Inter Valley Health Plan	Dept: Compliance Committee
POLICIES AND PROCEDURES	Effective Date: May 2016 Policy No: P400 Revised: Reviewed 3-31-2017, 3/1/2018, 5/1/2019, 5/1/2021, Sept 2021 Page **1** of **5**
Subject: Corporate Compliance Program Element IV – Effective Lines of Communication	

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

Authorized Signature: _____ **Date:** _9-17-2021

POLICY:
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). Notices of additions, changes and/or clarification to Medicare program rules may be received from multiple sources but are typically received via memos distributed through CMS' Health Plan Management System (HPMS).

DEFINITIONS:

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

Health Plan Management Systems – Also known as the HPMS. The online system utilized by The Centers for Medicare & Medicaid Services to distribute announcements and communications to contracted Medicare Advantage Health Plan and Prescription Drug Plans. HPMS memoranda may include, but are not limited to; guidance, regulatory changes, fraud alerts, regulatory submissions/deadlines, reminders, calendars, audit information, and non-compliance notices, etc.

Fraud/Waste/Abuse: Direct or indirect, result in unnecessary costs to the Medicare Program

Employees: For purposes of this policy and procedure, the term "associate" includes regular employees, temporary employees, volunteers, and interns. 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.

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Compliance Program: A program that promotes regulatory compliance and legal conduct to provide guidance to prevent, detect and help resolve non-compliant and illegal conduct, including fraud, waste or abuse.

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).

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.

PURPOSE:
To ensure effective lines of communication are in place between the Compliance Officer and employees, managers, directors, governing body members, First Tier/Downstream/Related Entities (FDRs), temporaries, interns, and health plan members.

PROCESSES FOR EFFECTIVE COMMUNICATION:

HPMS INFORMATION & FRAUD ALERTS:

- The Compliance department has processes in place for the handling & distribution of HPMS memos notices to the required process owners and/or functional area and tracks the memo through to completion/effectuation.

- Changes and information areas of implementation from all sources are shared to ensure effective compliance is achieved and maintained.
- Notices that apply to delegated functions are distributed to the FDRs when appropriate and addresses areas the FDR is delegated to oversight a process and contracted to perform.
    - Compliance also works with the owner and/or functional area to track and ensure timely response from FDRs.

REGULATORY INFORMATION:

- The Plan has processes in place to receive, record, and respond to compliance questions in a timely manner. Detailed information may be found within policy "P201 Duties of Compliance Officer and Corporate Compliance Committee".
    - Compliance researches each request to ensure that all regulatory information is included and seeks outside counsel as necessary.

FRAUD/WASTE/ABUSE:

- Compliance processes reports of potential or confirmed incidences of non-compliance from officers, directors, managers, associates, members and first-tier, downstream and related entities within 3 days of notification: ·
- Confidentiality is maintained, to the greatest extent possible; ·
    - Ensuring non-retaliation against those who report suspected misconduct in good faith. Inter Valley Health Plan publicizes the mechanisms to receive compliance questions, reports of potential risks, and reports of fraud, waste or abuse from employees, governing body, FDRs, and plan members.

POLICIES & PROCEDURES:

- The Plan's policies and procedures are distributed upon hire, annually with refresher training and upon required policy updates.
    - The Corporate Compliance Program and related policies and procedures are also available to employees through the Plan's Intranet.

- Compliance department maintains compliance-related documentation and oversights version control to track changes.
- FDRs are provided policy updates via email and may also access the Plan's Corporate Compliance Program and related FDR policies via the Plan's website portal for providers.

COMPLIANCE/FWA/HIPAA:

- Each employee, temporary employee and board member upon onboarding and annually receives compliance, fraud/waste/abuse, and HIPAA training via an online learning management system requiring a passing score of 85%
- All employees and board members of receive annual refresher training
  - training consists of:
    - compliance program;
    - related compliance policies,
    - desk card for information on how and who to report FWA and instances of non-compliance
    - standards of conduct.
  - All staff and board members are required to acknowledge receipt of these materials.
  - First Tier and Downstream entities, per CMS, are not required to complete Compliance and FWA training, unless the Plan requires per contract. IVHP does not require training within its contracts specifically.
    - All FDRs are emailed policies upon due diligence audit by compliance prior to contracting, annually, and when policy changes are required.
    - All brokers/agents are trained annually on the principles of Medicare Parts A, B, C and D; FWA; HIPAA; and the Plan's annual benefits packages.
      - A score of 90% is required to maintain active IVHP broker status.

REPORTING AUDITING & MONITORING:

- All Plan audits by legal entities; internal monitoring; internal auditing; first tier, delegated and downstream entity monitoring and auditing

information is reported up through the Compliance Governance Structure.

- FDRs audits and monitoring efforts are reported to the Delegation Oversight Committee by the various functional areas responsible and the dedicated delegated FDR auditors for Claims, Credentialing and Utilization/Quality Management and PBM Pharmacy Team.

- The Plan maintains a Corporate Compliance Committee to ensure oversight of the compliance program; fraud plan; risk assessment, work plan, audit plan and auditing & monitoring efforts.

- The Plan maintains a Board Compliance Committee delegated by the Board to perform governance oversight of the plan and meets quarterly.

- Quarterly reports are provided on committee activity, audits, FWA and HIPPA on quarterly basis to the Board of Directors.

- In addition, the Quality Improvement Committee provides quarterly reports to the Board of Directors to ensure all monitoring, auditing and oversight is shared with the plan governance.

References: Title 42 Code of Federal Regulations (CFR) · 42 CFR § 422.503(b)(4)(vi)(D) · 42 CFR § 423.504(b)(4)(vi)(D) CMS Medicare Managed Care Manual · Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements – Section 20.1 · Chapter 21 – Medicare Compliance Program Guidelines - Section 50.4 Prescription Drug Benefit Manual · Chapter 9 — Medicare Compliance Program Guidelines.