Inter Valley Health Plan	Dept: Office of the President Effective Date: October, 1999 Policy No: P201 Revised: September 2010 October 2011, 12/2012, January 2014, September 2015, March 2017, March 2018, May 2019, May 2021, Sept 2021 Page No: Page 1 of 7
POLICIES AND PROCEDURES	
Subject: Duties of Compliance Officer and Corporate Compliance Committee	

Reviewed and Accepted By:
(Committee or Department Head) Corporate Compliance Committee

Authorized Signature: **Date:** 9-17-2021

PURPOSE:

To outline the duties and responsibilities of the Compliance Officer, and Corporate Compliance Committee (CCO).

DEFINITIONS:

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

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §, 423.501).

Employee(s) refers to those persons employed by the sponsor or a First Tier, Downstream or Related Entity (FDR) who provide health or administrative services for an enrollee.

External Audit means an audit of the sponsor or its FDRs conducted by outside auditors, not employed by or affiliated with, and independent of, the sponsor.

FDR means First Tier, Downstream or Related Entity. First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to

a Medicare eligible individual under the MA program or Part D program. (See, 42 C.F.R. § 423.501).

Fraud is 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. 18 U.S.C. § 1347.

FWA means fraud, waste and abuse.

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.

Internal Audit means an audit of the sponsor or its FDRs conducted by auditors who are employed by or affiliated with the sponsor.

Monitoring Activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

NBI MEDIC means National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.

OIG is the Office of the Inspector General within DHHS. The Inspector General is responsible for audits, evaluations, investigations, and law enforcement efforts relating to DHHS programs and operations, including the Medicare program.

Pharmacy Benefit Manager (PBM) is an entity that provides pharmacy benefit management services, which may include contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; performing drug utilization review; and operating disease management programs. Some sponsors perform these functions in-house and do not use an outside entity as their PBM. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies. A PBM is often a first tier entity (FDR) for the provision of Part D benefits.

Special Investigations Unit (SIU) is an internal investigation unit responsible for conducting investigations of potential FWA.

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

POLICY:

Inter Valley Health Plan's Board of Directors and Board Compliance Committee have delegated authority to the Compliance Officer and Corporate Compliance Committee to implement the Plan's Corporate Compliance Program. The Compliance Officer and Corporate Compliance Committee define the program structure, training requirements, reporting, and compliance mechanisms, response and correction procedures, and compliance expectations of plan employees and first tier/downstream/ related entities. The Compliance Officer reports to the President/CEO in both a reporting and supervisory relationship with dotted line reporting to the Board of Directors. The Compliance Officer has express authority to provide unfiltered, in-person reports to the Plan's Corporate Compliance Committee (comprised of senior leadership of the plan), and the governing body. Compliance reporting follows the plans compliance structure

The Compliance Officer is a full-time employee, independent of daily responsibilities for operational areas, and focuses solely on compliance for the health plan. The Corporate Compliance Committee is chaired by the Compliance Officer. The Corporate Compliance Committee meets monthly or more often as needed. (or as needed).

CORPORATE COMPLIANCE COMMITTEE FUNCTIONS AND RESPONSIBILITIES

A. Accountable for the development, implementation, and overall effectiveness of the compliance program.

· The Compliance Committee, recommending approval, presents the following updated items annually to the Board of Directors Compliance Committee. Upon approval, the Compliance Committee of the Board recommends approval to Board of Directors:

- Compliance Program
- Compliance Policies & Procedures
- Charter for Committee
- Risk Assessment
- Work Plan
- Audit Schedule
- Training & Testing Materials
- Surveys/Tools to measure program effectiveness
- Annual CPE Audit Contract and CPE Final Report and any corrective action plans to address findings noted in final report.

B. Oversight of the annual Work Plan to capture all federal and state regulation and guidance that requires implementation; at-risk operational areas; and/or areas identified as a risk to the organization.

- Assist with policy development and new implementation of regulations.
- Discuss and add to work plan any new federal & state changes
- Ongoing assessment of risk to the plan; including operational areas
- Maintain an audit schedule that includes all internal and external audits. The audit schedule should be based on risk to the organization as identified within the Health Plan's adopted methodology and risk stratification.

C. Ensure that minutes of all Corporate Compliance Committees are documented and reflect major discussion points, decisions, actions, reporting, and follow-up.

D. The Corporate Compliance Committee is required to ensure compliance within CMS identified risk areas:

- Grievance and Appeals
- Delegated Entities and First-Tier Entity Oversight
- Part D – Pharmacy Benefit Management
- Enrollment/Disenrollment
- Network Adequacy
- Sales & Marketing
- Fraud/Waste/Abuse – Prevention, Detection & Mitigation; HIPAA, and incidents of reported non-compliance
- Special Investigations Unit
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E. Provide quarterly reports for the Compliance Committee of the Board of Directors and Board of Directors. results and activities related to the monitoring and auditing of

plan operations and performance improvements with a specific emphasis on high-risk functions noted by CMS, including but not limited to:

- Delegation and First-Tier Entity Oversight
- Grievance & Appeals
- Enrollment
- Claims
- Pharmacy
- Sales & Marketing
- Third-party vendors/FDR/delegated entity due diligence audits; Notices of Non-Compliance, Fraud/Waste/Abuse -Prevention, Detection, Mitigation; Sanctions; Breach notifications

G. The Compliance Officer has the authority to:

- Interview or delegate the responsibility to interview the Plan's employees and other relevant individuals regarding compliance issues, complaints, fraud hotline and potential non-compliance.
- Review company contracts and other documents pertinent to is Medicare business.
- Review or delegate the responsibility to review the submission of data to CMS to ensure that it is accurate and in compliance with CMS reporting requirements.
- Independently seek advice from legal counsel.
- Report potential FWA to CMS, NBI Medic, or law enforcement.
- Conduct and/or direct audits and investigations of FDRs.
- Conduct and/or direct audits of any area or function involved with Medicare Parts C or D.
- Recommend policy, procedure and process changes.

Reviewed and Accepted By:
(Committee or Department Head) Corporate Compliance Committee

9-17-2021

Authorized Signature: **Date:**

Resources: CMS Manuals Chapters 9 and 21

References:
Inter Valley Health Plan Corporate Compliance Program; Fraud Plan
P202 – Reporting Potential Issues or Areas of Noncompliance, Fraud and Abuse
P200 - Corporate Compliance Program Employee Training
P402- Compliance Auditing & Monitoring
Compliance Committee Charter
Board Compliance Committee Charter
42 C.F.R. 422.503(b)(4)(vi)(B), 423.504(b)(4)(vi)(B)