

Medicaid and Medicare Advantage

2020

PROGRAM INTEGRITY PLAN

Passport Health Plan, Inc. (Medicaid)

University Health Care, Inc. (Medicare Advantage)

Passport Health Plan's Program Integrity Plan to Prevent and Detect Fraud, Waste and Abuse

INTRODUCTION

"Passport" is comprised of associates under both Passport Health Plan Inc. servicing our Medicaid line of business (Passport Health Plan) and University Healthcare Inc. servicing our Medicare line of business (Passport Advantage). Passport Health Plan Inc. was previously identified as University Healthcare Inc.

Passport Health Plan, Inc. (Passport) is committed to maintaining program integrity through the promotion of ethical business conduct and the prevention and detection of fraud, waste, and abuse. Passport Program Integrity activities are delegated to its subcontractor Evolent Health LLC (Evolent). All Program Integrity activities are conducted in accordance with the requirements of applicable state and federal law, including but not limited to 42 CFR § 438.600 to 438.610 and the requirements set out in Subtitle F, Section 6501 through 6507, of the Patient Protection and Affordable Care Act (PPACA) of 2010. Passport complies fully with the program integrity requirements and standards set forth in 42 CFR 438.608, the contractual requirements of its contract with the Commonwealth of Kentucky (Commonwealth), Department for Medicaid Services (DMS), and all other state and federal requirements, standards, laws and regulations. Passport 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, standards, laws, and regulations.

Evolent began performing Program Integrity activities on behalf of Passport in 2016. Evolent's investigative staff handling Passport's Program Integrity activities within the Program Integrity Unit consists of four Evolent employees dedicated exclusively to Passport Kentucky cases.

DEFINITIONS

Fraud:

Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program. 18 U.S.C. § 1347.

Examples of Provider Fraud:

- Billing for items or services not rendered
- Unbundling of codes
- Submitting claims supplies and services that are not reasonable and necessary
- Double billing resulting in duplicate payment
- Upcoding the level of service provided
- Allowing an unlicensed person to perform services that only a licensed professional is permitted to perform

Waste:

The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, and Medicaid and Medicare programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse:

Actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

I. CHIEF COMPLIANCE OFFICER

The Chief Compliance Officer works in conjunction with the Passport Compliance Committee, Board Compliance Committee and the Board of Directors, to achieve the goals established for Passport’s Program Integrity Program. The Chief Compliance Officer oversees Passport internal committees, as set out in Passport’s Compliance Program, for the purpose of supporting program integrity efforts.

The Chief Compliance Officer utilizes various lines of communication with all Passport associates to convey messages about fraud, waste and abuse: the Compliance Hotline (Phone: 1-855-512-8500 E-mail: PassportListens@getintouch.com), the Passport intranet, meetings, Compliance Talks, and Compliance Week activities. In addition, the Chief Compliance Officer assigns a Compliance department staff person as a direct contact with each of the respective Passport departments for the purpose of communicating about and dealing with fraud, waste and abuse matters.

The Chief Compliance Officer is also responsible for coordinating all training efforts regarding fraud, waste, and abuse and Compliance and ensures Passport staff receive ongoing fraud, waste, and abuse education.

II. PROGRAM INTEGRITY TEAM

Designated staff within Passport’s Compliance Department make up the Program Integrity Team and are responsible for oversight of Program Integrity activities. The Program Integrity team includes the Chief Compliance Officer, Director, Compliance, and Managing Attorney, Regulatory Affairs. The Program Integrity Team works closely with the Evolent Program Integrity Unit (PIU).

III. PROGRAM INTEGRITY UNIT**A. Organization**

The Program Integrity 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.

Passport's designated Program Integrity Coordinator, which is a function required by the contract between Passport and DMS, is located in Kentucky.

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

The PIU is responsible for the oversight of Passport's fraud, waste and abuse investigations.

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, and abuse. The PIU also makes and receives such recommendations to and from DMS. The PIU initiates and maintains network and outreach activities to ensure effective interaction and exchange of information with all internal departments of Passport as well as outside groups, including but not limited to: Regulatory Agencies, Law Enforcement and other Managed Care Organizations (MCO).

B. 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 DMS 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 Passport's Medicaid 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, as required by 42 CFR 438.608, conducts continuous and on-going reviews of all Medicaid Information Systems (MIS) 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, Passport 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.

C. Algorithms

Through its subcontractors and collaboration with the Payment Integrity team, the PIU runs algorithms on claims data and prepares the data for reports submitted to the DMS. The reports include all algorithms pursued, issues identified, actions taken to address those issues and any overpayments collected.

- **Prospective Claims Review**

Passport conducts a prospective review of its medical claims through the use of the claim edits made available to Passport via its third-party administrator.

Passport's claims system 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 Passport's PIU, as well as representatives from Claims, Reimbursement, and Medical Affairs work closely together to identify and implement appropriate claim edits.

- **Retrospective Claims Review**

The PIU works with its fraud, waste and abuse subcontractor to perform retrospective claims reviews. Data analytics are used to proactively identify overpayments and potential fraud and abuse. Numerous algorithms are applied to historical claims to trend provider billing practices and identify aberrant patterns that signify overpayments or support the need for further investigation.

The PIU reviews findings to determine if additional investigation is warranted; if following additional investigation, the evidence reflects a credible allegation of fraud, the PIU will refer the finding to the DMS.

- **Prepayment Claims Review**

The PIU (or its designee) may conduct prepayment reviews of claims in accordance with applicable law and may request medical records, itemized bills, invoices or other substantiating documentation to support the charges billed. Health care professionals are asked to send copies of requested documentation within 30 days of the request or the appropriate federal and state guidelines.

D. Referral 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 intranet and internet web sites. Passport associates and members are also encouraged to call a PIU Investigator directly.

E. 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 categorizes cases based on priority. Cases with the greatest potential impact to the Commonwealth's Medicaid program and Passport are assigned the highest priority. These high-priority cases include cases involving:

- Any potential for member safety concerns
- 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, MIS data, claims information and other relevant documentation.

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.

Onsite and desk audits will be routinely performed by the PIU and designated contractors as a part of Program Integrity oversight activities.

At a minimum three (3) onsite audits per quarter, will be conducted by the PIU or subcontractor, in compliance with the DMS contract. Onsite audit notification, where appropriate, will be given to the Provider 14 days in advance.

However, when deemed necessary, the PIU or contractor will arrive for an “unannounced” audit and be given access to member medical records without advance notification. If the Provider does not cooperate with the PIU or contractor, Passport will take the next appropriate step of administrative recoupment and/or reporting to DMS and the OIG. Records must be provided within 2 business days from the date of the provider onsite notification letter, which is hand-delivered. The PIU works with investigators from DMS, the OIG, and other government agencies.

Upon approval of or at the direction of DMS, Passport suspends provider payments in accordance with Section 6402(h)(2) of the Affordable Care Act pending investigation of a credible allegation of fraud.

F. Reporting

The PIU reports information to the DMS as required by its contract with the Commonwealth. 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 the DMS.

The PIU documents investigative activity for each case. The PIU provides DMS with a copy of an investigative report and will provide supporting documentation upon completion of the investigation if the allegation of fraud, waste or abuse was substantiated or if requested by the DMS. If the PIU suspects a violation of criminal Medicaid fraud statutes or the Federal False Claims Act, the PIU immediately notifies the DMS of their findings and proceeds only in accordance with instructions received from the DMS.

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 DMS. Although the PIU works closely with other departments, referrals by the PIU to the DMS are not contingent upon approval by the Executive Leadership of Passport.

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

G. Administrative Actions

The PIU initiates the collection of provider overpayments. In some cases, the PIU may recommend the use of provider education or other administrative actions to reduce the likelihood that overpayments will occur in the future.

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.

IV. FRAUD, WASTE AND ABUSE TRAINING

All Passport and Evolent associates receive mandatory, annual, proficiency tested training covering fraud, waste and abuse awareness, Passport's non-retaliation policy, Passport's conflict of interest and code of conduct policies, the Federal False Claims Act, whistleblower protections, 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, webinars, Provider Workshops and the Provider Manual.

Members receive fraud, waste and abuse education and training through the Member Handbook, newsletters and other appropriate communications.

Passport and the PIU regularly review and update training programs and identify additional areas for future training. Passport attends all training offered by the Commonwealth/Fiscal Agent, Department for Medicaid Services, Program Integrity, Medicaid Fraud Control Unit, the Office of the Attorney General, and other Managed Care Organizations if provided sufficient notice. 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, Health Care Compliance Association, National Healthcare Anti-Fraud Association, the Healthcare Fraud Prevention Partnership, and America's Health Insurance Plans. Through these efforts, the PIU, Passport Compliance, and other appropriate staff receive ongoing education on fraud, waste, and abuse trends, including CMS initiatives.

V. OTHER PROGRAM INTEGRITY ACTIVITY:

A. Internal Reporting

If any Passport 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.

B. Accounts Receivable

Passport maintains an accounts receivable process to collect outstanding debt from members and providers. Monthly accounts receivable activity is reported to the DMS.

C. Explanation of Member Benefits

Passport's Member Services Department, in accordance with §42 CFR 455.20(a), continues to administer the Explanation of Member Benefits (EOMB) program for the

purpose of verifying with members that the services billed by providers were received. On a monthly basis a random sample of 500 plus Passport Medicaid Members is identified and surveyed for all claim types such as medical, pharmacy, dental and vision to verify the receipt of billed services.

D. Cooperation, Availability and Access to Data

Passport cooperates with all DMS audits and complies with any and all DMS request to supply documentation and records, including requests for system access. Passport will permit reviews, investigations or audits of all its books, records, or data at the request of the Department, the OIG, or the agent or contractor of any authorized state or federal agency. Passport also cooperates with the DMS, the state OIG, the United States Attorney's Office and other state and federal agencies in the investigation of fraud and abuse.