CASTLESTONE

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September 24, 2015

Hon. Nikki Haley
Governor of South Carolina
1205 Pendleton Street
Columbia, SC 29201

Dear Governor Haley:

South Carolina, like most states, spends a significant portion of its budget on Medicaid. As the program takes up more of the State financial resource, fraud and abuse grows as well. We propose to assist you in reducing the spending in the program.

The Department of Health and Human Services Inspector General has recommended that Medicaid programs closely calculate the return on investment of the anti-fraud efforts. We propose not only to do that, but to put our fees at risk accordingly.

Attached is an unsolicited proposal for Castlestone to implement its anti-fraud services for the State Medicaid program. If we are not successful, the State can reclaim up to 50% of our fees. If we deliver more than a 50% Return on Investment, Castlestone would earn performance fees.

Obviously, we are confident that we can help you reduce the cost of Medicaid for the State of South Carolina. We look forward to working with your Administration to accomplish just that.

Sincerely,

Jeff Leston
President
Enclosure

South Carolina Medicaid Program

Fraud Prevention and Identity Protection
Project Proposal

Presented by Castlestone Advisors

9/25/2015

Jeff Leston
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CASTLESTONE Advisors LLC

Castlestone Advisors is pleased to present this unsolicited proposal to prevent fraud and abuse in the South Carolina Medicaid plan. Our proposal will enhance the statewide efforts to reduce Medicaid costs. We propose to use our proprietary services to prevent, detect and deter fraud and abuse in the health plan, as well as protect the identities of members from being used to file false health claims.

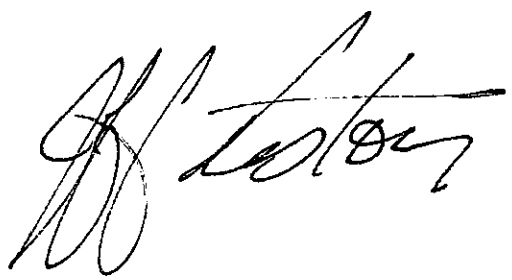
Castlestone proposes to put our fees at risk to demonstrate that our service can prevent detect and deter frauds in a range of outpatient services. We will earn our fees if and when only we demonstrably reduce costs to the plan.

This proposal reflects our experience and effectiveness in using existing technologies and infrastructure. This makes our process low cost, highly reliable and a powerful oversight tool as well as deterrent. Our approach also minimizes any impact on provider offices and existing systems, important for uptake and acceptance.

We understand that Managed Care Organizations (MCO) are payers for the Medicaid plan. Recent audit reports at the State and Federal level has shown that MCOs often do not actively pursue fraud and abuse, and we will act as an overseer to their efforts as well.

We are dedicated to providing real-world, practical solutions that address the issues that healthcare executives face. We look forward to serving the State of South Carolina.

Sincerely,



Background

The South Carolina Medicaid Plan covers over 1,000,000 beneficiaries, with an annual budget of $5.6 Billion. Like most states, it is one of the largest, if not the largest category of spending. Medicaid spending is expected to grow greater than the economy for the foreseeable future.

Along with the growth of expenditures comes growth in fraud and abuse. Much of the fraud is due to the perceived inability to verify outpatient transactions. Indeed, most of the fraud is committed on outpatient claims. We verify every outpatient claim.

We propose to deliver our services to the Plan and its members to prevent fraud and abuse. We will go at risk to align our incentives with those of the State.

TEN COMMON HEALTH CARE PROVIDER FRAUD SCHEMES

- *Billing for services not rendered.*
- Billing for a non-covered service as a covered service.
- *Misrepresenting dates of service.*
- *Misrepresenting locations of service.*
- *Misrepresenting provider of service.*
- *Waiving of deductibles and/or co-payments.*
- Incorrect reporting of diagnoses or procedures (includes unbundling).
- Overutilization of services.
- Corruption (kickbacks and bribery).
- *False or unnecessary issuance of prescription drugs.*

Source: Association of Certified Fraud Examiner's 2013 Fraud Examiner s Manual section on health care fraud —

The services in gold are the ones we propose to address for the Plan.

Castlestone Advisors was formed in 2004 to provide information technology solutions to the healthcare industry with a special focus on the application of standards and processes borne of decades of investments and use in the financial industry. We use them to improve information flows, reduce administrative costs and provide real-time information for transaction management and decision making.

Castlestone offers a unique and powerful extension of these basic services. Castlestone's VisitEye makes use of electronically coded cards to ease and speed the data collection but also to create date, time AND location stamped encounter records that make alerts and analyses more robust and accurate, and enable additional capabilities to reduce fraud.

Because this solution performs non-financial transactions using the infrastructure of the nation's credit card networks, it has significant anti-fraud capabilities built in, is highly secure, and offers real-time information.

Castlestone is part of the winning bid for the replacement of the New York Medicaid system, and our services are under consideration for identity protection and capture of encounters for the Florida State Employee Health Plan. Our services are also now under review for replacement of the Medicare card.

Our proposed project

Beneficiaries

Initial implementation would be for 1 million beneficiaries in the South Carolina Medicaid plan.

Card Issuance

Castlestone will issue identification cards to South Carolina Medicaid beneficiaries. These cards will be readable in any standard credit card terminal. Those beneficiaries covered by Managed Care will also be given a card so that authorities can oversee Managed Medicaid; today there are few tools available and State and Federal authorities have demanded greater oversight of Medicaid MCOs

Mandatory Use

Swiping or reading the chip, use of the card at the provider location will be mandatory when a beneficiary receives outpatient services. Providers will not be charged for any transaction fees

Service Lines

Castlestone will develop and implement verification codes for high-risk service lines that have a history of high fraud rates and which orders can be documented at the point of care. These include Durable Medical Equipment, Home Care, Diagnostic Imaging & Lab Services, and Outpatient physical therapy and occupational therapy services.

Term

The system should run at full capacity for a minimum of 24 months.

The State will be responsible for the following

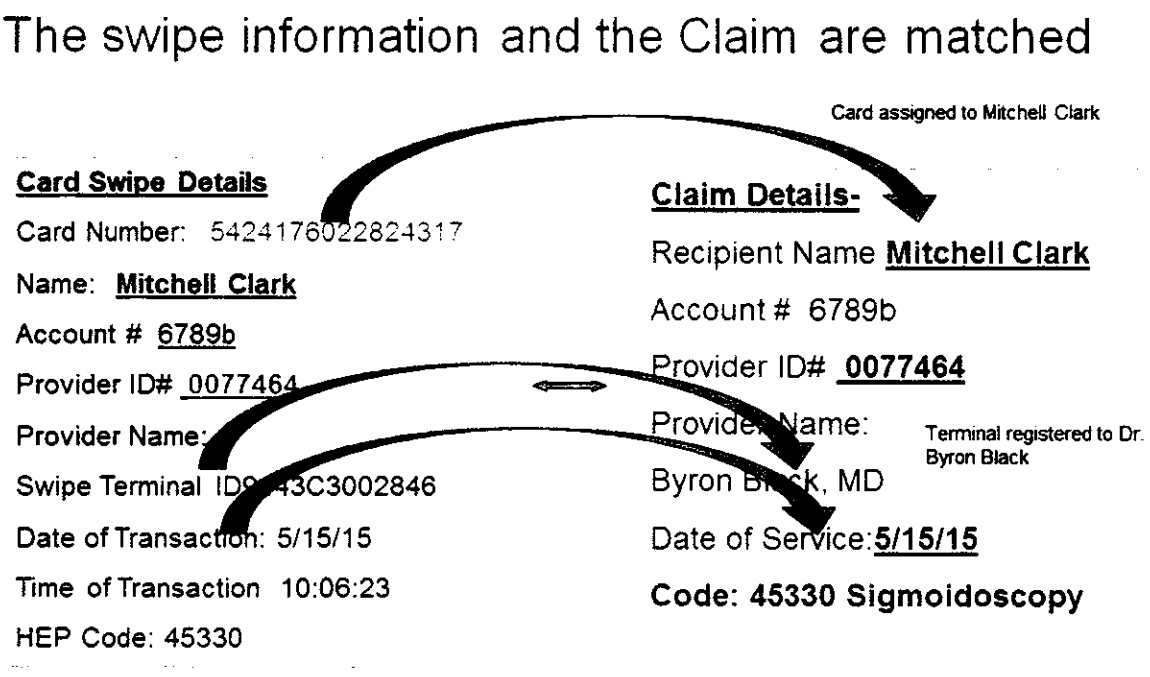
- Communication with Providers and Beneficiaries
- Delivery of Daily Updated Card Design and Accompanying Material Agreement

Use at the Point of Care- Outpatient Claims

When a beneficiary goes to a medical appointment, they merely swipe their card in the same reader used for credit card transactions. We will create a code for the physician office to enter. Castlestone will also create codes for entry for selected service lines.

Matching the Claims

On a daily basis, DHHS will pass incoming claims to Castlestone for our proprietary matching against the card swipe. Mismatches will be reported to DHHS.



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Castlestone will also use additional analytical tools of its choosing to identify other analysis and patterns that indicate potential fraud or abuse. These will be based on the temporal analysis of the encounter information, geographic analysis and other data not otherwise available, except through our technology.

Project Incentives

Castlestone and the State will agree to a baseline for measurement of the pilot effectiveness and projections of costs for population and services lines. The projections for future costs will be based on historical growth rates.

Costs and Beneficiaries	20012	2013	2014	2015	2016e	2017e	2018e	2019e

1. Outpatient visit spend
2. Home Care Services
3. Durable Medical Equipment
4. Prescription Drug
    a. Medications
    b. Emergency Room Visits
    c. Rehab Treatment
5. Transportation Services
6. IDTF (independent Testing and Diagnostic Facility and other ordered and referred services
7. Physical Therapy

Provider tracking

We would also propose to evaluate the change in provider behavi[illegible]e pilot area, and throughout the service area. Measuring the 'sentinel effect' and determining whether provider billings are influenced by the program.

Transactions and Services We Propose to Capture in the Pilot

We propose that we implement verification services for the following:

- Eligibility and Visit Verification
- Prescription Drug (Class II and Class III)
- Durable Medical Equipment orders and fills
- Orders for Home Care Services/Transportation services

- Independent Diagnostic Imaging
- Physical Therapy
- Mental Health Services

Castlestone will also perform analytics against claims in the pilot area to evaluate against the card swipe data and against other normative data that we have available to us. DHHS will provide to Castlestone de-identified claim data received for 90 days prior to and during the course of the pilot project.

At the end of each full year of implementation, with allowable time for claims runoff, the bonus for the project will be calculated as follows

Proposed ROI Calculation Methodology

1. The historical and forward projections for these costs will provide the baseline against which the project will be measured. The cost per beneficiary per service line will be measured and serve as the basis for ROI.

2. The *actual* expenditures made for those service lines, *less* the dollar value of claims where there is no matching transaction as reported by VisitEye will be measured against the projections for overall costs in the service lines. Decreases in operating costs such as the cost of investigation, prosecution and recovery and audit, which are not incurred, but can be used to identify other complex cases, will be measured as part of the Return on Investment calculations. The Cost per beneficiary per service line (actual) will be measured against the forecast.

3. Historical anomalies, such as significant drops in dollar and claim volume for a particular provider which lead to investigation, prosecution and recoveries from that provider, will be counted as part of the bonus calculation.

Identity Protection for South Carolinians

Many South Carolinians have had their identities stolen in data breaches, including Anthem's. While most health plans offer what is called identity protection, it is merely monitoring credit agencies for attempts to obtain mortgages or other forms of credit. Healthcare identities, on the other hand, are not protected.

Castlestone's services can verify that the claim received by DHHS, Anthem or any other payer were not the result of a stolen identity, but the patient actually being in the office. This has value for South Carolinians far beyond Medicaid.

Fees

We propose to deliver this service for $1.50 per beneficiary per year, or about $1.50 Million per year.

Rebate to the State

If, based on agreed to costs and ROI methodology, the Return on Investment is less than 50 percent (a reduction in projected costs of $2.25 Million), Castlestone will return to the State up to 50% of the fees paid. If the ROI is, for example, 35%, Castlestone will return 15% of its fees to the State. If the ROI is 25%, Castlestone will return 25% of its fees. If the ROI is zero, Castlestone will return 50% of its fees.

Performance Bonus

If the Return on Investment for each year is greater than 50% ($2.25 Million in net cost reductions per year), Castlestone will earn a fee of 25% of the amount of cost reduction in excess of $2.25 Million.

If the ROI exceeds 50% Castlestone shall be given the opportunity to bid for a contract for all South Carolina Medicaid beneficiaries.

This proposal is void after 90 days.

Jeff Leston, President and CEO Castlestone Advisors LLC

Jeff Leston has extensive experience in technology and its applications in financial services and healthcare. He formed Castlestone Advisors to provider the healthcare industry with information technology solutions, largely based on developments from the financial industry. He has developed products for healthcare companies, including Johnson & Johnson, United Healthcare, Rite Aid, Walgreen's and for health insurers, including MetLife and the Centers for Medicare and Medicaid Services

Mr. Leston conceived and implemented an antifraud project with National Government Services for the Medicare Durable Medical Equipment program, which was completed in 100 days. He has testified in front of the Illinois State Senate Medicaid Reform Committee on technologies to prevent fraud and abuse, to the New Jersey State Senate Oversight Committee on fraud in Managed Medicaid, and consulted to members of Congress and spoken on the subject at the National Healthcare Antifraud Association. He has authored papers on prescription drug abuse and identifies theft in healthcare.

In the early 1990's Mr. Leston led the first implementation of pattern recognition systems to detect healthcare claims fraud, based on technology used in the credit card industry.

Mr. Leston worked as an analyst and banker and investor in health care information systems and services companies, completing corporate finance, strategic and merger & acquisition assignments for software, medical delivery and services companies, including HBO & Company (now McKesson), Physicians Computer Network (now WebMD) , Shared Medical Systems (purchased by Siemens), Mecon & Company (purchased by General Electric) and Express Scripts and Medco.

Prior to working on Wall Street, Mr. Leston was a principal in a technology and operations consulting firm specializing in automation of the financial services industry. That firm was acquired by Ernst & Whinney (now Ernst & Young) in 1989, where Mr. Leston began developing solutions for the health first industry based on financial services practices. He has authored articles on the use of information technology as a marketing tool. Mr. Leston began his career with the IBM Corporation.