

MAX VISION CARE

EXHIBIT J-8 Anti Fraud Plan

Introduction

Max Vision Care, Inc. ("MVC") has developed an anti-fraud plan in compliance with Section 1348 of the California Health and Safety Code to facilitate the timely detection and investigation of suspected fraud, and the implementation of necessary corrective actions to avoid any recurrence of fraud. The anti-fraud plan organizes and implements an anti-fraud strategy for MVC that identifies and reduces costs to the plan, its providers, subscribers, enrollees and others caused by fraudulent activities, and protects consumers in the delivery of health care services through the timely detection, investigation and prosecution of suspected fraud.

MVC's Board of Directors is responsible for overseeing MVC's anti-fraud plan. The Chief Executive Officer is responsible for implementing MVC's anti-fraud plan and will make quarterly reports to Board of Directors regarding anti-fraud activities, to enable the Board of Directors to monitor the anti-fraud plan and recommend any necessary changes.

In instances where fraud is suspected, MVC's Chief Executive Officer works in consultation with other MVC management staff and outside counsel, where necessary, to investigate all credible allegations of fraud.

Inquiries concerning MVC's anti-fraud plan may be directed to MVC's Chief Executive Officer, Richard Hopping, O.D., at (866) 557 – 0518.

MAX VISION CARE, INC.
ANTI-FRAUD PLAN

Pursuant to Health and Safety Code Section 1348, Max Vision Care's ("MVC") anti-fraud plan includes, but is not limited to, the following requirements: (1) the designation of an organization with specific investigative expertise in the management of fraud investigations; (2) training of personnel and contractors concerning the detection of health care fraud; (3) procedures for managing incidents of suspected fraud; and (4) procedures for referring suspected fraud to the appropriate government agency.

I. Designation of an Organization with Specific Investigative Expertise in the Management of Fraud Investigations

MVC has designated the law firm of Miller & Holguin as its fraud investigator. Miller & Holguin has substantial experience in the management of fraud investigations.

II. Training of Personnel and Contractors Concerning the Detection of Health Care Fraud

MVC recognizes the importance of properly educating and training its personnel and contractors to detect fraud by MVC, MVC's providers and MVC's enrollees. As part of its anti-fraud plan, MVC requires its personnel and contractors to receive the following training in the detection of health care fraud:

A. Training of MVC Personnel

All MVC personnel will be trained in the detection of fraud annually, and all new personnel will be trained in the detection of fraud upon hire.

The training of MVC personnel will include a general training session for all MVC personnel regarding the most common types of health care fraud that impact managed care organizations, and may include specialized training for MVC personnel who work in the enrollment, credentialing, claims and marketing areas regarding the identification and detection of fraud that is likely to specifically impact their jobs. In addition, the Chief Executive Officer shall establish such other training and dissemination of information to all employees concerning the necessity of complying with all applicable laws and regulations, and shall keep MVC personnel abreast of current trends and issues relating to fraud and abuse on an ongoing basis through informational bulletins and discussions.

MVC personnel shall sign an Employee Statement of Understanding regarding the anti-fraud plan both at the time of their initial anti-fraud training, and thereafter on a yearly basis (see Attachment "A"). All such signed Statements of Understanding shall be kept in each employee's personnel file.

B. Training of MVC's Contracted Providers

All of MVC's contracted providers will receive a copy of MVC's anti-fraud plan, and will be required to either adopt and comply with MVC's anti-fraud plan, or to have their own anti-fraud plan/compliance program in place that meets or exceeds the standards of MVC's anti-fraud plan. MVC will also issue provider communications from time to time concerning fraud detection and related issues.

C. Areas of Training

Training includes an overview of health care fraud, a summary of the applicable fraud and abuse laws, training on how to identify potentially fraudulent claims (including indicators of fraud), examples of fraudulent activity that has been uncovered, and the procedure for referring suspected fraudulent activity to the Chief Executive Officer.

Training topics will include, but not be limited to, methods of detecting the following types of fraud:

- (1) Detection of Fraud by the Plan
 - (a) Marketing – Using marketing techniques that coerce, mislead or confuse potential enrollees, and engaging in marketing that discriminates among potential enrollees based on their health status.
 - (b) Underutilization/Quality of Care – Failing to employ or contract with sufficient providers to accommodate all enrollees; failing to provide geographically reachable services to enrollees; and categorically denying payment of claims.
 - (c) Enrollment Fraud – Using unnecessarily complex disenrollment procedures and materials.
 - (d) Licensure/Credentialing – Not adequately credentialing providers; contracting with unlicensed providers.
 - (e) Kickbacks – Accepting kickbacks in order to refer certain patients to a particular provider.
- (2) Detection of Fraud by Providers
 - (a) Marketing – Failing to comply with the applicable licensing board's advertising guidelines.

- (b) Kickbacks – Providers paying kickbacks to MVC employees in order to be referred patients.
 - (c) False Claims – Billing for services that were never performed or were not medically necessary; and waivers of copayments or deductibles.
 - (d) Licensure/Credentialing – Misrepresenting licensure status to MVC.
- (3) Detection of Fraud by Enrollees
- (a) Enrollment Fraud – Enrollees claiming to be eligible for MVC health coverage when they are, in fact, ineligible.
- (4) Identification of Possible Indicators of Fraud

The training will emphasize that certain circumstances may be indicative of fraudulent activity, and should be reviewed further. Such circumstances include, but are not limited to, the following:

- (a) Inconsistency between the services billed and the services rendered.
- (b) A provider's advertisement of "free" services.
- (c) An unusually high number of patients/patient visits in a given time frame.
- (d) A provider's lack of supporting documentation for a claim selected for audit.
- (e) A high-dollar claim for services dated soon after the effective date of coverage or just before the termination of coverage.

III. Procedures for Managing Incidents of Suspected Fraud

Upon reports or reasonable indications of fraud, the Chief Executive Officer will promptly initiate steps to investigate the conduct in question to determine whether fraudulent activity has occurred. As needed, the fraud investigator will be requested to conduct the investigation. If the Chief Executive Officer and/or fraud investigator determines that fraudulent activity has occurred, the Chief Executive Officer will develop an appropriate response, as described below.

A. Discovery of Fraudulent Activities

- (1) Reporting incidents of suspected fraud – All MVC personnel are responsible for preventing, detecting and reporting suspected fraud. If an employee

detects any suspicious activity, he or she is required to notify the Chief Executive Officer. The person reporting fraud may make himself/herself known by reporting the suspected fraud in person, or may report the suspected fraud anonymously via inter-office mail or U.S. Mail.

The manager of each department will be responsible for the early detection of fraud within his or her department. If fraud is suspected within a department, that department's manager is required to immediately notify the Chief Executive Officer. Each manager's performance evaluation will be based in part on his or her efforts to detect fraud.

- (2) Implementation of a Monitoring and Audit Program – The Chief Executive Officer will implement a monitoring and audit program, as necessary. Through the use of ongoing auditing and monitoring, the Chief Executive Officer will investigate any changes from the baseline audit that may be indicative of fraud. Ongoing auditing and monitoring will enable MVC to gather some of the information MVC will need to make annual reports to the Department of Managed Health Care as required by Health and Safety Code Section 1348(c).

As determined to be necessary by the Chief Executive Officer, the implementation of the monitoring and audit program may involve the following steps:

- (a) Interviewing personnel involved in enrollment, credentialing, claims, marketing and related areas to detect potential improper conduct.
- (b) Reviewing medical and financial records and other source documents that support claims for reimbursement.
- (c) Reviewing written materials and documentation prepared by the different departments within MVC.

B. Investigate the Incident to Determine whether there is a Violation of Law/Regulation/MVC Policy

The Chief Executive Officer or his or her designee will investigate all credible incidents of suspected fraud that are reported, and all credible incidents that are uncovered pursuant to the auditing and monitoring program. The investigation will involve interviews and document review. In the case where employee fraud is suspected, the Chief Executive Officer will determine whether the employee should be removed from his or her duties until the investigation is completed, and whether or not immediate steps should be taken to prevent the destruction of documents or other evidence relevant to the investigation. The Chief Executive Officer shall record

the progress of the investigation, including the results of interview and document reviews.

C. *Take Appropriate Remedial Measures*

If fraudulent activity has occurred, the Chief Executive Officer will consult with the manager of the department in which the fraudulent activity has occurred to determine the appropriate action necessary to correct the matter. The following remedial measures will be taken, as applicable:

- (1) Deny/recoup payment – If the fraudulent activity involves payment to a provider or to an enrollee, the payment will be denied if not yet made, and will be recouped if already made.
- (2) Terminate contract/discipline employee appropriately – If appropriate, contracts with providers will be terminated, and employees will be disciplined. Corrective action will be based upon the individual circumstances and the severity of the incidents. All personnel will be disciplined similarly, regardless of their position within MVC.
- (3) File appropriate reports – If fraudulent behavior constitutes a reportable offense, a report will be made to the appropriate entity. Examples include reports required by Business & Professions Code §805, and reports required by the National Practitioner Data Bank.
- (4) Notify appropriate government agencies – See Section 5, below.
- (5) Take further remedial measures – In order to decrease the possibility that fraud will reoccur, the Chief Executive Officer will educate MVC personnel and contractors regarding how to avoid the recurrence of any fraudulent activities that are discovered. In addition, the Chief Executive Officer will undertake additional investigations if it appears there may be a continuing pattern of fraud.

IV. Procedures for Referring Suspected Fraud to the Appropriate Government Agency

MVC is committed to aggressively investigating suspected fraud, and is committed to referring fraud for prosecution, as appropriate. At least annually, MVC shall submit a report to the Department of Managed Health Care regarding MVC's adherence to its anti-fraud plan generally, and the results of investigations conducted by MVC regarding suspected fraud.

The Chief Executive Officer will discuss the findings of fraud investigations with legal counsel to determine whether or not a violation of federal or state law or health care program requirements has occurred, whether or not the conduct should be disclosed to a governmental agency, and, if so, to which agency.

Such disclosure will observe the following guidelines:

- Providers that are found to be in violation of state licensing requirements will be reported to the appropriate state licensing board.
- Plan employees, providers or enrollees who are found to be in violation of other state laws will be reported to the District Attorney's Office.
- Providers that are found to be in violation of a federal criminal, civil or administrative law related to a federal health care programs will be reported to the Office of Inspector General, Department of Justice or the Centers for Medicare and Medicaid Services, as appropriate.
- Plan employees, providers or enrollees who are found to be in violation of other federal laws will be reported to the Department of Justice/U.S. Attorney's Office.

Anti-Fraud Plan Oversight

MVC's Board of Directors is responsible for overseeing MVC's anti-fraud plan. The Chief Executive Officer is responsible for implementing MVC's anti-fraud plan and will make quarterly reports to Board of Directors regarding anti-fraud activities, to enable the Board of Directors to monitor the anti-fraud plan and recommend any necessary changes.

A T T A C H M E N T A

EMPLOYEE STATEMENT OF UNDERSTANDING

I certify that I have read and understand the Max Vision Care, Inc. ("MVC") Anti-Fraud Plan and agree to abide by it during the entire term of my employment. I acknowledge that I have a duty to report to the Chief Executive Officer any actual or suspected violation of any laws, regulations, MVC policies and procedures or the Anti-Fraud Plan. Unless otherwise noted below, I am not aware of any possible such violations at this time. I also certify that I have not been convicted of, or charged with, a criminal offense related to health care, nor have I been listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.

I agree to promptly report any actual or suspected violations of which I become aware to the Chief Executive Officer. I understand that any violation of any laws, regulations, the Anti-Fraud Plan or any other MVC policy or procedure is grounds for disciplinary action, up to and including discharge from employment.

[Please use the back of this page if more space is needed.]

Date

Signature

Print/Type Name

Position

Please return this form to _____ for filing in the employee's personnel file.