No. COM-001	Anti-Fraud Policy	
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ANTI FRAUD POLICY

The Anti-Fraud Plan organizes and implements Canopy Health's Anti-Fraud strategy for (1) identifying fraud; (2) reducing costs to Canopy Health, providers, enrollees, and others caused by fraudulent activities; and (3) protecting Canopy Health's enrollees through timely detection, investigation and prosecution of suspected fraud. Under the Anti-Fraud Plan, Canopy Health will conduct fraud investigations and train plan personnel and contractors in the detection of health care fraud. The Anti-Fraud Plan also sets out Canopy Health's internal procedures for managing incidents of suspected fraud and for referring suspected fraud to appropriate government agencies. The Anti-Fraud Plan provides for the submission of an annual written report to the Department of Managed Health Care describing Canopy Health's efforts to deter, defeat and investigate fraud, and to report cases of fraud to a law enforcement agency.

The Anti-Fraud Plan elements include, but are not limited to:

- The designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations, as needed;
- Training of Network personnel and contractors concerning the detection of health care fraud;

- Canopy Health's procedure for managing incidents of suspected fraud
- Internal procedures for referring suspected fraud to the appropriate government agency.

Canopy Health provides the Department of Managed Health Care ("DMHC") an annual written report describing Canopy Health's efforts to deter, detect, and investigate fraud and any changes Canopy Health has made to improve efforts to combat health care fraud.

DEFINITIONS

Fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit and/or fraudulent use of medical insurance information.

Identity Theft is a fraud committed or attempted using identifying information of another person without authority.

Identity Abuse is a fraud committed by providing one's identity to another for the purpose of allowing that person to access one's benefits and services for themselves.

Protected Health Information (PHI) is individually identifiable health information (as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and identifying information as defined by the Federal Government in the Red Flag Rules (16 CFR § 681).

I. REPORTING HEALTHCARE FRAUD

A. Canopy Health will routinely publicize the Anti-Fraud reporting systems to employees, providers and other contractors. All Canopy Health employees will be provided information about the Anti-Fraud Plan upon their employment or retention and no less than annually, which will include information addressing:

1. What issues arise from fraud?
2. What is going on in the health care industry in terms of fraud?
3. What are examples of fraud in health care?
4. What are the government's requirements?
5. What is Canopy Health doing to address fraud?
6. What systems are currently in place to prevent and address fraud?
7. What continuing efforts has Canopy Health undertaken to prevent and address fraud?

B. An individual who suspects fraudulent activities within Canopy Health should immediately report it to his/her supervisor providing as much detail as possible regarding the suspected fraud. If an individual is uncomfortable reporting the suspected fraud to a supervisor, the reporting individual can call the Hotline (see Section I.C, below) or report the suspected fraud to the Chief Executive Officer or a member of Canopy Health's Board of Directors ("Board"). The Chief Executive Officer supervises the Canopy Health Compliance program. Canopy Health will attempt to keep all information confidential except to the limited extent it may be necessary to disclose the information to complete a comprehensive investigation, and as allowed by law.

C. Canopy Health will not retaliate against any person who reports an incident and individuals who choose to report anonymously may do so. Any individual, contractor, patient or employee may call Canopy Health's 24-Hour Hotline **1-833-480-0010** and leave a message regarding the suspected fraudulent or abusive activity. This message can either be anonymous or the reporting individual can leave their contact information.

D. Inquiries concerning the antifraud plan are directed to Renee Scott, Compliance Officer, 415-813-5947.

II. TRIGGERING AND CONDUCTING AN INVESTIGATION

A. The person receiving the information regarding suspected fraud will refer it to the Chief Executive Officer ("CEO") who will confer with the appropriate Board committee and/or the Chief Medical Officer, as appropriate. The occurrence of alleged misconduct or fraud will be reported to the Board through reports, as necessary, by Legal Counsel.

B. Sources of alleged fraud may include, but are not limited to:

1. Verbal allegations by identified staff (in person);
2. Verbal allegations by proxy;
3. Written allegations by a known party;
4. Public allegations;
5. Anonymous allegations (phone calls, written communication);
6. External allegations and referrals brought by partners, contractors, agents, or other external organizations.
7. Unusual occurrences or improper activities detected by staff and reported to the CEO.

C. If an initial determination of possible fraudulent activity is made, the Compliance Officer and/or designee conducts an investigation. In turn, that individual will consult a group of designated individuals who previously trained in health care fraud investigative techniques and form a Fraud Investigation Team, or—will contract with an external fraud investigator if appropriate, as determined by the Chief Executive Officer.

D. The Compliance Officer and/or the Fraud Investigation Team will initially evaluate the allegations and determine whether an investigation should be launched. If the issue is time sensitive, the Compliance Officer and/or the Chief Medical Officer will determine the necessity and timing of the investigation, based on the initial allegations the gravity of the incident and potential exposure.

E. The Fraud Investigation Team's responsibilities will be to:

1. Conduct investigation(s), seek evidence using investigative techniques such as:
    a. Auditing;
    b. Sampling;
    c. Interviews/questionnaires;
    d. Review of written communication and documentation (hard copy, electronic);
    e. Site visits;
    f. Log verifications.
2. Prepare a written report for the Board which includes the following:
    a. Type of occurrence;
    b. Allegation as charged;
    c. Date and time of purported occurrence;

d. Date and time the incident was reported;
e. Persons involved (use anonymity protection devices for
f. information sources if necessary);
g. Investigative methods;
h. Evidence found;
i. Potential exposure (monetary, quality of care, reputation, stakeholders)
j. Attachment of applicable policies and procedures;
k. Conclusions and recommendations.

III. REFERRING/REPORTING

A. The Compliance Officer will review and analyze the Fraud Investigation Team's report and the evidence discovered during the investigation.

B. The Compliance Officer, along with the CEO, Chief Medical Officer and appropriate Board designee will determine the appropriate disposition of the matter depending on the gravity of the exposure.

IV. MAKING DETERMINATION

A. In addition to any other operational actions that may result from the investigation, the following are general guidelines as to the determinations that may be made based on the investigation results.

Investigation Results	*Possible Determination*
No evidence of wrongdoing	Close case
Insufficient facts	▪ Conduct further investigation to determine whether new evidence will surface and

	conduct further investigation to make a better determination. ▪ Close case
Inconclusive investigation	▪ Close case ▪ Refer for future audit
Negligent wrongdoing/ Intentional wrongdoing	▪ Corrective action plan ▪ Warning ▪ Sanction ▪ Referral to law enforcement ▪ Report to appropriate regulatory agency
Fraud Waste and/or Abuse	▪ Warning ▪ Corrective Action ▪ Sanction ▪ Referral to law enforcement ▪ Report to appropriate regulatory agency

B. If a corrective action plan is required:

1. Stress its timeliness so that there are no grounds for additional, more serious punishment;
2. Designate team or person responsible for monitoring implementation;
3. Check progress in future audit;
4. Follow-up report, as necessary, on implementation of corrective action plan to Chief Operating Officer for determination and resolution.

V. QUALITY MANAGEMENT COMMITTEE

A. Annually assess:

1. Types of occurrences being reported (track and trend);
2. Quality and methods of investigations;
3. Quality of reports;

4. Quality of training provided.

B. Make recommendations to improve processes and refine the Anti-Fraud Plan, as needed.

C. The Compliance Officer and/or CEO report to the Board on a quarterly basis, the numbers and types of fraudulent activities reported.

D. Quality management issues should be referred to the Quality Management Committee.

VI. FRAUDULENT INVESTIGATION TEAM

A. Canopy Health will designate individuals who will lead an investigation upon request of the Compliance Officer. These individuals will be selected based on their expertise.

B. The Compliance Officer and the CMO will identify individuals who are appropriately trained to conduct and lead investigative teams for both common occurrences of health fraud and unusual types of fraud. These individuals may or may not be employees of Canopy Health depending upon the type of investigation.

C. Should a conflict of interest issue arise in the investigation or referral of a suspected instance of fraud, or if Compliance Officer determines that an external review of suspected fraud is necessary, the case is referred to outside counsel or a fraud investigation contractor for resolution.

VII. REFERRALS

A. **Regulatory:** Depending on the nature of fraud cases, Canopy Health may refer cases to the appropriate regulatory authority. Such referrals may be made to the local Department of Public Health, California Department of Health Services, DMHC, Centers for Medicare & Medicaid Services,

California medical licensing and disciplinary boards or any other appropriate agencies.

B. **Law Enforcement:** If the occurrence of fraudulent activity is confirmed, Canopy Health may refer cases to the appropriate local, state or federal authority for prosecution of health care fraud by enrollees, providers, agents, company employees, and other individuals. Referrals may be made to local police departments, the U.S. Postal Inspector, the Federal Bureau of Investigation, the Office of the Inspector General of the U.S. Department of Health and Human Services, the Internal Revenue Service or any other appropriate authority.

C. **Civil Prosecution:** In the event of fraud, the CEO or a member of the Board will evaluate the appropriateness of pursuing civil prosecution. Canopy Health will contact legal counsel as needed.

VIII. REPORTING TO THE DMHC

A. At least annually beginning in January 2016 and no later than January 31 of each year, Canopy Health shall submit to the DMHC an annual written report describing Canopy Health's efforts to deter, detect, and investigate fraud. The report shall include:

1. Results of investigations;
2. Cases of fraud that were reported to a law enforcement agency; and
3. Number of cases prosecuted (if known by Canopy Health).

IX. PREVENTING IDENTITY THEFT

A. To prevent identity theft, personal identification and financial information, including that designated as Protected Health Information ("PHI") maintained by Canopy Health must be kept confidential. Network employees (from the most senior to the most junior employee) must remain vigilant and be aware of the possibility of potential identity theft opportunities at Canopy Health. For that reason, Network employees and non-Network employees (including contractors and subcontractors), and anyone else who may be exposed to member PHI and financial information must remain vigilant for signs and indicators of identity theft. This can include, but is not limited to, the following examples:

1. **Medical identity theft or abuse.** An example of medical identity theft commonly involves someone stealing another's identity and either obtaining medical insurance in their name or using their current medical insurance policy or identification card to obtain treatment or prescriptions. If the person with coverage knowingly lends their "identity" to another individual to obtain treatment or coverage, this is considered medical identity abuse and both parties are subject to investigation and consequences. Network staff must remain vigilant with regard to the potential of one individual using either the identification card of another individual or using a false identification card (either with or without the permission of the other individual). Such incidents, or reasonably suspected incidents, must be reported immediately to a supervisor and then immediately to the Compliance Officer.
2. **Social Security Number ("SSN") identity theft.** An example of identity theft commonly involves someone stealing another

individual's SSN and obtaining employment or other government or non-government benefits in that other person's name. Vigilance is required at all times to maintain confidentiality and awareness of potential theft as medical charts and other health plan member information commonly contain SSNs.

3. **Credit identity theft.** Someone uses another individual's information to obtain loans, goods, or services and does not pay the bills. Vigilance is required at all times to maintain confidentiality and awareness of potential theft as medical charts commonly contain, as part of the patient's PHI, SSN, the patient's home address, phone number, age, and other identifying information that would allow the thief to use the chart or health plan membership information to apply for a credit card using another's identity.

B. Although there are three examples noted above, any mode or method of identity theft is relevant for the purposes of this Anti-Fraud Plan. Any and all suspected or known misuses of another individual's PHI, including any action or inaction that might also reasonably indicate such misuse, should be reported immediately both to the employee's supervisor and then to the Chief Operating Officer.

X. TRAINING AND EDUCATION

A. Canopy Health recognizes that the most effective way to combat fraud is to increase staff awareness through education. Canopy Health is therefore committed to the education and training of staff and providers on fraud and fraud prevention.

B. Working closely with Canopy Health's Board and CEO, Canopy Health will develop a strategic approach to educating Network staff about fraudulent activities that occur in health care environments. Information about fraud and Canopy Health's response to fraud will be disseminated to all staff. This training will be a regular part of Canopy Health's new employee orientation. An annual training session will be required for staff working in high-risk departments (*i.e.*, Accounting and Finance and Medical Records). Education and Training activities related to fraud prevention will include:

1. Canopy Health will provide information regarding the detection, prevention and investigation of fraudulent activity to all new staff during initial employment orientation. Employees will also be notified in writing of the procedures for reporting fraud and that there is no retribution taken against individuals reporting fraud.
2. Canopy Health will conduct periodic training sessions, as deemed necessary by the Board, for the purpose of educating staff on specific areas of concern relating to fraudulent activity.
3. Canopy Health staff will provide contracted providers with information regarding fraud and Canopy Health's response to fraudulent activity, and will notify contracted providers of their responsibility to report any abuse.
4. Canopy Health will inform each contractor of the Anti-Fraud Plan and procedures for investigating incidences of suspected fraud.
5. External experts for training will be consulted, as necessary, to augment and implement Canopy Health's training program.

XI. CONTRACTED PROVIDERS

A. Canopy Health contracts with certain independent practice associations based in the San Francisco Bay Area along with other providers, such as acute care hospitals, for the provision of health care services. Canopy Health's CMO is responsible for oversight of the delegated quality assurance activities implemented by contracted providers.

B. General oversight mechanisms include:

1. Providing contracted providers with a copy of the Anti-Fraud Plan.
2. Providing contracted providers with Canopy Health's quality management policies.
3. Ensuring contracted providers maintain the appropriate licenses and address deficiencies identified in audits or surveys by licensing agencies such as the Department of Health Services.
4. Investigating complaints and grievances and implementing corrective action when necessary.
5. Reviewing Canopy Health's contracted providers on an annual basis.
6. Evaluating written reports, implementing corrective action when necessary and providing feedback to the contracted providers.

XII. FREEDOM FROM RETALIATION AND AVOIDING CONFLICTS OF INTEREST

A. Canopy Health promotes an environment free from retaliation or threats of retaliation against individuals who report suspected fraud. As applicable, Canopy Health complies with section 3730(h) of Title 31 of the United States Code, which prohibits employer discrimination against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the Federal False Claims Act. In training sessions with employees regarding Canopy Health's Anti-Fraud

efforts, employees will be informed that there is no retaliation against employees for reporting fraudulent activities. Employees are also notified in writing of the procedures for reporting fraudulent activities, including that there is no retaliation against individuals for reporting fraudulent activities. If the reporting party still has concerns about retribution, the reporting party may choose to remain anonymous.

B. If the CEO or a member of the Board has a conflict of interest regarding an incident of suspected fraud, the individual must report the conflict of interest to the Board of Directors and disassociate him/herself from the relevant investigation. If appropriate, the investigation will be referred to outside counsel for investigation.

XIII. EXPERIENCE SUMMARY OF ANTI-FRAUD CONTACT

A. Renee Scott is the Compliance Officer at Canopy Health and is the contact person for anti-fraud items. Her experience is noted below:

   1. Ms. Scott has over 35 years of experience in health plan organizations, including 25 years in leadership roles including member services administration. Her prior experience includes responsibility for overseeing the investigation and disposition of fraudulent activities. Examples of those investigative outcomes include terminating membership based on misrepresentation of identity, living outside the service area, and inappropriate access and use of medical information.

B. To the extent fraud investigation is required, Canopy Health's outside legal counsel, Manatt, Phelps & Phillips ("Manatt"), will provide services relating to the management of such fraud investigations. Renee Scott will be the

contact person within Canopy Health who is responsible for communicating and coordinating with Manatt regarding any fraud investigation. A description of Manatt specific investigative expertise and experience in the management of fraud investigations is provided below:

1. Manatt has many regulatory, transaction, and compliance lawyers in offices located across the United States, with an established health care practice. Manatt regularly advises clients in connection with developing and improving internal mechanisms to enhance compliance and minimize risk of fraud in light of frequent legal, regulatory and policy changes. Manatt team is comprised of well-respected and nationally renowned lawyers across the United States, including:
    a. Charles Weir, Partner, has significant experience in investigations by the US Department of Justice, the US Securities and Exchange Commission, and the Department of Health and Human Services Office of Inspector General. He has guided many organizations across industries through internal investigations and responding to government subpoenas and information demands. He has experience representing major healthcare providers and has been involved in complex matters ranging from qui tam claims to suits brought under the False Claims Act, the California False Claims Act and Section 1871 of the California Insurance Code.
    b. Former government lawyers who led the health care fraud unit for their jurisdictions.

c. Lawyers who have extensive experience conducting investigations and negotiating settlements and corporate integrity agreements in some of the largest settlements obtained by the United States.
d. Numerous regulatory and compliance lawyers with extensive experience in Stark Law, the Anti-Kickback Statute and its safe harbor regulations, HIPAA and fraud and abuse prevention.

Revision History:

Version Date	Edited By	Reason for Change
9/26/16	M. Durbin	Creation date
1/11/18	R. Munson	Updated with Robb Munson as contact for anti-fraud questions per DMHC request via MWE
2/8/18	R. Munson	Updated with Robb's experience and removed "/legal counsel" after compliance officer per DMHC filing requirements
6/1/18	R. Scott	Updated with new 800 number.
1/25/19	R. Scott	Updated with additional information regarding the Chief Operating Officer's role and investigative information related to McDermott Will & Emery LLP.
1/1/20	R. Scott	Updated for change of firm to Manatt, Phelps & Phillips, LLP and lead investigator to Charles Weir.
4/1/20	R. Scott	Updated for elimination of the Chief Operating Officer position.