Program Integrity Anti-Fraud Plan

Policy Statement:
Sentara Health Plans (SHP) is committed to maintaining a Program Integrity Plan that will ensure that violations of the law are detected and prevented in a timely manner. SHP maintains a Program Integrity Plan designed to comply with state and federal laws and regulations. SHP has a fiduciary responsibility to ensure that federal and state taxpayer dollars are protected by preventing fraud, waste, and abuse (FWA).

Exceptions:
None

Procedures:
In accordance with 42 USC § 1902 (a) (68) of the Social Security Act, the core elements of SHP's Program Integrity Unit (PIU) compliance with the Medicaid program include:

- Written policies and procedures
- A formal DMAS Program Integrity Plan to detect FWA which is submitted to the state annually for review.
- Organizational staffing charts which include:
    - The relationships between staff and leadership
    - The chart should include the staff names, titles, and time dedicated by each staff member.
- New hire and annual required compliance training by all employees
- Ongoing education of employees, affiliates, vendors, providers, subcontractors of FWA Awareness through newsletters, web pages and mail-outs. The PIU staff are required to attend training programs provided by DMAS in accordance with 42 CFR § 438.608(A)(1)(iv).
- Effective lines of communication established with internal departments and external entities.
- Developing a process for reporting potential or actual fraud or abuse.
- Developing corrective action initiatives & retention of all records for future oversight and/or referral purposes.
- Ongoing auditing and monitoring for compliance with FWA mandates will include, but not limited to, the resources of SHP's:

    - Internal Audit Department,
    - Fraud, Waste and Abuse Compliance Subcommittee,
    - Program Integrity Unit (PIU),
    - Compliance Committee.

Written Program Integrity Policies and Procedures
SHP has created written policies and procedures that show SHP's commitment and compliance with applicable state and federal laws, regulations, and requirements for the prevention, detection, and reporting of potential FWA by members, providers, and subcontractors.

Virginia Fraud Against Taxpayers Act
Under the Virginia Fraud Against Taxpayers Act whistleblowers can bring suit in the name of the State of Virginia where an entity or person engages in conduct that defrauds the state or local governments of taxpayer dollars.

Social Security Act
The Office of Inspector General imposes exclusions from State and Federal Healthcare Programs under the authority of sections 1128 and 1156 of the Social Security Act. The law requires that no payment should be made by any Federal Healthcare Program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Federal Healthcare Programs are administered by the Centers for Medicaid and Medicare Services (CMS). This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider for which the excluded person provides services and anyone else who provides services through or under the direction of an excluded person. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

SHP is obligated to ensure that Medicaid, Medicare, and FEHB funds are not used to reimburse excluded individuals or entities by taking the following steps:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded. This includes owners with an interest of 5 percent or more.
- Search the HHS-OIG website (http://oig.hhs.gov/exclusions/), SAMs (https://www.sam.gov/), and monthly to capture exclusions and reinstatements that have occurred since the last search.
- Civil monetary penalties may be imposed against providers and managed care entities that employ or enter into contracts with excluded individuals or entities to provide services for Federal Healthcare Programs.

Deficit Reduction Act
It is SHP's responsibility to ensure that the requirements of the Deficit Reduction Act are met if SHP makes or receives more than five (5) million in annual Medicaid payments.

Virginia has a variety of laws to facilitate prosecution of Medicaid fraud and abuse and/or false claims regulations. Specific laws and regulations must be followed to ensure full compliance with the Deficit Reduction Act:

- Implementation of written policies regarding the Deficit Reduction Act and the False Claims Act. Policies are applicable to employees, Providers, Contractors, and/or agents of SHP.
- Employees, Providers, Contractors, and Agent education regarding:
    - The Deficit Reduction Act.
    - The Federal False Claim Act.
    - Administrative remedies for false claims and statements.
    - State laws pertaining to false claims and statements related to civil or criminal penalties.
    - Whistleblower protections under the Federal False Claims Act and under State Laws.
    - The role of laws in preventing and detecting fraud, waste, and abuse in Federal Health Care Programs.
    - SHP's policies and procedures for detecting and preventing fraud, waste and abuse including identifying, reporting, and investigating potential false claims.
- Inclusion of the following in the SHP Code of Compliance and other employee handbooks as applicable:
    - State and Federal laws regarding false claims and fraud and abuse.
    - Rights of employees for protection as whistleblowers.
    - SHP's policies and procedures for detecting FWA.
- Identification and investigation of potential false claims. Referrals of fraudulent or abuse billings are handled by the Program Integrity Unit.
- Identification and investigation of alleged fraud, waste, or abuse violations.
- For those Member's dually insured, ensure that claims are paid by other insurance companies prior to payment by Medicaid or Medicare, which are the payers of last resort.
- Only pay claims for individuals who are a citizen or national of the United States or a qualified alien who meets all other Medicaid program eligibility criteria.
- Comply with co-payment limit regulations.
- Require electronic claims from providers unless it is a small provider with fewer than twenty-five (25) full-time employees; or physicians, practitioners, or suppliers with fewer than ten (10 full-time equivalent employees; or other providers specified by CMS.

Sentara Health Plans will:

- Upon request, provide eligibility and claims payment data with respect to individuals who are eligible to receive Medicaid.
- Accept an individual's or other entity's assignment of rights to payments from the parties to the state.
- Respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than three (3) years after the date the item or service was provided.
- Agree not to deny a claim submitted solely on the basis of the date of submission.
- Require all employees to be trained on the Code of Compliance and the Fraud, Waste and Abuse training within thirty (30) days of hire and annually thereafter.
- Ensure that all potential violations of the Deficit Reduction Act will be investigated, and actions will be taken to resolve the identified problem.
- Review possible violations requiring potential reports to any government agencies.

Federal False Claims Act
The False Claims Act prohibits, among other things:

- Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval.
- Knowingly making, using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved.
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid; and
- Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.

The False Claims Act also contains a qui tam or "whistleblower" provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the State or Federal Government. The qui tam provision also protects a whistleblower from retaliation by his employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his employment because of the employee's lawful acts in furtherance of a false claims action.

Class Action & Qui Tam Litigation
SHP is required to notify DMAS when recovering funds from a class action and qui tam litigation.

Under the Federal False Claims Act (31 U.S.C §§3729-3733), anyone knowingly and willfully submitting or causing a person or entity to submit a false claim for government funds is liable for damages up to three (3) times the amount of the government's damages plus mandatory penalties of $5,500 to $11,000 per each false claim.

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS (42 U.S.C. §1128B, §1320a-7b) states that criminal penalties will result in conviction of a felony and a fine of not more than $25,000 and/or imprisonment for not more than five (5) years for whomever:

- Knowingly and willfully makes or causes to be made any false statement in applications for any benefit or payment under a Federal Health Care Program.
- Knowingly and willfully makes or causes to be made any false statement for use in determining rights to such benefit or payment.
- Has knowledge of the occurrence of any event affecting the initial or continued right to a benefit or payment which is fraudulent.
- Has knowledge of the occurrence of any event affecting the initial or continued right to any benefit or payment of any individual in whose. behalf he has applied for or is receiving such benefit or payment which is fraudulent.
- Knowingly and willfully converts the benefit or payment to use other than intended.
- Presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal Health Care Program and knows that the person furnishing the services is not licensed as a physician.
- For a fee knowingly and willfully counsels or assists an individual to dispose of assets in order to become eligible for medical assistance under a state plan.
- Knowingly and willfully charges for any service provided to a patient. under a Federal Health Care Program in excess or established rates.

THE FALSE CLAIMS ACT WHISTLEBLOWER EMPLOYEE PROTECTION ACT (31 U.S.C. §3730(h)) prohibits a company from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee because of lawful acts done by the employee on behalf of the employer or because the employee testifies or assists in an investigation of the employer.

ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS AND STATEMENTS (31 U.S.C. Chapter 8, §3801) Under this Act, any person who makes, presents, or submits a claim that is false or fraudulent is subject to a civil penalty of not more than $5,000 for each claim and an assessment of not more than twice the amount of a claim.

Ethical concerns regarding billing and claims payment may be confidentially reported to the PIU Fraud and Abuse Hotline at 1-866-826-5277. Reports may also be made via e-mail at www.compliancealert@sentara.com.

No adverse action or retribution of any kind will be taken against an employee because he/she reports as a suspected violation of the Deficit Reduction Act, the False Claims Act or other irregularity by another person or entity. If you are reporting your own actions, you may still be subject to disciplinary proceedings to the extent of your personal involvement in the reported activity.

Employees not in compliance with the Deficit Reduction Act, the False Claims Act and SHP's policies and procedures, may receive disciplinary action, up to and including termination.

Unsolicited Refunds
An unsolicited refund is when a provider has received payments in excess of the amount allowed and payable under state and federal regulations.

The Medicare and Medicaid Program Integrity Provisions under the Social Security Act Section 1128J [42 U.S.C. 1320a-7k] (d) Reporting and Returning of Overpayments, if a provider has received an overpayment the provider will report and return the overpayment "to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate."

Per Virginia Administrative code 12VAC30-70-80. Refund of overpayments, a provider who has self-identified an overpayment has occurred, the provider must fully refund the overpayment once the overpayment has been identified. If a provider is unable to refund the total overpayment at the time the overpayment was identified, the provider may request a repayment plan directly to SHP within 30 days of identifying the overpayment.

Subcontractor Compliance Requirements
Sentara Health Plans Compliance department is separate from the Program Integrity Unit. The compliance policies and procedures are housed within our Compliance department.

- SHP's Compliance Officer and the PIU track all non-compliance, the actions taken to correct the non-compliance, and the results of audits performed. These actions are required to be reported at SHP's Compliance Committee on a quarterly basis.
- SHP must require its subcontractors to perform routine audits as well as being subjected to oversite by the Plan.
- SHP does invest in data analytical software which provides the ability to analyze data. Data analysis provides the ability to identify potential errors and FWA.

Providers/Subcontractors
Providers are encouraged to report suspected cases of fraud, waste, and abuse by contacting the Sentara Health Plans Provider Relations Customer Service 1-800-line or by calling Sentara Health Plans' Fraud & Abuse Hotline at 757-687-6326 or 1-866-826-5277 or via e-mail @ compliancealert@sentara.com.

- The Sentara Health Plans Provider Relations department will communicate suspected cases of provider fraud and abuse to Sentara Health Plan's Program Integrity Unit for further investigation.
- Providers will be given a formal, written reminder of this right and responsibility not less than once per year.
- Sentara Health Plans uses subcontractors to help our internal PIU ensure that fraud, waste, and abuse is detected, and violations of the law are prevented, reported, and prosecuted in a timely manner. Sentara Health Plan will coordinate with external vendors to ensure accurate data is transmitted, researched, validated, and resolved.
- Failure to adequately police downstream contractors can result in false representation of the Program's costs and representing substantial False Claims Act exposure.

PIU uses vendors to generate leads and conduct audits and investigations:

- Cotiviti utilizes predictive modeling software to identify potential FWA and ranks providers for potential FWA. Cotiviti also provides investigative support using their PIU investigators and clinical staff. All investigations go through SHP's PIU and our FWA Subcommittee as necessary. SHP also uses STARSSolutions suite owned by Cotiviti. The suite includes a program named Sentinel which allows the PIU to rank providers, see provider outliers, peer to peer comparisons, etc. The suite includes a program named Informant which allows the PIU to run SHP's paid claims data for analytics. The suite includes a program named Commander which is the PIU's case tracker. All allegations and investigations are housed in Commander which includes housing all medical records audited, all correspondence, financials to include provider overpayments, etc.

- Amenity utilizes predictive modeling software to identify Inpatient claims that may have been billed incorrectly to SHP. They verify DRG claims, Inpatient vs. observation, and possible readmissions.
- Performant utilizes predictive modeling software to identify SNF claims that may have been billed incorrectly to SHP. They verify RUGs/PDPM.

Program Integrity Lead
The PIU Director, Carrie Abenante, will serve as primary contact for suspected and/or actual cases of fraud, waste, and abuse. Carrie Abenante is the Program Integrity Lead. Her contact information is:

Carrie Abenante
Director, Program Integrity
Sentara Health Plans
1330 Sentara Park
Virginia Beach, Virginia 23464
Phone: 757-687-6405

Collaboration with the Department of Medical Assistant Services (DMAS)
Sentara Health Plans will participate in the Program Integrity quarterly Collaborative meetings. At least 1 person from SHP's PIU is required to attend these meetings.

Program Integrity Training and Education
SHP employees' staff who are assigned to perform desk audits and on-site audits. The PIU staff conducts activities such as investigations, analytics, provider sanctions among many additional tasks. When required, SHP's PIU staff will attend training and orientation programs required by DMAS.

Beneficiary Verification of Services
SHP has established a process to accurately evaluate the delivery of billed services to the enrollee population by using statistically valid sample sizes and timeframes that determine whether enrollees received services billed by providers, pursuant to 42 CFR § 455.20 Recipient Verification Procedure.

- A statistically valid random sample of 1% will be pulled per month from all claims paid.
- Of the 1% claims pulled, member surveys will be sent to the members requesting they review the survey. If the members should see any inconsistencies, they should contact SHP.
- The PIU will triage the information received by the members and determine if an investigation should be opened.

Monitoring and Audit Plan
SHP maintains a Program Integrity Monitoring and Audit Plan which is a living document and updated continuously. The Audit Plan is submitted to DMAS on an annual basis. Through risk assessment SHP is able to identify and prioritize auditing strategies each year. The Audit Plan includes the following:

- Title and Type of Activity
- Description
- Risk Level
- Method of selection
- Method of investigation
- Number of planned investigations

The Monitoring and Audit Plan must also include a retrospective analysis of audits performed from the previous year, and must include, at a minimum, the following:

- Number of audits planned for each type.
- Number of audits completed.
- Identified trends.
- Name of Investigator
- Findings
- Recommendations and actions taken.

Pre-Payment Review
SHP is required to implement a pre-payment solution which should be included in the Monitoring and Audit plan activities. The Pre-payment process requires pending claims payment while medical records are reviewed. The claim payment should not be released until the audit has been completed.

Minimum Audit Requirements
A minimum number of audits are required by DMAS to be conducted by SHP annually totaling at least 3% of the total medical expenditures. The PIU completes a statistical random sample of the providers claims pulled for review. The sample size includes the number of claims to be reviewed, and the amount of those claims pulled for review. The medical records reviewed represent 3%.

Payment Suspension
Per 42 CFR §§455.23 and 438.608(a)(7)-(8), SHP must suspend payments to providers and subcontractors when DMAS has determined there is a credible allegation of fraud. SHP has 1 business day to suspend a provider once DMAS has notified the PIU that a provider should be suspended. The suspension will only be released when DMAS requests the release of the suspension.

If SHP believes there is good cause, as defined in 42 CFR §455.23, to not suspend payments or to suspend payment only in part to such a provider, SHP must notify the State immediately and a good cause exemption form must be submitted to the State outlining the reasons for exempting the provider from payment suspension. The State will evaluate the merit of the request for good cause exemption and notify the MCO of the decision.

SHP must confirm in writing to the State the implementation date of the payment suspension and the service claim types suspended, if directed by the State to suspend payments only in part. Confirmations must be submitted to the State within one (1) business day of (i) receipt of the Notice of Payment Suspension from the State, or (ii) receipt of the Final Determination that SHP submitted a good cause exemption form. Confirmations will be directed to: providerenrollment@dmas.virginia.gov. Upon receipt of confirmation from the MCO, the State will issue a Notice of Payment Suspension to the provider.

Program Integrity Reporting and Investigation Process
SHP follows all state and federal regulations, which support the detection, prevention and reporting of fraud, waste, or abuse of health care funds. As a Managed Care Organization (MCO), Sentara Health Plans is required to enforce program integrity standards through well-publicized disciplinary guidelines. SHP has established guidelines to meet contract requirements related to FWA efforts. To ensure the prevention, identification, and reporting of suspected fraud, waste and abuse by enrollees, providers, subcontractors, and employees of Sentara Health Plans in accordance with all state and federal laws and regulations.

SHP's Program Integrity Unit (PIU) has several methods for identifying, investigating, and referring suspected fraud cases (42 CFR §§ 455.13 and 455.14) to the State. The PIU is an internal investigative unit, separate from the Compliance Department, whose responsibilities are to:

- Detect and prevent fraud, waste, & abuse in accordance with the False Claims Act.
- Ensure proper value of medical, behavioral health, and prescription drugs, including correct coding, reimbursement, quantity, and quality.
- Utilize systems that ensure accurate eligibility, benefits, and reimbursement.
- Reduce or eliminate fraudulent or abusive claims payments.
- Identify enrollees with drug addiction problems.
- Identify and recommend providers for exclusion from the network because of fraudulent or abusive practices.
- Refer potential FWA cases to the appropriate authorities and conduct case development and support activities for those investigations.
- Prevent illegal activities and assist authorities by providing information needed to develop successful prosecutions.
- The PIU maintains a compliance E-mail and Hotline specifically for referrals from enrollees, providers, employees, employers, etc. regarding potential fraud, waste, or abuse.
- An effective FWA program addresses the following, but is not limited to:

- Laws and regulations related to Government Programs FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.).
- Obligations of the first tier, downstream, and related entities to have appropriate policies, procedures, and training to prevent, detect and correct fraud, waste, and abuse.
- Process for reporting to SHP suspected Fraud, Waste and Abuse in first tier, downstream, and related entities.
- Protections for employees of first tier, downstream, and related entities who report suspected fraud, waste, and abuse.
- Awareness of types of Fraud, Waste and Abuse that can occur in first-tier, downstream, and related entities.

The following is intended to be a high-level overview of a comprehensive plan to detect, prevent and report fraud, waste, and abuse (FWA). The Program Integrity Unit maintains a number of resources for fraud & abuse lead generation. Through systematic education and training programs, the PIU relies on leads from internal departments (claims, provider relations, customer service, marketing, etc.). Leads may also come from the Fraud & Abuse Hotline or the compliance e-mail. PIU generates a number of potential leads themselves through internal data mining efforts, the OIG work plan and PIU's work plan.

Detection of fraud, waste and abuse include but are not limited to:

- Pre-payment claims edits
- Post-payment claims review
- Retro-review desk audits on paid claims
- Ensuring Integrity of provider credentials
- Confidential reporting of suspected fraud, waste, and abuse
- Quality Control
- Utilization Management protocols

The following steps should be followed when triaging a referral and the investigation process of a suspicious claim or providers for potential fraudulent and/or abusive practices:

- All suspected fraud, waste, or abuse should be reported first to the PIU for triage.
- Internal referrals are forwarded to the PIU via compliance e-mail or direct contact. External referrals may come in via hotline, compliance e-mail or by direct contact. All referrals will be assessed in order to make a determination as to whether potential fraud or misconduct has occurred.
- Once the referral has been triaged and a determination has been made to open a case, the investigator will attach all pertinent analyses and/or documents, log all phone calls, e-mails, letters, and other correspondence to the case within the case tracker.
- A Notification of investigation will be sent to DMAS stating that SHP will be opening a case.
- The investigation will include a paid claims analysis complete with statistical analyses where appropriate to identify outliers.
- Upon completion of the audit, a findings letter will be sent to the group/facility. If the audit findings show an error rate of 33% or higher, a Corrective Action Plan (CAP) will be required. The CAP contains corrective steps identified from errors made by provider/practice. The CAP period will remain active between 6 and 12 months. Once the CAP period has expired, a follow up audit should occur to validate whether the provider has corrected the issues identified with the prior audit. The CAP is an effective way to help providers/practices correct their root causes for making errors and receiving improper payments.
- Extrapolation will be applied to the overpayment on an error rate of 50% or higher.
- If the investigation meets the definition of a reportable offense, a Referral of Suspected Provider Fraud will be sent to DMAS.
- Once all internal appeals have been exhausted by the provider, the provider will have 30 days to request a DMAS appeal.
- Once all internal and external appeals have been exhausted and there remains a provider overpayment, SHP will obtain the overpayment via check, offset from future claims payments, or enter into a contractual repayment plan with the provider. Allowing a repayment plan and/or settlement is at the discretion of the PIU and will be reviewed on a case-by-case basis. If a check is received by the provider, audited claims will be reversed against the posted check. If offset is necessary to obtain the overpayment, the PIU will submit a Change Gear ticket to Operations to

have all claims within the audit universe reversed to offset future claims that equate to the provider overpayment. When there is a contractual repayment plan in place, the provider will submit a monthly check. The investigator will have the claims totaling the monthly check reversed and posted with the monthly payment. All overpayments, whether received via check or offset from future payments will be accomplished by reversing and adjusting/denying claims. The adjustments/denials will be sent to DMAS via encounter data.

- All records pertaining to any investigation shall be retained for a period of ten years.
- Routine randomized audits will be undertaken annually to ensure providers, pharmacies, and all subcontractors are conforming to generally acceptable health insurance billing and payment standards. These routine audits will encompass both desk and on-site audits.

How the auditing and monitoring is determined on a case-by-case basis. The appropriate methods may be:

- Sample size
- Extrapolation of audit findings using statistically valid methods
- Applying targeted or stratified sampling methods by data mining and referrals

Treatment of Recoveries
If SHP recovers an overpayment of claims older than 3 years prior to the date that SHP notified DMAS, the overpayment will be given to DMAS per the Cardinal Care Contract. Additionally, if SHP does not recover an overpayment within 1 year of being authorized to recovery by DMAS, the overpayment will be recouped by DMAS. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

SHP's PIU uses an audit lookback period of 3 years for Medicaid, Medicare, and FEHB lines of business and a 9-month audit lookback period is used for the Commercial line of business. The lookback period is defined as pulling a universe of processed claims for audit.

Reconsideration of Audit Findings
The PIU allows providers to submit a reconsideration of the PIU's audit determinations within 30 business days of the provider receiving the findings of the audit.

Provider Appeals to DMAS
The Program Integrity Unit conducts its provider appeals. Once all PIU internal appeals have been exhausted, the PIU will notify the provider that they have 30 days to appeal to DMAS.

Pursuant to DMAS and Virginia, "Provider appeals to DMAS will be conducted in accordance with the requirements set forth in Virginia Code § 2.2-4000 et seq. and 12 VAC 30-20-500 et seq. There are two (2) levels of administrative appeal: (i) the informal appeal, and (ii) the formal appeal. The informal appeal is before an Informal Appeals Agent (IAA) employed by the Department. The formal appeal is before a hearing officer appointed by the Supreme Court of Virginia, and a Formal Appeals Representative employed by the Department helps present the Department's position."

Reporting Suspected Fraud and Abuse
Per 42 CFR §438.608(a)(1), Sentara Health Plans will notify the appropriate State and Federal agencies of potential violations of civil, administrative laws, and regulations within 30 days of identification of a potential violation. The laws identify the civil, criminal, and administrative remedies that may be imposed on those that commit fraud, waste, and abuse within the Medicare and Medicaid Programs.

Medicaid
All confirmed or credible allegations of fraud per 42 CFR §455.2, must be reported to DMAS within forty-eight (48) hours of discovery.

The "Notification of Provider Investigation" form is used to notify the State that SHP plans to conduct an audit of a provider/group. Once an allegation has been researched and determined to warrant further investigation/audit, it is at this point that a notification should be sent to DMAS via e-mail at mcopideliverables@dmas.virginia.gov.mailto: This is regardless of whether the target of that allegation is scheduled to be audited immediately or is merely being placed in the

queue to be audited when resources become available. Every Notification of Investigation should be reported on the quarterly fraud, waste and abuse report and remain on that spreadsheet until the case has been investigated and closed.

SHP will conduct investigations of suspected fraud, waste and abuse of its personnel, participating providers, and subcontractors. If the investigation uncovers evidence of fraudulent activity, SHP must notify DMAS by submitting the "Referral of Suspected Provider Fraud" form via e-mail at mcopideliverables@dmas.virginia.gov and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. Each case referred to DMAS needs to be reported on the quarterly fraud, waste, and abuse report.

Suspected member fraud must be reported to DMAS on the "Notice of Suspected Recipient" Fraud form. SHP must notify DMAS by submitting the form via e-mail at mcopideliverables@dmas.virginia.gov.

Medicare
All suspected fraud, waste, or abuse within Medicare's Part C or D should be referred to the Health Plan Management System (HMPS) PI Portal for FWA reporting. CMS expects Parts C and D Sponsors to initiate referrals for fraud cases within two weeks of detection.

Cases meeting any of the following criteria should be referred to the HPMS PI Portal:

- Potential criminal, civil, or administrative law violations.
- Allegations involving known patterns of fraud.
- Fraud or abuse involving patient safety.
- Schemes with large financial risk to the Medicare Program

The process for submitting the referral through the HPMS PI Portal is as follows:

Access the Health Plan Management System (HPMS) at the URL https://hpms.cms.gov and log in. Only two persons from the PIU will have access per CMS.

SHP's Medicare Contract Number is H2563.

Once the user has logged into HPMS, the FWA Reporting module is available under the Quality and Performance drop-down menu. (HPMS/Quality and Performance/FWA Reporting/Dashboard).

Select the Submit Data option from the FWA Reporting Navigation Menu.

Populate all required fields which are indicated by the presence of an asterisk. Additional documentation may be added as attachments. Click on submit button.

When reporting Inappropriate Opioid Prescribing, The Plan and/or PBM should report all FWA Opioid prescribing in the "Substantiated and Suspicious FWA" Measure. In the "Description of Allegations" section, enter "This submission is for the Inappropriate Prescribing of Opioids." The Inappropriate Opioid Prescribing measure will be updated to indicate, on a quarterly basis, whether the Plan reported any Substantiated and Suspicious FWA related to inappropriate opioid prescribing.

Once an Inappropriate Opioid Prescribing investigation/audit has been completed, SHP will submit a referral to the HPMS PI Portal if the findings yield substantiated or suspicious FWA activity. The referral will contain all supporting documentation, case information, and the description of the allegation (full narrative). HPMS Program Integrity will share the information with I-MEDIC. I_MEDIC will further review and determine if they will initiate an investigation based on the referral submitted.

For reference, the Documentation section of the FWA Reporting module contains the user guide and FAQ document.

FEHBP
When potential FWA has been identified, a case notification is required to be submitted in writing to the OPM-OIG within 30 business days. Potential FWA is reportable after a review of the allegation has been completed or potential FWA is found while investigating further. There is no dollar threshold when potential FWA has been identified.

Written notifications should include but are not limited to the following information:

- Provider(s) full name, practice name, address, telephone number, Tax ID, NPI;
- Member's full name, address, telephone number, date of birth, internal member ID;
- Written description of the potential FWA;
- A written summary of the evidence (Report of Investigation (ROI)) to include analysis of any suspected fraudulent claims pattern, CPT, and ICD-10 codes with explanation of findings (ex: of 1900 billed services, 800 of them were not performed equating to 42% of the claims being false);
- How the case was identified (ex: internal source such as customer service, pre- auth, proactive analysis, or external source such as member complaint, law enforcement Requests for Investigative Assistance Subpoena, etc.);
- Total FEHB Program Billed and Paid Amount for a three-year (3) time period (MCD 3 years);
- Fraud Type (ex. Billing for Services Not Rendered, up coding, unbundling, etc.);
- Provider Type (ex. Doctor Shopper, DME, Home Health, etc.);
- In-network/participating or Out-of-network/nonparticipating provider;
- Any specific knowledge of patient harm that could be a result of the suspect activity;
- If applicable, contact information for any Federal and/or State law enforcement/oversight agency, investigator, and/or attorney with whom the Carrier is coordinating its investigation;
- Include if a referral has been submitted to another law enforcement/oversight agency and a copy of the referral should be included with the notification to OPM/OIG.

The FEHB Attachment 3: CASE NOTIFICATION/STATUS UPDATE will be submitted with all required information.

Once the OPM/OIG receives the case notification, the OPM/OIG may share the submitted information with other FEHB Carriers that may be affected by the potential FWA. If Sentara Health Plans has reason to believe that sharing the information may jeopardize an on-going investigation conducted by another law enforcement agency, Sentara Health Plans should inform the OPM/OIG in the initial case notification. While Sentara Health Plans is waiting for a response to the case notification from the OPM/OIG, Sentara Health Plans should continue investigating to report updated findings to the OPM/OIG. If Sentara Health Plans has not received a response from the OPM/OIG within 90 days, Sentara Health Plans may proceed assuming that the OPM/OIG has declined to investigate. If the OPM/OIG declines to investigate, Sentara Health Plans will proceed with the investigation and no further communication with the OPM/OIG is required. If there is a "triggering event." A status update to the OPM/OIG is required.

Triggering events are:

- If Sentara Health Plans identifies significant new information and believes the OPM/OIG should reconsider the declination, a status update that provides a written summary of the new information should be submitted;
- If an investigation that was declined by the OPM/OIG is then accepted by another local, state, or federal law enforcement agency, Sentara Health Plans should submit a status update to the OPM/OIG advising the OPM/OIG of the law enforcement agency who accepted the case;
- If a case that was declined by the OPM/OIG is subsequently accepted for prosecution at the federal level, such as by a United States Attorney's Office or U.S. Department of Justice;
- If Sentara Health Plans enters into a settlement agreement with $20,000 or more of FEHB program funds. (See Notification of Carrier Settlement Agreements).

After the initial case notification, to facilitate additional information sharing, in certain instances defined below, Sentara Health Plans will provide the OPM/OIG with status updates on cases that the OPM/OIG has indicated that it is monitoring or investigating the potential FWA.

The status updates should be submitted in writing and include:

- The same general information as the initial notification;
- Will clearly indicate that it is a status update rather than an initial notification;
- Provide a summary of the new information;
- Should be submitted to either the assigned OPM/OIG agent or reviewing supervisor as indicated in the OPM/OIG response.

Sentara Health Plans will submit a status update to the OPM/OIG in the following instances:

- Sentara Health Plans Identifies significant new information;
- Sentara Health Plans determines that the allegations have no merit and/or no false or fraudulent activity took place as alleged;
- When the OPM/OIG specifically requests a status update;
- Sentara Health Plans closes the investigation and the OPM/OIG has either accepted, requested a referral, or advised Sentara Health Plans that the OPM/OIG is monitoring the case;
- Sentara Health plans would like to proceed with administrative debt collection, offset of overpayment or a settlement.

Sentara Health Plans is required to notify the OPM/OIG of all cases where reportable FWA has occurred. No case involving recovery of FEHB program overpayments which result from a reportable FWA should reach the settlement stage without prior communication to the OPM/OIG. In instances where the OPM/OIG has requested a referral from Sentara Health Plans and/or has advised Sentara Health Plans that the OPM/OIG has an open investigation, Sentara Health Plans should not enter into a Settlement Agreement for the recovery of FEHB program funds without obtaining authorization from the OPM/OIG. In cases where the OPM/OIG has advised Sentara Health Plans that the OPM/OIG is monitoring the allegations and prior to recovering FEHB program funds, Sentara Health Plans will send the OPM/OIG a status update to notify the intent to proceed with a Settlement Agreement or any other form of debt collection or recovery. Instances where the OPM/OIG has declined to investigate and the total FEHB program Identified loss is less than $20,000, Sentara Health Plans may proceed with a resolution Sentara Health plans deems appropriate.

If the overpayment is over $20,000, Sentara Health Plans must notify the OPM/OIG and provide a five (5) business day timeframe for the OPM/OIG to notify Sentara Health Plans stating that the OPM/OIG agrees or disagrees with the terms of the settlement. Sentara Health Plans will not include a confidentiality clause in the Settlement Agreement which would restrict the government's access to the agreement.

The language for the settlement agreement should state:
"*This settlement agreement in no way waives the rights of the United States Government under any Federal statute to pursue civil and/or criminal fines, penalties, recoveries, etc., for claims submitted to the Carrier under the Federal Employees Health Benefits (FEHB) Program."*

The requirement to include specific language in Settlement Agreements does not apply to Class Action Lawsuits, because Sentara Health Plans is not the "sole participant" in such litigation. If Sentara Health Plans enters into negotiations with a provider and there were monies identified paid through the FEHB program, but the FEHB program overpayments were excluded from the final Settlement Agreement for any reason, Sentara Health Plans must send notification to the OPM/OIG without delay.

If the OPM/OIG requests a referral based on a case notification or status update, Sentara Health Plans will submit a written referral within 90 days of the OPM/OIG's request for the referral. If Sentara Health Plans is unable to provide the full referral within 90 days, Sentara Health Plans must provide monthly status updates in writing beginning on the first day. The status updates should indicate the current status of the case and will provide the OPM/OIG with an estimated date on which the OPM/OIG will receive the full referral. If Sentara Health Plans determines the allegation has no merit and/or no false or fraudulent activity took place as alleged at any point after the OPM/OIG has requested a referral, Sentara Health Plans will promptly provide the OPM/OIG with an update explaining Sentara Health Plans final conclusion and disposition (ROI) of the case in lieu of the requested referral.

Referrals to the OPM/OIG must be in writing and include, but are not limited to, the following:

- Provider(s) full name, practice name, address, telephone number, Tax ID, NPI;
- Member's full name, address, telephone number, date of birth, internal member ID;
- Written description of the potential FWA;
- A written summary of the evidence (Report of Investigation (ROI)) to include analysis of any suspected fraudulent claims pattern, CPT, and ICD-10 codes with explanation of findings (ex: of 1900 billed services, 800 of them were not performed equating to 42% of the claims being false);
- How the case was identified (ex: internal source such as customer service, pre- auth, proactive analysis, or external source such as member complaint, law enforcement Requests for Investigative Assistance Subpoena, etc.);
- Total FEHB Program Billed and Paid Amount for a three-year (3) time period (MCD 3 years);
- Fraud Type (ex. Billing for Services Not Rendered, up coding, unbundling, etc.);

- Provider Type (ex. Doctor Shopper, DME, Home Health, etc.);
- In-network/participating or Out-of-network/nonparticipating provider;
- At least three examples of suspected false claims including copies of the submitted claim(s) (electronic or hard copy), explanation of benefits, and copies of the front and back of any issued check or automated clearing house for payment to the suspected provider;
- A copy of any medical policies that used in processing claims related to the suspected FWA claims submitted by the provider;
- A three year claims history in electronic format using the "Standard OIG Format;"
- Copies of all relevant and supporting documents obtained or created during the investigation (i.e., internal provider audits, medical review findings, medical records, etc.);
- All research performed, including any background information obtained such as investigative databases, information found on the internet, and other medical procedure research performed;
- All state and federal laws researched that are relevant to the case;
- Specific knowledge of patient harm that could be a result of FWA;
- Contact information for the PIU Investigator responsible for preparing the referral;
- Contact information for the local, state, and federal law enforcement agencies, investigator, and/or attorney with whom Sentara Health Plans is coordinating its investigation.

When requested, Sentara Health Plans must provide the OPM/OIG with FEHB claims information and supporting documentation relevant to investigations. The request will be sent to Sentara Health Plans by the "OPM/OIG Exposure Data Request Form" and/or written correspondence on agency letterhead.

In response to exposure requests, Sentara Health Plans must provide:

- A claims history via electronic format for the request. The scope of the claim's history required will be specified by the OPM/OIG Special Agent on the exposure request;
- Absent extenuating circumstances, the documentation is expected to be provided within 30 calendar days from the date of the request;
- Unless directed otherwise, Sentara Health Plans must comply with the standard data format established by the OPM/OIG;
- Any spreadsheets or documents containing sensitive or proprietary data forwarded to the OPM/OIG by Sentara Health Plans via email must be encrypted;
- Any sensitive or proprietary data sent via mail or delivery service should, at a minimum, be password protected;
- Any request from the OPM/OIG marked "Confidential" or similar language, MUST NOT BE SHARED with Private Lines of Business, Local Carriers, or the Public;
- CONTACT THE OPM/OIG AGENT DIRECTLY BEFORE ENGAGING IN ANY INVESTIGATIVE ACTIVITIES;

During the course of an investigation, the OPM/OIG may require Sentara Health Plans to provide additional documentation (i.e., hard copy claims, checks, correspondence, etc.) and/or investigative support in the form of data analysis, prosecutorial witnesses, discovery documentation, medical expertise, provider applications/contracts, etc.

Send all case notifications to the OPM/OIG designated Secure File Transport Protocol (SFTP) server site. In the absence of SFTP, send all case notifications to: OIGCaseNotifications@opm.gov

Formal Initiation of Recovery
SHP is required to notify DMAS prior to recovering overpayments from a provider due to FWA, using the Completed Investigation Form. For each closed case, SHP will produce an Audit Report (Report of Investigation (ROI)) that will be sent to DMAS at the time the audit is completed. The Audit report is sent to DMAS via e-mail at mcopideliverables@dmas.virginia.gov. The audit report should include, at a minimum the following:

- Purpose
- Methodology
- Findings
- Determination of Action and Final Resolution
- Claims Detail List/Spreadsheet

SHP will submit adjusted/denied claim encounters reflecting all identified overpayments regardless of whether they are recovered.

Quarterly Fraud/Waste/Abuse Report
SHP is required to submit electronically to DMAS each quarter all activities conducted by the PIU and include findings Identifying and overpayments related to these activities per 42 CFR §§ 438.604(a)(7), 438.606, 438.608(d)(3).

The quarterly report will include but not limited to the following:

- Allegations received and summary of the triaged review
- All investigations and the findings
- Summary of provider payment suspensions
- Claims edits and automated reviews
- COB and TPL savings and recoveries
- Service authorization savings
- Provider screening and denials
- Unsolicited Refunds (Provider identified overpayments)
- Archived Referrals (Historical Cases)
- Other Activities

Cooperation with State and Federal Investigations
SHP will cooperate with all FWA investigation efforts with DMAS and other State and Federal offices.

Fraud, Waste and Abuse Subcommittee
The Fraud, Waste and Abuse (FWA) Sub-committee was developed as a supplement to the Compliance Committee who is bound by the Code of Federal Regulations (CFR) §422.501 and Chapter 9, in addition to many other applicable State and Federal laws to have a Compliance Plan that consists, among other things, of “a comprehensive program to detect, prevent and report FWA as part of the company’s general Compliance Plan.”

Sentara Health Plans (SHP) is required to report “suspected” FWA per State and Federal regulations. The 42 CFR§438.608, 423.504 and Chapter 9 have specific requirements related to reporting FWA to CMS and the Part D MEDIC’s Objectives:

- Monitor FWA compliance for Governmental (Medicaid, Medicare, FEHB) programs (including Part D) per above guidance.
- Review and make regulatory reporting decisions on providers, members, employers, or brokers suspected of fraud, waste, or abuse.
- Oversight of new or proposed FWA programs or policies
- Ensure consistency and appropriateness of investigative process and reporting.
- Ensures Program Integrity Unit (PIU) processes balance compliance requirements with network integrity.
- Balance risks vs. rewards and make business decisions regarding PIU case activity.
- Make recommendations to Senior Leadership Team (SLT) regarding any cases that may involve litigation.

The Sub-Committee will be chaired by PIU and will include the following but limited to:

- Legal
- Compliance
- Network Management
- Medical Director
- Government Programs
- Operations
- Pharmacy

The Sub-committee will meet once a month or as applicable and will be responsible for the following:

- Review cases presented to the Subcommittee.
- Litigation risks
- Termination of contracted providers, groups, facilities

- Disenrollment of specific members or entire employer groups

All termination/rescission discussions must be approved by majority vote in a meeting with a quorum.

The Sub-committee will report to the Compliance Committee quarterly.

Fraud, Waste, and Abuse Hotline and E-mail
Sentara Health Plans (SHP) maintains a Fraud, Waste and Abuse (FWA) Hotline and E-mail in order to provide an avenue for employees, enrollees, providers, brokers, and employers to report potentially fraudulent activity.

The FWA Hotline telephone number and E-mail address are made available to enrollees and providers at Sentara.com as well as in the enrollee and provider handbooks. For SHP employees, the Hotline number is posted in common work and break areas.

All SHP employees are educated on FWA policies and procedures, to include the FWA Hotline and E-mail, upon hire and annually thereafter.

A caller may leave a confidential message on the Hotline voicemail or E-mail. The PIU will review the information provided and decide whether a formal investigation is warranted based upon the circumstances surrounding the referral. A summary of FWA Hotline calls and E-mails will be presented at the Quarterly Compliance Committee Meeting.

Procedures:
The PIU staff will conduct the following steps when retrieving Hotline calls or E-mails:

- Check the Hotline voicemail and E-mail boxes daily for any new messages. All messages will be returned within 48 hours of receipt.
- If the message does not concern fraud, waste or abuse (i.e. misdirected call), PIU will forward the message to the appropriate department or return the call to further assist and provide the proper contact information, as appropriate.
- If the message is a potential fraud or abuse lead, PIU will return the call for any additional information. PIU will then conduct a thorough review of the collected data and continue their investigation as appropriate. All calls or emails will be documented in the Compliance Hotline Log, with the following information captured:
    - Date/time of call
    - Name of caller
    - Reason for call
    - Follow up action(s) taken
    - After completion of an investigation (where approved and appropriate), PIU will:
    - Determine the appropriate resolution to include, but not limited to, retro-denials, retractions, corrective action plan implementation, legal action, etc.
    - If necessary, notify the appropriate state or federal agencies
    - Document and close hotline log entry in the case tracking system.

Fraud and Abuse Hotline: 1-866-826-5277
Email: compliancealert@sentara.com

Monitoring:
Outcomes Monitoring and Document Management: The PIU shall be responsible for developing, communicating, and maintaining this policy and related procedures and job aids necessary for the implementation and continuance of the policy. This policy shall be reviewed at least every year for repeal or amendment as appropriate.

Related Documents:

Policy	FWA004 Provider Suspension of Payments FWA007 Beneficiary Verification
Job Aids	None

Regulatory References	Cardinal Care Contract Section 18 Program Integrity Cardinal Care Contract Section 2.10 Organizational Structure and Personnel Requirements Cardinal Care Contract Section 9.8 Cardinal Care Contract Section 19.3 Cardinal Care Technical Manual False Claims Act 42 USC § 1902(a) (68) (A) Virginia Fraud against Taxpayers Act Article §8.01-216.1 through 216.19 Center for Program Integrity (CPI) 42 USC § 1902 (a) (68) of the Social Security Act Section 6402 (d) of the Affordable Care Act 42 CFR §§438.604(a)(7), 438.606, and 438.608(d)(3) 42 CFR §455.2 42 CFR § 455.20 Virginia Code § 2.2-4000 et seq Virginia Code § 12 VAC 30-20-500 et seq 31 U.S.C. §§ 3729-3733, Section 3729. False Claims Act Sections 1128 and 1156, Social Security Act Virginia Administrative Code 12VAC30-70-80 Social Security Act Section 1128J [42 U.S.C. 1320a-7k] (d) 42 CFR §438.608(a)(1) FEHBP Contract