

# Investigating Reports of Suspected FWA and Non-Compliance



<b>Department:</b>	<b>Compliance, Corporate</b>	<b>Policy No:</b>	<b>161</b>
Prepared By/Date:	Emily Coriale / June 1, 2018	Date Originated:	<b>6/1/2018</b>
Approved By/Date:	Compliance Committee – June 26, 2018	Last Revision Date:	<b>N/A</b>
<b>Areas of Impact:</b>	<b>All P3 Employees and Departments</b>	<b>Supersedes P&amp;P No.</b>	<b>N/A</b>

## A. PURPOSE:

To establish a process to investigate reports of suspected Fraud, Waste, or Abuse (“**FWA**”) and non-compliance in the P3 Health Group Holdings, LLC (“**P3**”)<sup>1</sup> Medicare Advantage (“**MA**”) program. Reports may be brought forth by any employee, including the Chief Executive Officer (“**CEO**”), senior administrators, managers, the governing body members, First Tier, Downstream and Related Entities (“**FDRs**”), and Members.

P3 maintains a zero tolerance policy toward FWA by any employee or FDR.

## 1. SCOPE:

- a. This policy applies to all of P3’s employees, management, contractors, student interns, and volunteers.
- a. This policy describes P3’s objectives and policies regarding investigations of suspected FWA.

## 2. DEFINITIONS:

Unless defined in the body of this policy (which would be indicated by a term in parenthetical, underlined and with quotations around the defined term), the following terms, have the following meanings for this policy:

**Abuse**: Includes 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 facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

**Client Plan Sponsor**: Any entity that holds a contract directly with CMS who is involved with the MA benefit or Part D benefit, and who contracts with P3 to provide certain services (e.g., Blue Cross Blue Shield of Arizona).

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<sup>1</sup>When the term “**P3**” is used herein, it also includes the following entities, in addition to P3 Health Group Holdings, LLC (“**Holdings**”) – P3 Health Partners, LLC; P3 Health Group Management LLC; P3 Consulting, LLC; P3 Health Partners-Nevada, LLC; Kahan Wakefield Abdou, PLLC; Bacchus Wakefield Kahan, PC; as well as any direct or indirect subsidiaries of Holdings, whether now existing or hereafter formed.

**CMS**: Centers for Medicare and Medicaid Services.

**Compliance Committee**: P3's compliance committee.

**Compliance Office**: P3's compliance officer and his or her designee(s).

**Covered Services**: Services or supplies deemed medically necessary to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms that meet accepted standards of medicine.

**Downstream Entity**: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an Medicare Advantage Organization ("**MAO**") or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

**FDR**: First Tier, Downstream or Related Entity.

**Fraud**: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care 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 health care benefit program.

**First Tier Entity**: Any party that enters into a written arrangement, acceptable to CMS, with a MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

**Health Insurance Portability and Accountability Act or HIPAA**: The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.

**NBI MEDIC**: National Benefit Integrity Medicare Drug Integrity Contractor. The purpose of the NBI MEDIC is to detect and prevent fraud, waste, and abuse in the Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level.

**Related Entity**: Any entity related to a MAO or Part D sponsor by common ownership or control and:

1. Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than \$2,500 during a contract period.

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

#### **4. POLICY:**

P3 and its FDRs will comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of covered CMS services, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, HIPAA, and other applicable statutes.

P3 employees, including the CEO, senior administrators, managers, the governing body members, and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to the P3. P3 maintains a strict policy of non-retaliation and non-retribution toward employees and its FDRs who make such reports in good faith. P3's employees and its FDRs are protected from retaliation under Title 31, United State Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections. Refer to the Reporting of Incidents of Intimidation and Retaliation policy for further information.

This policy is reviewed annually or as often as requirements change to ensure accuracy and that P3's compliance program is in alignment with all company standards and industry best practices.

P3 will establish a process for timely and reasonable investigation and reporting of suspected FWA and non-compliance in accordance with this policy.

P3's Compliance Officer will coordinate all activities associated with the investigation and reporting of suspected FWA and non-compliance.

P3 and its FDRs will fully cooperate with CMS, NBI MEDIC, Client Plan Sponsors and law enforcement agencies related to any FWA and non-compliance investigations or audits.

P3's Compliance Officer will coordinate all activities related to the investigation of any allegation of suspected FWA and non-compliance and will report all suspected incidents to the Compliance Committee and subsequently to all appropriate agencies, in accordance with CMS requirements and this policy.

P3's Compliance Officer will maintain a database and a uniform filing system to maintain suspected FWA and non-compliance referrals, including reports, investigations, and correspondence, in accordance with P3's Compliance Program.

P3's Compliance Officer will develop data and other supporting evidence for a FWA investigation, consult with P3's legal counsel, and work directly with Client Plan Sponsors, their first tier entities or CMS as applicable to the investigation, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies as appropriate, and other relevant entities.

Confidentiality of case files or other documentation relating to any investigation of a suspected FWA and non-compliance case is maintained at all times.

P3's Compliance Officer will report the status and results of all suspected FWA and non-compliance investigations to P3's Compliance Committee. P3's Compliance Officer will also report the status and results of investigations to applicable Client Plan Sponsors, adhering to specific contractual requirements as agreed upon between P3 and Client Plan Sponsors and/or their first tier entities.

P3 will fully coordinate and cooperate with CMS and law enforcement agencies related to any investigations or audits to support health oversight matters.

## 5. PROCEDURE / ACTION:

### Investigation - FWA:

- A. Upon detection of suspected FWA, the Compliance Officer will review the suspected activity using data from reports, including, but not limited to, the following:
  - i. Claims data;
  - ii. Encounter data;
  - iii. Medical Records;
  - iv. Member and Provider Complaints, Appeals, and Grievance reviews;
  - v. Utilization Management reports;
  - vi. Pharmacy data;
  - vii. Audits;
  - viii. Provider utilization profiles;
  - ix. Member utilization profiles;
  - x. Geographic and demographic studies;
  - xi. Evaluation of a Provider's Member capacity; and
  - xii. Interviews.
- B. P3 Health Partners' Compliance Officer shall complete the preliminary investigation, including the review of listed and other documents, within 5 business days, to ensure that the case is reported to the appropriate party(s) in a timely fashion (within 10 business days).
- C. All reports of potential FWA are documented in a tracking system within three (3) business days from the date that the case is opened.
- D. Documentation of the final disposition is to be documented within two (2) business days of the case being closed. Additionally, tracking and trending of identifiable root causes are included as part of the trend analysis on a quarterly basis. This information is reported at least quarterly to the Compliance Committee.

Following is a partial list of potential FWA classifications for member and provider Fraud and Abuse Program:

- i. Using another individual's identity or documentation of eligibility to obtain covered services.
- ii. Selling, loaning, or giving a member's identity or documentation of eligibility to obtain services.
- iii. Making an unsubstantiated declaration of eligibility.
- iv. Using a covered service for purposes other than the purpose for which it was described including use of such covered service.
- v. Failing to report other health coverage.
- vi. Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.
- vii. Altering a prescription.
- viii. Submission of claims for covered services that are not actually provided to the member.
- ix. Submissions of claims for covered services that are that are billed using a code that would result in greater payment than the code that reflects the covered services.
- x. Charging a member in excess of allowable co-payments and deductibles for covered services.
- xi. Billing a member for covered services without obtaining written consent to bill for such services.
- xii. Failure to disclose conflict of interest.

### Investigation – Non-Compliance:

- A. Any non-compliance reported to the Compliance Officer is investigated to determine the level of risk posed to beneficiaries and P3. The Compliance Officer investigates issues by conducting interviews and reviewing data, as applicable. Compliance investigation processes will vary depending on the nature of the issue reported.

Following is a partial list of potential non-compliance:

- i. Non-compliance with or violation of state or federal regulatory statutes.
- ii. Violation of HIPAA or HITECH rules.
- iii. Failure to meet a Client Plan Sponsor service level agreement.
- iv. Breach of contract.

### Corrective Actions – All

- A. In accordance with P3 policy, P3 will issue corrective actions to employees, and its FDRs, related to valid instances of FWA and non-compliance. Corrective actions will be monitored by the Compliance Committee, or the Department of Human Resources, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If such corrective action needs to be issued, P3's Compliance Officer will take appropriate action and notify the Compliance Committee at the first Compliance Committee meeting following (i) the date of identification of the suspected FWA and non-compliance, and/or (ii) the date of report to Client Plan Sponsors or other parties.

Compliance action/outcomes may include, but are not limited to:

- A. Corrective action plan
- B. Education
- C. Focused audit
- D. Increased monitoring activities
- E. Prepayment review
- F. Process review
- G. Referral to Human Resources/Legal
- H. Prosecution
- I. Allegation/Violation confirmed: Warning Letter - Administrative Action
- J. Referral to outside state and federal law enforcement

### Reporting to Client Plan Sponsors, Regulatory Agencies or Law Enforcement:

- A. P3 provides a method for employees, FDRs, and members to anonymously report suspected FWA and non-compliance to the Compliance Officer. P3's employees and its FDRs may call the Compliance and Ethics Hotline to anonymously report concerns regarding Fraud and Abuse.
- B. All FDRs have a contractual obligation to report suspected FWA and non-compliance. They will notify P3, in accordance with the terms and conditions of its contract and this policy.
- C. P3 will report to the Client Plan Sponsor, all cases of suspected FWA and non-compliance where there is reason to believe that an incident has occurred by P3's employees, FDRs, or members. The results of a preliminary investigation of the suspected FWA or non-compliance will be reported within ten (10) business days of the date P3 first became aware of, or is on notice of, such activity.
- D. Reports submitted to regulatory agencies or law enforcement must at a minimum include:
  - i. Name and/or SSN; UPIN; TIN; NPI of those involved in the incident;
  - ii. Source of original report (e.g. employee, anonymous hotline call, data mining);
  - iii. Type of provider (if applicable);
  - iv. Nature of complaint;

- v. Approximate dollars involved if known;
- vi. Approximate number of members impacted;
- vii. Legal and administrative disposition of the case;
- viii. The report shall be submitted on a Part D/MEDIC Complaint form that can be sent to CMS via e-mail, facsimile or mail; and
- ix. P3 will submit applicable police reports, investigation documentation (background, interviews, etc.), member information, provider enrollment data, confirmation of services, list items or services furnished by provider, pharmaceutical data, and any other pertinent information.

**6. DOCUMENTATION / REFERENCES:**

SUPPORTING DOCUMENTS

N/A

CROSS-REFERENCED P&PS

Reporting of Incidents of Intimidation and Retaliation Policy

MANUAL

Medicare Managed Care Manual (MMCM), Chapter 21 Sections 50.6.10 and 50.7

Prescription Drug Benefit Manual (PDBM), Chapter 9 Sections 50.6.10 and 50.7

RELEVANT REGULATORY CITATIONS

42 C.F.R. § 422.503(b)(4)(vi)(F)

42 C.F.R. § 423.504(b)(4)(vi)(F)

42 C.F.R. § 422.503(b)(4)(vi)(G)

42 C.F.R. § 423.504(b)(4)(vi)(G)

**7. HISTORY:**

DATE	REVISED BY	REASON FOR REVISION/CONTENT CHANGED