INTRODUCTION

The Health Plan is dedicated to promoting compliance with all applicable federal and state laws, rules, and regulations. This includes, but is not limited to, the requirements of Medicare Part C, Medicare Part D and Medicaid. All directors (i.e., board members), officers, employees, interns, volunteers, committee members, contractors and First Tier, Downstream and Related Entities (FDRs) are expected to meet various legal requirements. For these reasons, The Health Plan has developed and implemented the following Corporate Compliance Plan. The plan and its related policies, procedures and work plans are designed to ensure The Health Plan fulfills all statutory and contractual obligations in a fair, accurate and consistent manner.

The Corporate Compliance Plan not only addresses health care fraud, waste and abuse (FWA), but the requirements and obligations set forth by the Centers for Medicare and Medicaid Services (CMS) and other applicable laws and regulations. The plan covers the following areas:

- Written policies, procedures and standards of conduct
- Compliance officer, compliance committees and high level oversight
- Effective training and education
- Effective lines of communication
- Well publicized disciplinary standards
- System for routine monitoring and identification of compliance risks
- Procedures and systems for prompt response to compliance issues
- Medicaid addendum

Regulatory compliance is not an option—it is required. Failure to comply with all applicable federal and state regulations exposes The Health Plan to fines and potential loss of its Medicare and/or Medicaid program contracts. Non-compliance with the plan and all applicable regulatory statutes undermines The Health Plan’s reputation and credibility with its members, providers, and employees. The Corporate Compliance Plan will be reviewed at least annually and as often as circumstances dictate.

The Health Plan’s Board of Directors delegates the authority for the development and implementation of the Corporate Compliance Plan to Executive Management and the internal Corporate Compliance Committee. Oversight of the program shall include all facets of development, implementation, and review of the program including:

- Development, implementation and annual review
- Approval of compliance policies and procedures
- Review of general compliance, FWA and Health Insurance Portability and Accountability Act (HIPAA) training
The Health Plan
Corporate Compliance Plan
Reviewed 1/11, 1/12, 3/13, 10/14, 11/15, 11/16, 12/17, 01/19

- Review of the results of the organization’s annual compliance risk assessment
- Review of the compliance and audit work plan and audit results
- Review of any corrective action plans (CAPs)
- Review and approval of appointment of the Compliance Officer
- Review of performance goals for the Compliance Officer
- Evaluation of the Executive Management’s commitment to ethics and the compliance program
- Review of dashboards, scorecards, self-assessment tools, etc., that describe compliance activities and issues

The Compliance Officer will periodically report the status of corporate compliance activities to the Corporate Compliance Committee and to the Board of Directors through the Audit and Corporate Compliance Committee (A&C).

WRITTEN POLICIES, PROCEDURES, AND CODE OF CONDUCT

The Health Plan’s overall expectation for employee compliance begins with a commitment to comply with The Health Plan’s Code of Conduct, all applicable federal and state regulations, and applicable standards and sub-regulatory guidance. Compliance training occurs as part of the new hire process and is conducted annually thereafter, as determined by The Health Plan’s Compliance Department. In addition, The Health Plan has policies and procedures that establish expectations that The Health Plan employees are expected to follow. The Health Plan maintains compliance policies, procedures and written guidelines so all employees are of aware of their individual responsibility for compliant and ethical business practices.

Code of Conduct
All directors, officers, employees, interns and volunteers are required to review and attest to The Health Plan’s Code of Conduct as set forth in Attachment A upon hire or appointment and annually thereafter. FDRs are expected to adopt The Health Plan’s Code of Conduct or substantially similar document.

Conflict of Interest, Employee Security and Confidentiality Agreement, Computer Network Security Policy
All directors, officers, employees, interns and volunteers are required to review and sign the Conflict of Interest statement or questionnaire upon hire or appointment and on an annual basis thereafter. Employees, interns and volunteers are further required to review and sign the Employee Security and Confidentiality Agreement and Computer Acceptable Use Policy upon hire and annually thereafter.
**The Health Plan**
**Corporate Compliance Plan**
Reviewed 1/11, 1/12, 3/13, 10/14, 11/15, 11/16, 12/17, 01/19

**HIPAA Privacy Program**
The HIPAA Privacy Program sets the standards for employees in safeguarding confidential and protected health information. The Health Plan is committed to complying with applicable laws, regulations and policies related to the privacy of health information. All employees, interns and volunteers are required to complete the HIPAA Privacy and Security Training and perform their work duties with a conscious regard for the privacy rights of The Health Plan’s members.

Under the direction of The Health Plan’s Compliance Officer, the Privacy Program focuses on educating employees on their ongoing responsibility to protect member privacy and secure member information. The Compliance Department manages and updates the privacy policies and procedures, which are available to all The Health Plan employees via the intranet, through distributed materials, and directly from the Compliance Officer.

All FDRs must abide by The Health Plan’s Privacy Program policies or demonstrate that they have a dedicated privacy official who is responsible for ensuring that all individuals within the respective delegated entity are trained on HIPAA regulations and the reporting of privacy breaches. The FDR’s privacy official is also responsible for managing any issues related to privacy breaches and reporting to The Health Plan any actual or potential privacy breach that impacts The Health Plan’s members or business.

**FWA Plan**
The Health Plan maintains a FWA plan that demonstrates a commitment to prevent, detect and correct issues that could lead to FWA. Upon hire or appointment, all individuals must agree to comply with The Health Plan Code of Conduct and complete all mandatory FWA training courses. FWA training must include an overview of the laws and regulations related to Medicare FWA (e.g., False Claims Act, Anti-Kickback Statute, etc.). All directors, officers, employees, interns and volunteers must receive compliance and FWA prevention training:

1. Upon hire or appointment
2. Annually
3. When there are material changes to applicable laws or regulations
4. When employees are found to be noncompliant
5. As part of a CAP to address identified non-compliance
6. When an employee works in an area implicated in past non-compliance and/or potential FWA

FDRs should complete compliance and FWA training at least annually through their own internal compliance program or using training materials supplied by The Health Plan.

The Health Plan uses a number of system edits and programmatic reviews of data to detect potential fraud. The Health Plan maintains a hotline for
anonymous reporting and a Special Investigations Unit (SIU) that investigates all reports of potential FWA. The SIU works with designated state and federal agencies, the National Benefit Integrity Medicaid Drug Integrity Contractor (Qlarant NBI MEDIC), and law enforcement to pursue individuals or organizations who may be involved in activities that may be indicative of potential FWA.

Fraudulent or abusive activity may involve employees, members, subscribers, health care providers or vendors/subcontractors. FWA may involve inappropriate schemes, behaviors, false documentation, inappropriate prescriptions, or falsification of conditions in order to assist an individual to receive an otherwise uncovered service under Medicare, Medicaid, or other state or federal health program.

The Health Plan’s directors, officers, employees, and FDRs play an important role in The Health Plan’s compliance program and fraud prevention program and are required to report suspected FWA through the channels provided.

**The Health Plan’s Compliance and FWA Policies**

The Health Plan’s policies and procedures promote compliance and responsiveness to laws, regulations and day-to-day risks to help reduce the prospect of fraudulent, wasteful and abusive activity. Because risk areas evolve and change over time, The Health Plan’s policies and procedures must be reviewed at least annually and revised when there are changes in regulatory requirements or business needs.

The Health Plan’s policies demonstrate to employees, business partners, and the community at large, our strong commitment to honest and responsible business practices and regulatory compliance. The Health Plan’s published policies establish procedures and provide direction to employees to promote compliance with applicable laws and regulations, and reduce the prospect of fraudulent, wasteful, or abusive activities in our daily work.

The Health Plan requires that all FDRs adopt The Health Plan’s policies, procedures and Code of Conduct or maintain similar policies, procedures and standards of conduct that comply with current Medicare and Medicaid rules and regulations.

**Compliance Policies and Procedures**

The Health Plan has developed compliance policies and procedures to promote compliance with the requirements of the Medicare and Medicaid programs. The Health Plan’s operational areas have developed policies and procedures that support the compliance program by addressing the day-to-day activities of relevant business areas.
Delegated Entities, Providers, Vendors, Agents and FDRs

Various departments at The Health Plan provide services to The Health Plan’s members through third party arrangements. When a third party, such as a pharmacy benefit manager, a provider group, a dental provider, or another entity provides services to members, it is necessary to ensure that the third party entity adheres to all requirements of The Health Plan’s compliance program. Accordingly, designated staff of The Health Plan shall monitor the activities and performance of FDRs, providers and other vendors to ensure they fulfill their contractual requirements for Medicare Part C, Medicare Part D, and Medicaid as well as established performance standards. Delegation and vendor oversight activities shall include, but are not limited to:

- Contractual language which requires adherence to compliance requirements
- Audits to validate compliance with contractual, internal and regulatory requirements
- Development of CAPs in response to detected non-compliance
- Written reports of oversight activities
- Implementation and completion of CAPs
- Regular reporting to the Corporate Compliance Committee

COMPLIANCE OFFICER, CORPORATE COMPLIANCE COMMITTEE AND HIGH LEVEL OVERSIGHT

The Health Plan recognizes the importance of fostering a culture of compliance. To this end, The Health Plan maintains and supports a Corporate Compliance Committee and a Compliance Officer vested with clear roles, responsibilities and objectives.

Compliance Officer

The Health Plan’s Compliance Officer serves as an integral part of The Health Plan’s Corporate Compliance Plan and acts as the focal point for compliance activities. The Compliance Officer has direct access and is accountable to the President and Chief Executive Officer (CEO) and Board of Directors. The Compliance Officer is responsible for developing, operating and monitoring the compliance program. The Compliance Officer may delegate such responsibilities where appropriate. The Compliance Officer does not hold other responsibilities that could lead to self-policing of his or her activities.

Authority:

The Compliance Officer has the following authority:

- Interview, or delegate the responsibility to interview, the sponsor’s employees and other relevant individuals regarding compliance issues
The Health Plan
Corporate Compliance Plan
Reviewed 1/11, 1/12, 3/13, 10/14, 11/15, 11/16, 12/17, 01/19

- Review company contracts and other documents pertinent to the Medicare and Medicaid programs
- Review or delegate the responsibility to review the submission of data to Medicare and Medicaid to ensure that it is accurate and in compliance with reporting requirements
- Independently seek advice from legal counsel
- Report potential FWA to CMS, its designee, or other required state entities or law enforcement
- Conduct and/or direct audits and investigations of The Health Plan’s FDRs
- Conduct and/or direct audits of any area or function of The Health Plan, including areas involved with The Health Plan’s Medicare and Medicaid contracts
- Recommend policy, procedure, and process changes

Roles and Responsibilities:

- Oversee and monitor the implementation of the compliance program
- Report on a regular basis to the CEO, Corporate Compliance Committee and Board of Directors
- Periodically revise the compliance program in accordance with organizational needs and changes in applicable law and policy
- Develop, coordinate and participate in multifaceted educational and training programs that focus on the elements of an effective compliance program as well as specific risk areas
- Coordinate internal compliance reviews, auditing and monitoring activities
- Develop policies and programs that encourage employees to report suspected compliance issues, suspected fraud or abuse and other improprieties without fear of retaliation
- Assist in the oversight of the SIU

The Compliance Officer has the flexibility to design and coordinate internal investigations (e.g. responding to reports of suspected violations) and issue corrective actions (e.g. making necessary improvements to policies and practices, recommending appropriate disciplinary action, etc.) as deemed appropriate. Such activities may include, but are not limited to:

- Coordinate with the Human Resources Department and the Provider Relations Department to ensure that the National Practitioner Data Bank, the Office of Inspector General List of Excluded Individuals and Entities (OIG) and General Services Administration System for Award Management Excluded Parties List System (SAM) databases have been checked with respect to all employees, officers, directors, committee members, and providers to make sure they are not restricted from participation in federal health care programs.
The Health Plan
Corporate Compliance Plan
Reviewed 1/11, 1/12, 3/13, 10/14, 11/15, 11/16, 12/17, 01/19

- Report suspected fraud or misconduct to CMS or other appropriate agency, its designee and/or law enforcement.
- Ensure proper documentation is maintained for each report of potential non-compliance or FWA received through any reporting method (e.g. hotline, mail, or in-person). Such documentation includes corrective and/or disciplinary action(s) taken as a result of the investigation, the respective dates when each of these events and/or actions occurred, and the names of the person(s) who implemented these actions.
- Oversee the development, monitoring and implementation of CAPs.
- Independently investigate and coordinate potential fraud investigations and referrals where applicable including coordinating and cooperating with the Qlarant NBI MEDIC and/or appropriate law enforcement agency.

The Compliance Officer, as appropriate, collaborates with other sponsors, commercial payers, and other organizations when an FWA issue is discovered that may involve multiple parties.

Compliance Department

The Compliance Department provides support to the Compliance Officer in promoting ethical conduct, instilling a company-wide commitment to compliance with federal and state regulatory guidelines, and exercising diligence in ensuring the overall compliance program requirements are met. The Compliance Department is responsible for:

- Representing The Health Plan before all applicable state and federal regulatory agencies on Medicare and Medicaid related issues and serving as liaison for communications between the company, CMS and other regulatory entities.
- Establishing the overall framework for the compliance program to promote compliance with applicable Medicare, Medicaid and Federal and State regulatory and legal requirements.
- Ensuring consistent and timely reporting of relevant compliance issues to the Compliance Officer. The Compliance Officer, in turn, reports significant compliance matters to the Corporate Compliance Committee and has authority to escalate issues to executive management and the Board of Directors.
- Advising and overseeing the individual business units and health plans in the design of various monitoring activities.
- Establishing key performance measures, metrics, and reporting protocols as part of the organization’s auditing and monitoring of key risk areas.
- Monitoring, auditing and reporting key compliance and performance metrics for the purpose of resolving identified patterns and trends, working with business units on corrective actions, and assessing the effectiveness of the compliance program.
The Health Plan
Corporate Compliance Plan
Reviewed 1/11, 1/12, 3/13, 10/14, 11/15, 11/16, 12/17, 01/19

- Assessing new risk areas based on information gathered from a variety of sources including CMS, Medicaid guidance, internal assessments, member complaints, governmental inquiries or other avenues and recommending new or revised metrics, policies and procedures, enhanced training courses, or other activities that may be tracked and measured to demonstrate compliance.
- Reporting incidents of potential or identified non-compliance, and working with the applicable business units to implement appropriate and timely corrective actions that result in measurable compliance.
- Developing relevant and effective compliance training programs that support the compliance program and build compliance awareness for employees, management and FDRs.
- Performing independent reviews and ongoing monitoring and auditing of identified risk areas, monitoring of compliance or performance deficiencies, and ensuring effective corrective actions are implemented in a timely manner.
- Partnering with Internal Audit to incorporate high-priority risk areas into the Internal Audit work flow and provide background and consultative guidance to Internal Audit on audit topics involving The Health Plan’s Medicare and Medicaid contracts.

**Corporate Compliance Committee**

The Health Plan has established a Corporate Compliance Committee to advise and assist the Compliance Officer in the implementation of the compliance program. The committee will consist of members with relevant experience within The Health Plan and Executive Management.

The voting members of the Committee shall be comprised of the following:
- CEO
- Senior Vice President of Government Programs
- Senior Vice President of Finance and Analytical Services
- Senior Vice President of Clinical Services
- Senior Vice President of Human Resources
- Director of Pharmacy
- Vice President of Internal Audit & Quality
- Compliance Officer

Additional members of the Executive Management Team will be brought in on an ad hoc basis. Non-voting members will include Compliance, SIU and Internal Audit staff. The Committee’s chairperson is the Compliance Officer.
The Health Plan
Corporate Compliance Plan
Reviewed 1/11, 1/12, 3/13, 10/14, 11/15, 11/16, 12/17, 01/19

Roles and Responsibilities:

The committee’s responsibilities shall include:

- Meet at least four times per year, and as necessary
- Analyze the industry environment and legal requirements with which The Health Plan must comply including specific risk areas
- Assess existing policies and procedures that address risk areas
- Work with appropriate departments to promote compliance
- Recommend and monitor the development of internal systems and controls to carry out The Health Plan’s standards, policies and procedures
- Determine the appropriate strategy or approach to promote compliance including the detection of any potential violations through hotlines and other reporting mechanisms
- Support the Compliance Officer’s needs for sufficient staff and resources to carry out his/her duties
- Ensure The Health Plan has appropriate, up-to-date compliance policies and procedures
- Review and address audit reports of areas in which The Health Plan is at risk of FWA and ensure CAPs are implemented as appropriate
- Review the Corporate Compliance Plan annually

Governing Body

The Corporate Compliance Program operates under the purview of the Board of Directors. In order to promote effective oversight, the Board of Directors has established The Health Plan’s A&C. The purpose of the A&C is to assist the Board of Directors in fulfilling its oversight responsibilities of The Health Plan with respect to the performance of The Health Plan’s internal audit and compliance functions.

The A&C provides advice and counsel to management in its oversight of financial audits, internal controls, implementation of the Corporate Compliance Program, and ethics processes. The A&C serves as an independent and objective party to monitor these processes and provides an open avenue of communication between the independent auditor, financial and senior management, the Internal Audit and Compliance Departments, and the governing body.

The A&C, on behalf of the Board of Directors, will review and provide oversight to at least the following areas:

- Approval of the Code of Conduct (performed by the full Board of Directors)
- The scope, structure, process and effectiveness of the Corporate Compliance Program
The findings of any regulatory investigations, including the results of internal and external audits
Updates from management and the Compliance Officer on legal or regulatory matters that significantly impact, or present an unaddressed risk, to the organization
Governmental compliance enforcement activities such as notices of non-compliance, warning letters and/or formal sanctions
The communication of periodic updates from the Compliance Officer and Corporate Compliance Committee to the Board of Directors

The Health Plan’s Board of Directors delegates the authority for the day-to-day development and implementation of the Corporate Compliance Plan to Executive Management and the Compliance Officer. These items include, but are not limited to:

- Development, implementation and annual review of compliance policies and procedures
- Approval of compliance policies and procedures
- Review and approval of periodic compliance risk assessments
- Review of internal and external audit work plans and audit results
- Review and approval of CAPs resulting from internal or external audits
- Review, approval and appointment of the Compliance Officer
- Review of dashboards, scorecards, self-assessments and other applicable items that describe compliance issues

EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in The Health Plan’s overall compliance program. The Health Plan requires all directors, officers, employees, interns and volunteers complete mandatory compliance and FWA training courses. The following trainings must be completed within ninety (90) days of employment or appointment and annually thereafter:

1. Code of Conduct
2. General Compliance
3. FWA

Compliance Training for FDRs
All FDRs that provide services to Medicare Advantage and/or Part D enrollees should complete compliance and FWA training through their own internal compliance program or by using training materials supplied by The Health Plan.

Tracking Required Compliance Training
Each member of The Health Plan’s management is responsible for ensuring their employees complete all required compliance training. Required training courses are delivered electronically via the intranet. Training materials and test results are
maintained for ten (10) years. Failure to complete required compliance training subjects employees and their managers to performance or disciplinary actions, up to and including termination of employment. FDRs must maintain documentation of compliance and FWA training for at least ten (10) years.

The Health Plan works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of compliance with regulatory requirements and reinforcing the company expectations of ethical and lawful behavior.

The Health Plan has systems in place to receive, record, and respond to compliance reports of potential or actual non-compliance from employees, members, providers, vendors/subcontractors and FDRs.

The areas listed below are key to the Compliance Department communications strategy:

**Compliance and FWA Hotline, Website and Email**
The Health Plan’s hotline is a confidential, toll-free resource available to employees, members, providers, FDRs, vendors/subcontractors and the general public twenty-four (24) hours a day, seven (7) days a week to report violations of, or raise questions or concerns relating to non-compliance and/or FWA.

The Health Plan’s Compliance and FWA Hotline
877.296.7283
www.healthplan.org/report-healthcare-fraud
compliance@healthplan.org

Calls and online forms may be completed anonymously. These communications are never traced. Anyone can make a report without fear of intimidation or retaliation.

The Health Plan logs calls placed to The Health Plan’s hotline or online form to ensure proper investigation and resolution of reported matters and to identify patterns and opportunities for additional training or corrective action. All calls to The Health Plan’s hotline are investigated by The Health Plan’s Compliance Department and/or SIU.

The Health Plan educates employees about The Health Plan’s hotline and online form through:

1. Compliance/FWA training
2. The employee intranet website
3. Posters displayed in common work areas
4. The Health Plan’s policies and procedures
5. Newsletters, emails and other means
Members, providers and FDRs are educated about The Health Plan’s hotline and online form through:

1. The Health Plan’s internet website
2. The Compliance/FWA training for providers and FDRs
3. Provider newsletters and updates
4. The Health Plan’s member explanation of benefits

**Medicare Workgroup**

This workgroup has the responsibility to monitor all CMS publications, revisions, new laws and regulations that may affect the delivery of Medicare Part C and Medicare Part D services and communicate these changes to the affected operational areas.

**WELL PUBLICIZED DISCIPLINARY STANDARDS**

The Health Plan, as part of the compliance program, has published the Code of Conduct (Attachment A), which established standards of compliance that all directors, officers, employees, interns, and volunteers must follow. Everyone is responsible for abiding by the Code of Conduct and for reporting any situation believed to be illegal or unethical. FDRs must also comply with standards The Health Plan has established or demonstrate that they have implemented similar standards of compliance.

The Health Plan takes its commitment to the Code of Conduct seriously and takes appropriate and immediate investigative and disciplinary action if anyone violates the Code of Conduct, The Health Plan’s policies or applicable law.

The Health Plan’s strong commitment to ethical values and compliance includes:

**Involvement of CEO, Executive Management and Board of Directors**

The CEO of The Health Plan, Executive Management and the Board of Directors are involved in establishing The Health Plan’s standards of compliance.

**Enforcing Standards of Compliance**

The Health Plan’s policies provide specific instructions for handling reports of potential violations of company policies, administrative rules, regulations, or law. Any employee of The Health Plan who suspects a potential violation of policy or law is required to report the matter to any of the following:

1. His or her department supervisor or manager
2. The Compliance Officer
3. The Health Plan’s Compliance/FWA hotline
5. Compliance@healthplan.org
The Health Plan does not tolerate intimidation or retaliation against employees who, in good faith, report potential violations. A description of The Health Plan’s policy of non-intimidation/non-retaliation is found in the Code of Conduct, and is reinforced in a number of policies, procedures, guidelines, and training materials.

**PublicizingDisciplinary Guidelines**

All employees of The Health Plan are informed that violations of the Code of Conduct, The Health Plan’s policies, applicable regulations or laws may result in appropriate disciplinary action, up to and including termination of employment. Disciplinary policies are posted on the intranet and in the employee handbook.

**EFFECTIVE SYSTEM FOR ROUTINE MONITORING AND IDENTIFICATION OF COMPLIANCE RISKS**

Monitoring and auditing are critical elements in the compliance program. Compliance-related elements are used to develop metrics for evaluating performance against regulatory standards. Monitoring and auditing allows The Health Plan to identify areas that require corrective action in order to achieve compliance with specific regulatory requirements. This process of self-identification and corrective action, along with monitoring that such actions are effective, is a key element of our compliance program.

Auditing and monitoring activities are informed through the annual risk assessment process that reviews departmental risk areas. Compliance risks are separately reviewed through a variety of oversight activities, including:

- Compliance Department audits and self-assessments
- Internal audits
- Department and/or business unit self-audits and monitoring
- Third party data validation audits
- Monitoring and auditing of FDRs
- SIU monitoring, audits and investigations
- External audits by regulators or other external parties

**Risk Assessment**

The Compliance Department coordinates an annual enterprise risk assessment as part of its overall program to identify and mitigate compliance risks. The Corporate Compliance Committee is provided a report of the results of the annual risk assessment. This annual risk assessment is based upon data from a variety of sources including:

1. Regulatory risks based on CMS guidance
2. Risks as identified in the OIG work plan
3. Audit findings from CMS, WV Medicaid, and other regulatory agency or external entity
4. Notices of non-compliance from CMS
The Health Plan
Corporate Compliance Plan
Reviewed 1/11, 1/12, 3/13, 10/14, 11/15, 11/16, 12/17, 01/19

5. Items reported through the Complaint Tracking Module (i.e., CTMs)
6. Complaints related to sales and marketing issues
7. Secret Shopper issues and findings identified by CMS
8. Findings from business unit monitoring activities
9. Identified high risk areas
10. CAP monitoring
11. Member “touch points” such as appeals and grievances, claims, member services, enrollment and disenrollment, and premium billing
12. Results of surveys and interviews with senior staff

The results of the annual risk assessment drive the development of the Compliance Department’s annual compliance and audit work plan (AWP).

Audit and Compliance Work Plan
Annually, the Compliance Department prepares an AWP outlining the planned compliance activities for the coming year. The plan is submitted to Corporate Compliance Committee upon development for review. The AWP includes:

1. Audits to be performed
2. Audits scheduled for the year, including estimated timeframes
3. The First Tier Entities to be audited
4. Announced or unannounced audits
5. Audit methodology
6. Necessary resources
7. Types of audit (e.g., desk or onsite)
8. Person(s) responsible
9. Final audit report
10. Follow-up activities from findings including CAPs when applicable
11. Process for responding to audit results and for conducting follow-up reviews of non-compliance to determine if the corrective actions are successful

Work plan activities are documented in the AWP spreadsheet and Gorman’s Online Monitoring Tool (OMT). Ongoing AWP activities are documented in the AWP spreadsheet which includes a worksheet for each month’s activities. Specific auditing and monitoring activities are logged in OMT. CAPs implemented as a result of identified deficiencies are also documented in OMT and reviewed on at least a monthly basis. Progress on AWP activities are reviewed in monthly meetings which allows for any needed adjustments as well as the incorporation of ad hoc audits. The Compliance Department may modify its AWP based on issues that arise within the organization.

Medicare Compliance audits are based on regulatory guidance and, depending on the department audited, may rely on CMS guidance outlined in:

1. The Medicare Managed Care Manual
The Health Plan
Corporate Compliance Plan
Reviewed 1/11, 1/12, 3/13, 10/14, 11/15, 11/16, 12/17, 01/19

3. The CMS Audit Protocols
4. Other applicable CMS guidance and publications

Medicaid compliance audits are based on the WV Medicaid Contract and related correspondence as well as applicable regulations published by CMS.

Similar to the process CMS uses in its audits, the Compliance Department prepares a report of findings and works with appropriate staff to develop necessary CAPs. The audit report and CAPs are distributed to the Compliance Officer, Executive Management and the Corporate Compliance Committee. The Compliance Officer may report the audit findings and CAPs to the CEO and/or the Board of Directors as appropriate.

**Third Party Audits**
The Health Plan may contract with independent third parties to audit processes and operations against CMS standards and requirements. The results of the third party audits are reported to Executive Management, the Compliance Officer, the Corporate Compliance Committee, the CEO and the Board of Directors.

**Monitoring and Auditing of First Tier, Downstream, and Related Entities (FDRs)**
The Health Plan contracts with various parties to administer and/or deliver Medicaid, Medicare Part C and Medicare Part D benefits. These First Tier Entities and their downstream contractors must abide by specific The Health Plan contractual and regulatory requirements. Various departments of The Health Plan are responsible for overseeing the ongoing compliance of FDRs including, but not limited to:

1. Credentialing
2. Pharmacy
3. Provider Network
4. Finance
5. Medicare Operations
6. Medicare Sales
7. SIU
8. Medicaid Operations

The Health Plan performs auditing and monitoring to evaluate the FDRs' compliance with regulatory requirements as well as the overall effectiveness of the FDRs' compliance programs. FDR audit selection is based upon risk so that higher risk FDRs are audited more frequently than lower risk FDRs. In addition, all FDRs are asked to complete a compliance attestation on an annual basis.
Special Investigations Unit Monitoring, Audits and Investigations (FWA Issues)
The Health Plan’s SIU is responsible for investigating issues of possible FWA. The SIU also develops and implements training and awareness programs to promote a commitment to compliance by all employees, contracted providers, and FDRs. The SIU is the focal point for FWA investigations and works with Qlarant NBI MEDIC, the West Virginia Office of Program Integrity, law enforcement and other agencies, as required.

The SIU employs analytical data mining to identify referral patterns, possible payment errors, utilization trends and other indicators of potential FWA. Results of SIU investigations are reported to the Vice President of Internal Audit & Quality, the Compliance Officer, and the Corporate Compliance Committee.

Auditing by Federal Agencies or External Parties
The Health Plan views regulatory audits as an opportunity to confirm that our ongoing compliance efforts, supported by the Board of Directors, are effective and successful. In cases where an audit outcome indicates The Health Plan has not met a regulatory requirement, The Health Plan will use the audit findings to perform a root cause analysis and develop a CAP to address identified areas of non-compliance. The Health Plan may also contract with external companies to perform compliance related reviews and assist with programmatic changes to help drive compliance.

The Health Plan cooperates with federal agencies and external parties when audits are completed, and provides auditors access to information and records related to business processes and FDRs. The Health Plan allows access to all applicable documentation and records for audits and maintains all records for ten (10) years.

The Compliance Department serves as the point of contact for all audits related to the Medicare Part C and Medicare Part D programs and coordinates auditor requests with all internal departments. Staff from other The Health Plan’s departments are charged with coordinating state audits or reviews, although the compliance team should be notified of any audit activity and may assist in those audits as needed.

PROCEDURES AND SYSTEMS FOR PROMPT RESPONSE TO COMPLIANCE ISSUES

The Health Plan takes corrective actions whenever there is a confirmed incident of non-compliance. The Health Plan may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, regional collaborative work groups or member complaints, either directly to The Health Plan or through governmental units. Whenever The Health Plan identifies an issue of non-compliance or FWA, it is followed through until the issue is resolved.
The Compliance Officer, in conjunction with Compliance Department, SIU and other key staff, is responsible for reviewing cases of non-compliance and suspect activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, particularly issues involving suspected fraud, the Compliance Officer may delegate all or a portion of this responsibility to the appropriate internal expert, such as the SIU.

Any time an issue of non-compliance is discovered or a department’s process or system results in non-compliance with regulatory requirements, the business area is required to submit a CAP to the Compliance Department. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Compliance Department on a monthly basis, or at a frequency determined by the Compliance Officer. The Compliance Department monitors CAP implementation and requires that business departments regularly report the completion of all interim action steps. Once a CAP is complete, the Compliance Department may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the CAP. A summary of CAP activity is periodically reported to the Corporate Compliance Committee.

The Health Plan’s oversight of FDRs includes a requirement that FDRs submit a CAP when deficiencies are identified through compliance audits, ongoing monitoring and/or self-reporting. The Health Plan takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with The Health Plan that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

The Health Plan’s Corporate Compliance Plan is effective in promoting compliance, and controlling FWA at both the sponsor and FDR levels in the delivery of Parts C and Part D benefits to Medicare beneficiaries and other members covered by The Health Plan. Policies and procedures associated with this Corporate Compliance Plan further expand the activities and oversight of the program.
MEDICAID ADDENDUM

The Corporate Compliance Plan is applied consistently across all lines of business; however, there are specific requirements and regulations outlined in the contract between The Health Plan and the Bureau for Medical Services (BMS) for the Medicaid line of business. The contract is updated annually by BMS.

Additional BMS Requirements Pertaining to the Prevention and Detection of FWA

The Health Plan will collaborate with BMS, the Medicaid Fraud Control Unit (MFCU) and the Office of the Inspector General (OIG) on all activities relating to fraud and abuse. The Health Plan is committed to effectively coordinating both state and internal resources to respond to reports of potential fraud and abuse.

The Health Plan has adopted the following activities in order to effectively respond to potential FWA:

- Underutilization and overutilization of services are monitored for potential provider and beneficiary fraud in accordance with the monitoring guidelines outlined by BMS.
- Procedures are in place to verify whether services reimbursed were actually furnished to a sample of Medicaid members, as required by CFR 455.1.
- When The Health Plan is notified that a case has been accepted for state investigation, no further investigation will be conducted by The Health Plan unless specifically directed by the state entity conducting the investigation.

The Health Plan has adopted the following activities in order to effectively report potential FWA:

- Procedures for reporting information to BMS include submission of a report of cases involving suspected fraud and abuse within the time frame designated by BMS (by the 15th of each month and quarterly). This report includes all of the information specifically outlined in the contract for each case reported. An additional report is submitted to BMS annually by June 15 of each year.
- The Health Plan provides notification to BMS of any cases of suspected FWA regarding its Medicaid product that are reported to an entity other than BMS.

The Health Plan has adopted the following activities to effectively address overpayments and recoveries:

- The Health Plan is responsible for the recovery of all overpayments, including those due to FWA. The Health Plan maintains a process for
network providers to report receipt of an overpayment as designed by BMS.

- If the BMS Office of Program Integrity (OPI) of the MFCU has assumed responsibility for completion of an investigation and final disposition of any administrative, civil or criminal action taken by the State or Federal government, the BMS OPI or MFCU will direct the collection of any overpayment.

The Health Plan has adopted the following measurements and milestones to promote the effectiveness of the SIU:

- Routine SIU auditing and monitoring activities are identified in the AWP and tracked in OMT.
- Routine monitoring of claims to promote accurate claims submission and payment.
- Percentage of cases closed with no further actions.
- Percentage of cases closed with action taken in relationship to total cases (e.g., education, monitoring, flagged for pre-pay review).
- Percentage of cases referred to outside entities in relationship to total cases.
- The number of new leads generated from proactive data analysis or review.

The Health Plan has adopted the following activities to promote effective FWA training and education:

- Policies and procedures have been implemented by The Health Plan for the education of employees about the Federal False Claims Act in accordance with Section 6032 of the Deficit Reduction Act of 2005, for any entity that receives or makes Title XIX (Medicaid) payments of at least $5 million annually.
- The Health Plan actively participates in BMS meetings and trainings when designated by BMS.

**Oversight**
The Medicaid Workgroup monitors all Medicaid contracts, CMS publications, revisions, new laws and regulations that may affect the delivery of Medicaid services, and communicates these changes to the appropriate operational areas affected.