Integrity Advantage®

MFCU Training Program Evaluation and Creation
Solicitation Name: CRFP AGO2300000001

Integrity Advantage Solutions LLC
516 Adamsway Court, Toms River, NJ 08753
732-674-3267

Vendor Signature:

Date: 9/23/2022

Technical Proposal

September 27, 2022

Department of Administration, Purchasing Division
Toby Welch, Buyer
2019 Washington Street, East
Charleston, WV 25305
Attn:
Submitted Via Fax: (304) 558 – 3970

certified WBENC WOMEN'S BUSINESS ENTERPRISE

USWC EDWOSB Federal
U.S. Women's Chamber of Commerce

RE: Response to RFP No: CRFP AGO2300000001

Dear Mr. Welch,

Integrity Advantage is pleased to provide this response for MFCU Training Program Evaluation and Creation Services in support of the West Virginia Attorney General's Office.

Integrity Advantage provides fraud, waste and abuse (FWA) expertise for health plans and agencies of all sizes and lines of business. Combining decades of consultative, investigative, clinical, training and program development knowledge from experience across all lines of business as well as healthcare payment integrity vendors has given us an edge in supporting Special Investigations Units and MFCUs. Not only have we performed FWA investigations, medical reviews and built industry leading SIU programs, but we have also created training for various organizations and helped conceptualize models that detect FWA for analytic solutions in the market today. Payers rely on the expertise of our team to expand their capabilities and support their evolving FWA programs.

Integrity Advantage has a number of diversity certifications. We are certified nationally as a Woman Business Enterprise (WBE) through the Women's Business Enterprise National Council and are certified as an Economically Disadvantaged Woman Owned Small Business (EDWOSB) through the US Women's Chamber of Commerce, and state certifications in New Jersey, Massachusetts and Illinois, ensuring that you benefit from working with a diverse supplier for these services.

I am confident you will find clear alignment between the RFP requirements and the responses we provide demonstrating expertise in delivering value in training investigators. Thank you for the opportunity to respond to this solicitation.

Sincerely,

Jala Attia
President, Integrity Advantage
jattia@integrityadvantage.com
732-674-3267

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Executive Summary

Integrity Advantage is a premier fraud, waste, and abuse (FWA) services organization specializing in healthcare fraud, waste and abuse services. Integrity Advantage helps organizations increase the value of FWA efforts by providing services for the prevention, detection, investigation, and recovery of healthcare FWA as well as robust training and mentorship. Training and mentoring others is a passion, and we believe that this will shine through as you read our responses. From experienced Accredited Healthcare Fraud Investigators (AHFI) and Certified Professional Coders (CPC) to Registered Nurses (RN) and Licensed Professional Nurses (LPN), the Integrity Advantage team provides a level of experience and skill unmatched in the FWA services industry. Our current clients include health payers with Medicaid, Medicare, Federal Employees Health Benefit (FEHB) and Commercial lines of business, including various Managed Care Organizations (MCOs) and Medicare Advantage (MA) plans.

As a Certified Women's Business Enterprise (WBE) and Economically Disadvantaged Woman Owned Small Business (EDWOSB), the Integrity Advantage team is a trusted advisor to organizations who need a partner that has fulfilled every aspect of FWA operations. Integrity Advantage was awarded the WBE certification through the Women's Business Enterprise Center – East, a WBE National Council Regional Partner Organization in April of 2020 and has continued to maintain this certification. This certificate is attached as *Appendix #1*. We also hold an up-to-date certification as an EDWOSB through the U.S. Women's Chamber of Commerce, attached as *Appendix #2*.

As you will read in our response, we have provided training to dozens of SIU's around the country over the course of our team's tenure in this industry. Not only do we train customers, but our team continues to invest heavily in the FWA industry. We consistently publish thought leadership – creating articles, providing trainings, presenting webinars, and sharing best practices for the continued benefit of fraud fighters who want to improve payment integrity in the healthcare industry. We are members of the National Health Care Anti-Fraud Association (NHCAA), Association of Certified Fraud Examiners (ACFE), the American Academy of Professional Coders (AAPC) and the Healthcare Compliance Association (HCCA) - regularly presenting and training at these conferences on FWA topics. We stay up to date on industry trends by staying relevant in the industry and actually performing the services that give us insight into the challenges faced by investigative teams and the schemes that plague the healthcare system. Attending workgroups and conferences also help us stay up to date on any new issues. Our learnings from supporting organizations across the country ensures that you will benefit from best practices and insights gleaned from decades of experience identifying, investigating, training and building our knowledgebase of emerging trends.

We measure the success of our training programs by setting specific goals and objectives. Our approach begins with gathering a clearer picture of the WV MFCU strengths and opportunities to help us in the creation and delivery of recommended trainings to bridge gaps we've identified. and assessing how well the team has retained the training provided. The end result of these trainings will be:

- → Increase the quality and quantity of new cases opened;
- → Improve relationships with external agencies and managed care organizations;
- → More settlements and recoveries resulting from investigations;
- → Increased prosecution and convictions as a result of MFCU investigations;

We look forward to sharing our ability in meeting the requirements of this RFP and are confident that in many instances, our credentials exceed what you will find within the program integrity industry.

Technical Proposal – Section 4: Project Specifications

Please Note: Responses provided in this section correspond to Section 4 of the RFP Solicitation. The Goals and Objectives identified in 4.2.1 will be addressed in our responses to the Mandatory Project Requirements as described below.

4.2.2 Mandatory Project Requirements

4.2.2.1

[The vendor must prepare a proposed staffing plan for this RFP with details regarding where the work will be performed, the roles, qualifications, licenses and skill sets of person(s) performing the work, the anticipated hours involved for each phase of the project, the anticipated span of the project, and any expected fluctuations over time in staff or hours spent on the project.]

Integrity Advantage (IA) Response: Our approach to fulfilling the requirements of this RFP will be as follows:

- Phase 1: Information Gathering and Assessment. This entails a discovery and assessment period where we will work with your internal contact to assess current training materials and standard processes to evaluate gaps and tailor our training to your team.
- Phase 2: Creation and Delivery of Training. Based on areas identified during the assessment, we will create a training curriculum, materials and deliver on-site training for up to 25 staff.
- Phase 3: Ongoing Support and Mentorship. Once we have delivered training to your staff, we can provide additional support and guidance to aid in the staff's continued development, knowledge of fraud schemes and investigative techniques.

The assessment and training components of this project will be provided by primarily by Jala Attia and Jessica Gay. Role specific training may include specialists on the Integrity Advantage team in data analysis, coding and clinical reviews. Bios can be provided when we have determined scheduling. However, bios for Jala and Jess are included below.

- Jala Attia is President and Founder of Integrity Advantage and has 22 years of experience in healthcare fraud, waste and abuse (FWA) detection, investigation, training and program oversight. Jala has served in various investigative and leadership roles at state, health plan and technology vendors where she built industry leading SIU teams and directed the development and enhancement of post-payment and pre-payment fraud waste and abuse applications in support of dozens of health plans. Jala served on the Board of Directors for the National Healthcare Anti-Fraud Association (NHCAA) and participated in several committees to promote awareness of anti-fraud education and initiatives. She regularly speaks at industry conferences on topics related to healthcare FWA. Jala earned her BA from Rutgers University and an MBA from Georgian Court University. Jala holds certifications as an AHFI, CFE, and CHC.
- Jessica Gay is Vice President and Co-founder of Integrity Advantage. She has been in client-service leadership roles for nearly 20 years, with the last 11 years laser focused on the fight against healthcare fraud, waste and abuse. With experience as a business partner to more than 30 health payers across all

lines of business, clients rely heavily on her expertise in medical coding, investigations and data analytics for strategic planning, coding accuracy audits and training. Jessica often serves as a liaison between business and technical staff, translating user needs in order to drive efficient implementation of FWA analytics and case management. Her ability to share best practices, create customized solutions, and foster professional relationships in support of the fight against fraud, waste, and abuse has earned her a place as a trusted advisor to her clients. Prior to co-founding Integrity Advantage, she worked for a technology vendor supporting health payer clients to achieve results through the use of our FWA tools, training, consulting, data mining, investigation management and medical review support. Jessica is a CPC, AHFI, and CFE.

The mentoring and ongoing support components of this project will be provided by Integrity Advantage staff that more closely match the roles of the MFCU staff needing support. This includes data analysts, investigators, coders, nurses, and leadership.

Performance of the work will be provided virtually and on-site at the WV AGO's office.

We estimate the span of this project to be approximately three (3) to four (4) calendar months, with the first month gathering and assessing data in order for us to determine where we need to focus our training efforts. During the second month we expect to prepare the curriculum and deliver on-site training. The third and fourth month are intended for follow up support to ensure the team has retained the training provided and continue to thrive with mentoring.

Fluctuations in hours or time will likely be attributed to more support of current staff members and review of case work, scheduling difficulties for holidays, travel delays, or a request for additional training that might not have been initially recommended.

4.2.2.2

[The vendor must provide a primary point of contact who will be able to attend meetings or regularly scheduled conference calls as requested, and who will be accountable to provide training materials, evaluations and/or reports required by the MFCU.]

IA Response: The primary point of contact for delivery of this contract will be Jessica Gay. Jessica can be reached directly at jgay@integrityadvantage.com and 410-372-7841.

4.2.2.3

[The vendor must comply with all applicable federal and state laws, rules and policies, and with all components of this RFP.]

IA Response: Understood and acknowledged.

4.2.2.4

[The vendor must describe clearly and in detail the process or steps it will use to accurately assess the current state of MFCU's existing knowledge base regarding current investigative, auditing, and data analysis best practices available to be utilized in healthcare fraud investigations across the full spectrum of fraud schemes employed by dishonest healthcare providers; to create a new training curriculum intended to systematically address and rectify any identified gaps in the MFCU's existing knowledge base; to create new training programs utilizing current best practices in adult learning theory, principles, and delivery methods, that will maximize the MFCU's ability to successfully eliminate its existing knowledge gaps in such areas; and to delivery these newly created training programs to MFCU staff members as described in Section 4.2.1.5 of this RFP.]

IA Response: The process which will be used by Integrity Advantage involves a discovery phase where we gather information to help us gain a better understanding of the current staff skillsets, areas of opportunity and pain points. This discovery phase includes gathering documents, a survey and one-on-one interviews of all staff to identify individual strengths and weaknesses. Once this foundational understanding is in place, we will segment the topics into training areas and begin curriculum development to address the gaps that have been identified. Training will be delivered on site and will include scenario-based exercises designed to test the staff members retention of training content through application of learned outcomes to a case example.

4.2.2.5

[The vendor must describe clearly and in detail the process or steps it will use to help the MFCU to establish a pattern and practice where MFCU staff members routinely apply investigative, auditing, and data analysis best practices in their assigned investigations related to allegations of healthcare fraud and/or abuse, neglect, or financial exploitation of incapacitated adults.]

IA Response: The process used by Integrity Advantage to help the MFCU staff routinely apply investigative best practices will involve:

1) Pre-training survey to clearly identify the main issues where MFCU staff struggle
2) Setting expectations and goals before training to help the team understand key investigative methods on which to focus
3) Scenario-based working sessions
4) After-training assessment or quiz to test knowledge of methods and standards taught
5) Providing guidance documents that can be referenced when performing an investigation to ensure they consider all steps needed to thoroughly investigate an allegation
6) Post-training mentoring for those staff who need it, so staff can ask investigative questions and gain confidence to independently perform investigations
7) Post-training check-ups to determine if cases reflect the improved methodologies shared during training

4.2.2.6

[The vendor must describe clearly and in detail the process or steps it will use to help the MFCU to increase the quantity and quality of referrals the MFCU receives from various sources by enhancing relationships with program integrity staff, managed care organizations and other agencies.]

IA Response: Our training will help the team better understand the inner-workings of MCOs and others FWA stakeholders so that the team is more comfortable building relationships and providing feedback on referrals that are received for investigation. This, in collaboration with our process described in 4.2.2.5., will help establish better relationships with sources of referrals.

4.2.2.7

[The vendor must describe clearly and in detail the process or steps it will use to help the MFCU to expedite the successful completion of its investigations, and to improve the quality, efficiency, and effectiveness of its investigative results.]

IA Response: Our perspective of best practices in the industry combined with the experience and credibility of our team have proven to be the ideal way to improve quality, efficiency and effectiveness of investigations – leading to successful investigative results. Our team brings a wealth of knowledge and experience to WV MFCU including:

- → Accredited Healthcare Fraud Investigators (AHFI)
- → Certified Professional Coders (CPC)
- → Registered Nurses (RN)
- → Licensed Professional Nurses (LPN)
- → Certified Fraud Examiners (CFE)
- → Certified in Healthcare Compliance (CHC)

Bringing individuals who have personally performed the roles that your team performs to provide training and mentorship will improve confidence enabling them to work towards successful outcomes. Combine this with training materials that we leave behind and post – training follow up, we are confident that our proven method will result in successful outcomes for WV MFCU.

4.2.2.8

[The vendor must describe clearly and in detail the process or steps it will use to help the MFCU to enhance the ability of the agency's leadership to monitor and maintain case information for both reporting and resource management purposes.]

IA Response: Our team has worked extensively on reporting key metrics to regulators and internal stakeholders. During the assessment, our team will evaluate specific regulatory reports required for WV MFCU and determine how best to capture these metrics. The assessment will detail our review of the effectiveness of case management capabilities as well as recommendations on improvements, operational inefficiencies, program vulnerabilities and system enhancements. We will also provide industry benchmarks related to work volume.

4.2.2.9

[The vendor must describe clearly and in detail the process or steps it will use to advise and assist the MFCU in developing goals and planning for any operational modifications recommended by the vendor and deemed meritorious by MFCU management following the vendor's evaluation of its current operations. Such planning may include but not be limited to anticipated timeframes, recommended resources, and other such details.]

IA Response: Our approach to the process entailed to advise and assist is quite customized to each of our clients. In this instance, we would engage the MFCU management as we progress through the assessment in order to quickly address any goals or modifications that might be needed. However, the assessment will detail recommendations, the anticipated timeframes and resources.

In the event that mentorship is an operational modification deemed necessary and approved by MFCU management, IA will provide one-on-one mentorship of the identified staff. Needs will be individually assessed

4.3 Qualifications and Experience

4.3.1.1

[Please list the total number of healthcare fraud consultants or other staff members that your firm employs. Please describe the respective seniority of each consultant or other staff member.]

IA Response: Integrity Advantage currently employs 11 staff members – 2 are support staff and not included in the list below. For the nine (9) staff members noted below, we have provided the year they joined Integrity Advantage and the number of years' experience in the industry.

1. Jala Attia, President and Founder – Founded IA in 7/2017 (22 years)
2. Jessica Gay, Vice-President and Co-Founder – Joined IA in 8/2018 (11 years)
3. Kirsten Zimmerman, Certified Coder – Joined IA in 2021 (20 years)
4. Michelle Rua, Analytics and Investigations Consultant – Joined IA in 2021 (11 years)
5. Terri Riis-Christensen, Medical Coder – Joined IA in 2021 (27 years)
6. Deanna Sipp, Medical Review Supervisor – Joined IA in 2021 (28 years)
7. Monique Mayes, Nurse Coder – Joined IA in 2021 (13 years)
8. Lora Beth Naron, Nurse Coder – Joined IA in 2021 (20 years)
9. Cailin Kehoe, Medical Coder – Joined IA in 2021 (2 years)

We anticipate hiring two additional staff members this year in investigative roles.

4.3.1.2

[Describe your firm's background and history in providing services similar to those requested herein. This should include descriptions of past projects completed; the locations of the projects; client names and contact information; types of projects; project goals and objectives, and how those goals and objectives were accomplished.]

IA Response: As a newer small woman owned business, Integrity Advantage has been in business providing FWA services for more than four years. However, the background and experience of the Integrity Advantage team offers more than five decades of dedicated FWA and SIU service experience at different organizations. Our support has included not only program assessments and consulting support, but also data analysis and lead generation, case investigation, medical record reviews and appeals support. The list of clients where we have provided these services over the past two decades is quite long to include in its entirety. In the interest of focusing on the assessment and training requirements within this RFP, we have provided three of the most similar projects completed in the recent few years.

Project 1: Government Employees Health Association (GEHA) SIU

Type of Project	Consulting and Training
Location	Virtual and on-site at Lee's Summit, MO
Description	Program assessment, training, mentorship
Client Name and Contact Information	Angie Leslie, VP of Internal Audit and SIU 816-588-1446 angie.leslie@GEHA.com
Project Goals and Objectives	1. Evaluate SIU program and implement improvements for identified deficiencies 2. Bootcamp training for the entire SIU 3. 1-1 mentorship to staff to enable them to independently work investigations 4. Improve quality of investigative output and associated recoveries, savings and prevented losses 5. Improve quality and quantity of referrals to regulatory agencies
Method used to achieve Goals and Objectives	→ Information gathering to perform the assessment → Identified all areas of opportunity / gaps in a written report → Developed an action plan for all deficiencies identified → Implemented all action plan recommendations → Ongoing support and monitoring continues

Project 2: PHPNI

Type of Project	Training and Investigations
Location	Virtual
Description	Provide company-wide training and provide data analytics support, however we have since taken on all fraud investigations.
Client Name and Contact Information	Kelly Abouhalkah, Director of Operations 816-588-1446 kabouhalkah@phpni.com
Project Goals and Objectives	1. Provide annual company-wide FWA recorded training session 2. Assist in the identification of fraud schemes using advanced data analysis techniques 3. Provide 1-1 mentorship to staff to enable them to independently work investigations 4. Improve quality of investigative output
Method used to achieve Goals and Objectives	→ Created and delivered enterprise-wide recorded FWA training → Performed data analysis and identified known fraud schemes impacting PHPNI → Mentored staff to improve investigative competency

Project 3: Cardinal Health

Type of Project	FWA Program Assessment
Location	Virtual
Description	Provide an assessment of current FWA program and all staff
Client Name and Contact Information	Samantha Kelen, Compliance Director 914-357-3098 samantha.kelen@stellarhealth.com
Project Goals and Objectives	Determine if quality of investigative output and staffing meets industry standards. Provide recommendations for improvement of overall structure and staffing composition.
Method used to achieve Goals and Objectives	→ Information gathering to perform the assessment → Identified all areas of opportunity / gaps in a written report → Presented and discussed recommendations

4.3.1.3

[Provide copies of any written Code of Conduct, Ethics Policy, or Conflict of Interest Policy that your firm has currently enacted. If your firm does not have such a policy, please so state.]

Please see attached Integrity Advantage Code of Conduct as *Appendix 3*.

4.3.1.4

[Provide an explanation and indicate the current status or disposition of any business litigation, legal, regulatory or other proceedings in which your organization or any officer or principal thereof has been involved within the last five (5) years. If none, please so state.]

IA Response: None

4.3.1.5

[List the percentage of your firm's revenues that are derived from healthcare fraud consulting or investigative services. Please list any other services that your firm provides.]

IA Response: 100% of our revenue is derived from healthcare fraud consulting and investigative services. We do not provide any other services outside of healthcare fraud consulting and investigations.

4.3.1.6

[Please describe your firm's underlying philosophy in providing healthcare fraud consulting or investigative services. Also list any particular strengths your firm may have.]

IA Response: Our philosophy in providing healthcare fraud services is built on a foundation of integrity, transparency, trust and true partnership. This is at the heart of everything we do. We view all our clients as business partners and as such, communicate with them openly and candidly. The multifaceted experience of our team gives us tremendous strength in the industry. Having performed the various roles within the FWA realm has significantly enhanced our ability to quickly build rapport with our clients and help them achieve the best results.

4.3.1.7

[Please provide references, including contact information, who can attest to prior work performed by your firm and by the individuals who are included in your staffing plan for this project.]

IA Response: References that can attest to prior work performed by Integrity Advantage and individuals included in our staffing plan are as follows:

Name	Organization	Title	Email	Phone
Angie Leslie	GEHA	VP of Internal Audit & SIU	Angie.leslie@geha.com	(816) 434-4473
Rocco Cordato	MVP Healthcare	SIU Director	rcordato@mvphealthcare.com	(518)-386-7631
Kelly Abouhalkah	PHPNI	Director of Operations	kabouhalkah@phpni.com	(260)-432-6690 x430
Amy Gandhi	Evolent Health	Managing Director, Vendor Management	agandhi@evolenthealth.com	703-517-8937

4.3.2. Mandatory Qualification / Experience Requirements

4.3.2.1

[The vendor must have demonstrated experience preparing detailed, customized training materials for at least four (4) MFCUs or SIUs employed by health care insurer / payor organizations. A list of all such customized training materials prepared by the vendor, including the names of all such organizations for which the materials were prepared, shall be provided to the agency.]

IA Response: Attached please find four (4) customized training materials that were created for each client.

- ***Appendix 4*:** Sampling and extrapolation training created for Passport Health Plan
- ***Appendix 5*:** Bootcamp created for GEHA SIU
- ***Appendix 6*:** Schemes training for Health Alliance
- ***Appendix 7*:** Blues Academy Advanced Excel Training for Investigators basic exercises and an entry level guide for newer staff members *(Blues Academy represents all Blues SIU's across the country)*

As some of these presentations are long, we have provided condensed versions of the presentations for your review.

4.3.2.2

[The vendor must have demonstrated experience delivering detailed, customized training programs for at least four (4) MFCUs or SIUs employed by health care insurer / payor organizations. A list of all such customized training programs delivered by the vendor including the names of all such organizations which received such training programs, shall be provided to the Agency.]

IA Response: In some instances, we delivered formalized documents with Training Program Recommendations. In many instances, the training programs we created and referenced in 4.3.2.1. above, was not accompanied by a formal document, rather we went straight to creation of the training after an in-depth discussion with each client regarding the specific needs of individuals on the team. We provided customized training programs to PHPNI, GEHA, Passport Health Plan and Blues Academy. ***Appendix 8*** is an example of a formalized training program that we created specifically for one of these clients.

4.3.2.3

[The vendor must have demonstrated experience providing detailed, program assessments to investigative teams. A list of all such detailed, program assessments conducted by the vendor, including the names of all such organizations which received such training programs, shall be provided to the Agency.]

IA Response: Integrity Advantage has conducted a number of program assessments to health plans and investigative teams. The most recent was for Cardinal Health and GEHA. We are unable to disclose the results of these program assessments due to Non-Disclosure Agreements we have in place with these clients. However, we have redacted a sample program assessment for your review as ***Appendix 9.***

4.3.2.4

[The vendor must have demonstrated experience performing Medicaid provider fraud investigations for or on behalf of a Medicaid program and/or MCOs. A list including the names of all such organizations for or on behalf of which the vendor or its personnel performed Medicaid provider fraud investigations, shall be provided to the agency.]

IA Response: Integrity Advantage and it's personnel have been identifying new cases and performing Medicaid provider fraud investigations for decades. Beginning with Jala Attia more than 20 years ago working for the state of New Jersey's Attorney General's Office as a state fraud investigator. Over the course of their anti-fraud careers, our personnel have performed Medicaid provider investigations for Health Net, Centene, Healthfirst, MetroPlus, MVP, Highmark, BCBS, Sentara Health Plans, Hometown Health, Advanced Health and Integral Health. There are additional organizations we did not list above where Medicaid was not the primary line of business but rather Medicare with a small number of Medicaid membership.

4.3.2.5

[The vendor must have demonstrated experience providing one-on-one mentorship services to investigative team personnel. A list including the names of all such organizations whose personnel received such one-on-one mentorship services from the vendor or its staff, shall be provided to the agency.]

IA Response: The Integrity Advantage team have provided one-on-one mentorship services to the SIU teams at GEHA, Cardinal Health and PHPNI. It is difficult to demonstrate this experience in writing, as one-on-one mentorship occurs either in person or virtually via conference call.

4.3.2.6

[The vendor must have demonstrated current experience actively participating in industry events focused on health care fraud and abuse and/or conducting speaking engagement events at such events. A list of all such events and/or speaking engagements, including the names of all such organizations which served as the primary host or sponsor for each such event or speaking engagement, shall be provided to the agency.]

IA Response: Integrity Advantage staff have been active participants in the healthcare anti-fraud industry through engagement with many organizations:

- Jala Attia previously served on the Board of Directors for NHCAA and currently also serves as vice-chair of the ACFE Institute Board, the global non-profit educational arm of the Association of Certified Fraud Examiners.
- Jessica Gay currently serves on the Board of Directors for the Baltimore Chapter of the ACFE.

There are dozens of presentations that we have created and presented related to healthcare FWA during the time our staff has been in this industry. For the purposes of this RFP response, we will provide the list of presentations during the last 4 years that we have presented for a number of organizations and associations focused on healthcare fraud, waste and abuse:

- The National Healthcare Anti-Fraud Association (NHCAA)
  - Advanced Analytics Strategies for Investigators (Webinar)
  - Setting Goals for FWA Program Success (Webinar)
  - SIU Revamp: Assessing and Improving Your SIU's Performance (Webinar)
- The Association of Certified Fraud Examiners (ACFE)
  - Understanding Healthcare Fraud Investigations in a World Full of Greed (Webinar)
  - ABA Fraud Case Study (In Person)
- National Association of Medicaid Program Integrity (NAMPI)
  - Genetic Testing Schemes (In Person)
- The Health Care Compliance Association (HCCA)
  - Million Dollar Risks (Webinar)
  - FWA Program Audits are Coming to an SIU Near You. Are You Ready? (In Person)
- The Institute of Internal Auditors (IIA)
  - Understanding Healthcare Fraud Investigations in a World Full of Greed (In Person)

4.3.2.7

[The vendor must have demonstrated current experience creating course curricula and serving as faculty instructors for educational institutions. A list of all such course curricula created by the vendor or its staff and/or all such courses taught by the vendor or its staff, including the names of all educational institutions for which such curricula were prepared, or such courses were taught, shall be provided to the agency.]

IA Response: Jala Attia is a current adjunct faculty member of the University of New Haven, Henry Lee College of Criminal Justice, in New Haven, CT. As adjunct faculty, Jala has created two courses for the master's Healthcare Fraud program and teaches two additional courses. The course curriculum developed belongs to University of New Haven, however the list of courses currently taught are:

- Healthcare Fraud, Waste and Abuse Schemes and Trends
- Fraud, Waste and Abuse in the U.S. Healthcare Delivery
- Healthcare Fraud Investigation
- Healthcare Fraud Analytics

Jala also served as Adjunct Faculty for University of Phoenix teaching Healthcare Ethics and Social Responsibility in 2008-2011

Appendix

	Description
Appendix 1	WBE Certificate
Appendix 2	EDWOSB Certification Award Letter
Appendix 3	Integrity Advantage Code of Conduct
Appendix 4	Sampling and Extrapolation Training for Passport Health Plan
Appendix 5	Bootcamp Training for GEHA
Appendix 6	Schemes Training for Health Alliance
Appendix 7	Blues Academy Advanced Excel Training for Investigators
Appendix 8	Training Program Recommendations
Appendix 9	Redacted Assessment
Appendix 10	All Original RFP Documentation and Signed Certifications

WBENC
WOMEN'S BUSINESS ENTERPRISE NATIONAL COUNCIL

JOIN FORCES. SUCCEED TOGETHER.

hereby grants

National Women's Business Enterprise Certification

to

INTEGRITY ADVANTAGE SOLUTIONS LLC

who has successfully met WBENC's standards as a Women's Business Enterprise (WBE).
This certification affirms the business is woman-owned, operated and controlled and is valid through the date herein.

Certification Granted: April 28, 2020
Expiration Date: April 28, 2023
WBENC National Certification Number: WBE2001021

WBENC National WBE Certification was processed and validated by Women's Business Enterprise Center - East, a WBENC Regional Partner Organization.

Elizabeth M. Walsh

Authorized by Elizabeth M. Walsh, President
Women's Business Enterprise Center - East

WBECEAST
WOMEN'S BUSINESS ENTERPRISE CENTER
JOIN FORCES. SUCCEED TOGETHER.

NAICS: 541990, 541611, 561611
UNSPSC: 80101500, 80101507, 80101508, 80101513, 84131608

Center for Women & Enterprise · Great Lakes Women's Business Council · Greater Women's Business Council · Women's Business Council Southwest · WBECMETRONY · WBECGREATERDMV · WBEA · WBECFLORIDA · WBECORV · WBECPACIFIC · Women's Business Development Center · WBECSOUTH · WBECWEST

U.S. Women's Chamber of Commerce

EDWOSB Certification Award Letter

The identified small business is an eligible EDWOSB for the WOSB Program, as set forth in 13 C.F.R. part 127 and has been certified as such by an SBA Approved Third Party Certifier pursuant to the Third-Party Certifier Agreement, dated June 30, 2011, and available at www.sba.gov/wosb.

Date of Certification:	**January 31, 2021**
Company Name:	**Integrity Advantage Solutions, LLC**
DUNS / Government #:	**081047546**
Date Application Submitted:	**December 19, 2020**

The U.S. Women's Chamber of Commerce (USWCC) proudly certifies the above-named firm as an Economically Disadvantaged Women-Owned Small Business (EDWOSB), eligible for the WOSB Program, as set forth in 13 C.F.R., part 127 as per the "Date of Certification" based on circumstances existing on the "Date Application Submitted" as reported above.

This EDWOSB Certification will be effective for three years from the "Date of Certification" identified on this letter. The identified small business must attest annually to meeting the WOSB or EDWOSB eligibility requirements. If there is a change in SBA's regulations that makes the WOSB or EDWOSB ineligible or if there is a change in the WOSB or EDWOSB that makes the WOSB or EDWOSB ineligible, this WOSB or EDWOSB Certification is immediately invalid.

The above name firm must promptly inform the U.S. Women's Chamber of Commerce and SBA of any changed circumstances, including a change in SBA's regulation or a change in the WOSB or EDWOSB, that could make the WOSB or EDWOSB ineligible for the WOSB program or of any intended changes that may affect certification in the future. Upon such notice, the U.S. Women's Chamber of Commerce will consider whether such changed circumstances are grounds for withdrawal of this certification award. Failure to inform the USWCC of any such changed circumstances constitutes good cause for which the certification may be withdrawn or grounds for decline of the application for certification. The WOSB or EDWOSB must not misrepresent its certification status to any other party, including any local or State government or contracting official or the Federal government or any of its contracting officials.

Authorized by,

Margot Dorfman, CEO
U.S. Women's Chamber of Commerce

OVERVIEW

At Integrity Advantage ("the Company") we require that all of our employees conduct themselves according to the highest standards of ethics, integrity, and behavior when dealing with our clients, colleagues and other stakeholders. This includes, but is not necessarily limited to, full compliance with all legal obligations imposed by statute or any other source of law.

This Code establishes the standards of behavior that must be met by all employees. Where these standards are not met, appropriate disciplinary action will be taken. In cases where the breach involves serious misconduct, this may result in summary dismissal. In cases where a breach of the policy involves a breach of any law, then the relevant government authorities or the police may be notified.

OPERATION

The purpose of this policy is to make it clear what the Company expects from employees, and employees are required to be familiar with and comply with the terms of this policy at all times. Failure to do so may result in disciplinary action, including potentially termination of employment.

In so far as this policy imposes any obligations on the Company, those obligations are not contractual and do not give rise to any contractual rights. To the extent that this policy describes benefits and entitlements for employees, they are discretionary in nature and are also not intended to be contractual. They set the terms and conditions of employment that are intended to be contractual out in an employee's written employment contract.

The Company may unilaterally introduce, vary, remove or replace this policy at any time.

STANDARDS OF CONDUCT

The standards expected of employees and contractors include:

- Compliance with all Company and workplace policies, procedures, rules, regulations and contracts and all Federal and state laws;
- Devotion of the employee's entire time, attention and skill during normal working hours and at other times as reasonably necessary for the employee to perform their duties;
- To be honest and fair in dealings with customers, clients, co-workers, Company management and the general public, and to treat them with courtesy and respect;
- To be faithful and diligent, and actively pursue the Company's best interests at all times;
- To work in a safe and compliant manner, and to observe all workplace health and safety rules and responsibilities.
- Refraining from any discriminatory, bullying or harassing behavior toward customers, clients, co-workers, Company management and the general public.
- To not make any statements to the media about the Company's business, unless expressly authorized to do so by the Company.

- To not make any statements about the Company on social media, or any other public platform, that may harm the Company's reputation;
- To not, in connection with the employee's employment, accept any financial or other benefit from any entity other than the Company – unless acceptance of such benefit is in accordance with the Company's other workplace policies or is otherwise disclosed to the Company and expressly permitted by the Company;
- To not engage in any employment or provide any services to a supplier, customer or competitor of the Company, except with the Company's prior written consent;
- Immediately disclosing any potential, perceived or actual conflict of interest (whether direct or indirect) that may give rise to a conflict with the performance of the employee's obligations to the Company, or the Company's business, confidential information or reputational interests. The Company may direct employees to take action to eliminate or reduce any such conflict, and employees must comply with such directions;
- Do not use, or come to work while affected by use of prohibited drugs or alcohol;
- To not discriminate on the basis of personal characteristics including (but not limited to) sex, race, disability, pregnancy, age, marital status or sexual orientation;
- To be punctual;
- To respect the Company's property;
- To dress in an appropriate manner and to ensure that appearance is presentable, clean, neat and tidy;
- To not use Company internet or email to access, download and/or send sexually explicit material or other offensive material;
- To maintain both during employment and after termination of employment with the Company, the confidentiality of any confidential information, records or other materials acquired during the course of employment;
- At all times, behave in a way that upholds the Company's core values and the integrity and good reputation of the Company;
- Reporting any conduct of other workplace participants which is in breach of any of the above, or potentially in breach of any of the above, without delay.

OTHER POLICIES

Employees must read and attest to read this policy in conjunction with other relevant Company policies, including:

- IT Privacy and Security Policy
- Employee Handbook

Attestations must be signed annually and uploaded into the Rockstars > Policies > Attestations folder in the current year.

Integrity Advantage
We fit right in.

Sampling & Extrapolation

Passport Health Plan
January 2019

1

Disclaimer

Per CMS guidelines, the sampling methodology used to project overpayments must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimation methods. This methodology was approved previously.

NOTE: Trainees should be able to use excel proficiently, specifically pivot tables and advanced filters

2

Terminology

Stratify – to arrange or classify into groups

Sampling Frame and Sample Population – both are the subset of the universe of which you will pick your sample from

Descriptive Statistics – analytic tool in MS Excel that completes several statistical calculations

Mean - average

Standard Deviation - is a measure that is used to quantify the amount of variation of a set of data values

Unrestricted and Simple Random – both refer to a sample that is not stratified or separated into group

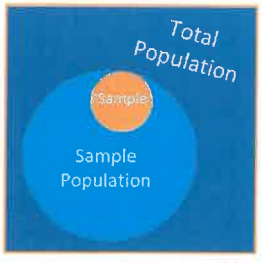
Extrapolation – a statistical method used to extend the results to an unknown situation by assuming that existing trends will continue, or similar methods will be applicable

3

What is Sampling? Why Sample?

4

What is sampling?



Sampling is the method of taking a portion or subset of a larger whole, in order to make projections about the whole. In our industry, it's taking a determined amount claims to review for accuracy and either requesting an actual overpayment or, if appropriate, an extrapolated overpayment.

5

2 Distinct Types of Sampling

Probability
[Statistically Valid Random Sample]

Simple Random / Unrestricted
Stratified

Typical Use:
- Extrapolate Overpayment
- Large Population
- Multiple or Complex Issues
- Higher ROI

Non-Probability
(Non-Statistical)

Purposeful

Typical Use:
- Direct / Actual Overpayment
- Small Population
- Isolated Issue

6

Why do we sample?

We sample for efficiency

- Save time
- Save money
- Less burden on the provider
- Less burden on the plan

7

Which type of sample is right?

Unfortunately it's not black and white – some reasons why you might select each type:

- Probe
  - Test it out – see if worth moving the case forward
  - Not permitted to extrapolate
  - Small data set
  - Isolated claims issue
- SVRS
  - To be able to extrapolate
  - Increase ROI
- SVRS with a probe
  - Get a glimpse while maintaining ability to extrapolate
  - Make an educated decision on resource allocation

8

Simple Random for Extrapolation

PROS:

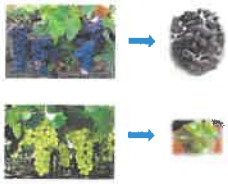
- All sampling items have the same chance of being selected
- It's simple to accomplish and is easy to explain to others

CONS:

- May not get a good representation of subsets of a population
- May be a large sample, especially if there is a lot of variance between sample items

9

Stratified Random for Extrapolation



- Sampling frame is separated into sections or *strata*
- Sampling units within a strata should be alike (homogenous) - group of CPT, Diagnoses, Range of Paid Amounts
- Essentially creating separate simple random samples for each strata

The sampling units must not have any claims/claim lines overlap, they must be unique

PROS:

- Represent key subgroups of the population
- Typically a more manageable sample size

CON:

- Extra work and time; may not provide a better precision, sample size or other value.

10

CMS Sampling & Extrapolation Policy

Program Integrity Manual, Chapter 8, Section 8.4
Use of Statistical Sampling for Overpayment Estimation

- 8.4.1.2 - The Purpose of Statistical Sampling
- 8.4.1.3 - Steps for Conducting Statistical Sampling
- 8.4.6.1.1 -Written Notification of Review
- 8.4.7.1 - Recovery From Provider or Supplier

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c08.pdf

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RAT-STATS 2010 for Windows

- Download RAT STATS – this application is the industry standard software used for statistical sampling, and it's been upheld in the court of law
- RAT-STATS is a free statistical software package
- Created by OIG in the late 1970s
- Primary statistical tool for OIG's Office of Audit Services
- https://oig.hhs.gov/compliance/rat-stats/index.asp

12

How to Sample

13

Steps to conducting a sample:

1) Identify the subject or focus of the sample
2) Determine the time period to be reviewed
3) Define the universe
4) Decide on the sampling unit
5) Define the sampling frame
6) Design the sample
7) Variable sample size determination
8) Random number generator
9) Medical Record review - determine if overpayment/underpayments exist
10) Extrapolate the overpayment

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Identify Focus & Time Period:

- Identify the subject or focus of the sample:
  - Most commonly you will have a subject, a provider or supplier, that you are working a case on
    - Proactive – sourced through data analysis or software
    - Reactive – Hotline, monthly meeting, OIG, etc.
  - May also use statistical sampling for Service Verification, which wouldn't have a subject focus but a service focus (CPT/HCPCS)
- Determine the period to be reviewed, driven by:
  - State Law
  - Contractual obligation
  - Allegation

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Universe & Sampling Unit

- Define the universe
  - Universe is all the paid claims for your subject or focus, for the timeframe determined
  - For example, Dr. Smith NPI 99999999, 01/01/2017 though 01/01/2019
  - Create an excel spreadsheet starting with your Universe and work to the right creating additional tabs for additional steps
- Sampling unit
  - A sampling unit is what you will take a sample of, typically one of the following: Member, Claim Line, Claim or Member Encounter (Member/Date of Service)
  - Consider allegation – make sure you can confirm or deny the allegation by reviewing the sample unit used
    - For example, home health will often require reviewing an episode of care, all claims for the time the Member was receiving on home health services. To make a determination for this scenario, you will need your sampling unit to be Member.
    - Most allegations/specialties review can be done by Member encounter (Member/date of service)

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Sampling Frame & Sample Design

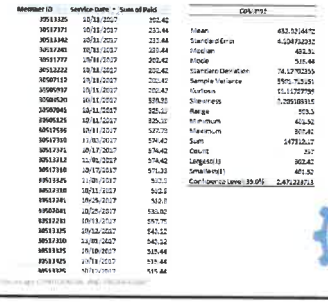
- Sampling Frame
  - The actual listing from which you will select the sample
  - May be the same as the universe, or a subset of the universe. The sample frame *may* be reduced for many reasons, including but limited to:
    - Only final paid claims (very rarely would you leave other claims in)
    - Sampling Unit paid amount < $XX.XX
    - Exclude claims without certain CPT/HCPCS
- Sample Design – it's an iterative process… be prepared
  - Often driven by the descriptive statistics (next step) and the sample size determination
  - If sample is too large for simple random, then may decide to stratify or even limit the sample frame to sampling units that paid more than or less than $X.XX
    - Stratified
    - Simple Random

After you have completed and committed to a design, you will want to create a tab titled 'Sampling Frame' with all claim lines, once this is solidified

17

Sample Size Determination

- Create pivot table in Excel by Sample Unit (Member/Date of Service to the right) including the sum of paid amount for that unit
- Run Descriptive Statistics on the sum of paid column using Excel Analysis ToolPak (select data on the header and all the way right should be 'Data Analysis')
- If you don't have see the 'Data Analysis' you may need to add to Excel
  - Select File -> Options -> Add-Ins
  - Select 'Go' next to Manage Add-ins, check Analysis ToolPak



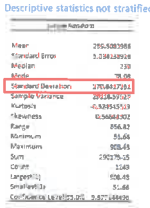
18

Stratification Example

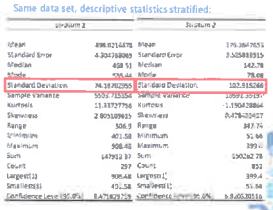
Compare the standard deviation of the descriptive statistics below; *by reducing the deviation, you reduce the sample size needed to statistically extrapolate* – therefore reducing the workload and increasing efficiency. There is rarely a need for more than 2 strata.

Examples of ways to stratify:
- Paid Amount
- CPT Code
- Diagnosis Code
- Rendering Physician
- Member

Descriptive statistics not stratified:



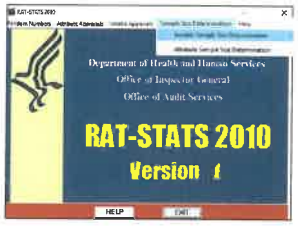
Same data set, descriptive statistics stratified:



19

Unrestricted / Single Random Sample Size Determination

Open RAT STATS, Select Sample Size Determination



- Always use Variable Sample Size Determination
- Select Unrestricted for a Simple Random Sample

20

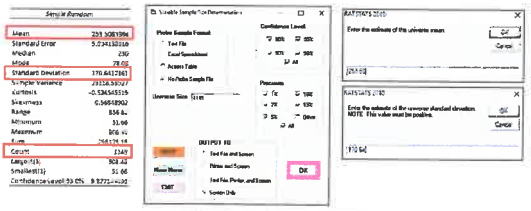
Unrestricted Sample Size Determination

For unrestricted, after selecting Variable Sample Size Determination:
-> then select 'Using a Probe Sample'
-> then select 'No Probe Sample File'

21

Unrestricted Sample Size Determination

Enter the universe size, which is the count from your descriptive statistics, then select 'All' 'Confidence Level' and 'All' for 'Precision', then enter the mean and standard deviation.

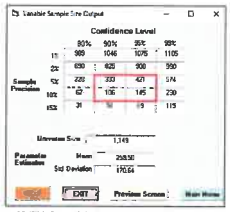


22

Unrestricted Sample Size Determination

These are the results based on our sample data for this presentation. OIG has a minimum if 90% confidence and 25% precision. We like to be more strict, so would want the sampling units to stay somewhere around the sweet spot, outlined in red:

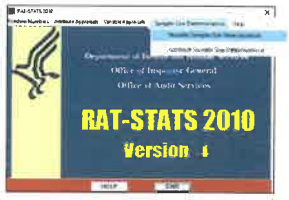
**Compare these unrestricted/simple random results with the stratified results to come... This is a much larger sample size, for the same data, that we will get next when we stratify!



23

Stratified Sample Size Determination

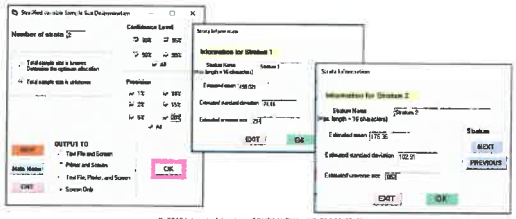
Open RAT STATS -> Select Sample Size Determination -> Select Variable Sample Size Determination -> Select Stratified for a Stratified Sample



24

Stratified Sample Size Determination

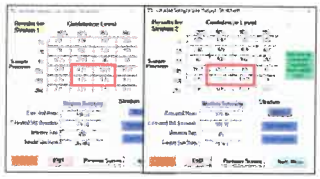
Input the descriptive statistics from Excel, as noted on previous slide the window shown below:



25

Stratified Sample Size Determination

These are the results based on our sample data for this presentation. OIG has a minimum if 90% confidence and 25% precision. We like to be more strict, so would want the sampling units to stay somewhere around the sweet spot, outlined in red:



You must pick the same Confidence and Precision for each stratum, as they will roll up into the overall sample size, pictured on next slide

Keep in mind, you need a minimum of 5 errors per stratum to extrapolate that stratum, so consider that when selecting your sample size per stratum. Errors are found in the medical review process.

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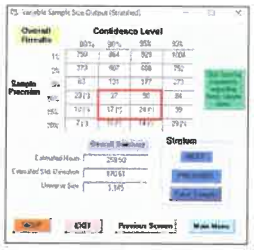
Stratified Sample Size Determination

The Overall Results total the Stratum sample sizes. As mentioned you must pick the same confidence and precision to roll up to the total sample.

Keep in mind, if your total sample is 37, and your sample unit is Member... you will need to review all claim lines for those 37 Members. If your sample unit is 37 member encounters, there often multiple claim lines per member encounter to consider.



27

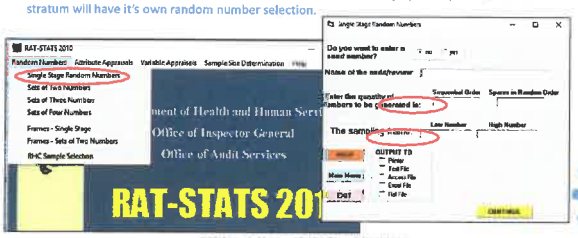
Random Number Generator

- Now that you know how many 'numbers' or sample units you need to select, RAT STATS will pick for you
- Copy pivot chart data from the descriptive statistics step earlier, paste into new spreadsheet – title the tab 'Random #s'
- Sort by paid, and make sure you document that you sorted that way
- Make sure each sample unit has it's own line, and add a 'Value' column, number each line as shown

28

Random Number Generator

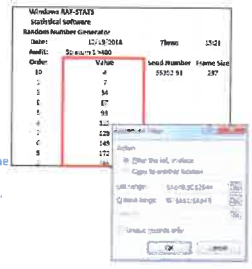
- Use RAT STATS Random Numbers, Single Stage Random Numbers function to select your sample items.
- Input the sample unit size previously determined into the Sequential Order box and frame size (count in descriptive statistics) in the Low Number box. In a stratified sample, it's imperative that each stratum will have it's own random number selection.



29

Random Number Output

- RAT STATS will offer several output options. I recommend Excel, as you can use the file for an advanced filter to select the rows for you. Shown below is a snapshot of the output, which is critical to keep as you need it to be able to recreate the sample, as required per CMS. The seed number (55302.91 in this example) is used to pick the numbers.
- Once you have the random number file, insert it ABOVE the sampling unit list that you created in the 'Random #s' tab.
- Access the advanced filter through the Data menu. Using the value column of the output file as the 'Criteria Range' and the value column on the sampling unit list as the 'List Range', the advanced filter will highlight the selected sample.



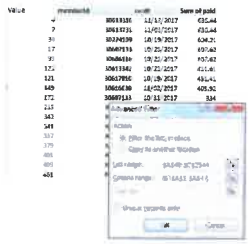
30

Random Number Output

- If your Advanced Filter worked the row numbers will be blue and you can see how Excel has hidden the unselected numbers. If it didn't work, check the header row and make sure the unit list and random number both say "Value".
- Now select and copy all the visible lines that are shown (all sample units) paste into it's own tab and title 'sample units'.
- Once you have a new tab set up (step above), BELOW the selected sample units, copy and paste all the claims from your Sampling Frame tab in slide 17.

31

Random Number Output



- Next, apply another advanced filter to all the claim lines from the sampling frame, that you just copied and pasted. Use the sampling units at the top, as the criteria, and full claims sampling frame at the bottom, as the list. This will identify the sample units for review, leaving you with a list of the selected units with all the claims data elements.
- Once your filter has run, copy and paste into a new tab, titled 'All Claim Lines for Sample'. Use this file for the medical record request letter, as well as the medical review spreadsheet.

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Medical Records Request Letter

Now that you have your claims to review, send a letter to the provider requesting the records.

Per CMS Program Integrity Manual (Pub 100-08), Chapter 8 – Administrative Actions and Statistical Sampling for Overpayment Estimates, the following guidance is provided:

8.4.6.1.1 -Written Notification of Review

- an explanation of why the review is being conducted (i.e., why the provider or supplier was selected),
- the time period under review,
- a list of claims that require medical records or other supporting documentation,
- a statement of where the review will take place (provider/supplier office or contractor site),
- information on appeal rights,
- an explanation of how results will be projected to the universe if claims are denied upon review and an overpayment is determined to exist, and
- an explanation of the possible methods of monetary recovery if an overpayment is determined to exist

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Complex Review

Once you receive the records, conduct a post-payment line-by-line review of each claim line, compared with the medical record. Each line will be deemed supported, not supported or partially supported.

Per CMS Program Integrity Manual (Pub 100-08), Chapter 8 – Administrative Actions and Statistical Sampling for Overpayment Estimates:

8.4.4.4 - Overpayment/Underpayment Worksheets

Worksheets shall be used in calculating the net overpayment. The worksheet shall include data on the claim number, line item, amount paid, audited value, amount overpaid, reason for disallowance, etc., so that each step in the overpayment calculation is clearly shown. Underpayments identified during reviews shall be similarly documented.

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Completed Review

Use the completed record review to reprice partially supported and calculate overpayments for not-supported claim lines.

Create a pivot table of the review and sort in the same way as the sample selection. This document with overpayments will be used to extrapolate the findings back to the sample frame. RAT STATS will do the calculations for you.

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Extrapolation

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Steps for Extrapolation of Results

Do NOT extrapolate your findings unless there are at least 5 errors in your sample. An error is any overpayment on a unit. If your sampling unit is Member, 5 claim lines not supported for that Member is 1 error. If you do not have at least 5 errors, simply request the actual overpayment dollars.

If you have 5 or more errors in your sample you may now extrapolate the overpayment using the following methods.

37

Overpayment Summary Spreadsheet

- Use the medical review spreadsheet to create a list of overpayments by sample unit.
- Typically, its easiest to put results of the medical review in a pivot table, then copy and paste into it's own spreadsheet. Be sure to have sample unit the same as when you selected the sample, if it was sorted by paid amount, you will need to pull paid amount and overpayment amount into your pivot table.
- Once you have the info in your pivot, copy and paste the data (not the pivot table) into it's own spreadsheet. Sort the sample unit by paid amount, then delete the paid amount column leaving your sampling unit and overpayment amounts.

Value	Member ID	Date of Service	Overpayment
1	30611312	10/31/2018	652.46
2	30607112	10/31/2018	42.87
3	30606037	10/31/2018	16.52
4	30607043	10/31/2018	243.86
5	30617676	10/31/2018	349.12
6	30617716	11/06/2018	319.34
7	30613731	11/03/2018	489.56
8	30617710	10/18/2018	28.57
9	30617710	10/31/2018	93.07
10	30607043	10/25/2018	535.46
11	30611173	10/16/2018	165.16
12	30607043	10/18/2018	136.64
13	30613316	10/10/2018	489.56
14	30613316	10/11/2018	535.46
15	30617716	10/18/2018	28.57
16	30613316	10/10/2018	16.52

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Stratified Overpayment Summary Spreadsheet

If your sample is stratified you will still follow the instructions on the Overpayment Summary Spreadsheet slide (previous slide), but will need to add another tab to the spreadsheet.

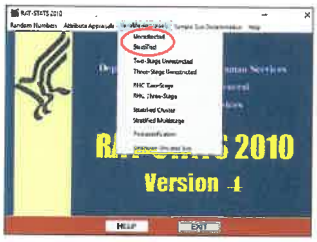
Create a separate summary tab like the one shown to the right, which will allow RAT STATS to extrapolate each stratum. List as many Strata you have, the universe is the count from your descriptive statistics of each strata, finally add your sample size. Be sure your numbers are accurate.

	A	B	C
1	Strata	Universe	Sample
2	1	297	10
3	2	852	40
4			

39

Overpayment Calculation/Extrapolation

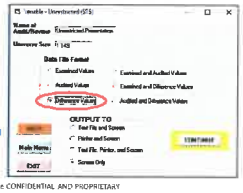
Once you have your spreadsheet created, you will open RAT STATs and select the Variable Appraisals. Use Unrestricted for Single Random Sample (not stratified), Stratified for Stratified Samples.



40

Simple Random (Unrestricted) Extrapolation

1. Enter the name of your review.
2. Enter your sampling frame size (count on descriptive statistics).
3. Select "specify input file", which is where you will browse your desktop or shared drive to select Overpayment Summary Spreadsheet.

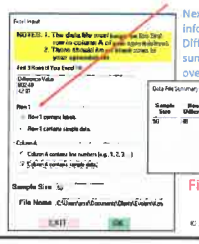


4. Select 'Difference Values' and select your input preference. Use 'Screen Only' if you plan to screenshot, as that is all you need.

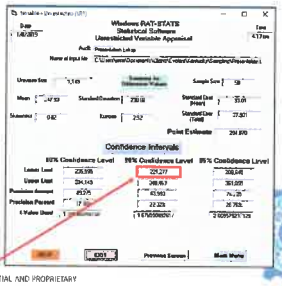
41

Unrestricted (Simple Random) Extrapolation

Now you need to confirm that RAT STATS is pulling your data in correctly. Confirm your first 3 rows of data match your file, indicate what is in Row 1 and Column A.



Next confirm the summary info: sample size, nonzero Differences (errors) and the sum of values (actual overpayment).



Final Overpayment Results $$ ->->

42

Overpayment Calculation

Why can't we ask for the highest dollar amount???

Per CMS Program Integrity Manual (Pub 100-08), Chapter 8 – Administrative Actions and Statistical Sampling for Overpayment Estimates.

8.4.5.1 - The Point Estimate

In most situations the **lower limit of a one-sided 90 percent confidence interval shall be used as the amount of overpayment to be demanded for recovery from the provider or supplier**. The details of the calculation of this lower limit involve subtracting some multiple of the estimated standard error from the point estimate, thus yielding a lower figure. This procedure, which, through confidence interval estimation, incorporates the uncertainty inherent in the sample design, is a conservative method that works to the financial advantage of the provider or supplier.

43

Stratified Extrapolation

1. Enter the name of your review.
2. Stratified appraisal will require you to enter number of strata.
3. Select "specify input file", which is where you will point to the Overpayment Summary Spreadsheet with the additional tab for stratified samples.

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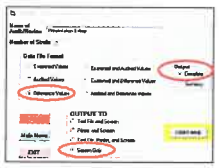
Stratified Extrapolation

Once you've specified the Overpayment Summary Spreadsheet:

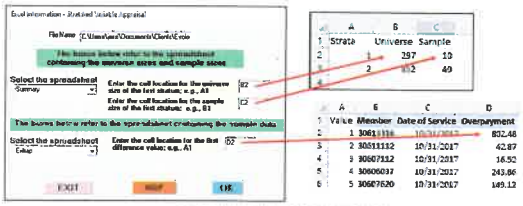
- Select Difference Values
- Select 'Output' Complete
- Select whichever 'Output To' you prefer (only need screen if you screenshot it)



45

Stratified Extrapolation

As RAT STATS works to understand the data you need to tell it specifically where to look for your certain data elements. In the example, you will see the selected drop down of 'summary' points to the information regarding the strata's universe and sample size, and the second drop down indicating 'extrap' which is the title of the results tab.



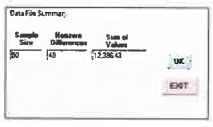
Strata	Universe	Sample
1	297	10
2	152	40

Value	Member	Date of Service	Overpayment
1	30611116	10/31/2017	802.48
2	30511332	10/31/2017	42.87
3	30607332	10/31/2017	16.92
4	30606037	10/31/2017	243.86
5	30607620	10/31/2017	149.12

46

Stratified Extrapolation

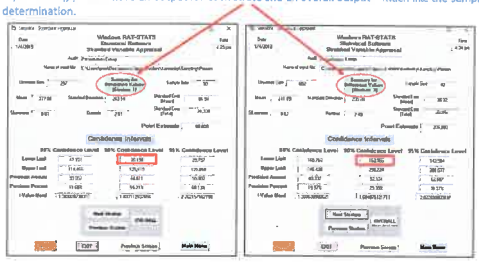
RAT STATs will show you a summary of the data file. Use this to confirm correctness of the file for sample size, non-zero (errors) and sum of values (overpayment total).



47

Overpayment Extrapolation

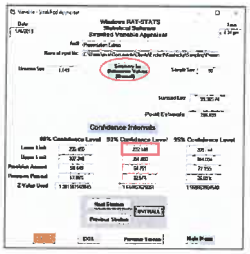
If you stratify, you will have an output for each strata and an overall output – much like the sample size determination.



48

Overpayment Extrapolation

- The total of each stratum will equal the overall overpayment, which should be requested from the provider.
- As mentioned noted on slide 39, CMS directs payers to request the Lower Limit of the 90% Confidence Level – here that is $222,148.



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Overpayment Communication

Per CMS Program Integrity Manual (Pub 100-08), Chapter 8 – Administrative Actions and Statistical Sampling for Overpayment Estimates

8.4.7.1 - Recovery From Provider or Supplier

...Include in the overpayment demand letter information about the review and statistical sampling methodology that was followed.

The explanation of the sampling methodology that was followed shall include:

- a description of the universe, the frame, and the sample design;
- a definition of the sampling unit,
- the sample selection procedure followed, and the numbers and definitions of the strata and size of the sample, including allocations, if stratified;
- the time period under review;
- the sample results, including the overpayment estimation methodology and the calculated sampling error as estimated from the sample results; and
- the amount of the actual overpayment/underpayment from each of the claims reviewed.

Also include a list of any problems/issued identified during the review, and any recommended corrective actions.

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HAPPY SAMPLING!

It's a lot of steps, but you'll get more efficient with each one. Take your time, document and collect! Who doesn't want more overpayments and recoupments!?!?

For questions contact:
Jessica Gay, Vice President
jgay@integrityadvantage.com
410-372-7841

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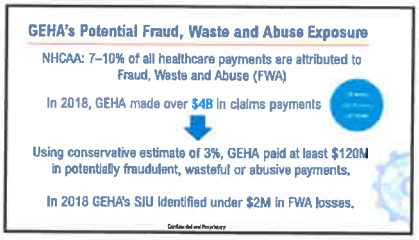
GEHA
Healthcare Fraud, Waste and Abuse Program
What to Expect ….

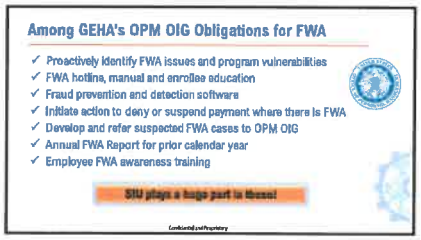
1


Why Integrity Advantage
Over 25 years supporting payers' FWA initiatives
We are here to provide tools you need to succeed

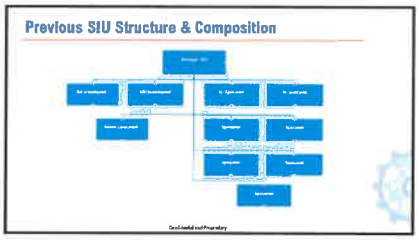
2


GEHA's Potential Fraud, Waste and Abuse Exposure
NHCAA: 7–10% of all healthcare payments are attributed to Fraud, Waste and Abuse (FWA)
In 2018, GEHA made over $4B in claims payments
Using conservative estimate of 3%, GEHA paid at least $120M in potentially fraudulent, wasteful or abusive payments.
In 2018 GEHA's SIU identified under $2M in FWA losses.

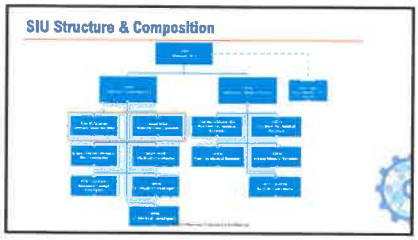
3


Among GEHA's OPM OIG Obligations for FWA
✓ Proactively identify FWA issues and program vulnerabilities
✓ FWA hotline, manual and enrollee education
✓ Fraud prevention and detection software
✓ Initiate action to deny or suspend payment where there is FWA
✓ Develop and refer suspected FWA cases to OPM OIG
✓ Annual FWA Report for prior calendar year
✓ Employee FWA awareness training
SIU plays a huge part in these!

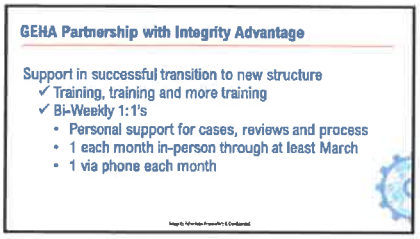
4


Previous SIU Structure & Composition

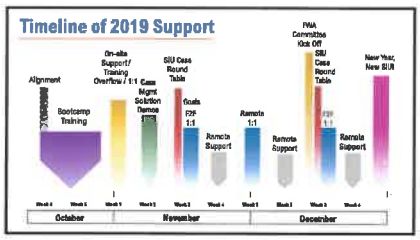
5


SIU Structure & Composition

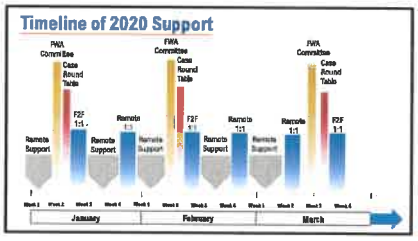
6


GEHA Partnership with Integrity Advantage
Support in successful transition to new structure
✓ Training, training and more training
✓ Bi-Weekly 1:1's
• Personal support for cases, reviews and process
• 1 each month in-person through at least March
• 1 via phone each month

7


Timeline of 2019 Support
October
November
December

8


Timeline of 2020 Support
January
February
March

9

Training – Not just SIU

SIU Training	GEHA Training
✓ Investigative Process	✓ FWA Awareness
✓ Data Mining	✓ SIU Authority and Responsibility
✓ Internal / External Referrals	✓ What to Refer to SIU
✓ Report Writing	✓ Consideration of monthly tips / important updates within SIU
✓ Interviewing	
✓ Medical Review	

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On-Site Support

- One on One's
  - ✓ Why?
  - ✓ When?
  - ✓ What to expect of us?
  - ✓ What will we expect of you?
- Training Overflow

11

GEHA Partnership with Integrity Advantage (cont)

- ✓ Identification and Implementation of Case Mgmt. Solution
- ✓ Revised Job Descriptions and Annual Goals
- ✓ Creation of SIU Policies & Procedures
- ✓ Monthly Case Round Tables (SIU only)
- ✓ OIG Case Notifications
- ✓ Reduce providers on prepay
- ✓ Launch, facilitate and support FWA Committee Meeting
- ✓ Access - Direct line to Jess and/or Jala

12

Case Management Plan

- Short Term Plan
  - Start thinking - how many service forms do you have?
  - Recommendations for action – we will help!
- Long Term Plan – Breakout!
  - Must have criteria
  - Nice to have criteria
- What to expect from us?
- What will we expect from you?

13

Job Descriptions & Annual Goals

- Why do we need them?
- What to expect from us?
- What will we expect from you?

14

SIU Policies and Procedures

- What about DLP's?
- Why do we need this?
- What to expect from us?
- What will we expect from you?

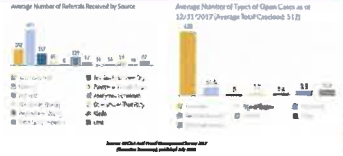
15

Monthly SIU Case Roundtables

- Why do we need this?
- Who will attend?
- What to expect from us?
- What will we expect from you?

16

NHCAA Industry Stats: Referrals & Cases



17

You Are Not Alone: Support From GEHA Team

- Eliminate siloed functions and increase communication
- Committee / Workgroup involvement
- Increase referrals to SIU
- Improve communication with providers and members
- Prepayment process streamlining
- Restoration of responsibilities to appropriate department(s)

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FWA Committee Meeting

- What is it?
- Why do we need it?
- Who will attend?
- What to expect from us?
- What will we expect from you?

19

OIG Case Notifications and Exposure Requests

- Process?
- What to expect of us?
- What will we expect of you?

20

Reduce Providers on Prepay

- Why do we need to do this?
- How will we do this?
- What will we expect of you?
- What you should expect of us

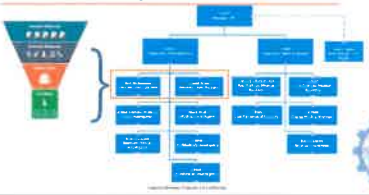
21

Intake Process

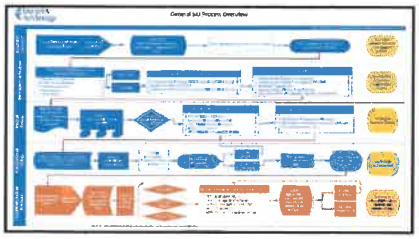
- Why do we need to do this?
- How will we do this?
- What will we expect of you?
- What you should expect of us

22

SIU Structure & Composition



23



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SIU Bootcamp Training Agenda

- ✓ Fraud Basics
- ✓ Schemas and Analysis
- ✓ Stages of an Investigation
- ✓ Report Writing and Case Documentation
- ✓ Legal and Regulatory
- ✓ Medical Review and Peer Review
- ✓ Provider and Member Calls
- ✓ Sampling Basics
- ✓ Excel Training
- ✓ Break out groups

25

Let's Address Your Concerns…

- ✓ How do we balance our *existing workload* to accommodate this new structure and new work?
- ✓ How do we know that each person can handle their responsibilities?
- ✓ What about exposure requests from OIG?
- ✓ Help us understand anything else that you are concerned with

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GEHA

Health Care Fraud, Waste and Abuse

SIU Bootcamp Training

Fall 2019

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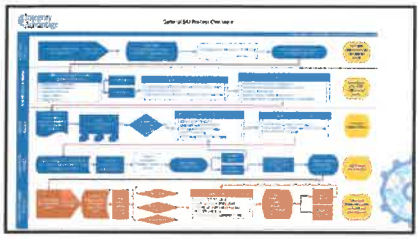


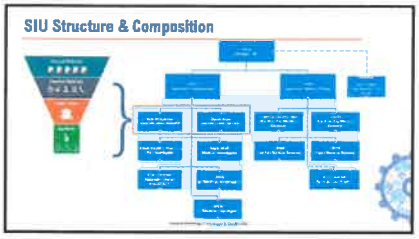
28

Intake Process

- Why do we need to do this?
- How will we do this?
- What will we expect of you?
- What you should expect of us

29

SIU Structure & Composition



30

Agenda

- ✓ Fraud Basics
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- ✓ Medical Review
- ✓ Provider and Member Calls
- ✓ Sampling Basics
- ✓ Excel Training
- ✓ Break out groups

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Disclaimer

Any views expressed within this report are those of Integrity Advantage and do not reflect the official position of any other organization, agency, or company. This training is based on our experience and training within the healthcare fraud, waste and abuse space and is subject to change as codes change and/or more information is made available.

This information serves as guidance for you as you continue to learn.

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Fraud Basics

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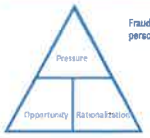
Why FWA in healthcare ?

- Healthcare spending in the U.S. is estimated at a staggering $3.3 trillion, representing 17.9% of the Gross Domestic Product
- By 2026, national healthcare spending is projected to reach $5.7 trillion
- Improper payments due to fraud, waste and abuse (FWA) are estimated to be between $80 Billion to $200 Billion annually, diverting funds that could otherwise be used for legitimate health care services.

34

Cause for Fraud – According to Cressey



Fraud Triangle – the three components to cause an ordinary person to commit fraud:

- Pressure > Motivation
- Opportunity > Method
- Rationalization > Justification

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Who Can Commit Healthcare Fraud?

- Beneficiaries/Members
- Providers
- Brokers/Agents
- Plan
- Pharmacies
- Suppliers
- … anyone with ability to impact claim submissions

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Areas Susceptible to Fraud

- Medical Claims
- Prescription Claims
- Beneficiary Enrollments
- Beneficiary Coverage
- Insurance Sales

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Fraud, Waste, and Abuse (FWA)

- What is FWA? FWA is a commonly used acronym for the causes of most inappropriate payments by health insurers
  - Fraud - the *intentional* misrepresentation of fact for material gain as ***determined by a court of law***
  - Waste - overutilization, underutilization, or misuse of resources
  - Abuse - consists of business practices that are not consistent with sound standards

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What Constitutes Fraud?

Fraud – the **intentional** misrepresentation or deception in order to gain something of value. In order to prove fraud you must show the intent, the deception and the gain. Fraud is a legal concept only determined by Judge or Jury.

CPM Definition: 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. Fraud can be committed by a contractor, a subcontractor, a large provider, a provider, and/or a FDHB beneficiary/enrollee. It includes any act that constitutes fraud under applicable Federal and/or state law.

Examples include but are not limited to the following schemes:
- billing for services that were never rendered,
- misrepresenting who provided the services,
- altering claim forms, electronic claim records or medical documentation, and
- falsifying a patient's diagnosis to justify tests, surgeries or other procedures that aren't medically necessary.

An investigator should never make a determination or finding of "Fraud"

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What Constitutes Waste?

Waste is unnecessary costs to the health care system, typically attributed to systemic weakness or failures within an insurers process

- Absence or Failure of Claim Edits
- Lack of Policies
- Lack of Policy Enforcement
- Overutilization of Services

Example:

Health Plan does not have a claims edit to prevent paying a claim billed with more than 3 units of CPT A4310 – MUE Limit is 3

40

What Constitutes Abuse?

Abuse is often would-be Fraud without being able to prove the intent

- Generally abuse is the result of provider practices that are inconsistent with sound medical practices, that result in unnecessary cost to the program, or that result in reimbursement for services which are not medically necessary or that fail to meet professionally recognized standards for health care

Example:

Dr. Romo consistently bills the same 25 lab codes for all patients

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Cost Containment

Cost containment is the business practice of maintaining expense levels to prevent unnecessary spending or thoughtfully reducing expenses to improve profitability without long-term damage to the company. Waste is often part of cost-containment

- Errors
- Policy holes
- One-off scenarios

Cost Containment vs FWA Investigation

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Stages of Investigation

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Stages of Investigation

1. Detection
2. Allegation Assessment
3. Investigative Strategy / Planning
4. Information Gathering
5. Evaluation of Evidence
6. Determination of Action
7. Case Resolution

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Contents of a Typical Case File

- Initial Allegation
- Assessment of Allegation
- Investigative Plan
- Reports: Investigative Case Report (ICR), Memorandum of Interview (MOI), On-Site Audit Report
- Surveys
- Data Analysis
- Statistically Valid Random Sample or Probe Sample
- Correspondence (with Providers, Law Enforcement, etc.)
- Medical Record Review (based on SVRS) – smart system that will pull SVRS based on patterns of billing, flags and ability to substantiate the allegation
- Overpayment demand
- Case notifications
- Tracking Financials (Identified Losses, Recoveries, Savings, Prevented Losses)
- Case Summary
- Settlement Docs (Corrective Action Plans, Settlement Agreement, Repayment Plan)

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Where do we get cases?

Internal Sources:
- Health Plan Employees
  - Customer Care
  - Utilization Review
  - Provider Relations
  - Claim Processing
- Proactive Data Analysis

External Sources:
- Health Plan Members/Patients and Providers
- Vendors
- Law Enforcement
- Other Insurers
- Other Providers
- News/Notifications

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Detection

Data Analysis or Software Analytics
- GEHA Standards and policy
- Customary Standards
  - Medical practice standards
  - Patient risk
  - Exposure
  - Identified aberrant billing patterns
- Investigative Analysis
  - Claims data analysis
  - Background research

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Allegation Assessment

- Data analysis
  - Can you see or validate the allegation with data?
  - Do you need to talk to members to substantiate?
- Pattern Analysis
  - Is the allegation limited to one member?
  - Is there indication of a systemic issue?
- Past Cases, Allegations or Complaints?
  - Have there been past cases? Seemingly unrelated… any tie in?
  - Any member complaints?
  - News articles?

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Allegation Assessment (cont'd)

- Exposure Identification
  - Collect provider/member claims data
  - Identify total payment to suspect
- Trend and Pattern Identification
  - Utilize internal resources to detect trends
    - Milliman
    - Hotline
    - ACoE
- Sample Parameter Identification
  - Determine sample after identifying aberrant billing patterns and/or suspect payments

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Investigative Strategy / Planning

Blueprint of the Case

Consists of 5 parts:

1. Statement of Predication
2. Elements to Prove
3. Preliminary Investigative Steps
4. Secondary Investigative Steps
5. Findings or Conclusion

Target dates of completion

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Information Gathering: *Research*

Background Information
- Licensing
- Disciplinary Actions/Exclusions
- Locations
- National Provider Identifier
- Provider Contracts
- Ownership Information
- Any other existing cases?

Data Analysis
- Exposure Identification
- Trend Identification
- Pattern Identification

Sources of Information
- Internal searches
- Medical Directors
- Corporate document requests
- CPT Coding Handbooks, etc.
- NHCAA SIRS
- External consultants
- The sources are endless

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Sources of Information

Publicly Available Internet Resources
- NPPES – National Provider Identifier (NPI) Registry
- Westlaw
- Department of State/Health
  - Licensing Verification
  - Division of Corporations
  - Physician Discipline and Professional Misconduct
  - State Exclusion Lists
- OIG– Exclusion List and Annual Reports, CIAs and Press Releases
- ProPublica

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More Sources (cont'd)

Publicly Available Internet Resources
- CMS.Gov
  - LCDs/NCDs – Decisions by Medicare and their administrative contractors that provide coverage information and determine whether services are reasonable and necessary on certain services offered by participating providers within a geographical area.
  - Program Manuals
  - Physician Fee Schedule Lookup – (Look up global surgical package, modifiers)
  - NCCI Edits – (pairs of CPT and/or HCPCS that should not be reported together)

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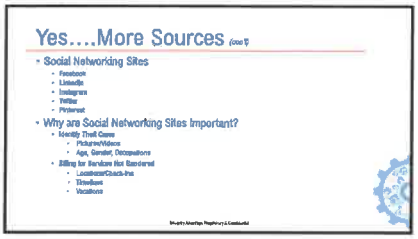
….. More Sources (cont'd)

- Healthcare/Coding Resources
- Findacode.com
- Healthguideusa.org
  - Health license lookup by specialty and state
- Ratemds.com
  - Provider reviews and ratings
- Healthgrades, Vitals, etc.
  - Comprehensive physician and hospital information
  - Reviews and ratings
- Provider and Manufacturer Websites
  - Date hours of operation information
  - Types of services provided
  - Advertising services to "new patients"

54



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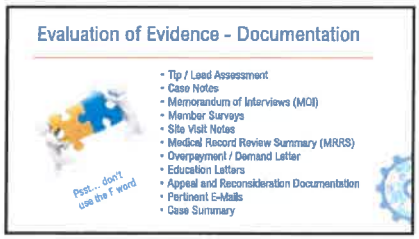

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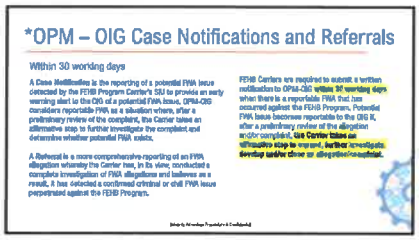

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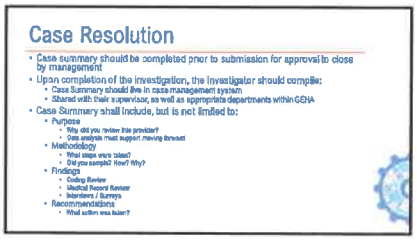

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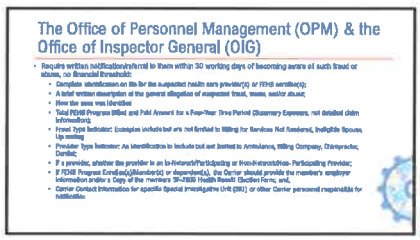

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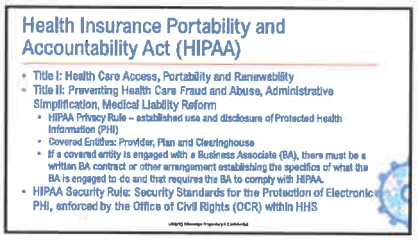


63

HIPAA (cont.)

HIPAA Security Rule: *Security Standards for the Protection of Electronic PHI*

- Established national standards for protecting PHI held or transmitted electronically
- Covered entities must 1) ensure the confidentiality, integrity, & availability of all e-PHI they create, receive, maintain, or transmit, 2) identify & protect against reasonably anticipated threats to the security or integrity of the information, 3) protect against reasonably anticipated impermissible uses or disclosures, and 4) ensure compliance by their workforce.
- Business Assoc. liability- If a covered entity knows of an activity or practice constituting a material breach by the BA it must take reasonable steps to cure the breach or end the violation. Violations include failure to implement safeguards

64

Legal and Regulatory

Federal Laws Concerning Healthcare Fraud

- False Claims Act (FCA) – penalizes folks who knowingly submit claims paid for false claims
  - Qui Tam – "whistleblower" provision of the FCA
- Anti-Kickback – Prohibits receiving or paying anything of value to induce referrals by a federal health program
- Stark Law – Prohibits physicians referrals of federal health patients for designated health services to an entity with which the physician or an immediate family member has a financial relationship
- Patient Protection and Affordable Care Act (PPACA) – Increased FWA prevention funding and abilities

Federal Regulatory Entities

- CMS – Guidance and Regulations, Coverage Determinations – Local (LCD) & National (NCD)
- The Office of Personnel Management (OPM) Office of Inspector General (OIG)

State Laws

65

False Claims Act (31 USC § 3729)

- Penalizes those who:

  A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

  (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim....

  (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or ***knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government***
- Penalty of $5,000-$10,000 per claim and treble damages
- Reduced penalty available for those who self-report within 30 days of discovering the violation, cooperate with the investigation, and there isn't already a case in progress

66

FCA Qui Tam Provisions (31 USC § 3730)

- An individual may bring an action under the FCA, known as a Qui Tam action. The action is brought in the name of the Government, and the individual is known as the "relator" or more commonly as the "whistleblower".
- Must be brought within 6 years of the violation or within 3 years after the Government knew or should have known of the violation
- Relator must be the "original source"; complaint cannot be based on public knowledge; must have specific knowledge of the alleged fraud
- Specific claims: *United States ex rel Simpson v. Bayer Corp.*, alleging off-label marketing does not constitute a FCA violation unless it can be tied to specific false claims
- Retaliation by Defendant against the relator prohibited
- Relator's award is 15-25% of the amount recovered by the Government depending on their level of involvement in the case plus "reasonable" expenses and "reasonable" attorneys' fees
- If the Government does not intervene, relator's award is 25-30%

67

Corporate Integrity Agreements (CIA's)

- Avoid exclusion
- Typically last 5 years
- Common requirements:
  - Hire Compliance Officer/create Compliance Committee
  - Develop written standards & policies
  - Comprehensive training program for employees
  - Hire independent review org. to conduct reviews annually
  - Establish confidential disclosure program
  - Restrict employment of ineligible persons
  - Report overpayments, reportable events, investigations/legal proceedings
  - Report implementation to OIG & annual reports to OIG regarding compliance activities

  https://oig.hhs.gov/compliance/corporate-integrity-agreements/cia-documents.asp

68

Anti-Kickback Statute (42 USC § 1320a-7b(b))

- Prohibits
  - soliciting or receiving anything of value
  - offering or paying anything of value
  - Directly or indirectly
  - To induce referrals or other transactions paid for in whole or in part by a Federal health care program
- Applies to referrals made by anyone, to any services, & to all federal health programs
- Penalties
  - Criminal penalties: Fine up to $25,000 per violation & up to 5 years imprisonment per violation, Exclusion
  - Civil penalties: Fines of up to $50,000 per violation, treble damages, Exclusion, possible FCA liability

69

Stark Law (42 USC § 1395nn)

"Limitation on certain physician referrals"

- Prohibits physician referrals of Medicare or Medicaid patients for designated health services to an entity with which the physician or an immediate family member has a financial relationship
- Entity receiving the referral may not submit a claim for payment for the DHS
- Financial relationship defined as an ownership or investment interest or compensation arrangement
- Difference between Stark & AKS: Stark applies only to physician referrals, the specified DHS, and Medicare/Medicaid payments

70

Stark Law *(Cont'd)*

Penalties

- Denial of payment/overpayment refund
- Civil monetary penalties for intentional violations, up to $15,000 per service
- Up to $100,000 for participation in circumvention schemes
- Treble damages
- Exclusion
- Potential FCA liability

71

PPACA

Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. 119)

- Increased funding for FWA prevention
- Increased Medicare enrollment screening procedures based on risk categories
- States must follow minimum screening requirements established federally
- CMS may suspend payments based on a credible allegation of fraud
- State Medicaid program must exclude a provider who is excluded federally
- FCA "indirect" or "reverse" false claims- overpayments received must be reported and returned within 60 days of identification or the date a cost report due
- Relaxed requirements for qualifying as an "original source" in Qui Tam actions

72

PPACA (cont'd)

- Payments made through the state exchanges are subject to FCA if federal funds included
- Removed knowledge requirement from AKS
- Physicians must provide written notice to patients of ownership/compensation interests with providers of in-office ancillary services
- Reduced Stark penalties for technical violations
- No new physician-owned hospitals

73

Healthcare Fraud (18 U.S.C. § 1347)

(a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

(1) to defraud any health care benefit program; or

(2) 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, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section

74

Criminal False Claims (18 USC § 287)

- Criminal counterpart of the Civil False Claims Act

Whoever makes or presents to any person or officer in the civil, military, or naval service of the United States, or to any department or agency thereof, any claim upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent, shall be imprisoned not more than five years and shall be subject to a fine in the amount provided in this title.

75

Mail Fraud (18 U.S.C § 1341)

- Makes it a federal crime to engage in any scheme to defraud any person that involves use of the Postal Service or any private or commercial interstate carrier
- Applies any time a mailing occurs as part of a fraudulent scheme. Merely mailing a fraudulent health care claim or even mailing a premium payment connected to a fraudulent scheme constitutes a violation of this statute
- Mail fraud is the most common criminal federal statute applied in fraud cases.
- Penalized by a fine or imprisonment up to 20 years or both; if the fraud involves a federal disaster or emergency, or effects a financial institution the penalty is a fine up to $1M and up to 30 years imprisonment or both

76

Wire Fraud (18 U.S.C. § 1343)

Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such schemes or artifice, shall be fined under this title or imprisoned not more than 20 years, or both. (If the fraud involves a federal disaster or emergency, or affects a financial institution the penalty is a fine up to $1M and up to 30 years imprisonment or both)

77

Other Possible Criminal Offenses

Criminal False Statements (18 USC § 1001)

Prohibits knowingly and willfully within the jurisdiction of any branch of the Federal Government falsifying/concealing materials a material fact, making a materially false, fictitious, or fraudulent statement or representation, or making or using any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry. Carries a penalty of not more than 5 years, with some exceptions

Money Laundering (18 USC § 1956)

- Health care fraud is a specified unlawful activity in the statute

Conspiracy (18 USC § 371)

- If two or more persons conspire either to commit any offense against the United States, or to defraud the United States, or any agency thereof in any manner or for any purpose, and one or more of such persons do any act to effect the object of the conspiracy, each shall be fined under this title or imprisoned not more than five years, or both. (exception if the object is a misdemeanor)

Racketeer-Influenced Corrupt Organization (18 USC § 1961-1962)

- Designed for organized crime but broad enough to apply to illegal activities relating to any enterprise affecting interstate commerce or foreign commerce
- Allows prosecution of a criminal enterprise as a whole

78

Schemes & Analysis

79

Provider FWA – Common Schemes

- Up-coding
- Billing for Services not rendered
- Medically Unnecessary
- Altering diagnosis codes
- RX Fraud
  - Overprescribing
  - Drug diversion
- Two Tier Billing
- Duplicate Billing
- Billing for 'Free' Services
- Unbundling
- Kickbacks
- …. and the list keeps growing

80

Up-Coding

- Coding for services or supplies in a way that increases payment beyond what was rendered
- Variety of ways and typical code sets:
  - Changing the place of service
  - Billing for higher level Evaluation and Management codes
  - Increased timed-code units
  - Increased J-Code units

81

Billing for Services Not Rendered

Submission of claims for services never provided to the patient or supplies not delivered to the patient

- Examples:
  - A patient sees their physician, in addition to the services rendered to the patient that day, the providers office adds a service or supply that you didn't receive… could be a brace, an extra lab test, a modality… could be added by the physician or the biller
  - Durable Medical Equipment (DME) supplier buys a list (off the dark web, from an employee of a provider) of members information and starts billing

82

Medically Unnecessary Services

CMS defines Medically Necessary as "health-care services or supplies needed to prevent, diagnose or treat and illness, injury, condition, disease or it's symptoms that meet accepted standards of medicine." Therefore, services and supplies that are not needed would fall under unnecessary.

- Performing services that are not medically necessary in the evaluation, diagnosis and/or treatment of the patient
- Common in multi practice setups
- Difficult to prove… but it can be done!
- There's a fine line…. Be careful
- Pros and Cons – IS THIS FRAUD?

83

Altering Diagnosis Codes

- Intentionally and wrongfully describing a *non covered* service in a way that it becomes a covered service
- "Creative Billing"
- Patients are sometimes involved in this type of fraud
- Rhinoplasty as septoplasty, tummy tuck as hernia repair, breast augmentation as lumpectomy
- How do you investigate this type of fraud?
  - What is the provider specialty?
  - Run reports…Look at other patients and see if you have a similar pattern
  - Review the records

84

Billing for 'FREE' Services and Supplies

- Submitting claims to carrier for services/supplies that are advertised as free or patient believes to be free
- In the form of coupons, vouchers, gift certificates, etc.
- Ploy to get the patient in the door and "find" something wrong with them

85

Unbundling

- Intentionally separating the components of a multi-component CPT code in order to increase reimbursement (labs are common)
- Billing for services covered in a global period
- Bloodwork and ancillary services
- Claim splitting
- Modifier -59
- National Correct Coding Initiatives (NCCI Edits published by CMS)

86

Kickbacks

- Paying a fee to a member, physician or other entity for the referral of a patient
- Elements necessary to prove a kickback include:
  - Knowing and willful
  - Anything of value was provided as "payment"
  - Anything solicited, received, offered or paid
  - In exchange for or to induce a referral

87

Pharmacy Schemes

- Dispense expired, fake, or diluted drugs
- Altered Rx's
  - Quantities
  - Dispense As Written (DAW)
  - Split Rx's and charge for another if they cannot fill a whole Rx
- Provide generics when the prescription requires that brand be dispensed
- Bill PBM's for prescriptions that are not filled or picked up
- Diversion of drugs

88

Transportation

Many plans cover transportation to patients who are unable to drive to medical destinations and even some to non-medical destinations

- Inflation and/or fabrication of mileage report and trip sheets
- Group transportation billed as individual
- Up-coding from Basic Life Support (BLS) to Advanced Life Support (ALS)
- Trips to nowhere
- Unknown agreements between facilities (kickback)
- Needed to show it's FWA…
  - Obtain trip sheets
  - Obtain mileage logs
  - Surveillance, if possible
  - Member interview

89

Mental Health Providers

- Impossible day analysis
- Upcoding length of visits by increasing units
- Cookie cutter billing
  - All have 60 mins of psychotherapy (90837 / 90838)
- Bill for individual visits when they are actually group sessions (unbundling)

90

Durable Medical Equipment

- Solicitation
- Scheduled billing
- Kickbacks
- Billing for equipment never provided
- Billing for equipment already picked up
- Refusing to pick up equipment
- Upcoding:
  - new vs. used
  - rental vs. purchase
  - electric wheelchair vs. motorized scooter vs. standard wheelchair
  - OTC quality billed as custom (orthotics)

91

Labs

Laboratory Providers often:

- Unbundle complete blood panel or general health panel into itemized tests
- Duplicate billing for same code as the physician
- Panel billing – not specific to order and patients
- Services Not Rendered
- Kickbacks

92

Waiver of Co-pay / Co-Ins / Deductible

- Provider intentionally and routinely does not collect co-pay, co-ins, or deductible from patients
- What's wrong with that???
  - Provider certification
  - Misrepresentation of the amount billed to carrier
- Providers who have been known to do this:
  - Chiropractors and PT's
  - Dentists
  - Primary Care Physicians

93

Home Health / Hospice Providers

- Submit altered and/or forged documents inflating the # of visits or hours
- Upcoding - inflate level of care (cooking, cleaning, etc)
- SNR – will bill as if they were there, but in reality, they may never have even visited the home
- Look for patterns of all patients with max benefit visits

94

Report Writing & Case Documentation

95

Case Documentation Must Be....

- Objective
- Clear
- Concise
- Correct (factually and grammatically)
- Complete
- Timely

Answer: Who What When Where Why How
Remember, this case can go to court...
Who will be reading your report?

"Failing to prepare is preparing to fail"

Organization is a MUST

96

Documenting the Evidence Chain

As soon as you get it, document:

1. What it is?
2. When did you receive it?
3. Where did you get it?
4. Who gave it to you? Or, who did you give it to you?
5. Why do you have it?

DO NOT MAKE ANY MARKS ON HARD COPY EVIDENCE;
ALWAYS MAKE A COPY AND KEEP THE ORIGINAL SAFE

97

Other Documentation:

Case Notes...

- Include all pertinent info – Less is More.
- Clarify exactly what you are talking about!
- Make sure the information you document is factual, not "feelings"
- Unbiased, objective narrative

Letters...

- To members/providers/attorneys
- Do not disclose case specifics – just facts, not suspicions
- Do not make any "fraud" statements

MCR's...

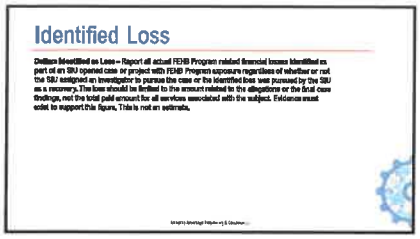
- Permanent record of facts obtained (Must be specific, always assume a case will go to trial!)

98

Let's Talk Numbers.....

- Exposure - Paid
- Identified Loss - Paid
- Savings - Prepayment
- Recoveries – Post Payment
- Prevented Losses – Estimated Savings
  - Change in Behavior - clear change in billing practices
  - Process Improvement - internal controls put in place

99



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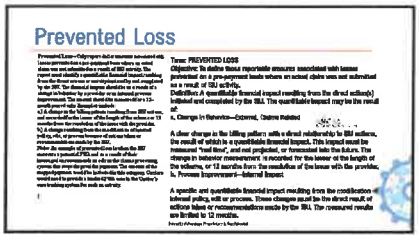

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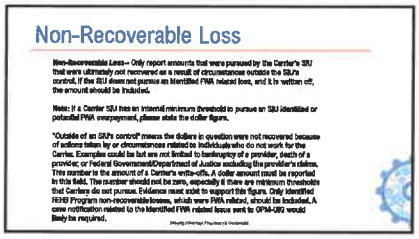

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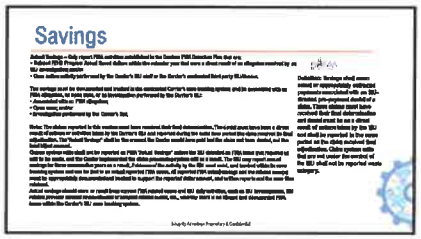

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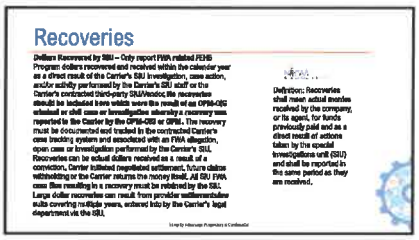

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Integrity Advantage®

Healthcare Fraud, Waste and Abuse Data Mining for Fraud Schemes

Health Alliance

August 2022

1

Your Speakers

Jessica Gay, CPC, AHFI, CFE

Vice President and Co-Founder, Integrity Advantage

2

About Integrity Advantage

- Our team has decades of experience in healthcare fraud, waste and abuse at state, commercial payers and vendors
- Our *niche* is healthcare fraud, waste and abuse (FWA) and Special Investigations Unit (SIU) program support
- Provide services ranging from consulting and program assessments to fully outsourced Special Investigations Unit (SIU) and customized training
- Accredited Healthcare Fraud Investigators (AHFI), Certified Fraud Examiners (CFE), Certified Professional Coders (CPC) and Certified in Healthcare Compliance (CHC), Registered Nurses (RN), Licensed Practical Nurse (LPN), Professional Science Masters (PSM)
- Diversity Certifications – WBE (Women's Business Enterprise) and EDWOSB (Economically Disadvantaged Woman Owned Small Business)

3

Agenda

Data Mining Basics

Schemes for the following focus areas:

- Applied Behavioral Analysis
- Ground Ambulance
- Psychotherapy
- Telemedicine

4

Fraud, Waste and Abuse Estimates

National Health Care Anti-Fraud Association (NHCAA)
Estimates 3–10% of all healthcare payments are attributed to Fraud, Waste and Abuse (FWA)

5

Data Mining Basics: Thing to Consider

- Know your plan demographics
  - Number of lives covered
  - Geographic spread
- Have a minimum threshold for the following:
  - Total dollars paid
  - Member count
  - Service count
- Embrace outlier analysis

6

ABA Flags

- Overbilling of time-based applied behavior analysis services
- Overbilling or underbilling of time-based applied behavior analysis assessments
- Autism diagnosis at an unusual age
- Single provider diagnosing autism

7

Overbilling of Time-Based Applied Behavior Analysis Services

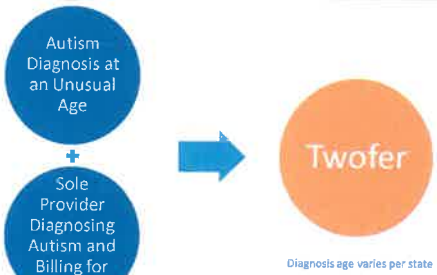
- 97153-97158, 0373T
- 15-minute increments
- How much is too much time?

8

Overbilling or Underbilling: Time-Based Applied Behavior Analysis Assessments

- 97151, 97152, 0362T
- 15-minute increments
- What's the normal frequency?

9



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Ground Ambulance Schemes

- Outlier analysis - non-emergency transportation that is not medical necessary
- Upcoding ground transport from BLS to ALS
- Overutilization of unlisted service code
- COVID-19 related – services not rendered for "treat in place"

11

Ground Ambulance Codes

Code	Emergency?	ALS or BLS
A0426	Non-Emergency	ALS
A0427	Emergency	ALS
A0428	Non-Emergency	BLS
A0429	Emergency	BLS

ALS - Advanced life support BLS - Basic life support

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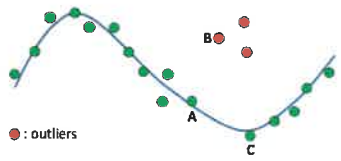
Outlier Analysis - Non-Emergency Transportation That is Not Medical Necessary

What is outlier analysis?

How can we use it to find problem providers?



A0426 or A0428, with modifier that contains D, P, or J in the ones place

13

Upcoding Ground Transport From BLS to ALS

14

Overutilization of Unlisted Procedure Code A0999

"What's the big deal, I like to be vague in my billing...," said no one.

15

COVID-19 related – Services Not Rendered For "Treat in Place" A0998

16

Psychotherapy Schemes

- High utilization of add-on psychotherapy code to an EM
- High utilization of 60-minute psychotherapy codes
- High utilization of uncommon add-on code may indicate services not rendered

17

High Utilization of Add-on Psychotherapy Codes to an EM

- Any Evaluation and Management (EM) service billed with the one of the following psychotherapy add-on codes: 90833, 90836, 90838
- Look for member encounter dates greater than 1 once a month

18

High Utilization of 60 Minute Psych Codes

90837
90838
90839

You must be superhuman, no bathroom breaks or eating?

And no one was late to their session?

19

High Utilization of Uncommon Add-on Code

90785 is as uncommon as a pink cat

20

Telemedicine Schemes

Billing telemedicine for services that can't be conducted virtually

Long-distance telemedicine services

Claim splitting - place of service

21

Billing Telemedicine for Services That Can't Be Conducted Virtually

Modifiers: 95, GT, GQ, GO

22

Long-Distance Telemedicine Services

23

Claim Splitting - Place of Service

And you get 2 claims for today...
So, we can really rake in the $$$!

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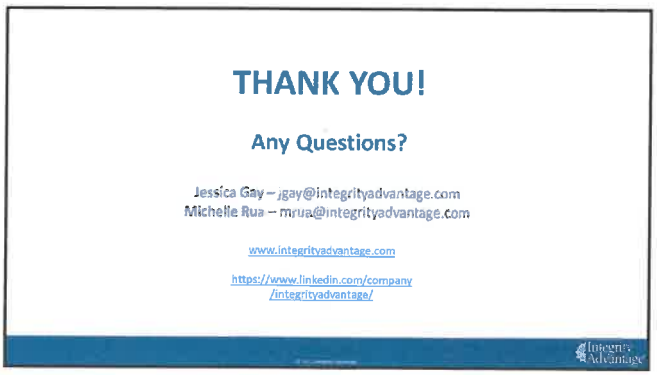
Summary
Data Mining Basics
3 ABA Schemes
4 Ambulance Schemes
3 Behavioral Health Schemes
3 Telemedicine Schemes

25


THANK YOU!
Any Questions?
Jessica Gay – jgay@integrityadvantage.com
Michelle Rua – mrua@integrityadvantage.com
www.integrityadvantage.com
https://www.linkedin.com/company/integrityadvantage/

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Integrity Advantage

BlueCross BlueShield Association

A Guide to Navigating the Excel Interface

Navigating the interface: a refresher. This document contains the following:

- ✓ Sheets Within a Workbook
- ✓ The Ribbon
- ✓ How to Select All
- ✓ How to Sort and Filter
- ✓ Keeping Your Sheets and Workbooks Organized

Disclaimers:

This document was created using Microsoft® Excel® for Microsoft 365 MSO (Version 2207 Build 16.0.15427.20182) 64-bit. Some of the exact visuals may differ if you are in a different version of Excel, however most should be comparable. To see which version of Office you're using, Microsoft has directions here.

In this document, we will be using screenshots for illustrative purposes from the file ***2021*** [redacted]*, provided for learning purposes by the Blues Academy. All data in this file has been contrived for learning purposes and does not contain actual claims activity or PHI. All provider, member and related identifying information contained in this workbook are fictitious. Any similarities to actual persons are purely coincidental.*

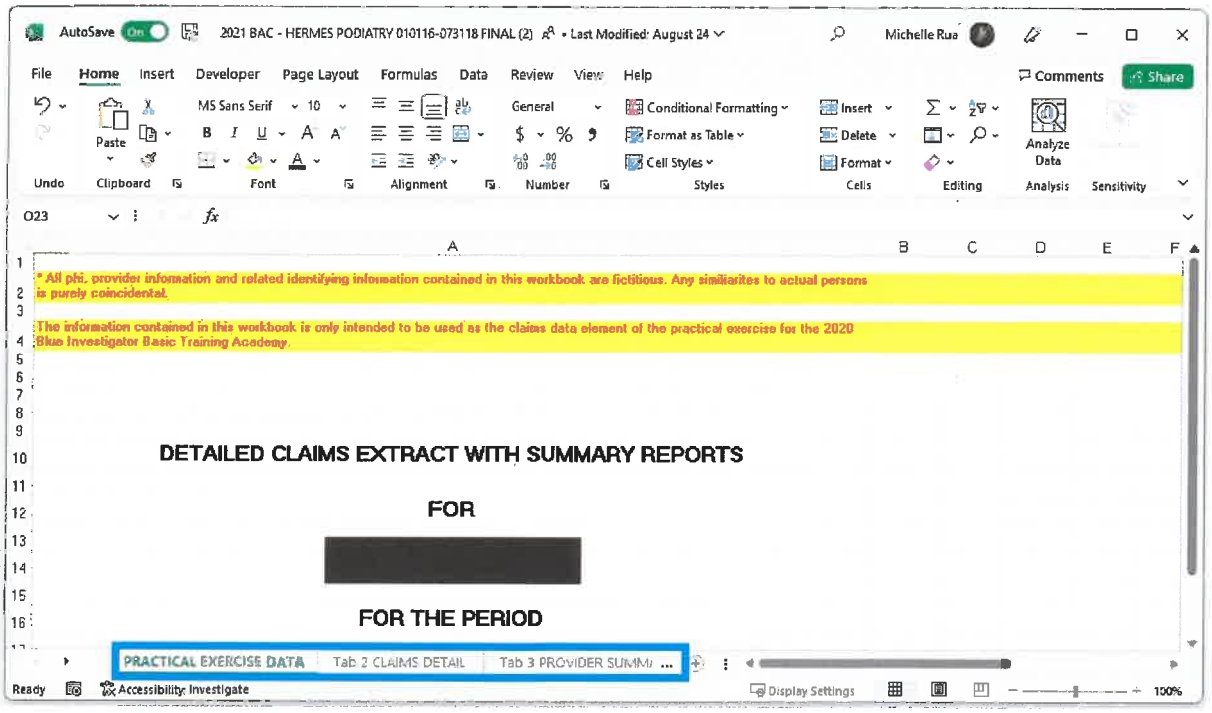
Furthermore, there are many ways to complete the same tasks in Excel, from toolbars, right clicking and keyboard shortcuts. These are some of the preferred ways for us.

Contents

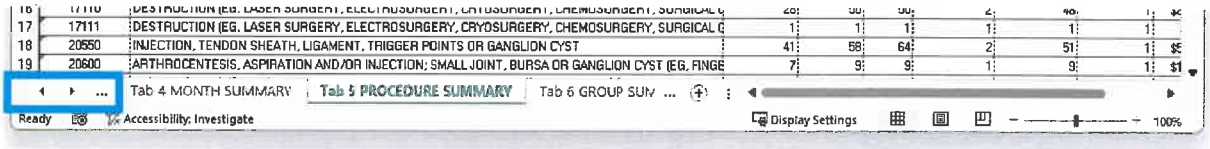
I. Sheets in the Workbook

a. When reviewing this Workbook, one of the first things we may notice are the Sheets at the bottom. These are sometimes referred to as Tabs.

b. There are multiple Sheets that contain different sets of information.



c. Clicking through sheets will show us the information on each. Using the arrow selectors on the left will allow us to view all sheets without having to individually select each one.

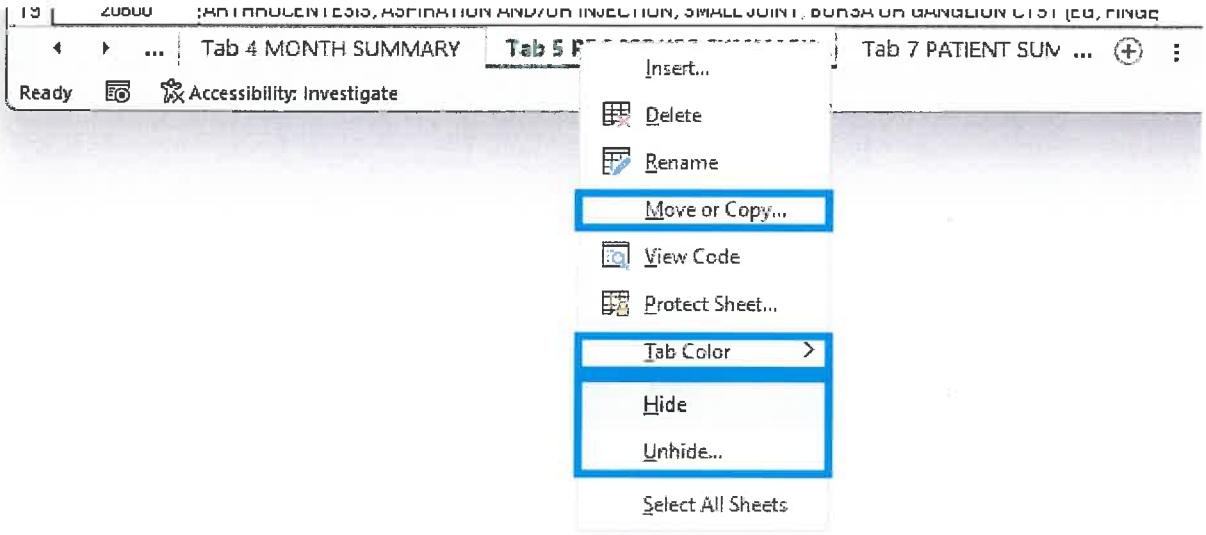


a. Move or Copy
   i. You can Move or Copy your Sheet to a different location, including a new Workbook

b. Tab Color
   i. This menu will allow you to change the Tab color of your Sheet, which may increase the organization to your Workbook

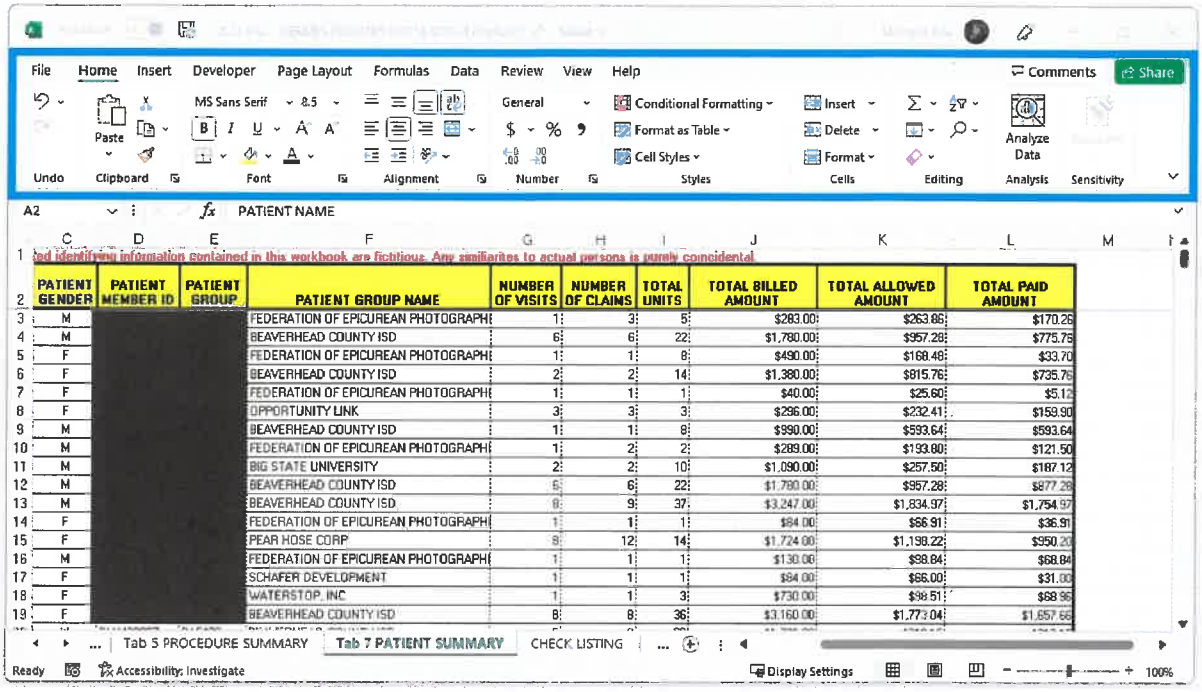
c. Showing/Hiding Sheets
   i. Right (or alternate if using a lefty mouse) clicking will allow you to view Sheet options. From there, you can Hide/Unhide Sheets to organize your Workbook

d. There are additional functionalities in this menu, as shown below



II. The Ribbon

a. The Ribbon is the interface that contains the user commands



PATIENT GENDER	PATIENT MEMBER ID	PATIENT GROUP	PATIENT GROUP NAME	NUMBER OF VISITS	NUMBER OF CLAIMS	TOTAL UNITS	TOTAL BILLED AMOUNT	TOTAL ALLOWED AMOUNT	TOTAL PAID AMOUNT
M			FEDERATION OF EPICUREAN PHOTOGRAPH	1	3	5	$283.00	$263.86	$170.26
M			BEAVERHEAD COUNTY ISD	6	6	22	$1,780.00	$957.28	$775.75
F			FEDERATION OF EPICUREAN PHOTOGRAPH	1	1	8	$490.00	$168.48	$33.70
F			BEAVERHEAD COUNTY ISD	2	2	14	$1,380.00	$815.76	$735.75
F			FEDERATION OF EPICUREAN PHOTOGRAPH	1	1	1	$40.00	$25.60	$5.12
F			OPPORTUNITY LINK	3	3	3	$296.00	$232.41	$159.90
M			BEAVERHEAD COUNTY ISD	1	1	8	$990.00	$593.64	$593.64
M			FEDERATION OF EPICUREAN PHOTOGRAPH	1	2	2	$289.00	$193.80	$121.50
M			BIG STATE UNIVERSITY	2	2	10	$1,090.00	$257.50	$187.12
M			BEAVERHEAD COUNTY ISD	6	6	22	$1,780.00	$957.28	$877.28
M			BEAVERHEAD COUNTY ISD	8	9	37	$3,247.00	$1,834.97	$1,754.97
F			FEDERATION OF EPICUREAN PHOTOGRAPH	1	1	1	$84.00	$66.91	$36.91
F			PEAR HOSE CORP	8	12	14	$1,724.00	$1,198.22	$950.20
M			FEDERATION OF EPICUREAN PHOTOGRAPH	1	1	1	$130.00	$98.84	$68.84
F			SCHAFER DEVELOPMENT	1	1	1	$84.00	$66.00	$31.00
F			WATERSTOP, INC	1	1	3	$730.00	$98.51	$68.96
F			BEAVERHEAD COUNTY ISD	8	8	36	$3,160.00	$1,773.04	$1,657.66

b. Ribbon Highlights: the following list contains some important features and where they can be found in Excel. There are additional add-ons that can be enabled, so you may have more than those listed below.

i. **File**: contains Save and Save As, Account Settings, and more

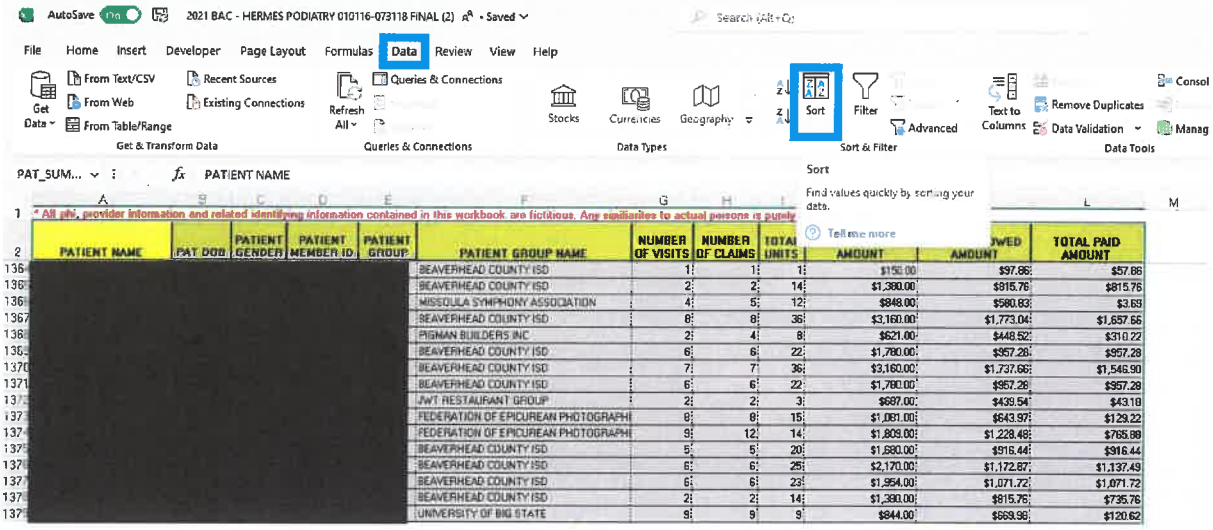
ii. **Home**: contains text formatting
iii. **Insert**: Contains PivotTables, Charts
iv. **Page Layout**: Print options, Page Themes
v. **Formulas**: Auto Sum, Insert Function, Formula Tracing
vi. **Data**: External Data Import, Remove Duplicates feature, Advanced Filter feature, Data Validation
vii. **Review**: Spell Check, Workbook Protection
viii. **View**: Gridlines, Page Break Preview
ix. **Help**: Searchable Excel Help Menu

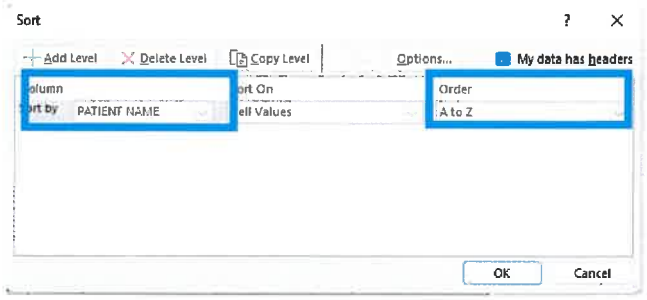
III. How to Select-All

a. This helpful shortcut may come in handy when you're working with large data sets. It will allow you to quickly select all data without selecting blank rows and columns and without taking time to scroll.
   i. Command: Ctrl + Shift + Right Arrow + Down Arrow
   ii. Begin by selecting the cell where your data starts. This is likely A1. Once selected, hold down the Control and Shift buttons to select all data in the data set.
      1. Note: This will not work if you have data with blanks in the column headings or blanks in the first column of information because Excel is looking for where the data "stops." Should the formula stop before you've covered the entire range, simply hit the down or right arrow one more time.
   iii.

IV. Sorting and Filtering

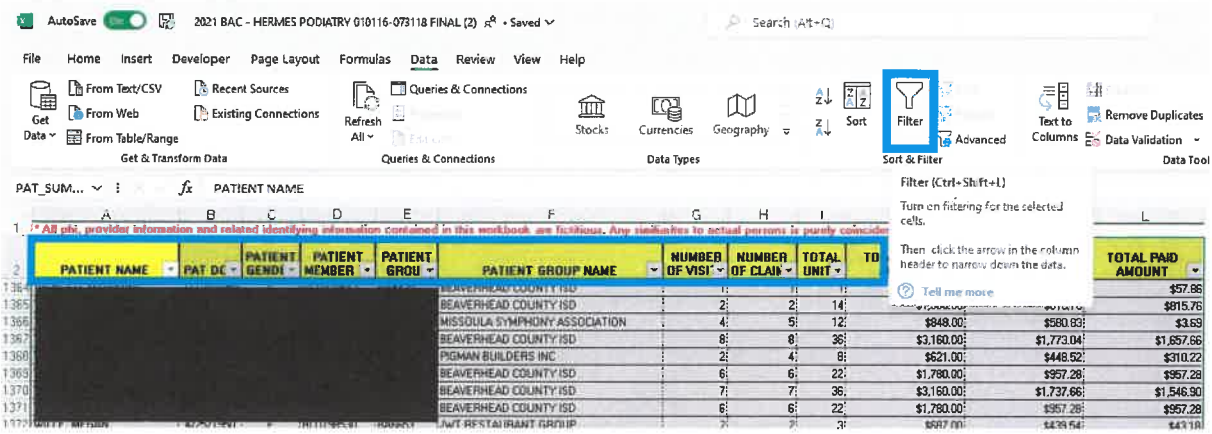
a. As with many capabilities of Excel, there are multiple ways to Sort and Filter your data.
b. Sorting
   i. One way to sort is to select all of your data and then navigate to the Excel Ribbon. In the Ribbon, navigate to the Data tab and then find Sort.





ii. Upon selection, you can specify which column(s) upon which you'd like to sort and if you'd like them in ascending or descending order.
    1. Example of a time you might want ascending order: member name sorted A to Z.
    2. Example of a time you might want descending order (Z to A): paid amount high to low.

c. Filtering
    i. Filtering your data is extremely helpful in the context of navigating large data sets. To Filter, in the Ribbon, navigate to the Data tab and select Filter, located right next to Sort. You'll know you've added Filters to your data when dropdowns appear next to each of your column headers.



V. Tips for Keeping Your Workbooks Neat and Organized

a. Add a data specs Sheet to all Workbooks containing some or all of the following:
   i. Data pull date
   ii. Data pull source
   iii. Claims date range(s): paid/service, etc
   iv. Person who pulled or provided the data
   v. Key identifiers for data: NPI, TIN, Provider ID, etc.
b. Label all Sheets with specific names
c. Use color coding to your advantage – group sheets by color to separate information
d. Don't be afraid to move or copy a sheet into another Workbook for your records and to simplify your process
   i. For example, use separate Workbooks for investigation and sampling, even if both are driven off the same initial data set.
e. Eliminate having too many tables/elements on a single Sheet, instead break them out among multiple named Sheets

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BlueCross BlueShield Association

Exercises: Complete on your own, and we will go through together and share answers.

- Top Member:
  - By Service Count – BLU786072
  - Unique DOS - BLU111627
- Top Proc Code:
  - By Claim (HINT: not claim line) count – A5512
  - By unique member – L1940
- Top 2 modifiers by Paid Amount: RT/LT
- How many members over 90 years old? 32

Integrity Advantage

BlueCross BlueShield Association

Exercises: Complete on your own, and we will go through together and share answers.

- What is % of total claim lines with 59 modifier?
    - Create a pie chart to illustrate
- Create an annual trend chart for spend and services
    - Add the quarterly numbers
    - What year and quarter hasn't the largest totals?

Investigator and Intake Staff Training Recommendations	
Category	**Training Item**
Health Care System	• Medicare training – Parts A, B, and D and Medicare Advantage (Medicare+Choice) • Medicaid • Tricare • Patient Protection and Affordable Care Act (ACA) • Key Federal and State Agencies - CMS, HHS-OIG, DOJ, USPS-OIG, DOL-OIG (ERISA group plans) State MFCU's • HIPPA
Internal Processes	• Claim adjudication/processing training – the "Life of a Claim" from receipt, to claim edit application, to payment or denial, should include manual review overview • Understand how adjudication processes affect claim data nuances
Legal	Burden of proof – private, civil and criminal • Civil – Civil False Claims Act (including qui tam), Stark Anti-Referral Statute, Anti-Kickback Statue, Civil Monetary Penalties Statues • Criminal – Health Care Fraud Statue, Health Care Benefit Program False Statements Statue, Mail Fraud, Wire Fraud, Money Laundering Fraud Other – HITECH Act, Federal Antitrust Laws, and Anti-Fraud Information Sharing
Investigative Writing	Investigative writing – objective vs subjective writing
Investigative Process	The anatomy of a healthcare fraud investigation Interviewing – drafting effective questions, conducting effective interviews, and report writing
FWA Schemes	Training on the identification of and effective investigation of the following FWA schemes: • Dental • Pharmacy • Facility billing
Resources	Identification and use of the following resources to learn what information is important and how to incorporate the findings into investigations: • state specific licensure for professionals and facilities • state specific Secretary of State corporation listings • state specific laws, regulations and regulators • public internet resources to gain knowledge relevant to investigations
Other	Learn how to recognize the limits of SIU investigations so that staff do not continue to deep dive into a case that will not yield ROI or results.

Specific Training By Employee	
Intake	
Lisa X	Excel – pivot tables, advance filters Milliman training General SIU Training
Joseph X	Excel – pivot tables, advance filters
Investigators	
Allison X	Investigative techniques
Kim X	Sampling and extrapolation Excel– advance filters
Medical Review (Optional Suggestions)	
Barbara X	Investigative techniques, Milliman PI
Kim X	Excel– Pivot tables, Milliman PI
Sally X	Excel – pivot tables, Milliman PI

Evaluation of HealthPlan's Special Investigations Unit (SIU)

The information contained in this report provides our evaluation of HealthPlan's SIU people, process and technology. Within this report, we identify findings and recommendations. The views expressed within this report are those of Integrity Advantage and do not reflect the official position of any other organization, agency, or company. Assumptions made in this analysis are not reflective of any other author(s) and are subject to change and revision as more information is made available.

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Executive Summary

HealthPlan is a participant in the Commercial, Medicare, Medicaid and Federal Employees Health Benefits Program (FEHBP). HealthPlan has responsibility for the implementation and oversight of its members' healthcare benefits under contracts with Centers for Medicare and Medicaid (CMS), Medicaid managed care contracts, and the Office of Personnel Management (OPM). HealthPlan is considered a mid-size health plan with nearly 2M covered lives and just over $4B in claims paid annually.

Under the aforementioned contracts, HealthPlan is required to proactively identify, investigate, prevent and report allegations of fraud, waste and abuse (FWA) by developing and maintaining a comprehensive program.

In July of this year, HealthPlan engaged Integrity Advantage to perform an assessment of the Special Investigations Unit. Integrity Advantage has over 25 years' experience in fraud, waste and abuse program development, management and oversight in the healthcare anti-fraud industry in both the payer and vendor environments. Our focus was a tactical assessment of the current people, processes and technology used in the SIU.

During our assessment we found that, in its current state, HealthPlan's SIU is not staffed with the proper mix of skillsets to operate effectively or efficiently. There is a lack of investigative knowledge, oversight, training, and processes within the SIU. No case management technology exists to track and report on all investigative work. Communication across the organization is lacking, and although it seems to have improved over the past several months, some business units do not have a fundamental understanding of the SIU's responsibilities. This barrier in communication impacts referrals to SIU from within the organization. In addition, work performed by the SIU is almost exclusively focused on prepayment claims from providers who have claims flagged for review. Very little proactive identification of cases is done. While the referrals to HealthPlan's regulatory agency have increased, this focus on prepayment claims has resulted in a burdensome backlog of outstanding claims inventory as well as "claims processing" functions residing within SIU.

In order to improve overall efficiency within the SIU, processes should be revamped to include training for management and staff, reorganization and structuring of SIU roles and responsibilities, implementation of a case management solution and staff balancing with the right skills sets to match current membership and claims volumes. Eliminating the "daily claim processing" mindset is essential. These changes must occur while staying focused on improving collaboration and communication across the organization. This can be achieved through an internal fraud, waste and abuse workgroup that would meet regularly to keep HealthPlan leadership informed of issues that might impact other business units, as well as gather feedback on how to mitigate risks.

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Scope of the Evaluation

This report provides our review of HealthPlan's SIU against industry best practices and provides recommendations that will further the mission of detection, investigation, prevention and reporting of fraud, waste and abuse.

Specifically, Integrity Advantage performed a review of documentation related to SIU people, processes, and technology including but not limited to:

- Recent regulatory oversight reports describing any SIU deficiencies
- Relevant regulatory directives
- Policies and procedures or work instructions in use by SIU
- Two years most recent Fraud and Abuse Annual Reports filed by HealthPlan to regulatory agencies
- Current documentation of roles / responsibilities of the team
- Organizational charts
- Identification of all teams/departments outside of the SIU where there is workshare or cross functional support
- Individual contributor SIU goals
- Recoveries, savings and prevented losses claimed by SIU
- Current staff resumes and qualifications
- Annual training held or taken by staff
- Sample referrals sent to regulatory agencies

We interviewed internal stakeholders on-site and received brief demonstrations of existing technology applications to understand their current use within HealthPlan's SIU. All SIU staff were interviewed as well as leadership from the following business areas:

- Internal Audit
- Claims Operations
- Legal
- Provider Network Management
- Medical Management / Utilization Management
- Recovery
- Customer Service
- Pharmacy
- Appeals

Our findings are based on industry experience in the healthcare fraud, waste and abuse arena and a thorough understanding of SIU benchmarks among health plans. We have provided findings and specific recommendations within each section and summarized the immediate areas of focus at the end of the report.

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People

Current State Assessment

HealthPlan's SIU consists of 10 staff members, most of which are inexperienced from the standpoint of understanding the lifecycle of a healthcare fraud, waste and abuse investigation. HealthPlan is aware of the need for additional staff and are waiting to make the right hiring decisions as there has been significant attrition and other staff changes in recent years. At present, there is little proactive data mining, analysis or investigative work being performed to identify inappropriate behavior that may be impacting HealthPlan. Historically and ongoing, SIU function is focused on prepayment, often for providers that the current staff has limited knowledge of and didn't initiate. We believe that the lack of communication and implementation of needed changes may be causing some staff members to struggle with understanding the new HealthPlan culture and mindset.

During interviews with the SIU team members, many did not understand the general expectations and requirements of the SIU around detection, investigation or prevention, nor how their job duties relate to these expectations. Furthermore, their goals do not align with responsibilities expected of the SIU. It is our opinion that without significant training, additional experienced staff and strong leadership, the SIU is not able to handle the complexity of healthcare fraud, waste and abuse investigations.

During interviews, the team provided feedback on the type of support they feel they would need in order to be successful:

- Training on how to perform investigations, the typical workflow, types of schemes, data analysis techniques and how to handle discussions with providers
- Regular 1-1's with leadership that can provide guidance specific to healthcare fraud allegations and how to move forward with investigations
- Case tracking / management application that captures completed work and drives next steps
- An understanding of individual advancement opportunities in the healthcare fraud industry

Recommendations

In our years working with health plans across the industry, we learned a variety of ways to successfully staff the SIU based upon plan size, lines of business, region, regulatory oversight and other factors. Our recommendations are based on all of these factors.

- **Structure and Composition**. Roles within the SIU must be updated to reflect a structure that would allow leads to come into the SIU and be vetted for assignment to staff. Claims processing responsibilities should be removed from the SIU. Assigning staff to roles that best fit their skillset will allow each member to master a role with specific SIU functions as well as foster better teamwork from intake, investigation and medical review, through case resolution. SIU staff composition should align more closely with HealthPlan's claim payment ratios: 70% Medical, 20% Pharmacy, 9% Dental, <1% Vision.

- **Job Descriptions & Goals.** For each role there should be a clear job description and specific goals assigned and reviewed periodically. Job descriptions will fit into larger job families that will provide the team members with an understanding of career progression on the team.

- **Size.** Based on size and membership, we recommend HealthPlan aim to have approximately 15 SIU staff members with a mix of investigators, medical reviewers, coders, management and admin staff. Of note, additional hires should have specific healthcare fraud investigation experience, not necessarily law enforcement, as the face of healthcare fraud investigations has evolved into a data driven role.

- **Training.** We recommend a customized training program be developed to address the various components of an investigation, from data analysis, interviewing, report writing, etc. In addition, HealthPlan should leverage existing memberships with trade associations to access webinars and other training opportunities to benefit staff.

Additional information related to individual staff can be found in *Appendix A*.

Process

Current State Assessment

A successful SIU has clear, accessible and documented processes implemented. Staff should be trained on organizational and departmental processes upon hire, as well as annually, as processes often change to match business needs. The assessment of the current processes of the HealthPlan SIU reveals that there is a need for consistency, thorough documentation of processes, as well as a significant shift in the function of the department and its interaction with other business units.

- **Deficient Process Documentation.** The current process documentation exists primarily as Desk Level Procedures (DLP's). At present, the DLPs do not accurately reflect the processes followed by the SIU team. The processes that are documented reflect claims adjudication processes rather than investigative processes. There is no apparent workflow in place to trace an incoming lead/tip to investigation or to completion.

- **Lack of Actual Caseloads / Casework.** The SIU should be spending the majority of its time performing investigations into providers, members and other entities who may attempt to defraud HealthPlan. However, HealthPlan's SIU is inundated with requests related to individual claims for review. The SIU is essentially operating as a claim processing shop and reacting to service forms that are routed to them each day based on prepay claims. The team works each claim as a 'case' and provides claims processing guidance rather than performing a retroactive analysis of a provider's overall billing patterns to determine if FWA exists. This is partly why reporting is difficult, as was getting an accurate case count during our on-site review. Furthermore, the focus on prepay review of individual claims has created a significant backlog in claims processing across the organization.

- **Dependence on Peer Review Vendors.** SIU team members mentioned using peer review vendors in order to validate whether claims should be paid or not, based on medical necessity and appropriateness of billing. Typically, SIUs have nurses and/or coders that

would handle most medical record reviews. Peer review entities who use MD's or DMD's to perform the reviews are unnecessarily driving up the cost of each review. There are instances that a peer review is warranted, however it should not be the norm.

- **Lack of Collaboration Across HealthPlan.** Nearly all of the business units we spoke with want a true partnership with SIU for the betterment of the organization. The SIU is seen as a "roadblock" by some departments, due to the lack of response or ability to complete things quickly. The SIU staff feel this and also mentioned this concern. All departments, including the SIU want communication lines opened; they want an environment where they share their work and concerns to improve outcomes for members and providers. However, conflicts in processes exist that are straining these relationships. For example, the Customer Care team is answering a large volume of calls from providers or members questioning claims that are 'with' SIU. Customer Care is not able to handle the calls in way that is satisfactory to the members. This creates frustration for Customer Care and providers, but more significantly the members who try to avoid paying balance billed charges by the provider whose claims are under review.

- **Difficulty Collaborating with leased network owners.** SIU Management indicated that when attempting to collaborate with leased network owners SIU leadership, efforts are not reciprocated. We expect that as HealthPlan's investigative case load grows, there will be opportunities to work with leased network owners to pursue a provider. More effort should be spent in building relationships with the SIU Managers at leased network owners to jointly pursue providers under investigation.

Recommendations

There must be a complete shift in the mindset of the SIU team as well as HealthPlan's expectation of the SIU. The SIU must have the authority to act in accordance with requirements of your regulatory agency. Improvement in this area will take time and includes a variety of education / communication across the organization.

SIU Specific Recommendations

1. Revamp SIU structure and processes to align with best practices in the healthcare SIU industry as well as HealthPlan's exposure across claims types.
2. Create a 'intake team' focused on reviewing referrals and other work sent to SIU to determine what should be discussed with management and assigned for investigation.
3. Eliminate DLP's for SIU and replace with SIU Policy and Procedure Manual that provides overall investigative guidance and methodology while still requiring staff to think independently.
4. Deliver training to the SIU to include, but not limited to:
    a. Investigative process for healthcare fraud, waste and abuse investigations
    b. Claims analysis
    c. Report writing
    d. Interviewing / Handling calls with Providers and Members
    e. Medical record review

5. Implement a Fraud, Waste and Abuse workgroup within HealthPlan, meeting once per month, which will bring together key business units (Claims, Customer Care, Utilization Mgmt., Appeals, Provider Network, Legal, Cost Recovery, Pharmacy, etc.) who will not only benefit from better communication with SIU, but also can provide insight and support for cases under investigation by SIU.
6. Eliminate all but the most egregious providers from prepay to allow the team time to be trained to handle the types of referrals that will result in fruitful investigations and recoupments.
7. Select a vendor that can perform medical record reviews using coders and nurses to augment the team while staffing up. It is not necessary to have an MD peer review of claims during an investigation. Leveraging coders and nurses will reduce the cost and increase the volume of reviews completed.
8. Begin using sampling and extrapolation in investigations to increase efficiency of reviews and reduce administrative burden on providers.
9. Provide Claims/Customer Care a list of the revised assignments related to providers under review so that service forms are routed to the appropriate SIU person.
10. Establish a process which will require SIU to handle calls (internal or external) related to investigations they are working.
11. Work with the recovery department to provide standard wording related to overpayment recovery letters and ensure SIU is copied on all recovery spreadsheets so as not to duplicate reporting of recoveries. Recovery should work closely with SIU in both recovery efforts and referrals from internal sources of recoupment.
12. Create and deliver training for all HealthPlan business units to understand SIU's responsibilities and know what should be referred to SIU, to increase internal referrals made by other teams.
13. Referrals should be routed to one person within the SIU for final review before being sent to Legal. Once the SIU is staffed properly with the right skillsets, Legal should be notified, but not have to do a final check on the referrals before they are sent to law enforcement.

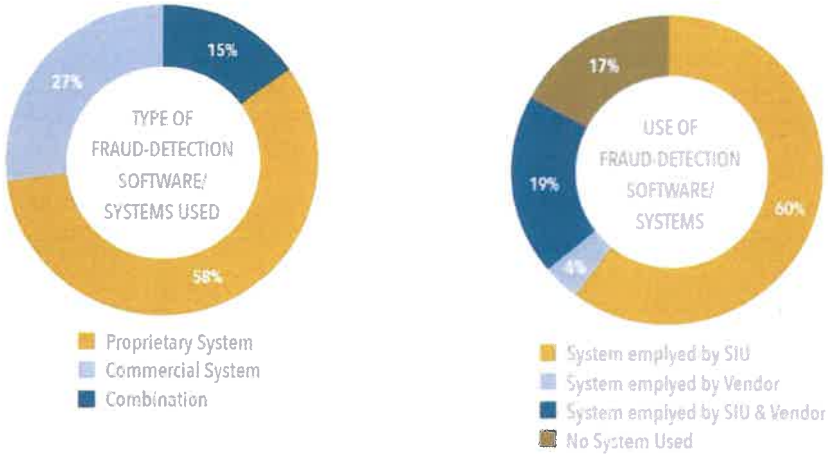
Recommendations for other business units within HealthPlan

1. Commit to participating in a Fraud, Waste and Abuse Workgroup as noted in #5 above.
2. Devise a process with Recovery to handle extrapolated case recoveries as the current process does not allow for groupings of claims to be blocked from further adjudication in the event that a provider settlement is made.

Technology

Fraud detection software can significantly increase identification of inappropriate behavior in need of investigation. However, our experience has shown that in many instances, it is not appropriately leveraged by staff. Many health plans license a technology solution used by their internal SIU. Other plans outsource all or part of the SIU responsibilities to a vendor. Some plans HealthPlan's size have an internal SIU and augment the SIU with vendor.

According to the NHCAA's last published annual report, the vast majority of health plans use fraud detection software that was either developed in house or commercially available.



Source: NHCAA Anti-Fraud Management Survey 2017 (Executive Summary), published July 2018.

Current State Assessment

HealthPlan's SIU has several technology platforms available for use; some are more actively used by the SIU than others. Only one technology solution, which is being sunset (FICO Insurance Fraud Manager) is specifically focused on healthcare fraud, waste and abuse detection. There is no true case management capability to support the tracking and reporting of the SIU's activities. The team currently relies on Macess to 'track' their work, but as we describe further below, Macess does not contain the necessary functionality to provide investigative case management.

Applications Currently in Use

- **Macess** is an enterprise-wide solution used for interdepartmental communication regarding claims. The SIU relies heavily on Macess, as it drives not only communication within the organization, but also their workload and 'case tracking'. Macess as a claims focused communication tool appears to work as needed. As a case management tool, it severely lacks functionality to support an investigation or capture the reporting elements to comply with regulatory requirements around FWA.

- **FACETS** is the enterprise-wide claims processing application. It is widely used by the SIU, however the SIU team's access should be limited to viewing, not processing or editing claims.
- **FICO Insurance Fraud Manager** is an analytic platform specifically for FWA detection in healthcare. HealthPlan has had a subscription for about 20 years, however due to the amount of turnover in the department, few staff could effectively use the tool and it is slated to be discontinued on 12/31/2019. FICO could be a useful tool to HealthPlan, however, not only would the data feed need to be evaluated, the contract would need to be renegotiated to better align with cost and the team trained on its use. We recommend that HealthPlan move forward with sunsetting the application. Once the SIU is set up for success, the plan should review options for proactive data analysis that can integrate with whichever case tracking system is implemented.
- **Westlaw** is an enterprise-wide research tool licensed by Thompson Reuters. Review of the tool's capabilities appear to meet the needs of the team as it transitions to investigation focused work. The tool provides demographic information of a provider or member, gathers ownership and lien information as well as discloses links between family and/or business entities both written and visually.
- **Milliman** is an ad-hoc data analysis tool that houses all medical, dental and vision claims in a single warehouse. The tool allows staff to access the data they need through this application. Although currently underutilized due to the way the department is operating, with additional training on process, this tool will be a great resource. We noted a concern regarding the paid amounts being incorrect, an issue that was reported in April of this year that may not yet have been fixed.
- **CVS Enhanced Safety and Monitoring System (ESMS)** Safety and Monitoring System (SMS) comes standard with CVS as the Pharmacy Benefit Manager (PBM). ESMS is the current add-on subscription to the enterprise solution which provides valuable information for the SIU to launch investigations and provides insight into trends and schemes in HealthPlan pharmacy claims.
- **EncoderPro** is a coding research tool that is invaluable in healthcare analysis. Although there are others similar in function, EncoderPro is one of the top, which offers levels of subscription based on the needs of the staff and department. If staff members acquire a Certified Professional Coder (CPC) certification, or a CPC is hired for the team, there is a level of subscription that can allow the coder to gain CEU's for no additional cost. Given the lack of coding expertise on the team, this is an essential tool for moving the knowledge base forward.

Applications Under Consideration for Future Use

- **CVS Premier Audit** is the next level of analytics provided by CVS and is being considered for purchase by HealthPlan. The overarching benefit of this add-on subscription, over the current subscription (CVS ESMS) is a CVS direct contact specifically for HealthPlan SIU. Considering the value derived from the current subscription, the significant cost of this add-on, and proportion of HealthPlan claim spend related to pharmacy, Integrity

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Advantage would not recommend moving forward with Premier Audit subscription at this time.

- **CLEAR** is a Thompson Reuters background check and research tool used to assist in FWA investigations. Many recent enhancements to the application, specifically for healthcare FWA, appear to have elevated what was historically a simple background tool, to a type of analysis / lead generation tool. Integrity Advantage will monitor tool enhancements for future recommendation conversations, however at this time, with the current Westlaw subscription and Milliman FWA add-on underway, we do not believe CLEAR would be a reasonable investment.

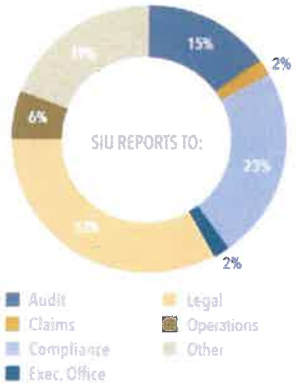
Technology Recommendations

1. Identify and implement a SIU case management solution that will have robust tracking and reporting capabilities, while providing a dashboard for leadership. Keep in mind when selecting a case management solution, you should factor in future interoperability with other solutions that augment the fraud, waste and abuse program.
2. Maintain use of Westlaw, for at least the next year, rather than subscribe to another background screening tool. The current subscription appears to provide the information needed for investigations.
3. Strong post payment analytics need to be prioritized, as the current solution will have limited capabilities in this area. Explore potential proof of concept opportunities to determine which analytics vendor might be a good fit for HealthPlan in the future.
4. If possible, delay the additional CVS subscription (Premier Audit), as the current subscription provides value to the SIU and pharmacy claims spend is only 20% of overall claims spend.
5. Long term prepay support (technology and services) should be considered for future. Services should focus on the appropriateness of services rendered and billed.

Other Findings and Recommendations

Positioning of SIU

We believe that the SIU's positioning under the Audit division, is appropriate at this juncture. In their latest Annual Management Survey (2017 results), the National Healthcare Anti-Fraud Association (NHCAA) published results that reflect input from 52 payers across the country, representing over $850 billion in health benefit payments and 3.8 billion claims. Of those respondents, 15% reported to Audit.

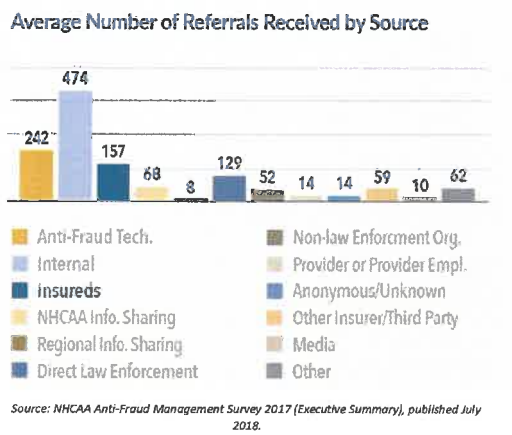


Reporting of SIU Activities within HealthPlan

Metrics associated with SIU performance are not being reported up at higher levels of HealthPlan, outside of the annual regulatory reports. This reduces SIU's accountability and limits visibility at higher levels of the organization. Once specific and measurable goals have been set, SIU activity should be reported to executive levels of HealthPlan at least monthly.

Referrals from Other Sources

SIU's generally receive their referrals from a variety of sources. The figure to the right provides information related to the various sources of referrals received.



Source: NHCAA Anti-Fraud Management Survey 2017 (Executive Summary), published July 2018.

During interviews, we encountered issues in other departments that should have been handled by the SIU. One such area was Member Enrollment where questionable claims (claims submitted after the death of a member or for unqualified spouse/dependents) were not referred to SIU, but rather handled without SIU involvement or knowledge. HealthPlan must ensure other business units send referrals to SIU if a questionable claim arises, as these instances may need to be reported as part of the Annual Fraud and Abuse report filed.

In addition, SIU must participate in regional and national workgroups that will provide additional leads for which HealthPlan has exposure. With HealthPlan's membership spread across the nation, many fraud schemes seen in various regions are likely to impact HealthPlan members.

Use of the "F" word.

On several occasions, SIU staff and other team members referred to provider behavior as "fraudulent." This was evidenced in email communications and notes displayed during interviews. It is imperative that HealthPlan staff do not issue a "fraud" verdict during communications (oral or written). As emails may be considered discoverable during litigation, we recommend prefacing it with "alleged" or "potentially" fraudulent or "potentially inappropriate behavior" in order to protect HealthPlan.

Summary

While there are a number of recommendations in this report, the current state SIU is not equipped to handle your regulatory requirements with current staff, process and technology. Although, progress has been made over the past year, the SIU has not demonstrated enough improvement in the areas that are most critical to its success. The SIU should be leading the FWA charge at HealthPlan, and the recommendations made throughout this document will drive this mission forward and require them to take on this responsibility.

The short-term, immediate focus needs to be on:

1. Restructuring the SIU and staff roles to align with an investigative approach
2. Creating and delivering SIU staff training
3. Selecting a SIU case management application
4. Reducing / eliminating the claims processing responsibilities within SIU
5. Setting clear and measurable goals that will be tracked and reported to leadership
6. Establish an FWA workgroup at HealthPlan for collaboration and communication

If HealthPlan chooses to move forward with these recommendations, we suggest that you notify your regulatory agency that HealthPlan is making changes to further enhance and improve fraud and abuse detection, investigation, prevention and reporting efforts. The changes may result in a decrease in savings reported by SIU but will increase identification and investigation of cases that can be referred to Law Enforcement, as well as potential recoveries, savings and prevented losses.

The recent culture and leadership changes at HealthPlan have made a positive impact on the organization as a whole. With focus on implementing the recommendations made in this report, we are confident that HealthPlan's SIU people, process and technology focused on detecting, investigating, preventing and reporting FWA will significantly improve in the short and long term.

Integrity Advantage

Appendix A: Staff

SIU Manager

SIU Nurse Reviewer

Sr. SIU Analyst 1

Sr. SIU Analyst 2

SIU Analyst 3

SIU Analyst 4

SIU Analyst 5

SIU Analyst 6

SIU Investigator 1

SIU Investigator 2

***Please note:** Our time spent on-site interviewing staff was limited. The implementation and training process will provide additional insight as to whether the staff are a good fit for the team long term.*

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Medicare Fraud Control Unit Training Curriculum

TABLE OF CONTENTS

SECTION 1: GENERAL INFORMATION

1.1. Introduction:

The West Virginia Department of Administration, Purchasing Division (hereinafter referred to as the "Purchasing Division") is issuing this solicitation as a request for proposal ("RFP"), as authorized by W. Va. Code §5A-3-10b, for the Office of the West Virginia Attorney General (hereinafter referred to as the "Agency") to obtain an accurate and objective assessment of the current training program in place for the Medicaid Fraud Control Unit ("MFCU") and to create and deliver a new training curriculum and new training programs that will address any knowledge gaps and incorporate best practices in new training programs for the MFCU.

The RFP is a procurement method in which vendors submit proposals in response to the request for proposal published by the Purchasing Division. It requires an award to the highest scoring vendor, rather than the lowest cost vendor, based upon a technical evaluation of the vendor's technical proposal and a cost evaluation. This is referred to as a best value procurement. Through their proposals, vendors offer a solution to the objectives, problem, or need specified in the RFP, and define how they intend to meet (or exceed) the RFP requirements.

Proposals should be prepared in such a way as to provide a straightforward, concise delineation of capabilities to satisfy the requirements of the RFP. Emphasis should be concentrated on conformance and clarity of content.

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SECTION 2: INSTRUCTIONS TO VENDORS SUBMITTING BIDS

Instructions begin on next page.

INSTRUCTIONS TO VENDORS SUBMITTING BIDS

1. REVIEW DOCUMENTS THOROUGHLY: The attached documents contain a solicitation for bids. Please read these instructions and all documents attached in their entirety. These instructions provide critical information about requirements that if overlooked could lead to disqualification of a Vendor's bid. All bids must be submitted in accordance with the provisions contained in these instructions and the Solicitation. Failure to do so may result in disqualification of Vendor's bid.

2. MANDATORY TERMS: The Solicitation may contain mandatory provisions identified by the use of the words "must," "will," and "shall." Failure to comply with a mandatory term in the Solicitation will result in bid disqualification.

3. PREBID MEETING: The item identified below shall apply to this Solicitation.

☑ A pre-bid meeting will not be held prior to bid opening

☐ A **MANDATORY PRE-BID** meeting will be held at the following place and time:

All Vendors submitting a bid must attend the mandatory pre-bid meeting. Failure to attend the mandatory pre-bid meeting shall result in disqualification of the Vendor's bid. No one individual is permitted to represent more than one vendor at the pre-bid meeting. Any individual that does attempt to represent two or more vendors will be required to select one vendor to which the individual's attendance will be attributed. The vendors not selected will be deemed to have not attended the pre-bid meeting unless another individual attended on their behalf.

An attendance sheet provided at the pre-bid meeting shall serve as the official document verifying attendance. Any person attending the pre-bid meeting on behalf of a Vendor must list on the attendance sheet his or her name and the name of the Vendor he or she is representing.

Additionally, the person attending the pre-bid meeting should include the Vendor's E-Mail address, phone number, and Fax number on the attendance sheet. It is the Vendor's responsibility to locate the attendance sheet and provide the required information. Failure to complete the attendance sheet as required may result in disqualification of Vendor's bid.

All Vendors should arrive prior to the starting time for the pre-bid. Vendors who arrive after the starting time but prior to the end of the pre-bid will be permitted to sign in but are charged with knowing all matters discussed at the pre-bid.

Questions submitted at least five business days prior to a scheduled pre-bid will be discussed at the pre-bid meeting if possible. Any discussions or answers to questions at the pre-bid meeting are preliminary in nature and are non-binding. Official and binding answers to questions will be published in a written addendum to the Solicitation prior to bid opening.

4. VENDOR QUESTION DEADLINE: Vendors may submit questions relating to this Solicitation to the Purchasing Division. Questions must be submitted in writing. All questions must be submitted on or before the date listed below and to the address listed below to be considered. A written response will be published in a Solicitation addendum if a response is possible and appropriate. Non-written discussions, conversations, or questions and answers regarding this Solicitation are preliminary in nature and are nonbinding.

Submitted emails should have the solicitation number in the subject line.

Question Submission Deadline: Tuesday September 20, 2022 @ 4:00 p.m.

Submit Questions to: Toby L Welch
2019 Washington Street, East
Charleston, WV 25305
Fax: (304) 558-3970
Email: Toby.L.Welch@wv.gov

5. VERBAL COMMUNICATION: Any verbal communication between the Vendor and any State personnel is not binding, including verbal communication at the mandatory pre-bid conference. Only information issued in writing and added to the Solicitation by an official written addendum by the Purchasing Division is binding.

6. BID SUBMISSION: All bids must be submitted on or before the date and time of the bid opening listed in section 7 below. Vendors can submit bids electronically through *wv*OASIS, in paper form delivered to the Purchasing Division at the address listed below either in person or by courier, or in facsimile form by faxing to the Purchasing Division at the number listed below. Notwithstanding the foregoing, the Purchasing Division may prohibit the submission of bids electronically through *wv*OASIS at its sole discretion. Such a prohibition will be contained and communicated in the *wv*OASIS system resulting in the Vendor's inability to submit bids through *wv*OASIS. The Purchasing Division will not accept bids, modification of bids, or addendum acknowledgment forms via email. Bids submitted in paper or facsimile form must contain a signature. Bids submitted in *wv*OASIS are deemed to be electronically signed.

Any bid received by the Purchasing Division staff is considered to be in the possession of the Purchasing Division and will not be returned for any reason.

For Request for Proposal ("RFP") Responses Only: Submission of a response to a Request for Proposal is not permitted in *wv*OASIS. In the event that Vendor is responding to a request for proposal, the Vendor shall submit one original technical and one original cost proposal prior to the bid opening date and time identified in Section 7 below, plus N/A convenience copies of each to the Purchasing Division at the address shown below. Additionally, the Vendor should clearly identify and segregate the cost proposal from the technical proposal in a separately sealed envelope.

Bid Delivery Address and Fax Number:
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130
Fax: 304-558-3970

A bid submitted in paper or facsimile form should contain the information listed below on the face of the submission envelope or fax cover sheet. Otherwise, the bid may be rejected by the Purchasing Division.

VENDOR NAME:
BUYER: Toby L Welch
SOLICITATION NO.: CRFP AGO2300000001
BID OPENING DATE: Tuesday September 27, 2022
BID OPENING TIME: 1:30 p.m.
FAX NUMBER: 304-558-3970

7. BID OPENING: Bids submitted in response to this Solicitation will be opened at the location identified below on the date and time listed below. Delivery of a bid after the bid opening date and time will result in bid disqualification. For purposes of this Solicitation, a bid is considered delivered when confirmation of delivery is provided by *wv*OASIS (in the case of electronic submission) or when the bid is time stamped by the official Purchasing Division time clock (in the case of hand delivery).

Bid Opening Date and Time: Tuesday September 27, 2022 @ 1:30 p.m.

Bid Opening Location: Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

8. ADDENDUM ACKNOWLEDGEMENT: Changes or revisions to this Solicitation will be made by an official written addendum issued by the Purchasing Division. Vendor should acknowledge receipt of all addenda issued with this Solicitation by completing an Addendum Acknowledgment Form, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

9. BID FORMATTING: Vendor should type or electronically enter the information onto its bid to prevent errors in the evaluation. Failure to type or electronically enter the information may result in bid disqualification.

10. ALTERNATE MODEL OR BRAND: Unless the box below is checked, any model, brand, or specification listed in this Solicitation establishes the acceptable level of quality only and is not intended to reflect a preference for, or in any way favor, a particular brand or vendor. Vendors may bid alternates to a listed model or brand provided that the alternate is at least equal to the model or brand and complies with the required specifications. The equality of any alternate being bid shall be determined by the State at its sole discretion. Any Vendor bidding an alternate model or brand should clearly identify the alternate items in its bid and should include manufacturer's specifications, industry literature, and/or any other relevant documentation demonstrating the equality of the alternate items. Failure to provide information for alternate items may be grounds for rejection of a Vendor's bid.

☐ This Solicitation is based upon a standardized commodity established under W. Va. Code § 5A-3-61. Vendors are expected to bid the standardized commodity identified. Failure to bid the standardized commodity will result in your firm's bid being rejected.

11. EXCEPTIONS AND CLARIFICATIONS: The Solicitation contains the specifications that shall form the basis of a contractual agreement. Vendor shall clearly mark any exceptions, clarifications, or other proposed modifications in its bid. Exceptions to, clarifications of, or modifications of a requirement or term and condition of the Solicitation may result in bid disqualification.

12. COMMUNICATION LIMITATIONS: In accordance with West Virginia Code of State Rules §148-1-6.6, communication with the State of West Virginia or any of its employees regarding this Solicitation during the solicitation, bid, evaluation or award periods, except through the Purchasing Division, is strictly prohibited without prior Purchasing Division approval. Purchasing Division approval for such communication is implied for all agency delegated and exempt purchases.

13. REGISTRATION: Prior to Contract award, the apparent successful Vendor must be properly registered with the West Virginia Purchasing Division and must have paid the $125 fee, if applicable.

14. UNIT PRICE: Unit prices shall prevail in cases of a discrepancy in the Vendor's bid.

15. PREFERENCE: Vendor Preference may be requested in purchases of motor vehicles or construction and maintenance equipment and machinery used in highway and other infrastructure projects. Any request for preference must be submitted in writing with the bid, must specifically identify the preference requested with reference to the applicable subsection of West Virginia Code § 5A-3-37, and must include with the bid any information necessary to evaluate and confirm the applicability of the requested preference. A request form to help facilitate the request can be found at:
www.state.wv.us/admin/purchase/vrc/Venpref.pdf.

15A. RECIPROCAL PREFERENCE: The State of West Virginia applies a reciprocal preference to all solicitations for commodities and printing in accordance with W. Va. Code § 5A-3-37(b). In effect, non-resident vendors receiving a preference in their home states, will see that same preference granted to West Virginia resident vendors bidding against them in West Virginia. Any request for reciprocal preference must include with the bid any information necessary to evaluate and confirm the applicability of the preference. A request form to help facilitate the request can be found at: www.state.wv.us/admin/purchase/vrc/Venpref.pdf.

16. SMALL, WOMEN-OWNED, OR MINORITY-OWNED BUSINESSES: For any solicitations publicly advertised for bid, in accordance with West Virginia Code §5A-3-37 and W. Va. CSR § 148-22-9, any non-resident vendor certified as a small, women- owned, or minority-owned business under W. Va. CSR § 148-22-9 shall be provided the same preference made available to any resident vendor. Any non-resident small, women-owned, or minority-owned business must identify itself as such in writing, must submit that writing to the Purchasing Division with its bid, and must be properly certified under W. Va. CSR § 148-22-9 prior to contract award to receive the preferences made available to resident vendors. Preference for a non-resident small, women-owned, or minority owned business shall be applied in accordance with W. Va. CSR § 148-22-9.

17. WAIVER OF MINOR IRREGULARITIES: The Director reserves the right to waive minor irregularities in bids or specifications in accordance with West Virginia Code of State Rules § 148-1-4.6.

18. ELECTRONIC FILE ACCESS RESTRICTIONS: Vendor must ensure that its submission in *wv*OASIS can be accessed and viewed by the Purchasing Division staff immediately upon bid opening. The Purchasing Division will consider any file that cannot be immediately accessed and viewed at the time of the bid opening (such as, encrypted files, password protected files, or incompatible files) to be blank or incomplete as context requires and are therefore unacceptable. A vendor will not be permitted to unencrypt files, remove password protections, or resubmit documents after bid opening to make a file viewable if those documents are required with the bid. A Vendor may be required to provide document passwords or remove access restrictions to allow the Purchasing Division to print or electronically save documents provided that those documents are viewable by the Purchasing Division prior to obtaining the password or removing the access restriction.

19. NON-RESPONSIBLE: The Purchasing Division Director reserves the right to reject the bid of any vendor as Non-Responsible in accordance with W. Va. Code of State Rules § 148-1-5.3, when the Director determines that the vendor submitting the bid does not have the capability to fully perform or lacks the integrity and reliability to assure good-faith performance."

20. ACCEPTANCE/REJECTION: The State may accept or reject any bid in whole, or in part in accordance with W. Va. Code of State Rules § 148-1-4.5. and § 148-1-6.4.b."

21. YOUR SUBMISSION IS A PUBLIC DOCUMENT: Vendor's entire response to the Solicitation and the resulting Contract are public documents. As public documents, they will be disclosed to the public following the bid/proposal opening or award of the contract, as required by the competitive bidding laws of West Virginia Code §§ 5A-3-1 et seq., 5-22-1 et seq., and 5G-1-1 et seq. and the Freedom of Information Act West Virginia Code §§ 29B-1-1 et seq.

DO NOT SUBMIT MATERIAL YOU CONSIDER TO BE CONFIDENTIAL, A TRADE SECRET, OR OTHERWISE NOT SUBJECT TO PUBLIC DISCLOSURE.

Submission of any bid, proposal, or other document to the Purchasing Division constitutes your explicit consent to the subsequent public disclosure of the bid, proposal, or document. The Purchasing Division will disclose any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to include any "trade secrets" as defined by West Virginia Code § 47-22-1 et seq. All submissions are subject to public disclosure without notice.

22. WITH THE BID REQUIREMENTS: In instances where these specifications require documentation or other information with the bid, and a vendor fails to provide it with the bid, the Director of the Purchasing Division reserves the right to request those items after bid opening and prior to contract award pursuant to the authority to waive minor irregularities in bids or specifications under W. Va. CSR § 148-1-4.6. This authority does not apply to instances where state law mandates receipt with the bid.

23. EMAIL NOTIFICATION OF AWARD: The Purchasing Division will attempt to provide bidders with e-mail notification of contract award when a solicitation that the bidder participated in has been awarded. For notification purposes, bidders must provide the Purchasing Division with a valid email address in the bid response. Bidders may also monitor *wv*OASIS or the Purchasing Division's website to determine when a contract has been awarded.

24. ISRAEL BOYCOTT CERTIFICATION: Vendor's act of submitting a bid in response to this solicitation shall be deemed a certification from bidder to the State that bidder is not currently engaged in, and will not for the duration of the contract, engage in a boycott of Israel. This certification is required by W. Va. Code § 5A-3-63.

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SECTION 3: GENERAL TERMS AND CONDITIONS

GENERAL TERMS AND CONDITIONS:

1. CONTRACTUAL AGREEMENT: Issuance of an Award Document signed by the Purchasing Division Director, or his designee, and approved as to form by the Attorney General's office constitutes acceptance by the State of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid, or on the Contract if the Contract is not the result of a bid solicitation, signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract.

2. DEFINITIONS: As used in this Solicitation/Contract, the following terms shall have the meanings attributed to them below. Additional definitions may be found in the specifications included with this Solicitation/Contract.

2.1. "Agency" or **"Agencies"** means the agency, board, commission, or other entity of the State of West Virginia that is identified on the first page of the Solicitation or any other public entity seeking to procure goods or services under this Contract.

2.2. "Bid" or **"Proposal"** means the vendors submitted response to this solicitation.

2.3. "Contract" means the binding agreement that is entered into between the State and the Vendor to provide the goods or services requested in the Solicitation.

2.4. "Director" means the Director of the West Virginia Department of Administration, Purchasing Division.

2.5. "Purchasing Division" means the West Virginia Department of Administration, Purchasing Division.

2.6. "Award Document" means the document signed by the Agency and the Purchasing Division, and approved as to form by the Attorney General, that identifies the Vendor as the contract holder.

2.7. "Solicitation" means the official notice of an opportunity to supply the State with goods or services that is published by the Purchasing Division.

2.8. "State" means the State of West Virginia and/or any of its agencies, commissions, boards, etc. as context requires.

2.9. "Vendor" or **"Vendors"** means any entity submitting a bid in response to the Solicitation, the entity that has been selected as the lowest responsible bidder, or the entity that has been awarded the Contract as context requires.

3. CONTRACT TERM; RENEWAL; EXTENSION: The term of this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below:

☐ **Term Contract**

Initial Contract Term: The Initial Contract Term will be for a period of _____ _____. The Initial Contract Term becomes effective on the effective start date listed on the first page of this Contract, identified as the State of West Virginia contract cover page containing the signatures of the Purchasing Division, Attorney General, and Encumbrance clerk (or another page identified as _____), and the Initial Contract Term ends on the effective end date also shown on the first page of this Contract.

Renewal Term: This Contract may be renewed upon the mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any request for renewal should be delivered to the Agency and then submitted to the Purchasing Division thirty (30) days prior to the expiration date of the initial contract term or appropriate renewal term. A Contract renewal shall be in accordance with the terms and conditions of the original contract. Unless otherwise specified below, renewal of this Contract is limited to _____ successive one (1) year periods or multiple renewal periods of less than one year, provided that the multiple renewal periods do not exceed the total number of months available in all renewal years combined. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's office (Attorney General approval is as to form only)

☐ **Alternate Renewal Term** – This contract may be renewed for _____ successive _____ year periods or shorter periods provided that they do not exceed the total number of months contained in all available renewals. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's office (Attorney General approval is as to form only)

Delivery Order Limitations: In the event that this contract permits delivery orders, a delivery order may only be issued during the time this Contract is in effect. Any delivery order issued within one year of the expiration of this Contract shall be effective for one year from the date the delivery order is issued. No delivery order may be extended beyond one year after this Contract has expired.

☐ **Fixed Period Contract:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and must be completed within _____days.

☐ **Fixed Period Contract with Renewals:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and part of the Contract more fully described in the attached specifications must be completed within _____ days. Upon completion of the work covered by the preceding sentence, the vendor agrees that:

☐ the contract will continue for _____ years;

☐ the contract may be renewed for _____ successive _____ year periods or shorter periods provided that they do not exceed the total number of months contained in all available renewals. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's Office (Attorney General approval is as to form only).

☑ **One-Time Purchase:** The term of this Contract shall run from the issuance of the Award Document until all of the goods contracted for have been delivered, but in no event will this Contract extend for more than one fiscal year.

☐ **Construction/Project Oversight:** This Contract becomes effective on the effective start date listed on the first page of this Contract, identified as the State of West Virginia contract cover page containing the signatures of the Purchasing Division, Attorney General, and Encumbrance clerk (or another page identified as _____), and continues until the project for which the vendor is providing oversight is complete.

☐ **Other:** Contract Term specified in _____

4. AUTHORITY TO PROCEED: Vendor is authorized to begin performance of this contract on the date of encumbrance listed on the front page of the Award Document unless either the box for "Fixed Period Contract" or "Fixed Period Contract with Renewals" has been checked in Section 3 above. If either "Fixed Period Contract" or "Fixed Period Contract with Renewals" has been checked, Vendor must not begin work until it receives a separate notice to proceed from the State. The notice to proceed will then be incorporated into the Contract via change order to memorialize the official date that work commenced.

5. QUANTITIES: The quantities required under this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below.

☐ **Open End Contract:** Quantities listed in this Solicitation/Award Document are approximations only, based on estimates supplied by the Agency. It is understood and agreed that the Contract shall cover the quantities actually ordered for delivery during the term of the Contract, whether more or less than the quantities shown.

☐ **Service:** The scope of the service to be provided will be more clearly defined in the specifications included herewith.

☐ **Combined Service and Goods:** The scope of the service and deliverable goods to be provided will be more clearly defined in the specifications included herewith.

☑ **One-Time Purchase:** This Contract is for the purchase of a set quantity of goods that are identified in the specifications included herewith. Once those items have been delivered, no additional goods may be procured under this Contract without an appropriate change order approved by the Vendor, Agency, Purchasing Division, and Attorney General's office.

☐ **Construction:** This Contract is for construction activity more fully defined in the specifications.

6. EMERGENCY PURCHASES: The Purchasing Division Director may authorize the Agency to purchase goods or services in the open market that Vendor would otherwise provide under this Contract if those goods or services are for immediate or expedited delivery in an emergency. Emergencies shall include, but are not limited to, delays in transportation or an unanticipated increase in the volume of work. An emergency purchase in the open market, approved by the Purchasing Division Director, shall not constitute of breach of this Contract and shall not entitle the Vendor to any form of compensation or damages. This provision does not excuse the State from fulfilling its obligations under a One-Time Purchase contract.

7. REQUIRED DOCUMENTS: All of the items checked in this section must be provided to the Purchasing Division by the Vendor as specified:

☐ **LICENSE(S) / CERTIFICATIONS / PERMITS:** In addition to anything required under the Section of the General Terms and Conditions entitled Licensing, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits upon request and in a form acceptable to the State. The request may be prior to or after contract award at the State's sole discretion.

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The apparent successful Vendor shall also furnish proof of any additional licenses or certifications contained in the specifications regardless of whether or not that requirement is listed above.

8. INSURANCE: The apparent successful Vendor shall furnish proof of the insurance identified by a checkmark below prior to Contract award. The insurance coverages identified below must be maintained throughout the life of this contract. Thirty (30) days prior to the expiration of the insurance policies, Vendor shall provide the Agency with proof that the insurance mandated herein has been continued. Vendor must also provide Agency with immediate notice of any changes in its insurance policies, including but not limited to, policy cancelation, policy reduction, or change in insurers. The apparent successful Vendor shall also furnish proof of any additional insurance requirements contained in the specifications prior to Contract award regardless of whether that insurance requirement is listed in this section.

Vendor must maintain:

☑ **Commercial General Liability Insurance** in at least an amount of: $1,000,000.00 per occurrence.

☐ **Automobile Liability Insurance** in at least an amount of: _____per occurrence.

☐ **Professional/Malpractice/Errors and Omission Insurance** in at least an amount of: _____per occurrence. Notwithstanding the forgoing, Vendor's are not required to list the State as an additional insured for this type of policy.

☐ **Commercial Crime and Third Party Fidelity Insurance** in an amount of: _____ per occurrence.

☐ **Cyber Liability Insurance** in an amount of: _____ per occurrence.

☐ **Builders Risk Insurance** in an amount equal to 100% of the amount of the

Contract. [ ] **Pollution Insurance** in an amount of: _____ per

☐currence.

☐ **Aircraft Liability** in an amount of: _____ per occurrence.

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9. WORKERS' COMPENSATION INSURANCE: Vendor shall comply with laws relating to workers compensation, shall maintain workers' compensation insurance when required, and shall furnish proof of workers' compensation insurance upon request.

10. VENUE: All legal actions for damages brought by Vendor against the State shall be brought in the West Virginia Claims Commission. Other causes of action must be brought in the West Virginia court authorized by statute to exercise jurisdiction over it.

11. LIQUIDATED DAMAGES: This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue any other available remedy. Vendor shall pay liquidated damages in the amount specified below or as described in the specifications:

☐ _____ for _____.

☐ Liquidated Damages Contained in the Specifications.

☑ Liquidated Damages Are Not Included in this Contract.

12. ACCEPTANCE: Vendor's signature on its bid, or on the certification and signature page, constitutes an offer to the State that cannot be unilaterally withdrawn, signifies that the product or service proposed by vendor meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise indicated, and signifies acceptance of the terms and conditions contained in the Solicitation unless otherwise indicated.

13. PRICING: The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification. Notwithstanding the foregoing, Vendor must extend any publicly advertised sale price to the State and invoice at the lower of the contract price or the publicly advertised sale price.

14. PAYMENT IN ARREARS: Payments for goods/services will be made in arrears only upon receipt of a proper invoice, detailing the goods/services provided or receipt of the goods/services, whichever is later. Notwithstanding the foregoing, payments for software maintenance, licenses, or subscriptions may be paid annually in advance.

15. PAYMENT METHODS: Vendor must accept payment by electronic funds transfer and P-Card. (The State of West Virginia's Purchasing Card program, administered under contract by a banking institution, processes payment for goods and services through state designated credit cards.)

16. TAXES: The Vendor shall pay any applicable sales, use, personal property or any other taxes arising out of this Contract and the transactions contemplated thereby. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

17. ADDITIONAL FEES: Vendor is not permitted to charge additional fees or assess additional charges that were not either expressly provided for in the solicitation published by the State of West Virginia, included in the Contract, or included in the unit price or lump sum bid amount that Vendor is required by the solicitation to provide. Including such fees or charges as notes to the solicitation may result in rejection of vendor's bid. Requesting such fees or charges be paid after the contract has been awarded may result in cancellation of the contract.

18. FUNDING: This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made available. If that occurs, the State may notify the Vendor that an alternative source of funding has been obtained and thereby avoid the automatic termination. Non-appropriation or non-funding shall not be considered an event of default.

19. CANCELLATION: The Purchasing Division Director reserves the right to cancel this Contract immediately upon written notice to the vendor if the materials or workmanship supplied do not conform to the specifications contained in the Contract. The Purchasing Division Director may also cancel any purchase or Contract upon 30 days written notice to the Vendor in accordance with West Virginia Code of State Rules § 148-1-5.2.b.

20. TIME: Time is of the essence regarding all matters of time and performance in this Contract.

21. APPLICABLE LAW: This Contract is governed by and interpreted under West Virginia law without giving effect to its choice of law principles. Any information provided in specification manuals, or any other source, verbal or written, which contradicts or violates the West Virginia Constitution, West Virginia Code, or West Virginia Code of State Rules is void and of no effect.

22. COMPLIANCE WITH LAWS: Vendor shall comply with all applicable federal, state, and local laws, regulations and ordinances. By submitting a bid, Vendor acknowledges that it has reviewed, understands, and will comply with all applicable laws, regulations, and ordinances.

> **SUBCONTRACTOR COMPLIANCE:** Vendor shall notify all subcontractors providing commodities or services related to this Contract that as subcontractors, they too are required to comply with all applicable laws, regulations, and ordinances. Notification under this provision must occur prior to the performance of any work under the contract by the subcontractor.

23. ARBITRATION: Any references made to arbitration contained in this Contract, Vendor's bid, or in any American Institute of Architects documents pertaining to this Contract are hereby deleted, void, and of no effect.

24. MODIFICATIONS: This writing is the parties' final expression of intent. Notwithstanding anything contained in this Contract to the contrary no modification of this Contract shall be binding without mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any change to existing contracts that adds work or changes contract cost, and were not included in the original contract, must be approved by the Purchasing Division and the Attorney General's Office (as to form) prior to the implementation of the change or commencement of work affected by the change.

25. WAIVER: The failure of either party to insist upon a strict performance of any of the terms or provision of this Contract, or to exercise any option, right, or remedy herein contained, shall not be construed as a waiver or a relinquishment for the future of such term, provision, option, right, or remedy, but the same shall continue in full force and effect. Any waiver must be expressly stated in writing and signed by the waiving party.

26. SUBSEQUENT FORMS: The terms and conditions contained in this Contract shall supersede any and all subsequent terms and conditions which may appear on any form documents submitted by Vendor to the Agency or Purchasing Division such as price lists, order forms, invoices, sales agreements, or maintenance agreements, and includes internet websites or other electronic documents. Acceptance or use of Vendor's forms does not constitute acceptance of the terms and conditions contained thereon.

27. ASSIGNMENT: Neither this Contract nor any monies due, or to become due hereunder, may be assigned by the Vendor without the express written consent of the Agency, the Purchasing Division, the Attorney General's office (as to form only), and any other government agency or office that may be required to approve such assignments.

28. WARRANTY: The Vendor expressly warrants that the goods and/or services covered by this Contract will: (a) conform to the specifications, drawings, samples, or other description furnished or specified by the Agency; (b) be merchantable and fit for the purpose intended; and (c) be free from defect in material and workmanship.

29. STATE EMPLOYEES: State employees are not permitted to utilize this Contract for personal use and the Vendor is prohibited from permitting or facilitating the same.

30. PRIVACY, SECURITY, AND CONFIDENTIALITY: The Vendor agrees that it will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the Agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the Agency's policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/default.html.

31. YOUR SUBMISSION IS A PUBLIC DOCUMENT: Vendor's entire response to the Solicitation and the resulting Contract are public documents. As public documents, they will be disclosed to the public following the bid/proposal opening or award of the contract, as required by the competitive bidding laws of West Virginia Code §§ 5A-3-1 et seq., 5-22-1 et seq., and 5G-1-1 et seq. and the Freedom of Information Act West Virginia Code §§ 29B-1-1 et seq.

DO NOT SUBMIT MATERIAL YOU CONSIDER TO BE CONFIDENTIAL, A TRADE SECRET, OR OTHERWISE NOT SUBJECT TO PUBLIC DISCLOSURE.

Submission of any bid, proposal, or other document to the Purchasing Division constitutes your explicit consent to the subsequent public disclosure of the bid, proposal, or document. The Purchasing Division will disclose any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to include any "trade secrets" as defined by West Virginia Code § 47-22-1 et seq. All submissions are subject to public disclosure without notice.

32. LICENSING: In accordance with West Virginia Code of State Rules § 148-1-6.1.e, Vendor must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agency or political subdivision. Obligations related to political subdivisions may include, but are not limited to, business licensing, business and occupation taxes, inspection compliance, permitting, etc. Upon request, the Vendor must provide all necessary releases to obtain information to enable the Purchasing Division Director or the Agency to verify that the Vendor is licensed and in good standing with the above entities.

SUBCONTRACTOR COMPLIANCE: Vendor shall notify all subcontractors providing commodities or services related to this Contract that as subcontractors, they too are required to be licensed, in good standing, and up-to-date on all state and local obligations as described in this section. Obligations related to political subdivisions may include, but are not limited to, business licensing, business and occupation taxes, inspection compliance, permitting, etc. Notification under this provision must occur prior to the performance of any work under the contract by the subcontractor.

33. ANTITRUST: In submitting a bid to, signing a contract with, or accepting a Award Document from any agency of the State of West Virginia, the Vendor agrees to convey, sell, assign, or transfer to the State of West Virginia all rights, title, and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to Vendor.

34. VENDOR NON-CONFLICT: Neither Vendor nor its representatives are permitted to have any interest, nor shall they acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency.

35. VENDOR RELATIONSHIP: The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by this Contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents. Vendor shall be responsible for selecting, supervising, and compensating any and all individuals employed pursuant to the terms of this Solicitation and resulting contract. Neither the Vendor, nor any employees or subcontractors of the Vendor, shall be deemed to be employees of the State for any purpose whatsoever. Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension, or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, licensing fees, etc. and the filing of all necessary documents, forms, and returns pertinent to all of the foregoing.

Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, Social Security taxes, and employer income tax returns.

36. INDEMNIFICATION: The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the Contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

37. NO DEBT CERTIFICATION: In accordance with West Virginia Code §§ 5A-3-10a and 5-22-1(i), the State is prohibited from awarding a contract to any bidder that owes a debt to the State or a political subdivision of the State. By submitting a bid, or entering into a contract with the State, Vendor is affirming that (1) for construction contracts, the Vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, neither the Vendor nor any related party owe a debt as defined above, and neither the Vendor nor any related party are in employer default as defined in the statute cited above unless the debt or employer default is permitted under the statute.

38. CONFLICT OF INTEREST: Vendor, its officers or members or employees, shall not presently have or acquire an interest, direct or indirect, which would conflict with or compromise the performance of its obligations hereunder. Vendor shall periodically inquire of its officers, members and employees to ensure that a conflict of interest does not arise. Any conflict of interest discovered shall be promptly presented in detail to the Agency.

39. REPORTS: Vendor shall provide the Agency and/or the Purchasing Division with the following reports identified by a checked box below:

☑ Such reports as the Agency and/or the Purchasing Division may request. Requested reports may include, but are not limited to, quantities purchased, agencies utilizing the contract, total contract expenditures by agency, etc.

☐ Quarterly reports detailing the total quantity of purchases in units and dollars, along with a listing of purchases by agency. Quarterly reports should be delivered to the Purchasing Division via email at purchasing.division@wv.gov.

40. BACKGROUND CHECK: In accordance with W. Va. Code § 15-2D-3, the State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check. Service providers should contact the West Virginia Division of Protective Services by phone at (304) 558-9911 for more information.

41. PREFERENCE FOR USE OF DOMESTIC STEEL PRODUCTS: Except when authorized by the Director of the Purchasing Division pursuant to W. Va. Code § 5A-3-56, no contractor may use or supply steel products for a State Contract Project other than those steel products made in the United States. A contractor who uses steel products in violation of this section may be subject to civil penalties pursuant to W. Va. Code § 5A-3-56. As used in this section:

a. "State Contract Project" means any erection or construction of, or any addition to, alteration of or other improvement to any building or structure, including, but not limited to, roads or highways, or the installation of any heating or cooling or ventilating plants or other equipment, or the supply of and materials for such projects, pursuant to a contract with the State of West Virginia for which bids were solicited on or after June 6, 2001.

b. "Steel Products" means products rolled, formed, shaped, drawn, extruded, forged, cast, fabricated or otherwise similarly processed, or processed by a combination of two or more or such operations, from steel made by the open heath, basic oxygen, electric furnace, Bessemer or other steel making process.

c. The Purchasing Division Director may, in writing, authorize the use of foreign steel products if:

    1. The cost for each contract item used does not exceed one tenth of one percent (.1%) of the total contract cost or two thousand five hundred dollars ($2,500.00), whichever is greater. For the purposes of this section, the cost is the value of the steel product as delivered to the project; or

    2. The Director of the Purchasing Division determines that specified steel materials are not produced in the United States in sufficient quantity or otherwise are not reasonably available to meet contract requirements.

42. PREFERENCE FOR USE OF DOMESTIC ALUMINUM, GLASS, AND STEEL: In Accordance with W. Va. Code § 5-19-1 et seq., and W. Va. CSR § 148-10-1 et seq., for every contract or subcontract, subject to the limitations contained herein, for the construction, reconstruction, alteration, repair, improvement or maintenance of public works or for the purchase of any item of machinery or equipment to be used at sites of public works, only domestic aluminum, glass or steel products shall be supplied unless the spending officer determines, in writing, after the receipt of offers or bids, (1) that the cost of domestic aluminum, glass or steel products is unreasonable or inconsistent with the public interest of the State of West Virginia, (2) that domestic aluminum, glass or steel products are not produced in sufficient quantities to meet the contract requirements, or (3) the available domestic aluminum, glass, or steel do not meet the contract specifications. This provision only applies to public works contracts awarded in an amount more than fifty thousand dollars ($50,000) or public works contracts that require more than ten thousand pounds of steel products.

The cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than twenty percent (20%) of the bid or offered price for foreign made aluminum, glass, or steel products. If the domestic aluminum, glass or steel products to be supplied or produced in a "substantial labor surplus area", as defined by the United States Department of Labor, the cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than thirty percent (30%) of the bid or offered price for foreign made aluminum, glass, or steel products. This preference shall be applied to an item of machinery or equipment, as indicated above, when the item is a single unit of equipment or machinery manufactured primarily of aluminum, glass or steel, is part of a public works contract and has the sole purpose or of being a permanent part of a single public works project. This provision does not apply to equipment or machinery purchased by a spending unit for use by that spending unit and not as part of a single public works project.

All bids and offers including domestic aluminum, glass or steel products that exceed bid or offer prices including foreign aluminum, glass or steel products after application of the preferences provided in this provision may be reduced to a price equal to or lower than the lowest bid or offer price for foreign aluminum, glass or steel products plus the applicable preference. If the reduced bid or offer prices are made in writing and supersede the prior bid or offer prices, all bids or offers, including the reduced bid or offer prices, will be reevaluated in accordance with this rule.

43. INTERESTED PARTY SUPPLEMENTAL DISCLOSURE: W. Va. Code § 6D-1-2 requires that for contracts with an actual or estimated value of at least $1 million, the Vendor must submit to the Agency a disclosure of interested parties prior to beginning work under this Contract. Additionally, the Vendor must submit a supplemental disclosure of interested parties reflecting any new or differing interested parties to the contract, which were not included in the original pre-work interested party disclosure, within 30 days following the completion or termination of the contract. A copy of that form is included with this solicitation or can be obtained from the WV Ethics Commission. This requirement does not apply to publicly traded companies listed on a national or international stock exchange. A more detailed definition of interested parties can be obtained from the form referenced above.

44. PROHIBITION AGAINST USED OR REFURBISHED: Unless expressly permitted in the solicitation published by the State, Vendor must provide new, unused commodities, and is prohibited from supplying used or refurbished commodities, in fulfilling its responsibilities under this Contract.

45. VOID CONTRACT CLAUSES: This Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law.

46. ISRAEL BOYCOTT: Bidder understands and agrees that, pursuant to W. Va. Code § 5A-3-63, it is prohibited from engaging in a boycott of Israel during the term of this contract.

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

(Printed Name and Title) Jala Attia, President

(Address) 516 Adamsway Court, Toms River, NJ 08753

(Phone Number) / (Fax Number) 732-674-3267 phone / 732-288-1677 fax

(email address) jattia@integrityadvantage.com

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through *wv*OASIS, I certify that: I have reviewed this Solicitation/Contract in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation/Contract for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that this bid or offer was made without prior understanding, agreement, or connection with any entity submitting a bid or offer for the same material, supplies, equipment or services; that this bid or offer is in all respects fair and without collusion or fraud; that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; that I am authorized by the Vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on Vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

By signing below, I further certify that I understand this Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law; and that pursuant to W. Va. Code 5A-3-63, the entity entering into this contract is prohibited from engaging in a boycott against Israel.

Integrity Advantage Solutions, LLC
(Company)

Type text here
(Signature of Authorized Representative)

Jala Attia, President
(Printed Name and Title of Authorized Representative) (Date)

732-674-3267 phone / 732-288-1677 fax
(Phone Number) (Fax Number)

jattia@integrityadvantage.com
(Email Address)

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP AGO23*001

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received: No Addedendums Received
(Check the box next to each addendum received)

- ☐ Addendum No. 1
- ☐ Addendum No. 2
- ☐ Addendum No. 3
- ☐ Addendum No. 4
- ☐ Addendum No. 5
- ☐ Addendum No. 6
- ☐ Addendum No. 7
- ☐ Addendum No. 8
- ☐ Addendum No. 9
- ☐ Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Integrity Advantage Solutions, LLC
Company

Authorized Signature

9/23/2022
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

REQUEST FOR PROPOSAL
Medicare Fraud Control Unit Training Curriculum

SECTION 4: PROJECT SPECIFICATIONS

4.1. Background and Current Operating Environment: [The Office of the West Virginia Attorney General, located at 1900 Kanawha Boulevard East, Room E-26, Charleston, West Virginia, is seeking a single qualified vendor who can assist the Agency to improve and expand the knowledge base and investigative expertise of its Medicaid Fraud Control Unit ("MFCU"), thereby improving the quality and effectiveness of its investigative results.

The West Virginia Legislature has found that substantial sums of money have been lost to the state and federal government in the operation of the medical programs of the state due to the overpayment of moneys to medical providers, which overpayments have resulted from both the abuse of and fraud in the reimbursement process. The Legislature has vested the MFCU with the power to investigate all violations of applicable state and federal laws pertaining to the provision of goods or services under the medical programs of the state, including the Medicaid program, as well as the power to investigate cases involving the abuse, neglect or financial exploitation of residents in board and care facilities and patients in health care facilities which receive payments under the medical programs of the state.

4.2. Project Goals and Mandatory Requirements: [This project will assist the MFCU, through the procurement of independent educational and training services, in carrying out its statutory investigative responsibilities].

Vendor should explain and describe how it will perform each of the following services in its proposal.

Vendor should describe its approach and methodology to providing the service or solving the problem described by meet the goals/objectives identified below. Vendor's response should include any information about how the proposed approach is superior or inferior to other possible approaches.

4.2.1. Goals and Objectives – The project goals and objectives are listed below.

4.2.1.1 [To accurately assess the current state of the MFCU's existing knowledge base regarding current investigative, auditing, and data analysis best practices available to be utilized in healthcare fraud investigations across the full spectrum of fraud schemes employed by dishonest healthcare providers.]

4.2.1.2 [To accurately identify any existing gaps in the MFCU's knowledge base regarding such investigative and auditing best practices, or regarding newly emerging healthcare fraud schemes.]

4.2.1.3 [To create a new training curriculum intended to systematically address and rectify such existing knowledge gaps.]

4.2.1.4 [To create new training programs utilizing current best practices in adult learning theory, principles, and delivery methods, that will maximize the MFCU's ability to successfully eliminate its existing knowledge gaps in areas such as healthcare terminology; components and lifecycle of a healthcare claim; investigative techniques; triaging new referrals; data analysis; report writing; documentation of case files; interviews and communication; medical record reviews; data visualization; presenting investigative findings; common fraud schemes; and emerging trends in healthcare fraud.]

4.2.1.5 [To deliver these newly created training programs to MFCU staff members through a series of two or more in-person sessions in Charleston, West Virginia, with each session lasting no less than three days and no more than five days.]

4.2.1.6 [To assist the MFCU in preparing adult learning outcome assessment methods that will provide the agency's leadership with an accurate and objective understanding of the extent to which each individual MFCU team member successfully accomplished the learning objectives established for each new training program, so that any MFCU team members who may need additional or supplemental training or assistance to successfully accomplish those learning objective can be provided the additional support they need to do so.]

4.2.1.7 [To establish a pattern and practice where MFCU staff members routinely apply investigative, auditing, and data analysis best practices in their assigned investigations related to allegations of healthcare fraud and/or the abuse, neglect, or financial exploitation of incapacitated adults.]

4.2.1.8 [To increase the quantity and quality of referrals the MFCU receives from various sources by enhancing relationships with program integrity staff, managed care organizations and other agencies.]

4.2.1.9 [To expedite the successful completion of the MFCU's investigations, and to improve the quality, efficiency, and effectiveness of the MFCU's investigative results.]

4.2.1.10 [To enhance the ability of the agency's leadership to monitor and maintain case information for both reporting and resource management purposes.]

4.2.1.11 [To increase the amount of money recovered through civil settlements and criminal recoveries resulting from the MFCU's investigations.]

4.2.1.12 [To increase the number of criminal prosecutions and convictions resulting from the MFCU's investigations.]

4.2.2. Mandatory Project Requirements – The following mandatory requirements relate to the goals and objectives and must be met by the Vendor as a part of its submitted proposal. Vendor should describe how it will comply with the mandatory requirements and include any areas where

its proposed solution exceeds the mandatory requirement. Failure to comply with mandatory requirements will lead to disqualification, but the approach/methodology that the vendor uses to comply, and areas where the mandatory requirements are exceeded, will be included in technical scores where appropriate. The mandatory project requirements are listed below.

4.2.2.1 [The vendor must prepare a proposed staffing plan for this RFP with details regarding where the work will be performed, the roles, qualifications, licenses and skill sets of person(s) performing the work, the anticipated hours involved for each phase of the project, the anticipated span of the project, and any expected fluctuations over time in staff or hours spent on the project.]

4.2.2.2 [The vendor must provide a primary point of contact who will be able to attend meetings or regularly scheduled conference calls as requested, and who will be accountable to provide the training materials, evaluations and/or reports required by the MFCU.]

4.2.2.3 [The vendor must comply with all applicable federal and state laws, rules and policies, and with all components of this RFP.]

4.2.2.4 [The vendor must describe clearly and in detail the process or steps it will use to accurately assess the current state of the MFCU's existing knowledge base regarding current investigative, auditing, and data analysis best practices available to be utilized in healthcare fraud investigations across the full spectrum of fraud schemes employed by dishonest healthcare providers; to create a new training curriculum intended to systematically address and rectify any identified gaps in the MFCU's existing knowledge base; to create new training programs utilizing current best practices in adult learning theory, principles, and delivery methods, that will maximize the MFCU's ability to successfully eliminate its existing knowledge gaps in such areas; and to deliver these newly created training programs to MFCU staff members as described in Section 4.2.1.5 of this RFP.]

4.2.2.5 [The vendor must describe clearly and in detail the process or steps it will use to help the MFCU to establish a pattern and practice where MFCU staff members routinely apply investigative, auditing, and data analysis best practices in their assigned investigations related to allegations of healthcare fraud and/or the abuse, neglect, or financial exploitation of incapacitated adults.]

4.2.2.6 [The vendor must describe clearly and in detail the process or steps it will use to help the MFCU to increase the quantity and quality of referrals the MFCU receives from various sources by enhancing relationships with program integrity staff, managed care organizations and other agencies.]

4.2.2.7 [The vendor must describe clearly and in detail the process or steps it will use to help the MFCU to expedite the successful completion of its investigations, and to improve the quality, efficiency, and effectiveness of its investigative results.]

4.2.2.8 [The vendor must describe clearly and in detail the process or steps it will use to help the MFCU to enhance the ability of the agency's leadership to monitor and maintain case information for both reporting and resource management purposes.]

4.2.2.9 [The vendor must describe clearly and in detail the process or steps it will use to advise and assist the MFCU in developing goals and planning for any operational modifications recommended by the vendor and deemed meritorious by MFCU management following the vendor's evaluation of its current operations. Such planning may include but not be limited to anticipated timeframes, recommended resources, and other such details.]

4.3. Qualifications and Experience: Vendor should provide information and documentation regarding its qualifications and experience in providing services or solving problems similar to those requested in this RFP. Information and documentation should include, but is not limited to, copies of any staff certifications or degrees applicable to this project, proposed staffing plans, descriptions of past projects completed (descriptions should include the location of the project, project manager name and contact information, type of project, and what the project goals and objectives where and how they were met.), references for prior projects, and any other information that vendor deems relevant to the items identified as desirable or mandatory below.

4.3.1. Qualification and Experience Information: Vendor should describe in its proposal how it meets the desirable qualification and experience requirements listed below.

4.3.1.1. [Please list the total number of healthcare fraud consultants or other staff members that your firm employs. Please describe the respective seniority of each consultant or other staff member.]

4.3.1.2. [Describe your firm's background and history in providing services similar to those requested herein. This should include descriptions of past projects completed; the locations of the projects; client names and contact information; types of projects; the project goals and objectives, and how those goals and objectives were accomplished.]

4.3.1.3. [Provide copies of any written Code of Conduct, Ethics Policy, or Conflict of Interest Policy that your firm has currently enacted. If your firm does not have such a policy, please so state.]

4.3.1.4. [Provide an explanation and indicate the current status or disposition of any business litigation, legal, regulatory or other proceedings in which your organization or any officer or principal thereof has been involved within the last five (5) years. If none, please so state.]

4.3.1.5. [List the percentage of your firm's revenues that are derived from healthcare fraud consulting or investigative services. Please list any other services that your firm provides.]

4.3.1.6. [Please describe your firm's underlying philosophy in providing healthcare fraud consulting or investigative services. Also list any particular strengths that your firm may have.]

4.3.1.7. [Please provide references, including contact information, who can attest to prior work performed by your firm and by the individuals who are included in your staffing plan for this project.]

4.3.2. Mandatory Qualification/Experience Requirements – The following mandatory qualification/experience requirements must be met by the Vendor as a part of its submitted proposal. Vendor should describe how it meets the mandatory requirements and include any areas where it exceeds the mandatory requirements. Failure to comply with mandatory requirements will lead to disqualification, but areas where the mandatory requirements are exceeded will be included in technical scores where appropriate. The mandatory qualifications/experience requirements are listed below.

4.3.2.1. [The vendor must have demonstrated experience preparing detailed, customized training materials for at least four (4) Medicaid Fraud Control Units (MFCUs) or Special Investigation Unit (SIUs) employed by health care insurer/payor organizations. A list of all such customized training materials prepared by the vendor, including the names of all such organizations for which the materials were prepared, shall be provided to the Agency.]

4.3.2.2. [The vendor must have demonstrated experience delivering detailed, customized training programs for at least four (4) Medicaid Fraud Control Units (MFCUs) or Special Investigation Unit (SIUs) employed by health care insurer/payor organizations. A list of all such customized training programs delivered by the vendor, including the names of all such organizations which received such training programs, shall be provided to the Agency.]

4.3.2.3. [The vendor must have demonstrated experience providing detailed program assessments to investigative teams. A list of all such detailed program assessments conducted by the vendor, including the names of all such organizations which received such training programs, shall be provided to the Agency.]

4.3.2.4. [The vendor must have demonstrated experience performing Medicaid provider fraud investigations for or on behalf of a Medicaid program and/or Medicaid Managed Care Organizations (MCOs). A list including the names of all such organizations for or on behalf of which the vendor or its personnel performed Medicaid provider fraud investigations, shall be provided to the Agency.]

4.3.2.5. [The vendor must have demonstrated experience providing one-on-one mentorship services to investigative team personnel. A list including the names of all such organizations whose personnel received such one-on-one mentorship services from the vendor or its staff, shall be provided to the Agency.]

4.3.2.6. [The vendor must have demonstrated current experience actively participating in industry events focused on healthcare fraud and abuse and/or conducting speaking engagements events at such events. A list of all such events and/or speaking engagements, including the names of all such organizations which served as the primary host or sponsor for each such event or speaking engagement, shall be provided to the Agency.]

4.3.2.7. [The vendor must have demonstrated current experience creating course curricula and serving as faculty instructors for educational institutions. A list of all such course curricula created by the vendor or its staff and/or all such courses taught by the vendor or its staff, including the names of all educational institutions for which such curricula were prepared or such courses were taught, shall be provided to the Agency.]

SECTION 5: VENDOR PROPOSAL

5.1. Economy of Preparation: Proposals should be prepared simply and economically providing a concise description of the items requested in Section 4. Emphasis should be placed on completeness and clarity of the content.

5.2. Incurring Cost: Neither the State nor any of its employees or officers shall be held liable for any expenses incurred by any Vendor responding to this RFP, including but not limited to preparation, delivery, or travel.

5.3. Proposal Format: Vendors should provide responses in the format listed below:

5.3.1. **Two-Part Submission:** Vendors must submit proposals in two distinct parts: technical and cost. Technical proposals must not contain any cost information relating to the project. Cost proposal must contain all cost information and must be sealed in a separate envelope from the technical proposal to facilitate a secondary cost proposal opening.

5.3.2. **Title Page:** State the RFP subject, number, Vendor's name, business address, telephone number, fax number, name of contact person, e-mail address, and Vendor signature and date.

5.3.3. **Table of Contents:** Clearly identify the material by section and page number.

5.3.4. **Response Reference:** Vendor's response should clearly reference how the information provided applies to the RFP request. For example, listing the RFP number and restating the RFP request as a header in the proposal would be considered a clear reference.

Proposal Submission: All proposals (both technical and cost) must be submitted to the Purchasing Division **prior** to the date and time listed in Section 2, Instructions to Vendors Submitting Bids as the bid opening date and time.

REQUEST FOR PROPOSAL
Medicare Fraud Control Unit Training Curriculum

SECTION 6: EVALUATION AND AWARD

6.1. Evaluation Process: Proposals will be evaluated in two parts by a committee of three (3) or more individuals. The first evaluation will be of the technical proposal and the second is an evaluation of the cost proposal. The Vendor who demonstrates that it meets all of the mandatory specifications required, attains the minimum acceptable score and attains the highest overall point score of all Vendors shall be awarded the contract.

6.2. Evaluation Criteria: Proposals will be evaluated based on criteria set forth in the solicitation and information contained in the proposals submitted in response to the solicitation. The technical evaluation will be based upon the point allocations designated below for a total of 70 of the 100 points. Cost represents 30 of the 100 total points.

Evaluation Point Allocation:

Project Goals and Proposed Approach (§ 4.2)	
- Approach & Methodology to Goals/Objectives (§ 4.2.1)	15 Points Possible
- Approach & Methodology to Compliance with Mandatory Project Requirements (§ 4.2.2)	15 Points Possible
Qualifications and experience (§ 4.3)	
- Qualifications and Experience Generally (§ 4.3.1)	20 Points Possible
- Exceeding Mandatory Qualification/Experience Requirements (§ 4.3.2)	20 Points Possible
Total Technical Score:	70 Points Possible
Total Cost Score:	30 Points Possible

Total Proposal Score: 100 Points Possible

6.3. Technical Bid Opening: At the technical bid opening, the Purchasing Division will open and announce the technical proposals received prior to the bid opening deadline. Once opened, the technical proposals will be provided to the Agency evaluation committee for technical evaluation.

6.4. Technical Evaluation: The Agency evaluation committee will review the technical proposals, assign points where appropriate, and make a final written recommendation to the Purchasing Division.

6.5. Proposal Disqualification:

6.5.1. **Minimum Acceptable Score ("MAS"):** Vendors must score a minimum of 70% (49 points) of the total technical points possible in order to move past the technical evaluation and have their cost proposal evaluated. All vendor proposals not attaining the MAS will be disqualified.

6.5.2. **Failure to Meet Mandatory Requirement:** Vendors must meet or exceed all mandatory requirements in order to move past the technical evaluation and have their cost proposals evaluated. Proposals failing to meet one or more mandatory requirements of the RFP will be disqualified.

6.6. Cost Bid Opening: The Purchasing Division will schedule a date and time to publicly open and announce cost proposals after technical evaluation has been completed and the Purchasing Division has approved the technical recommendation of the evaluation committee. All cost bids received will be opened. Cost bids for disqualified proposals will be opened for record keeping purposes only and will not be evaluated or considered. Once opened, the cost proposals will be provided to the Agency evaluation committee for cost evaluation.

The Purchasing Division reserves the right to disqualify a proposal based upon deficiencies in the technical proposal even after the cost evaluation.

6.7. Cost Evaluation: The Agency evaluation committee will review the cost proposals, assign points in accordance with the cost evaluation formula contained herein and make a final recommendation to the Purchasing Division.

Cost Evaluation Formula: Each cost proposal will have points assigned using the following formula for all Vendors not disqualified during the technical evaluation. The lowest cost of all proposals is divided by the cost of the proposal being evaluated to generate a cost score percentage. That percentage is then multiplied by the points attributable to the cost proposal to determine the number of points allocated to the cost proposal being evaluated.

Step 1: Lowest Cost of All Proposals / Cost of Proposal Being Evaluated = Cost Score Percentage

Step 2: Cost Score Percentage X Points Allocated to Cost Proposal = **Total Cost Score**

Example:

Proposal 1 Cost is $1,000,000
Proposal 2 Cost is $1,100,000
Points Allocated to Cost Proposal is 30

Proposal 1: Step 1 – $1,000,000 / $1,000,000 = Cost Score Percentage of 1 (100%)
Step 2 – 1 X 30 = Total Cost Score of 30

Proposal 2: Step 1– $1,000,000 / $1,100,000 = Cost Score Percentage of 0.909091 (90.9091%)

Step 2 – 0.909091 X 30 = Total Cost Score of 27.27273

6.8. Availability of Information: Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d.

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Integrity Advantage Solutions, LLC
(Company)

Jala Attia, President
(Representative Name, Title)

732-674-3267 phone / 732-288-1677 fax
(Contact Phone/Fax Number)

9/23/2022
(Date)