PASSPORT ADVANTAGE (HMO SNP)

2017

Program Integrity Plan

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Passport Advantage (HMO SNP) Program Integrity Plan to Prevent and Detect Fraud, Waste and Abuse

Passport Advantage (PAD) is committed to maintaining program integrity through the promotion of ethical business conduct and the prevention and detection of fraud, waste, and abuse. PAD Program Integrity activities are delegated to its first tier entity Evolent Health (Evolent) and are conducted in accordance with the requirements of applicable state and federal law, including but not limited to 42 CFR § 422.503 and 42 CFR § 423.504 and the requirements set out in Subtitle F, Section 6501 through 6507, of the Patient Protection and Affordable Care Act (PPACA) of 2010. PAD complies fully with the fraud, waste and abuse requirements set forth in 42 CFR 422.503 and 42 CFR 423.504. PAD has developed this Program Integrity Plan for the purpose of establishing internal controls, policies and procedures to ensure the prevention, detection and deterrence of Fraud, Waste and Abuse in accordance with those state and federal requirements.

CHIEF COMPLIANCE OFFICER

The Medicare Chief Compliance Officer works in conjunction with the University Healthcare Inc. (PAD) Board Compliance Committee and the University Healthcare, Inc. Board of Directors, to achieve the goals established for the PAD Program Integrity Program. The Chief Compliance Officer oversees PAD internal Committees, as set out in PAD's Compliance Plan, for the purpose of supporting program integrity efforts:

The Chief Compliance Officer maintains effective lines of communication with all Passport Advantage associates by way of meetings, Compliance Talks, Compliance Week activities, the Compliance Hotline and the Passport intranet. In addition, the Chief Compliance Officer assigns a Compliance staff person as a direct contact with each of the respective Passport Advantage Departments for the purpose of communicating in regard to Fraud, Waste and Abuse issues.

The Chief Compliance Officer is also responsible for coordinating all training efforts regarding Fraud Waste and Abuse and Compliance for Passport associates.

PROGRAM INTEGRITY UNIT

Organization

PIU functions are performed by Evolent's PIU team which is part of Evolent's Compliance Department. The PIU ensures that Fraud, Waste and Abuse activities are conducted by staff with separate authority to direct PIU functions and activities on an ongoing and continuous basis. The Associate Director, Program Integrity serves as the Program Integrity Coordinator. The PIU is responsible for the oversight of Passport's Fraud, Waste and Abuse investigations.

The Chief Compliance Officer, in conjunction with the Executive Leadership and the Compliance Committees continue to assess adequacy of PIU staffing and ensure sufficient staffing at all times.

The PIU, through the Chief Compliance Officer, receives and makes recommendations to the Board and Executive Leadership for improving and enhancing Passport's ability to prevent, detect and deter fraud, waste or abuse. The PIU also makes and receives such recommendations to and from CMS. The PIU initiates and maintains network and outreach activities to ensure effective interaction and exchange of information with all internal Departments of PAD as well as outside groups, including but not limited to: Regulatory Agencies, Law Enforcement and other MCO's.

Function

The PIU establishes and reviews policies and procedures for detecting, deterring and preventing Fraud, Waste and Abuse, thereby ensuring compliance with State and Federal requirements. The PIU is also responsible for controlling, evaluating and revising Fraud, Waste and Abuse detection, deterrence and prevention procedures to ensure compliance with applicable law and federal and state requirements.

Policies and procedures are in place to:

- Identify instances of provider and member Fraud, Waste and Abuse;
- Identify potentially abusive utilization patterns that may lead to Fraud, Waste and Abuse; and
- Receive, investigate, and track the status of allegations of Fraud, Waste and Abuse by members or providers received from members, providers or other sources.

The PIU is responsible for identifying and referring to CMS via Medicare Drug Integrity Contractor (MEDIC) any suspected Fraud or Abuse by members or providers. The PIU proactively detects incidents of Fraud, Waste and Abuse through the use of algorithms, investigations and record reviews. To carry out its duties, the PIU has access to all necessary Passport records and data.

The PIU is responsible for the identification of vulnerabilities in PAD's program. The PIU takes appropriate action to address any vulnerabilities including, but not limited to:

- Provider education;
- Recoupment of overpayments;
- Recommendations to other departments regarding program improvement;
- Recommendations for changes to policy; and
- Dispute resolution meetings.

The PIU, conducts continuous and on-going reviews of all data including member and provider grievances and appeals for the purpose of identifying potentially fraudulent acts.

The PIU and subcontractors work together to review claims and conduct data mining, analysis and investigations that aid in the prevention and detection of health claims fraud. Additionally, PAD aggressively works to prevent, detect and end member card sharing through the investigative efforts of the PIU. The PIU promptly responds to any potential program integrity offenses detected, and initiates corrective action where appropriate.

Algorithms

Through its subcontractors, the PIU runs algorithms on claims data and assists with the preparation of reports. The reports include all algorithms run, issues identified, actions taken to address those issues and any overpayments collected.

- **Prospective Claims Review**

PAD conducts a prospective review of its medical claims through the use of the software which is made available to PAD via its third party administrator, DST.

The software has been updated with the most current National Correct Coding Initiative (NCCI) edits and clinical edits adopted by other nationally-recognized professional societies and uses claim and payment policies from a number of primary sources.

Staff from the PIU, as well as representatives from Claims, Reimbursement, and Medical Affairs work closely together with PAD's third party administrator to identify and implement appropriate edits.

- **Retrospective Claims Review**

The PIU works with its Fraud, Waste and Abuse subcontractor to perform retrospective claims reviews. Numerous algorithms are applied to historical and paid claims to trend provider billing practices and identify aberrant patterns that signify overpayments or support the need for further investigation.

The PIU reviews subcontractor findings to determine if additional investigation is warranted; if following additional investigation, the evidence reflects a credible allegation of fraud, the PIU engages CMS and the Office of the Inspector General (OIG).

Complaint System

The PIU is responsible for receiving, investigating and tracking Fraud, Waste and Abuse complaints received from members, providers, Passport associates and all other sources.

Providers, members, associates, and any other individuals concerned about Fraud, Waste and Abuse issues can call the Passport Health Plan Hotline at 1-855-512-8500, or E-mail the Compliance Hotline mailbox. Callers have the option of remaining anonymous. All calls are confidential and are investigated by the PIU This process is communicated in member materials, through ongoing training and internal and external communication activities, and on both Passport's intra- and internet web sites. Passport associates and members are also encouraged to call a PIU Auditor directly.

Investigations and Record Reviews

The PIU conducts reviews of all suspected Fraud, Waste and Abuse in accordance with its policies and procedures. The PIU determines the factual basis of allegations concerning fraud or abuse made by Members, Providers and any other source through these reviews. The PIU follows cases from the time they are opened until they are closed.

The PIU also conducts reviews as they are received from CMS in the form of alerts, and those are handled based on the risk score that is associated with the alert. These alerts are handled both internally and delegated to subcontractors.

The PIU categorizes cases based on priority. Cases with the greatest potential impact to the program are assigned the highest priority. These high-priority cases include cases involving:

- Multi-state fraud or problems of national scope, or fraud or abuse crossing State boundaries;
- High dollar amount of potential overpayment; and
- Likelihood for an increase in the amount of fraud or abuse, or enlargement of a pattern.

In conducting its preliminary review, the PIU reviews background information, data, claims information and other relevant documentation, but does not interview the subject concerning the alleged fraud or abuse.

The PIU works with internal departments and subcontractors to conduct desk and onsite audits of providers and any other relevant investigative activity, including claims analysis and internal monitoring.

The PIU works with investigators from CMS, the OIG, and other government agencies.

Reporting

The PIU reports information to CMS and OIG as required by its contract with CMS. Reporting activities include its investigative reports, reasonable belief of the occurrence of fraud or abuse, and monthly and quarterly reports in the format determined by CMS.

The PIU generates an investigative report from each case. The PIU provides CMS and OIG with a copy of the investigative report and supporting documentation upon completion of the preliminary review. If the PIU suspects a violation of criminal fraud statutes or the Federal False Claims Act, the PIU immediately notifies the MEDIC/OIG of their findings and proceeds only in accordance with instructions received from the OIG. The PIU also reports the results of desk and onsite audits of Passport's providers.

The PIU reports all cases of suspected fraud, abuse or inappropriate practices by Subcontractors, Members or Associates and all cases where there is a reasonable belief that provider fraud or abuse occurred to CMS and OIG. Although the PIU works closely with other departments, referrals by the PIU to the CMS and OIG are not contingent upon approval by the Executive Leadership of Passport.

PAD immediately reports any incidents or allegations concerning physical or mental abuse of its members to the Department for Community Based Services (DCBS), OIG Division of Fraud, Waste and Abuse in accordance with state law and the PAD Policy and Procedure PHP 45.

Administrative Actions

The PIU initiates the collection of provider overpayments. In some cases, the PIU may recommend the use of provider education.

The PIU also attempts to recover member overpayments that were declined for prosecution. The PIU sends a written request for payment via certified mail pursuant to its policies and procedures.

FRAUD, WASTE AND ABUSE TRAINING

All PAD associates receive mandatory, annual, proficiency tested training covering Fraud, Waste and Abuse awareness, PAD's non-retaliation policy, PAD's conflict of interest and code of conduct policies, the Federal False Claims Act and other state and federal fraud laws.

Subcontractors also provide annual Fraud, Waste and Abuse training to all associates within the subcontractor's organization. Passport verifies this training during its pre-delegation and annual surveys.

Providers receive Fraud, Waste and Abuse education and training through appropriate venues such as provider newsletters, Provider Roundtable Conferences, Provider Workshops and the Provider Manual; as well as attesting to FWA training through the Medicare Learning Network.

Members receive Fraud, Waste and Abuse education and training through the Member Handbook, newsletters and other appropriate communications.

PAD and the Program Integrity Unit ("PIU") regularly review and update training programs, and identify additional areas for future training. Members of the PIU attend training offered by the Commonwealth/Fiscal Agent, Centers for Medicare and Medicaid Services, Department for Medicaid Services, DMS Program Integrity, Medicaid Fraud Control Unit, and the Office of the Attorney General. Passport actively pursues training opportunities for PIU members and Compliance Department staff from other state and federal agencies, including the U.S. Attorney's Office, as well as relevant professional organizations such as American Health Lawyers Association, Society of Corporate Compliance and Ethics, and Health Care Compliance Association, National Healthcare Anti-Fraud Association and America's Health Insurance Plans.

OTHER PROGRAM INTEGRITY ACTIVITY:

Internal Reporting

If any PAD department or subcontractor discovers or is made aware of an incident of possible Member or Provider fraud, waste or abuse, the incident is immediately reported to the Compliance Department.

Accounts Receivable

PAD's Compliance Department, in conjunction with the Provider Claims Services Unit (PCSU)/ TPA, oversees PAD's accounts receivable process to collect outstanding debt from providers.

Cooperation, Availability and Access to Data

Passport cooperates with all CMS audits and complies with any and all CMS request to supply documentation and records, including requests for system access. Passport also cooperates with CMS, the state OIG, the United States Attorney's Office and other state and federal agencies in the investigation of fraud and abuse.