Inter Valley Health Plan

POLICIES AND PROCEDURES

Subject: Compliance – Prompt Response to Detected Offenses

Dept: Corporate Compliance Committee

Effective Date: May 24, 2016

Policy No: P401

Revised: 3-31-2017, 3/1/2018, 5/1/2019, 5/2021, 9/2021

Reviewed and Accepted By:

(Committee or Department Head) _____Corporate Compliance Committee_____

9/17/2021

Authorized Signature: _____ **Date:** _____

POLICY:

To ensure a process is in place to respond to detected offenses, to initiate corrective action to prevent similar offenses, and to report to government authorities when appropriate.

Scope/Limitations: This policy and procedure applies to all individuals employed, contracted, volunteer or otherwise representing Inter Valley Heath Plan (Plan); and those of any FDRs who participate in the administration of IVHP's programs.

DEFINITIONS

Associate: Associate For purposes of this policy and procedure, the term "associate" includes regular employees, temporary employees, volunteers, and board members, members, operational units, entities, or departments with specific business functionality. Centers for Medicare & Medicaid Services (CMS) The Federal agency within the U.S. Department of Health and Human Services (HHS) that administers the Medicare and Medicaid programs.

Compliance Officer An associate employed full time by the Plan responsible, either directly or through delegation, for overseeing the company's compliance program.

Corporate Compliance Program: A written document that defines the specific manner in which the compliance program is implemented across the organization.

Corrective Action Request (CAR) Request for corrective action to address an adverse finding.

Corrective Action Plan (CAP) A description of the actions to be taken to correct deficiencies identified during an audit, ongoing monitoring, or self-reporting; and to ensure future compliance with the applicable requirements. A CAP usually contains accountabilities and sets timelines. Delegation Oversight Committee is responsible for overseeing the ongoing compliance of delegated medical, dental, vision, chiropractic, alternative care and mental health service providers.

First Tier/Downstream/Related Entity (FDR) Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between Inter Valley Health Plan and a first tier entity. These written arrangements continue down to the level of ultimate provider of health, pharmacy and/or administrative services to members. First Tier Entity Any party that enters into a written

arrangement acceptable to CMS with Inter Valley Health Plan to provide administrative services or health care or pharmacy services for a Medicare eligible individual under a MA or Part D Plan. The term will also include delegates, such as providers, third party administrators, or other entities who have been delegated responsibility for activities defined in this policy.

Governing Body means that group of individuals at the highest level of governance of the sponsor, such as the Board of Directors or the Board of Trustees, who formulate policy and direct and control the sponsor in the best interest of the organization and its enrollees. As used in this chapter, governing body does not include C-level management such as the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, etc., unless persons in those management positions also serve as directors or trustees or otherwise at the highest level of governance of the sponsor.

Medicare Advantage (MA) An organization that is a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the requirements to offer an MA plan. Medicare Advantage Organization (MAO) An organization that is a public or private entity organized and licensed by a State as a risk-bearing entity that is certified by CMS as meeting the requirements to offer an MA plan.

PROCEDURE

- Inter Valley Health Plan follows the Centers for Medicare & Medicaid Services (CMS) requirements contained in the Medicare Compliance Program Guidance as well as Parts 422 and 423 of Title 42 of the Code of Federal Regulations (CFR). It is the policy of Inter Valley Health Plan to comply with all applicable regulations and guidance related to MA and Part D lines of business
- Inter Valley Health Plan implement appropriate corrective actions in response to potential or identified non-compliance with applicable requirements. See detailed policies: "P202 Reporting Potential Issues of Fraud and Non-Compliance and P201 Duties of Compliance Officer and Corporate Compliance Committee
- Non-compliance with regulations or guidance applicable to Medicare programs may be identified through: ·
    - Internal Audit department auditing;
    - Compliance and Corporate Compliance ongoing risk assessment

- Auditing and/or monitoring;
- Special Investigations Unit (SIU) activities,
- delegation oversight,
- direct reporting – via in person, mail, fax, or hotline

- All identified issues or potential issues, regardless of how they are reported, are reviewed by the Compliance Officer taking into consideration the following:
  - Does the issue have a negative impact on beneficiaries? ·
  - How many beneficiaries are affected? ·
  - Is there significant harm or potential harm to members?
  - Could the issue result in a high volume of calls or complaints to CMS or the Plan? ·
  - Does the issue impact access to care for beneficiaries? ·
  - Is the deficiency a result of a systemic issue that may impact the Company's ability to comply with applicable requirements?
  - Does the issue require CMS intervention to resolve? ·
  - Could there be political or media interest in the issue that could generate calls to CMS?
  - Does the issue involve or was it caused by a delegate or vendor over whom the Plan has oversight responsibility?
  - Did the issue involve or impact a key compliance area of focus, such as enrollment/disenrollment, sales/marketing allegations, appeals and grievances, delegated vendors and access to prescription drugs?
    - If the Compliance Officer working with the Corporate Compliance Committee and/or legal counsel determines the issue is reportable to CMS, law enforcement, or any other governmental agency.
      - potential non-compliance issue will be reported within 48 hours of identification.
    - The Compliance Officer tracks Issue of non-compliance
    - Intervention and/or disciplinary action may be issued if corrective action deliverables are not completed timely and the delay is not justified.
    - All reports are closed within 60 days.

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- Any reported issue that affects member access to care or well-being (including financial wellbeing) is escalated to Corporate Compliance Committee
  - Corporate Compliance Committee intervention based on circumstances, should the corrective action plan due date fall past due beyond 30 days.
    - Impactful scenarios may include:
      - Declared Natural Disaster
      - Delays due to systems implementations
      - FDR declared staffing issues with root cause

- Corrective Action Plans (CAP) may be required when deficiencies are identified through auditing or monitoring activities.
  - CAP tasks typically include, but may not be limited to: ·
    - Review and revision, as applicable, of policies, procedures, desktop work instructions, workflows, member materials, , to ensure compliance with CMS regulation and guidelines; ·
    - Training of applicable staff on policies, procedures, desktop work instructions, workflows, member materials,
    - Periodic self-auditing/monitoring by the applicable functional areas process to ensure compliance is achieved and maintained.

- Failure to cooperate with the CAP process may result in disciplinary action, up to and including termination of employment, or termination of delegated responsibility and/or contract with the organization.
- The Compliance Officer reviews CAPs developed and associated tasks to determine if it is reasonable to expect compliance to be achieved and maintained once the root cause is identified, beneficiary impact analysis performed (if applicable), the corrective action plan is effectuated and brought to the Corporate Compliance

Committee with a recommendation to approve and move towards validation, if acceptable.

- If concerns are identified, the Compliance Officer working with the Corporate Compliance Committee addresses concerns with the functional area owner
  - Functional area owner of the CAP works to revise the corrective action plan as appropriate and resubmits for CAP acceptance by Compliance Officer and Corporate Compliance Committee.

- First Tier/Downstream Related Entities**:** IVHP requires all FDRs to submit a CAP when deficiencies are identified through
  - compliance audits,
  - ongoing monitoring
  - or self-reporting.
- Delegation Oversight Committee reviews FDR CAPs developed and associated tasks to determine if it is reasonable to expect compliance to be achieved and maintained once the root cause is identified, beneficiary impact analysis performed (if applicable), the corrective action plan is effectuated and brought to the Corporate Compliance Committee with a recommendation to approve and move towards validation, if acceptable.
  - If concerns are identified, the Delegation Oversight Committee working with the FDR Compliance Auditor addresses concerns with the FDR
    - FDR owner of the CAP works to revise the corrective action plan as appropriate and resubmits for CAP acceptance by Delegation Oversight Committee.
    - Any continued non-compliance by FDR is escalated to the Compliance Officer and Corporate Compliance Committee for intervention via phone outreach and/or letter to the FDR stating contractual obligations; regulatory requirements to bring FDR into compliance.
  - Inter Valley Health Plan will take administrative action, which may include termination of the contract, if an FDR does not comply with a CAP or does

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not meet its regulatory obligations as outlined in its contract with Inter Valley Health Plan.

- Identified deficiencies that involve illegal activity are referred to the NBI MEDIC; the Office of the Inspector General (OIG), and/or law enforcement as appropriate.

- Compliance Officer performs Write Up Upon receipt of an not related to possible fraud or other misconduct,
- Compliance Officer: Ensures the reporting functional area completed write up and that it is completed appropriately and includes, at a minimum:
  - The affected CMS contract(s);
  - An executive summary of the issue;
  - The regulatory and/or internal requirement(s) that apply to the issue;
  - A description of the incident;

  A description of similar incidents that occurred previously; vi. The number and demographics of impacted members;
  - A root cause analysis; and
  - beneficiary impact analysis (if applicable)
  - The Corrective Action Alan describing steps to correct and prevent recurrence of the issue.
  - Determines if it is reasonable to expect that compliance will be achieved and maintained once the plan and associated tasks are effectuated;
  - Works with Corporate Compliance Committee the owner(s) to revise the corrective action plan and/or associated tasks if concerns are identified
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The Compliance Officer enters all relative Information as noted within write-up into CMS Monthly Issues Meeting log for reporting information to the Plan's CMS Regional Account Manager at CMS-required monthly meetings or more expeditiously if the warranted.

References: Title 42 Code of Federal Regulations (CFR) · 42 C.F.R. §422.503(b)(4)(vi)(G) · 42 C.F.R. §423.504(b)(4)(vi)(G) CMS Medicare Managed Care Manual •– Section 20.1 • Chapter 21 – Medicare Compliance Program Guidelines – Section 50.7 Prescription Drug Benefit Manual • Chapter 9 – Medicare Compliance Program Guidelines