performed the Performance Review.