PURPOSE OF THE POLICY

To document the creation, review and the approval of policies and procedures to ensure standardization throughout Health Alliance.

STATEMENT OF THE POLICY

Policies and procedures are established for each Health Alliance department, to document intra and interdepartmental processes, promote high quality service and assist in improved decision-making.

Policies and procedures must be created in a standard format, Pharmacy drug format or Medical Policies format to ensure consistent communication and definition and are maintained on the Health Alliance Reference Library

All policies and procedures must be reviewed annually and updated to incorporate changes in applicable laws, regulations and CMS and/or HFS guidelines as needed.

PROCEDURES

New Policies and Procedures

1. Creation

1.1 All Health Alliance staff members are authorized to draft a policy and procedure using the approved template located under new documents, “More” tab, in Word templates (see Trove Author Instructions on how to complete the template and print off a copy of the template Quick Reference cheat sheet).

2. Approval

2.1 All new policies and procedures must be approved as stated below:
   • Administrative policies and procedures
The appropriate committee (Senior Management/Director Committee, Compliance Committee, Member Rights and Responsibilities Committee)
- Policies must be signed by the policy owner
- The History Section should indicate the name of the approving committee and the date of approval

- Medical policies
  - Medical Directors Committee
  - Policies must be signed by the Chief Medical Officer or designee

- Credentialing policies
  - Credentialing Committee
  - Policies must be signed by the Credentialing Committee chairperson

- Departmental policies and procedures
  - Department Manager or Director
  - Policies must be signed by the Department Director

- Interdepartmental policies and procedures
  - Each Manager or Director of Affected Departments, as specified on the policy and procedure
  - Policies must be signed by the Director or designee of the Department that owns the policy

3. Policy Owner

3.1 A new policy must be approved by the appropriate committee or department(s) as outlined in Section 2.1.

3.2 A new policy may be approved via a voting key email to the committee members or Affected Departments.
- Voting buttons should be:
  - Approve
  - Approve w/comments
  - Reject w/comments and
  - Not Applicable. The “Not Applicable” voting button should not be used for administrative policies as these policies apply to the entire organization.
  - Allow a minimum of 5 business days for response.

3.3 Within 10 days of receiving voting response emails from committee members or Affected Departments, the Policy Owner will inform committee members or Affected Departments via email that:
- The policy has been approved with no changes
- The policy has been approved with the following changes (list the changes – or include a red-line of the document)
- The policy is undergoing changes and will be resent to the committee or Affected Departments for approval at a later date, or
- The comments received suggest discussion and a decision from the committee or department are needed. The owner of the policy will have the appropriate committee member or department Director include the policy on the next committee or department meeting agenda.

3.4 Forward the original signed copy of the approved policy and procedure to the Trove Librarian.

4. Policy Owner and Affected Departments
4.1 Within 10 days of approval of a new policy and procedure, the policy owner must inform all Affected Departments.

4.2 All Affected Departments must advise staff of the new policy and procedure and provide education as needed.

5. Trove Authors/Librarian

5.1 Formatting will be done by the Authors assigned for each area (see *Formatting and Implementation of Policies and Procedures*).

5.2 Official electronic copies will be maintained on the Trove Documents drive under the TroveAuth&Lib folder by the Authors.

5.3 Once signed copies are received by the Trove Librarian, they will loaded to the Reference Library, scanned and saved to the Trove Documents drive under Signed P&Ps by the department and year the P&P was updated.

Revised Policies and Procedures

6. Policy Owners

6.1 The policy owner, as specified on the policy and procedure, must review the policy annually by the Review Date on the policy.

6.2 The policy owner is responsible for revising the policy and procedure as needed (to obtain the Word document of the policy and procedure contact the Author for your area).

6.3 Revised policies must be approved as stated below:

- Administrative policies and procedures
  - The appropriate committee (Senior Management/Director Committee, Compliance Committee, Member Rights and Responsibilities Committee)
  - Policies must be signed by the committee chairperson.
- Medical policies
  - Medical Directors Committee
  - Policies must be signed by the Chief Medical Officer or designee
- Credentialing policies
  - Credentialing Committee
  - Policies must be signed by the Credentialing Committee chairperson
- Departmental policies and procedures
  - Department Manager or Director
  - Policies must be signed by the Department Director
- Interdepartmental policies and procedures
  - Each Manager or Director of Affected Departments, as specified on the policy and procedure
  - Policies must be signed by the Departmental Director or designee of every Affected Department

6.4 A revised policy may be approved via a voting key email to the committee members or Affected Departments.

- Voting buttons should be:
  - Approve
  - Approve w/comments
  - Reject w/comments and
– Not Applicable. The “Not Applicable” voting button should not be used for administrative policies as these policies apply to the entire organization.

- Allow a minimum of 5 business days for response.

6.5 Within 10 days of receiving voting response emails from committee members or Affected Departments, the policy owner will inform committee members or Affected Departments via email that:

- The revised policy has been approved
- The revised policy has been approved with the following changes (list the changes – or include a red-line of the document)
- The policy is still undergoing changes and will be resent to the committee or Affected Departments for approval at a later date, or
- The comments received suggest discussion and a decision from the committee or department are needed. The owner of the policy will have the appropriate committee member or department Director include the policy on the next committee or department meeting agenda.

6.6 If the policy is revised the Header Section must include the revised date and a new review date and the History Section must reflect the revised date, why the policy was revised and the name of the person who reviewed and revised it.

6.7 If no revisions are necessary, the Header Section must include a new review date and the History Section must reflect the review date and the name of the reviewer.

6.8 Forward the original signed copy of the approved revised policy and procedure to the Librarian.

6.9 Within 10 days of approval of a revised policy and procedure, the policy owner must inform all Affected Departments.

6.10 All Affected Departments must advise staff of the revised policy and procedure and provide education as needed.

7. Trove Authors/Librarian

7.1 Proper formatting will be done by the Authors assigned for each area (see Formatting and Implementation of Policies and Procedures).

7.2 Official electronic copies will be maintained on the Trove Documents Drive under the TroveAuth&Lib folder by the Authors.

7.3 Once signed copies are received by the Trove Librarian, they will loaded to the Reference Library, scanned and saved to the Trove Documents drive under Signed P&Ps by the department and year the P&P was updated.

7.4 The Librarian will distribute a monthly report to each department Director listing policy and procedures due for annual review.

HISTORY

Created: 03/01/01 – T. Jensen
02/19/01 – Policy Committee approval.
02/27/01 – Steering Committee approval of Section 1.2.

Revised: 03/26/01 – Executive Committee revisions.
04/08/01 – Policy Committee approval of Executive Committee recommendations.
09/20/01 – T. Jensen-Revised Section 2.1 and added a new section 2.2.
04/09/02 – K. Mitsdarfer-Updated drive name.
07/07/03  –  K. Mitsdarfer-Reviewed no changes.
03/21/05  –  M. Zachary-New format, added section on revised policies
03/06  –  M. Zachary-No changes.
03/01/07  –  M. Zachary-No changes.
02/11/08 –  M. Zachary-No changes.
02/11/09 –  S. McAdams-No changes.
02/01/10 –  S. McAdams-No changes.
07/29/10 –  T. Jensen-Revised policy to include HCH, reflect HA Reference Library instead of Trove and remove appropriate references of Trove.
02/01/11 –  S. McAdams-No changes.
02/01/12 –  S. McAdams-No changes.
02/12/13 –  L. Slaughter-Removed all reference to HCH, added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANHP) to Policy Applies To field, updated Instructions in Section 1.1 and added Sections 5.3 and 7.3 outlining where signed policies are stored.
05/14/14 –  S. McAdams/L. Slaughter-Added Pharmacy drug format and Medical Policies language and attachments to Statement of the Policy.
11/03/14 –  T. Jensen-Added in corporate changes in laws, regulations and CMS/HFS guidelines to policy section.
07/14/15 –  S. McAdams-Reviewed with no changes.
04/01/16 –  S. McAdams-Reviewed with no changes.
06/28/17 –  S. McAdams-Updated Owner title.

APPROVED BY

Signature(s): ________________________________________________
(Signature copies are kept in Compliance)

Date: ______________
PURPOSE OF THE POLICY

Illinois HMO regulations at 50 Ill. Adm. Code 5421.90, requires the Board of Directors and Officers of Health Alliance to disclose conflicts of interest. This disclosure must include any contractual or financial arrangement between the Board, Officers and Health Alliance. Employees who are Authorized Signers under the Payment Authorization policy, Pharmacy and Therapeutics Committee, Marketing, Underwriting and Medical Management staff are also required to disclose any conflicts of interest.

The Preamble to the Final Rule regulating the Medicare Prescription Drug Benefit in section 101 of Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires members of the Pharmacy and Therapeutics Committee to disclose conflicts of interest.

This policy attempts not only to identify and eliminate or manage actual conflicts of interest, but whenever possible, to prevent even the appearance of conflicts. The policy provides for remedies to manage conflicts constructively and for sanctions when the policy is violated.

STATEMENT OF THE POLICY

Health Alliance Medical Plans, Inc. (Health Alliance) requires a standard procedure to report potential conflicts of interest.

APPLICABILITY

This policy applies to all members of the Health Alliance Board of Directors, Officers, Directors, Managers, Pharmacy and Therapeutics Committee members, and all Marketing, Underwriting and Medical Management staff.

REPORTING CONFLICTS OF INTEREST

Conflicts of interest arise when a member of the Board of Directors, a Health Alliance Officer, Director, Manager, Pharmacy and Therapeutics Committee member or employee is in a position to influence either directly or indirectly Health Alliance business decisions that could lead to
gain for the individual, the individual’s relatives or others to the detriment of Health Alliance and its mission and integrity. Relatives mean brothers, sisters, parents, spouse, in-laws and children.

1. Examples of conflict of interest include:
   - Ownership of a significant financial interest in any outside concerns that does business with, or is a competitor of Health Alliance.
   - Provision of services for compensation to any outside concern that does business with, or is a competitor of Health Alliance.
   - Acceptance of gifts of more than $100, excessive entertainment or other substantial favors from any outside concern that does business with or is seeking to do business with Health Alliance or a competitor. This excludes “door prizes” and other giveaway items received at trade association meetings and conferences.
   - Obtaining any personal financial benefit or advantage from a transaction to which Health Alliance is a party.
   - Directing purchasing opportunities to a family-owned company or an associated entity.

**Please note:** that these are only examples. This is not intended to be an exhaustive list of all possible conflicts of interest. There may be other instances or practices that constitute conflicts of interest. It is best to disclose all circumstances and let the Senior Vice President of Corporate Affairs & General Counsel and/or Executive Director of Compliance provide guidance.

**PROCEDURES**

1. **All Staff**

1.1 It is essential that the members of the Board of Directors, Officers, Directors, Managers, Pharmacy and Therapeutics Committee members and all Consumer Product Sales, Marketing, Risk Adjustment Revenue Management, Pricing & Underwriting and Quality & Medical Management staff acknowledge any situation that may involve a conflict of interest as soon as it becomes known.

1.2 While it is impossible to list every circumstance giving rise to possible conflicts of interest, examples in this policy will serve as a guide.

1.3 All members of the Board of Directors, Officers, Directors, Managers, Pharmacy and Therapeutics Committee members and all Consumer Product Sales, Marketing, Risk Adjustment Revenue Management, Pricing & Underwriting and Quality & Medical Management staff must submit the **Conflict of Interest Statement** annually. A copy of this policy and the Conflict of Interest Statement will be sent by the Compliance Department to the individuals specified above and signed forms are due by November 30th of each year.

1.4 Completed Conflict of Interest reporting forms will be reviewed by the Executive Compliance Director or designee. Any disclosures requiring further review will be sent to the Senior Vice President of Corporate Affairs & General Counsel. The Senior Vice President of Corporate Affairs & General Counsel may request additional information to ensure that he/she understands the nature and extent of the conflict. If it is determined that a conflict of interest exists or a business practice is deemed questionable, the Senior Vice President of Corporate Affairs & General Counsel will manage, reduce or eliminate the conflict of interest.

1.5 Prior to the imposition of any conditions or restrictions, the Senior Vice President of Corporate Affairs & General Counsel will give the individual an opportunity to submit additional information and/or meet with the individual. The individual will be encouraged
to suggest procedures, protocols or other measures designed to manage, reduce or eliminate the conflict.

1.6 Some examples of restrictions that may be imposed include:
- Requiring full disclosure of significant financial interest and other relevant information.
- Monitoring of activities by either internal or external independent auditors at the expense of the individual.
- Modifying the conflict of interest or business practice.
- Severing relationships that create conflicts.
- Removing purchasing decision authority.
- Removing individual from position or employment.

1.7 Any imposed conditions or restrictions will be made in writing.

1.8 Members of the Board of Directors and Health Alliance Officers must disclose any contractual or financial arrangement they have with Health Alliance or with any providers or other persons who have a financial relationship with Health Alliance.

1.9 Failure to disclose potential conflicts of interest will be grounds for disciplinary action as per the Carle Employee Discipline and Misconduct policy and the Health Alliance Employee Discipline and Misconduct Addendum policy.

1.10 Employee failure to abide by any sanctions or remedies will result in disciplinary action as per the Carle Employee Discipline and Misconduct policy and the Health Alliance Employee Discipline and Misconduct Addendum policy. Severity of the actions depends on the extent of the violations of the policy. Inadvertent, unintentional and minor breaches require lesser sanctions, whereas known, deliberate and major violations demand the most severe sanctions.

1.11 Board of Director member failure to abide by any sanction or remedies will result in termination of the relationship with Health Alliance as a board member.

1.12 Diligent efforts (to the extent provided by law) will be made to maintain confidentiality of information provided on the Conflict of Interest reporting form as well as on the remedies and sanctions, if any.

1.13 Questions about this policy should be directed to the Executive Director of Compliance.

HISTORY

Created: 10/01/00 – S. Tuft
Revised: 03/12/02 – T. Jensen-Revised policy to reflect the Health Alliance Payment Authorization policy instead of the Carle Clinic policy.
07/01/03 – T. Jensen-No changes.
08/18/03 – J. Johnson/J. Griffith/T. Jensen-Updated Owner, Statement of the Policy and sections 1.1, 1.3, 1.4, 1.5, 1.9, 1.10 and 1.12.
09/01/04 – T. Jensen-No changes.
03/16/06 – M. Zachary-Added P&T Committee per MMA requirement; updated owner; removed ‘questionable business practices’ to another document; immaterial edits.
03/01/07 – M. Zachary-No changes.
03/27/08 – M. Zachary-Slight change to title from Reporting Potential Conflicts of Interest to Conflicts of Interest Reporting, no other changes.
09/12/08 – T. Jensen-Changed titles.
04/01/09 – S. McAdams-No changes.
06/01/10 – S. McAdams-No changes.
01/01/11 – T. Jensen-Removed references to CCA, changed titles and added 1.11.
07/01/11 – S. McAdams-No changes.
07/01/12 – S. McAdams-Minor changes, added Pharmacy and Therapeutic Committee to Purpose of Policy, paragraph one, no other changes.
02/12/13 – L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field.
03/14/13 – T. Jensen-Added Health Alliance Connect to Policy Applies to field.
09/19/13 – L. Slaughter-Added Consumer Products Sales and Medicare Advantage Revenue Management to Section 1.1 and 1.3.
10/13/14 – S. McAdams-Reviewed with no changes.
10/27/15 – S. McAdams-Changed date in Section 1.3.
04/11/16 – T. Jensen-Updated Compliance Director to Executive Compliance Director throughout policy, updated Policy Applies To and changed Medicare Advantage Revenue Management in Section 1.1 and 1.3 to Risk Adjustment Revenue Management.
04/26/17 – S. McAdams-Updated Owner from Executive Compliance Director to VP, Chief Compliance & Risk Officer.

**APPROVED BY**

Compliance Committee: 03/02; 08/03

Signature(s): ______________________________________________
(Signature copies are kept in Compliance)

Date: ______________
PURPOSE OF THE POLICY

To summarize the state and federal regulations regarding record retention and destruction and to provide guidance to Health Alliance employees as to the length of time to keep records and the procedures to follow to destroy out-of-date records.

STATEMENT OF THE POLICY

It is the policy of Health Alliance that formal guidance is provided for retention of records and destruction of records.

DEFINITIONS

**Non-Record Materials** – material not filed as evidence of the company’s administrative or business activities or for the informational content thereof; extra copies of documents or reproductions of documents maintained for convenience or reference; stocks of printed or reproduced documents kept for supply purposes, where file copies have been retained for record purposes; books, periodicals, newspapers, posters, pamphlets and other materials made or acquired and preserved solely for reference or exhibition purposes; and/or, private materials neither made nor received by a company pursuant to law or in connection with the transaction of business.

**Records** – all books, papers and documentary materials regardless of physical form or characteristics, made, produced, executed or received by any domestic insurance company pursuant to law or in connection with the transaction of its business and preserved or appropriate for preservation by such company as evidence of the organization, function, policies, decisions, procedures, obligations and business activities of the company or because of the informational data contained therein. A list of records specific to Health Alliance is found at the end of this policy.

PROCEDURES

1. General Rules
1.1 Each Department should classify the information they create or maintain as a ‘record’ or ‘non-record’ using the definitions under Statement of the Policy.

1.2 Records should be maintained according to the DOI approved Schedule of Record Retention. Non-record items that are not useful should be recycled appropriately.

1.3 Departments should determine what information they access on a regular basis (at least quarterly) and store that information within their department.

1.4 Records that do not require frequent or at least quarterly access should be stored in banker’s boxes as per standard operating procedure. Items for permanent storage should be clearly marked. Non-permanent records should include a destroy date and should be filed in boxes according to their destroy date.

1.5 Department Managers should respond promptly to requests for review of items in non-permanent storage.

1.6 Department Managers should keep detailed accounts of document inventory and location so that records can be easily and expeditiously retrieved for audits or inspections.

1.7 If possible, records should be maintained in alphabetical order with the outside of the boxes clearly labeled.

2. Retention Periods

2.1 Illinois insurance law does not provide a specific retention time for maintenance of records other than claims. Claims are required to be maintained for three (3) years: the current year and the two preceding years, for the purpose of examination.

2.2 Illinois insurance law requires that all records must be preserved and kept available for the purpose of examination and until authority to destroy or otherwise dispose of such records is secured from the Director of Insurance. Such procedures are outlined below in Destruction of Records.

2.3 Iowa insurance law does not address retention of records.

2.4 Illinois insurance regulations require Third Party Administrators (TPAs) to maintain adequate books and records of all transactions involving a plan sponsor and covered beneficiaries for the duration of the agreement and five (5) years thereafter. A TPA is not required to maintain copies of such records if the originals are returned to the self-funded employer prior to the end of such 5-year period. The TPA shall maintain evidence of the return of the originals for the balance of the 5-year period.

2.5 Medicare Advantage regulations require Plans to maintain records for ten (10) years. If microfilming is utilized, Health Alliance must prove to the Centers for Medicare and Medicaid Services (CMS) regional office that the microfilming procedures are efficient, economical, and reliable and are supported by an adequate retrieval system. CMS may determine there is a special need to retain a particular record or group of records for longer than ten (10) years. CMS must notify Health Alliance at least thirty (30) days before the scheduled destruction date.

2.6 Policies and procedures, written communication and written documentation required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule must be retained for a minimum of six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

2.7 IRS regulations relating to financial audits indicate a seven (7) year record retention period.

2.8 ERISA guidelines specify a record retention period of not less than six (6) years and a Department of Labor advisory concerning ERISA plans suggests an eight (8) year period for claims, plan documents and other records.

2.9 McGladrey & Pullen CPAs also provided guidance for record retention periods.
2.10 These guidelines provide the minimum retention period of records. While space is limited for both on-site and off-site storage, it is better to err on the side of maintaining a record longer than is required, than to destroy records before their appropriate destroy date.

3. Destruction of Records

3.1 Non-record materials may be destroyed at any time and do not require prior approval of the Illinois Director of Insurance (DOI).

3.2 Records that have been maintained, either in accordance with this policy, regulation or standard operating procedure, may only be destroyed according to this Policy and the approved Schedule of Record Retention.

3.3 The Director of Compliance shall submit new schedules of records to the DOI whenever the content of the schedule is changed.

3.4 Once approval is received from the DOI, the Director of Compliance will send notification that records may be destroyed according to the revised schedule.

3.5 Confidentiality of patient identifying information must be upheld at all times.

REFERENCES

2. Illinois Insurance Code 5/511.106 (Third Party Administrator Requirements)
3. Illinois Insurance Regulation Part 901 and Part 919.30
4. Illinois Insurance Code 5/133
5. HIPAA Privacy Rule 164.530(j) Standard: Documentation
6. Affidavit for Permission to Destroy Records
7. Standards for FFM maintenance of records 45 CFR 156.705

HISTORY

Created: 10/12/00 – J. Griffith
Revised: 12/01/01 – J. Johnson-Revisions made to schedule of records excel link.
12/02/02 – T. Jensen-Revisions made to policy and schedule to reflect HIPAA Privacy Rule requirements.
12/30/03 – T. Jensen-No changes.
12/30/04 – T. Jensen-Added Schedule of Record Retention link to 1.2. Changed Section 4 to Reference Section.
08/29/05 – M. Zachary-Revised Sections 2 and 3; changed HCFA to CMS; changed Premier Choice to Medicare Advantage; changed CMS record retention period to 10 years; revised Schedule for CMS 10 year record retention.
11/01/06 – M. Zachary-No changes.
11/01/07 – M. Zachary-No changes.
04/01/08 – M. Zachary-Revised Schedule of Record Retention.
04/10/09 – S. McAdams-No changes.
06/01/10 – S. McAdams-No changes.
07/01/11 – S. McAdams-Minor changes.
06/01/12 – S. McAdams-Minor changes
02/12/13 – L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field.
06/20/14 – S. McAdams-Reviewed and removed references to McGladney & Pullen and DOI Record Retention Schedules.
05/14/15 – T. Jensen-Reviewed with no changes.
02/17/16 – L. Goodpaster-Updated to ensure reference to FFM/QHP plans to
clarify current processes of their record retention. Also cited #7 under reference
section.
2/17/17 – T. Jensen-Reviewed – changed title of policy owner

APPROVED BY

Signature(s): ________________________________________________
(Signature copies are kept in Compliance)

Date: ________________
PURPOSE OF THE POLICY

This policy establishes guidelines for the education and training of all Health Alliance employees on the organization’s compliance, privacy and security guidelines and specific policies and procedures.

DEFINITIONS

Refer to the Privacy: Definitions policy for the definition of terms referred to in this policy.

1. **Downstream Entity**
   - *Downstream entity* means any party that enters into a written arrangement, acceptable to Centers for Medicare and Medicaid Services (CMS), with persons or entities involved with the MA benefit, below the level of the arrangement between a MA organization (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.

2. **First Tier Entity**
   - *First tier entity* means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

3. **Related Entity**
   - *Related entity* means any entity that is related to the MA organization by common ownership or control and (1) Performs some of the MA organization's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an oral or written agreement; or (3) Leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

STATEMENT OF THE POLICY

1. **Initial Education**

   1.1 New Employees (including executive and senior management) and Contracted Individuals:
      - New employees, interns, temporary employees and Contracted Individuals must receive general education on the organization’s Compliance Program, including fraud, waste and abuse. Refer to the Education Chart for a list of the required training for each category.
A pre-test and post-test is required to show effectiveness and track completeness of training.

For purposes of this policy, Contracted Individuals mean individuals with whom Health Alliance contracts and is on-site for a specified period of time and is given a User ID and password to access our systems (i.e. consultants, vendors, etc.)

1.2 General education must be conducted and appropriate compliance forms and agreements signed prior to a new employee or other individual obtaining access to Protected Health Information or confidential proprietary business information via oral, paper or electronic means (no more than 30 days from hire).

1.3 All employees, interns, temporary employees and Contracted Individuals must sign the appropriate confidentiality and security agreement.

1.4 All signed forms and agreements must be forwarded to the Compliance Department for tracking purposes.

1.5 Board Members:
- The Chief Compliance and Risk Officer educate all new board members on the Compliance Program, no more than 90 days after appointment.

2. Annual and Specific Education

2.1 Employees:
- All employees receive general compliance, fraud, waste and abuse, privacy and security education on an annual basis.
  - A pre-test and post-test is required to show effectiveness and track completeness of training.

2.2 Employees must sign the Employee Confidentiality and Security Agreement.

2.3 Additional and/or specific education is provided to employees upon regulatory changes and as policies and procedures are changed, to the extent the changes affect their jobs.

2.4 Board Members:
- The Chief Compliance and Risk Officer reeducate the Corporate Compliance Committee of the Board of Directors members on the Compliance Program elements on an annual basis.

3. First-tier, Downstream and Related Entities

3.1 FDR’s providing administrative services for our Medicare Advantage and Part D plans are required to complete CMS Compliance and Fraud, Waste and Abuse Training Modules located on the CMS Medicare Learning Network.

HISTORY

Created: 12/01/04 – T. Jensen-This policy has replaced the Privacy: Education & Training policy.

Revised:
07/01/05 – T. Jensen-Added language from the Privacy: Education & Training policy regarding employee confidentiality and security agreements.
08/01/06 – T. Jensen-Minor clarification changes.
04/01/07 – T. Jensen-Added fraud, waste and abuse training under new employee education and annual education sections.
07/01/07 – M. Zachary-No changes.
03/01/08 – M. Zachary-No changes.
04/01/09 – T. Jensen-Revised to link to Education Chart and other minor changes.
02/01/10 – T. Jensen-Added link to the FWA training policy and procedure.
02/01/11 – T. Jensen-No changes.
11/21/12 – S. McAdams-Reviewed with minor formatting changes.
02/12/13 – L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field. Changed Audit Committee in Section 2.5 to Compliance Committee.
03/14/13 – T. Jensen-Added Health Alliance Connect to Policy Applies to field.
04/01/14 – T. Jensen-Added specific language around FDR and reformatted policy.
05/01/15 – S. McAdams-Reviewed with no changes.
03/03/16 – T. Jensen-Revised to add “no more than 90 days” for FDR training to section 3.1.
04/11/16 – T. Jensen-Updated Compliance Officer to Chief Compliance and Risk Officer and Compliance Director to Executive Compliance Director throughout policy and updated Policy Applies To.
04/11/17 – T. Jensen-Changed Owner title and updated Section 3.1.

APPROVED BY

Compliance Committee 04/05
Privacy Officer 07/05, 08/06, 04/07, 03/08, 04/09, 02/10
Compliance Officer 08/06, 04/09, 02/10, 02/11

Signature(s): ________________________________________________
(Signature copies are kept in Compliance)

Date: ________________
PURPOSE OF THE POLICY

To comply with the Centers for Medicare and Medicaid Services (CMS) guidelines for the Medicare Advantage (MA), Part D Sponsor (Part D) and Qualified Health Plan (QHP).

STATEMENT OF THE POLICY

The Compliance Department monitors federal legislation, regulations and CMS guidance (e.g. Medicare Managed Care Manual, Part D Manual, HPMS Memos) that affects our Medicare and QHP products and prepares analysis/summary when appropriate. MA and Part D changes are communicated to the appropriate staff via our Online Monitoring Tool (OMT).

Compliance assigns the appropriate employees MA or Part D notices, tasks, audit guide elements and indicators in OMT and employees are required to review and provide Compliance with a detailed description of how we are complying/a plan to comply with the requirements and attach supporting documentation.

Contract owners are responsible to forward guidance to the appropriate vendors.

HISTORY

Created: 10/11 – T. Jensen
Revised: 10/12 – T. Jensen-No changes.
04/13 – T. Jensen-Added HFS and FDR language.
01/14 – R. Aiken-No changes.
02/10/15 – S. McAdams-Reviewed with no changes.
04/11/16 – T. Jensen-Updated Owner title, Policy Applies To and Purpose of the policy.
04/11/17 – T. Jensen – Remove references to Medicaid/HFS.

APPROVED BY

Signature(s): ________________________________________________

(Signature copies are kept in Compliance)
PURPOSE OF THE POLICY

To establish a mechanism to report suspected misconduct, compliance violations and potential fraud or abuse of another employee, provider, employer group, vendor or other client of Health Alliance.

STATEMENT OF THE POLICY

Health Alliance employees must comply with all applicable federal and state laws, regulations and standards, all Health Alliance policy and procedures and all applicable Carle policies.

Any activity suspected, in good faith, to be misconduct, a compliance violation, potential fraud or abuse and a privacy or security incident must be reported. A compliance violation includes but is not limited to, a violation of the Ethics and Compliance in the Workplace: A Guide to Employee Conduct, a violation of a Health Alliance policy and procedure, an impermissible use or disclosure of protected health information, or a violation of federal and state criminal, civil and administrative laws, rules and regulations. Failure to report a clear or potential violation is itself, a violation of this policy. Individuals who report suspected misconduct, compliance violations, potential fraud or abuse and privacy or security incidents will not be subject to retaliation, retribution, harassment or other penalty of any kind for good faith reporting of known or suspected violations. Also refer to the Security - Violations and Security Incidents Policy.

This does not include complaints from a provider regarding claims, billing or contract issues or complaints from a member regarding quality of care issues. Provider billing issues should be directed to the Contracting and Provider Services (CPS) Department and quality of care complaints are documented by Customer Service and forwarded to the Member Relations Department for review.

The Chief Compliance and Risk Officer or designee will follow the Internal Compliance Investigations policy when investigating reports of suspected misconduct, compliance violations and potential fraud or abuse.

PROCEDURES
1. Confidentiality and Anonymity

1.1 Every effort will be made to keep the identity of the individual reporting the violation confidential. However, total confidentiality cannot be guaranteed. For the highest level of confidentiality, reports should be made to the Compliance Line where the report can remain anonymous. If you choose to provide your name through the Compliance Line service, your identity will not be disclosed, up to the limits of the law. This means that Health Alliance may be required to report actual violations of law and must also cooperate with legitimate government investigations which could ultimately compromise your identity.

2. No Retaliation

2.1 Good faith reporting is an expected, accepted and protected behavior. Conduct intended to retaliate against an individual for making a good faith report, or to coerce an individual to make a false report is a violation of this policy. If you feel you may be the subject of any retaliation, retribution, harassment penalty, coercion or attempt to influence, you should immediately contact the Chief Compliance and Risk Officer. This does not mean you can exempt yourself from the consequences of your own wrongdoing or inadequate performance by reporting it. But it does mean the consequences of doing so may not be more severe because you have made the report. Generally, your prompt disclosure of an error, even if the error involves wrongdoing or inadequate performance, will be considered a constructive action.

3. Channels for Reporting Suspected Misconduct, Compliance Violations, Potential Fraud or Abuse and Privacy and Security Incidents

3.1 Employees:
- Report concerns to an immediate supervisor or manager, through the department’s chain of command or to the Human Resource Department.
- Report concerns through an exit interview with the Director of Human Resources.

3.2 Employees and other individuals can report concerns to:
- The Chief Compliance and Risk Officer. Contact Scott McAdams by telephone at (217) 365-3238 or by email at scott.mcadams@healthalliance.org.
- A member of the Compliance Committee. Compliance Committee Contact List is also located in the Health Alliance Reference Library in the Contact Lists folder.
- The Privacy Officer. Contact Traci Jensen by telephone at (217) 337-3418 or by email at traci.jensen@healthalliance.org.
- The Security Officer. Contact Wyatt Scheiding by telephone at (217) 337-3493 or by email at wyatt.scheiding@healthalliance.org.
- The Health Alliance Compliance Line at 217-383-8304. This service may be anonymous and is available 8:00 a.m. to 5:00 p.m., Monday through Friday. Reports may be made at any time after hours by leaving a voicemail message, with the information stated in Section 2.
- The Compliance Line email address, at ComplianceLine@healthalliance.org
- The Office of Inspector General Compliance Hotline at 1-800-447-8477.

4. Information That Should Be Reported

4.1 When making a report, provide as much of the following information as possible:
4.2 Reports of potential provider fraud related to our Medicare Advantage or Part D benefits should include:
- Provider name, all known billing and tax identification numbers, and addresses.
- Type of provider involved in the allegation and the perpetrator, if an employee of the provider.
- Type of item or service involved in the allegation.
- Place of service.
- Nature of the allegation(s).
- Timeframe of the allegation(s).
- Narration of the steps taken and information uncovered during the Health Alliance screening process.
- Date of Part D service, drug code(s).
- Beneficiary name, beneficiary Health Insurance Claim (HIC) number, address and telephone number.
- Name and telephone number of the Health Alliance employee who received the complaint.
- Contact information of the complainant, if not the beneficiary.
- All documents pertaining to prior sanctions and/or compliance history and corrective actions taken, if any.

5. Report Follow-Up

5.1 All individuals who reports concerns may follow up on the investigation. If you would like to be kept up-to-date with the investigation (if any), you may contact the Chief Compliance and Risk Officer. If you wish to remain anonymous you may call the Compliance Line and reference the report number you were given when you initially made the report.

HISTORY

Created: 03/15/00 – J. Griffith
Revised: 05/01/01 – T. Jensen-Revised Section 5.1 replaced “Investigating Reports of Misconduct” policy name to “Internal Compliance Investigations” policy name, created link to the policy and made minor grammatical changes.
03/01/02 – T. Jensen-Revised Sections 1.1 to reference new/revised avenues for reporting suspected misconduct, 1.4 and 1.9.
05/01/03 – T. Jensen-Changed name of the policy.
05/01/04 – T. Jensen-Changed name of Compliance Officer.
08/23/05 – T. Jensen-No changes.
11/01/06 – M. Zachary-No changes.
12/19/06 – T. Jensen-Changes were made to incorporate reporting of potential fraud or abuse from any individual and add Human Resources Dept on 1.1.
02/11/08 – M. Zachary-No changes.
02/01/09 – T. Jensen-Changes were made to 1.2 to name and contact information for the Compliance Officer
02/15/09 – S. McAdams-Changed Owner title.
02/01/10 – T. Jensen-Added “an impermissible use or disclosure of protected health information” to example of compliance violation per NCQA consultant request.
10/01/10 – T. Jensen-Added privacy or security incident as a reportable issue.
10/01/11 – T. Jensen-No changes.
11/21/12 – S. McAdams-Reviewed with minor formatting changes.
02/12/13 – L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field.
03/14/13 – T. Jensen-Added Health Alliance Connect to Policy Applies to field.
04/24/14 – T. Jensen-Reviewed with no changes.
05/01/15 – S. McAdams-Reviewed with no changes.
04/11/16 – T. Jensen-Changed Compliance Officer to Chief Compliance and Risk Officer throughout policy and updated Policy Applies To.
04/26/17 – S. McAdams-Updated Owner from Executive Compliance Director to VP, Chief Compliance & Risk Officer.

APPROVED BY

Compliance Committee 4/30/01; 03/06/02; 05/06/03, 01/24/07
Compliance Officer 05/01/04, 12/19/06, 10/01/10, 10/01/11
Privacy Officer 05/03, 05/04, 08/05, 12/06, 02/08, 02/09, 02/10, 10/10, 10/11, 11/12

Signature(s): ____________________________________________________________
(Signature copies are kept in Compliance)

Date: ________________
**PURPOSE OF THE POLICY**

To comply with the Centers for Medicare and Medicaid Services (CMS) related to the Medicare Advantage (MA), Part D and Qualified Health Plan (QHP) regulations and guidelines.

**STATEMENT OF THE POLICY**

Health Alliance performs risk assessments on internal operational processes on an annual basis to determine high risk areas. Identified high risk areas are included on the annual Compliance Audit Schedule.

The avenues used to identify high-risk areas for our MA and Part D plans are as follows:

- HA Formal Risk Assessment Tool
- OIG Work Plan
- Medicare Audit Guide through Gorman’s Online Monitoring Tool (OMT)
- CMS Enforcement Actions for other Medicare Advantage Organizations
- Periodic interviews with management, including VP of Government Business

**Risk Assessment / Scoring Methodology:**

Health Alliance utilizes factors/criteria to assess risk and assigns a risk level. Refer to the Health Alliance Formal Risk Assessment Guide.

**HISTORY**

Created: 01/01/10 – T. Jensen
Revised: 06/13/11 – T. Jensen-No changes.
05/22/12 – T. Jensen-No changes.
02/12/13 - L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field.
03/14/13 – T. Jensen-Added Health Alliance Connect to Policy Applies to field.
04/24/14 – T. Jensen-Reviewed with no changes.
05/01/15 – S. McAdams-Reviewed with no changes.
04/11/16 – T. Jensen-Updated Owner title, Policy Applies To and Purpose of the Policy.
11/16/16 – T. Jensen- Revised to accurately reflect avenues using to identify risk areas and reference to the risk assessment guide.

APPROVED BY

Signature(s): ____________________________________________
(Signature copies are kept in Compliance)

Date: _________________
PURPOSE OF THE POLICY

To comply with the Centers for Medicare and Medicaid Services (CMS) guidelines for the Medicare Advantage (MA) and Part D Sponsor (Part D).

STATEMENT OF THE POLICY

Health Alliance manages risk of compliance with the MA and Part D laws, regulations and CMS guidelines, such as HPMS memos, annual call letter, readiness checklist, audit protocols and manual updates as follows:

- Monitors legislative activity and all CMS guidelines
- Identifies gaps in compliance
- Develops work plans and oversee tasks to completion
- Audit areas of high risk
- Monitors processes on an ongoing basis

HISTORY

Created: 01/01/10 – T.
Revised: 06/13/11 – T. Jensen-No changes.
05/22/12 – T. Jensen-No changes.
02/12/13 – L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field.
03/14/13 – T. Jensen-Added Health Alliance Connect to Policy Applies to field.
04/24/14 – T. Jensen-Reviewed with no changes.
05/01/15 – S. McAdams-Reviewed with no changes.
04/11/16 – T. Jensen-Updated Owner title, Policy Applies To and Purpose of the Policy.
04/11/17 – T. Jensen-Removed references to Medicaid/HFS

APPROVED BY

Signature(s): __________________________________________
(Signature copies are kept in Compliance)
PURPOSE OF THE POLICY

To comply with the Centers for Medicare and Medicaid Services (CMS) regulations and guidelines related to the Medicare Advantage (MA), Part D and Qualified Health Plan (QHP).

STATEMENT OF THE POLICY

The Chief Compliance and Risk Officer oversees the monitoring and auditing of various activities and operations of Health Alliance, providing an assessment of the effectiveness of the Compliance Program, and indicating the areas where departmental processes may need to be developed, revised or improved. To the extent that the monitoring activities reveal suspected misconduct or violation, refer to the Internal Compliance Investigation policy.

Departments must periodically monitor internal operations and external processes performed by our Delegated Vendors to ensure continued compliance with applicable federal laws/regulations and CMS guidance. Monitoring reports are forwarded to the Chief Compliance and Risk Officer and applicable Compliance Manager for review.

An annual audit schedule is developed based on high risk identified from the risk assessment (refer to the Risk Assessment - Internal Operations policy) and conducts audits listed in the schedule.

Employees conducting MA-PD compliance one-time auditing and monitoring based on the CMS audit protocols must select a sample from an identified universe. A random sample size of at least 30 cases is selected for one time audits and monitoring. In the event the cases are less than 30, the auditing or monitoring activity is completed at 100%. Compliance reserves the right to review 100% of cases. Compliance complies with generally accepted auditing standards.

PROCEDURES

1. Chief Compliance and Risk Officer and/or designee

1.1 Conduct audits of identified high risk areas. Documents audit findings in a standardized format to present to the department director, Compliance Committee and the Compliance Committee of the Board of Directors. Maintains written audit documentation.

1.2 Follows up with department directors to ensure process improvements have been implemented.
1.3 Reviews the Compliance Program policies and procedures and associated documents, including the Guide to Employee Conduct, on an annual basis for its effectiveness and compliance with laws, regulations and CMS guidelines.

2. Departments

2.1 Develop, maintain and perform routine monitoring of operational processes within the department to ensure compliance with applicable laws, regulations and CMS guidelines.

2.2 Review policies and procedures on an annual basis.

2.3 Review CMS MA and Part D audit protocols for compliance with the Medicare laws, regulations, Managed Care Manuals and Centers for Medicare and Medicaid Services (CMS) guidance and provide details of compliance via Online Monitoring Tool (OMT) or other avenues.

2.4 Monitors delegated vendor operations to ensure ongoing compliance and works with vendor on any corrective actions.

2.5 Documents findings and corrective actions and maintain files.

2.6 Forward reports to Chief Compliance and Risk Officer for review.

3. Chief Compliance and Risk Officer and/or designee

3.1 Reviews monitoring reports and identifies patterns of non-compliance.

3.2 A Corrective Action Plan (CAP) is applied when department monitoring activity fails to meet an internal threshold of 95%, unless CMS identifies a stricter threshold, for at least three (3) consecutive months.

3.3 Review responses of actionable items communicated to departments. Refer to Communication of new/Revised MA & PD Statues, Regulations and CMS Guidelines policy for further details.

HISTORY

Created: 05/01/01 – T. Jensen
Revised: 03/02/02 – T. Jensen-Changes made to Section 1 “Compliance Dept Personnel” to refer to the Audit Guide instead of listing out process on this policy.
04/30/03 – J. Johnson-Added Section 4 “Manager of Internal Audit” and changed “Audit and Compliance Committee of the Board of Directors” to Audit Committee of the Board of Directors.
10/22/04 – T. Jensen-Changed Section 4 title to “Compliance Officer” and reference of internal audit manual to audit guide.
11/14/06 – M. Zachary-No changes.
11/14/07 – M. Zachary-No changes.
11/01/08 – T. Jensen-No changes.
11/01/09 – T. Jensen-No changes.
11/01/10 – T. Jensen-No changes.
10/17/11 – T. Jensen-Revised entire policy section.
11/21/12 – S. McAdams-Reviewed with minor formatting changes.
02/12/13 – L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field.
02/19/13 – T. Jensen-Changed Audit Committee of Board to Compliance Committee of the Board.
03/14/13 – T. Jensen-Added Health Alliance Connect to Policy Applies to field.
04/16/13 – T. Jensen-Added FDR monitoring processes.
04/24/14 – T. Jensen-Reviewed with no changes.
05/01/15 – S. McAdams-Reviewed with no changes.
04/11/16 – T. Jensen-Updated title Compliance Director to Executive Compliance Director and Compliance Officer to Chief Compliance and Risk Officer throughout policy and updated Policy Applies To, Purpose of the Policy and Statement of the Policy.
11/16/16 – T. Jensen-Updated policy to reflect delegated vendor term.
04/09/17 – Y. Hoey – Updated policy to reflect sampling size, monitoring threshold.

**APPROVED BY**

Signature(s): ________________________________________________  
(Signature copies are kept in Compliance)

Date: ________________
PURPOSE OF THE POLICY

Documenting the provider outlier auditing process to ensure the payment integrity of the health plan as well as identify potential fraud waste and abuse (FWA).

STATEMENT OF THE POLICY

The Health Alliance SIU performs provider billing desk audits based on outlier data identified during data mining efforts. The auditing focus is based on but is not limited to, yearly OIG work plans, Internal coding analysis work plans, National Healthcare Anti-Fraud Association (NHCAA) Reports, internal reports of potential aberrant provider billing behaviors or quality of care, Law Enforcement reports, FWA vendor analysis, and other data mining efforts.

PROCEDURES

1. FWA Assessment

1.1 FWA can potentially be identified through, but not limited to, the following ways: an external report, an internal report, software analytics, provider auditing, or vendor efforts.

2. Request Claims Data For Initial Probe Audit

2.1 Investigators/auditors request data from Information Management Analytics (IMA) based on previous 18 calendar months of provider billing unless the nature of the case/audit focus requires a different time frame.

3. Select Probe Sample

3.1 Audit targets are selected via investigator, auditor, pharmacist, or medical director discretion as to which claims may pose the highest risk to health plan payment integrity. The probe audit sample size is between three (3) to ten (10) dates of service.

3.2 In audits involving random samples: Audit targets are selected via random sampling using 90% confidence level and 10% error rate methodology via statistical sampling tools (such as OIG Rat-Stats)
3.3 Random samples are based on product line percentages of the data universe within the report unless the universe is less than 50 claims. If the universe is less than 50 claims all claims will be reviewed.

4. Request/Review Medical Records

4.1 Medical records are requested via fax or mail unless the provider has the ability to permit/allow the investigators/auditors review records via secure online portal.
4.2 Providers are instructed to send the requested medical records to Health Alliance within 30 days of receipt of letter from SIU or Chief Medical Officer/Medical Director. Second medical record request letters will be sent by Chief Compliance & Risk Officer and will instruct provider to be send within 15 days. A failure to comply with requests for records will result in recoupment requests or provider payment offset of the claims in question.

5. Passing Rates and Report of Initial Findings

5.1 If the individual provider sample is less than 5 claims the provider passing rate must be 100%. If the sample size is greater than 5 claims the passing rate must be above 90%.
5.2 The SIU may submit results for analysis or verify results with a Medical Director and/or External Peer Review (EPR)
5.3 All internal probe audit results are reported to the Chief Compliance & Risk Officer

6. Request of Additional Medical Records

6.1 Medical records are requested via fax or mail unless the provider has the ability to let the investigators/auditors review records via secure online portal.
6.2 Providers are instructed to send the requested medical records within 30 days of receipt. Second requests are instructed to be sent within 15 days. A failure to comply with requests for records will result in recoupment requests of the claims in question.

7. Report of Findings & Recoupment Assessment

7.1 All audit results are assessed for potential recoupment of funds from the provider based on adverse findings
7.2 The SIU will review all provider appeals based on SIU audit recoupment requests (see the SIU: Provider Appeal Process policy).
7.3 The SIU may submit appeals for analysis or verify results with a Medical Director, Executive Director of Network Management and/or External Peer Review (EPR)
7.4 All audit results are reported to the Chief Compliance & Risk Officer

8. Post Audit Corrective Actions & Monitoring

8.1 The SIU may recommend to the Compliance Officer, but is not limited to, the following:
   - The scope of the providers billing review be expanded and audited again during a set timeframe
   - The provider be put on a Pre-Payment review for all claims
   - The provider be given a Corrective Action Plan (CAP)
   - The provider be terminated; provider payment off-set initiated; or a demand letter sent
- Request to seek appropriate direction from OIG or law enforcement based on audit findings

8.2 Audit reports will be presented to FWA Committee and Compliance Committee

9. Reporting of Potential Fraud

9.1 If Fraud becomes evident at any point of the auditing process an immediate report will be made to the Chief Compliance & Risk Officer and the appropriate government/law enforcement entities which may include but is not limited to:

- HFS-OIG (Medicaid Program)
- HHS-OIG & MEDIC (Medicare Supplement/Medicare Part C & D Programs)
- OPM-OIG (FEHB Program)
- FBI (Commercial Fully Insured & Self-Funded Programs)

HISTORY

Created: 01/01/15 – S. McAdams
Revised: 05/01/17 – S. McAdams-Specified probe audit sample size as 3 to 10 dates of service in Section 3.1. Changed Executive Director of CPS to Executive Director of Network Management in Section 7.3 and under Affected Departments changed CPS to Provider Network Management.

APPROVED BY

Signature(s): ________________________________________________
(Signature copies are kept in Compliance)

Date: ________________
PURPOSE OF THE POLICY

To prevent fraud, waste and abuse through the timely identification of overpayments/underpayments as well as properly report and recoup such in accordance with CMS policy.

STATEMENT OF THE POLICY

It is the policy of the Health Alliance Pharmacy Department to identify overpayments and underpayments due to improper coverage determinations and/or fraud, waste and abuse at any level as well as timely report and pay, where applicable, such overpayments in accordance with CMS policy.

PROCEDURES

1. Pharmacy Department

1.1 Pharmacy Benefit Manager (PBM), OptumRx will produce reports for the Health Alliance Pharmacy Department.

1.2 The PBM and the Pharmacy Department will review the reports and take appropriate action including recovery of discrepant amounts where applicable.

1.3 Notification to the member of overpayment/underpayment shall take place within thirty (30) days of identifying such overpayment/underpayment.

1.4 Reports are generated quarterly by the Pharmacy Benefit Manager, OptumRx, outside overpayment/underpayment recoupment:

- Claims Reports – Demographics, High Quantity, High Dollar, Decimal Package Size and Compounds
  - Demographics tab- identifies drugs that are contraindicated based on:
    - Member ID
    - Member Gender
    - Member Age
    - General Therapeutic Class
    - Specific Therapeutic Class
    - Brand Name & Strength
- High Quantity tab- identifies instances where the package size ratios of the drug dispensed are outside the normal ratio for those general therapeutic classes and drugs.
- High Dollar tab-Identifies claims in excess of $500 in order to facilitate identification of potentially aberrant payments.
- Decimal Package Size tab-Identifies instances where the decimal package size for selected general therapeutic classes of drugs are outside normal parameters.
- Compounds tab-Identifies compound claims that were processed for the members during the reporting period.
- Data tab- Inclusive data
  • Controlled Substances by Member
    - Totals tab (Summary of totals by member number)
    - Summary of Controlled Substances by member
      • Counts of the number of Physicians and Pharmacies each member used during the reporting period
      • Summary of total dollars paid by plan and co-pays paid by member
    - Details tab
      • Details the total number of claims and quantities of CII, CIII & CIV drug classes
      • Detail of the Prescriber and Pharmacies each member used during the reporting period
      • Detail of each claim and member
  • Controlled Substances by Physician
    - Identifies the top three percent (3%) of physicians prescribing Class II, III, and/or IV drugs during the reporting period based on total number of drugs dispensed in that class for the plan.
  • Pharmacy Utilization
    - Identifies pharmacies dispensing one hundred (100) or more prescriptions for the plan during the reporting period. This reports helps identify those pharmacies that are dispensing significant quantities for the plan in order to make them more visible for continuing oversight.
  • Physician Utilization
    - Identifies physician that have prescribed to plans members during the reporting period. This report helps identify Prescriber Dispensing Pattern using Total Number of Utilizing Pharmacies, Total Number of Utilizing Members, Average Number of Prescriptions per Member, and other trend information. This report allows the plans to look at these various data elements “side-by-side” in order to detect potentially aberrant patterns of behavior.

1.5 A pharmacist reviews each desktop report and records any significant findings and or corrective actions required as a result of the report reviews.

1.6 Infusion Part D drug claims that are billed online through the PBM will be put through the routine FWA detection as indicated above. The services for the pump/pole and supplies are reviewed internally through a manual review by a Health Alliance pharmacy staff member to ensure that the service matches a drug code also being billed on the appropriate date of service in MedAccess.

1.7 Infusion services that are submitted directly to the health plan are manually reviewed for appropriate billing services and authorizations before being processed.

HISTORY
Revised: 01/01/10 – T. Howerton-Added MedImpact FWA desktop reports.
01/01/11 – T. Howerton-Added infusion FWA detection.
01/01/12 – H. Wilson-No changes.
03/21/12 – N. Holtz-Edited for clarity, added PDP Members.
01/01/13 – R. Snyder-No changes.
12/16/13 – H. Wilson-No changes.
12/03/14 – A. Buhr-P&T review, no changes.
12/02/15 – T. Migut-Changed PBM from MedImpact to OptumRx.
12/07/16 – A. Buhr-No changes.

APPROVED BY

Signature(s): ________________________________________________
(Signature copies are kept in Compliance)

Date: ________________
PURPOSE OF THE POLICY

To set forth the duties and responsibilities for conducting and documenting internal investigations of reported suspected misconduct, compliance violations (including issues of non-compliance with Medicare guidelines), potential fraud or abuse and privacy or security incidents.

STATEMENT OF THE POLICY

The Chief Compliance and Risk Officer or designee is responsible for promptly conducting an investigation into all substantive reports of suspected misconduct, compliance violations and potential fraud or abuse. The Privacy Officer investigates all privacy incidents. The Security Officer investigates all security incidents. A compliance violation includes but is not limited to, a violation of the Ethics and Compliance in the Workplace: A Guide to Employee Conduct, a violation of a policy and procedure or a violation of federal and state criminal, civil and laws, regulations and CMS guidance related to our lines of business.

PROCEDURES

1. Receiving Suspected Misconduct, Compliance Violations (including issues of non-compliance with Medicare guidelines), Potential Fraud or Abuse and Privacy and Security Incidents

1.1 All compliance line reports are documented on the Compliance Issue Report Form and then transferred to the Compliance Line Issue Log

1.2 All Medicare issues of non-compliance are documented on the Medicare Issue Report form and transferred to the Medicare Issues Log.

1.3 All QHP issues of non-compliance are documented on the QHP Issue Report form and transferred to the QHP Issues Log.

2. Conducting an Investigation

2.1 A preliminary investigation is conducted to determine the accuracy of the report. The timeline for completing the investigation is determined by the severity of the violation.
The actions taken during the preliminary investigation may include a review of relevant documents, applicable laws and regulations, interview of the appropriate staff, including the reporter (if report is not anonymous).

2.2 If the findings of the preliminary investigation do not support the claim, the findings are documented on the form and the report is closed.

2.3 If the preliminary investigation determines the report warrants further action, some or all of the following actions will be completed based on the report:
   - Root cause analysis
   - Further review of pertinent documents (e.g. claims or billing, records, reports and other evidence).
   - Further interviews conducted of those involved or who may have specific knowledge of the issue.

2.4 The individual who reported the issue may follow up on the status of an investigation at any time.

3. Documenting an Investigation

3.1 The description of the issue, root cause analysis, investigation and remediation/corrective action plan is documented on the appropriate Issues form and Log.

3.2 Supporting documentation will be maintained in the Compliance Department files.

4. Reporting misconduct or compliance violation (including issues of non-compliance with the Medicare guidelines, Privacy or security, etc.)

4.1 Chief Compliance and Risk Officer consults with the Senior Vice President of Corporate Affairs and General Counsel when necessary.

4.2 Reports of medium and high risk issues, investigations and corrective actions are submitted to the Compliance Committee and the Corporate Compliance Committee of the Board of Directors.

4.3 For reporting issues to the proper agency, refer to the **MA-PD Self-Reporting** policy.

4.4 Refer to the **Corrective Action Process** and the **Carle Employee Discipline and Misconduct** policies for further details.

**HISTORY**

Created: 05/01/01 – T. Jensen
Revised: 05/01/02 – T. Jensen-Document was revised to remove reference to external compliance line vendor as well as new database process.
04/24/03 – T. Jensen-No changes.
03/01/04 – T. Jensen-No changes.
03/23/05 – M. Zachary-Minor grammatical changes.
11/01/06 – M. Zachary-No changes.
12/19/06 – T. Jensen-Revisions made to include provider fraud as a topic of investigation.
02/11/08 – M. Zachary-No changes.
01/01/09 – T. Jensen-No changes.
02/01/09 – S. McAdams-Changed owner title.
02/01/10 – T. Jensen-No changes.
10/01/10 – T. Jensen-Added privacy or security incidents as a reportable issue, made changes to the procedures to streamline the process.
02/01/11 – S. McAdams-No changes.
02/01/12 – S. McAdams-No changes.
02/12/13 – L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field.
02/12/13 – S. McAdams-Made minor corrections and changed Audit Committee to Compliance Committee.
03/14/13 – T. Jensen-Added Health Alliance Connect to Policy Applies to field.
04/24/14 – T. Jensen-Reviewed with no changes.
05/01/15 – S. McAdams-Reviewed with no changes.
04/11/16 – T. Jensen-Updated Compliance Director to Executive Compliance Director and Chief Compliance Officer to Chief Compliance and Risk Officer throughout policy and updated Policy Applies To.
04/26/17 – S. McAdams-Updated Owner from Executive Compliance Director to VP, Chief Compliance & Risk Officer.
04/30/17 – T. Jensen-Updated all sections of the policy.

APPROVED BY

Compliance Committee on 4/30/01; 05/06/03, 01/24/07, 11/16
Director of Compliance 05/02, 04/03, 03/04, 03/05, 12/06, 02/08, 02/09, 02/10, 10/10, 10/11
Privacy Officer 04/03, 03/04, 03/05, 12/06, 02/08, 02/09, 02/10, 10/10, 10/11

Signature(s): ________________________________
(Signature copies are kept in Compliance)

Date: __________________
PURPOSE OF THE POLICY

To set forth the duties and responsibilities for implementing the corrective actions needed to resolve confirmed misconduct, compliance violations (including issues of non-compliance with Medicare guidelines), potential fraud or abuse cases and privacy or security incidents.

STATEMENT OF THE POLICY

The Chief Compliance and Risk Officer oversee all corrective actions related to a compliance violation, misconduct, or potential fraud or abuse. The Privacy Officer oversees corrective actions related to a privacy incident. The Security Officer oversees corrective actions related to a security incident.

Findings or issues of non-compliance may be identified through various methods, such as compliance audits, external audits, reports to compliance or from the compliance line process.

Depending on the severity of the issue/finding will determine the corrective action/remediation timeframe and how it is documented (i.e. on the issues form, within the audit report or via a spreadsheet or OMT.)

Findings or issues of MA non-compliance may warrant a follow up audit or the corrective action may require monitoring to be put into place. The Audit Schedule will reflect follow up audits. Monitoring will be reported to the Medicare Compliance Subcommittee for oversight.

Corrective Action/Remediation plans are documented. Any issue that warrants disciplinary action will be handled by the director of the department with the assistance from the Director of Human Resources and the Chief Compliance and Risk Officer using Carle’s Employee Discipline and Misconduct policy.

HISTORY

Created: 05/01/01 – T. Jensen
Revised: 05/01/02 – T. Jensen-Added reference to the Disciplinary Addendum under the Statement of Policy section.
04/24/03 – T. Jensen-No changes.
05/01/04 – T. Jensen-No changes.
12/05/05 – M. Zachary-No changes.
11/14/06 – M. Zachary-No changes.
12/19/06 – T. Jensen-Revisions made to incorporate reporting of fraud requirements.
02/11/08 – M. Zachary-No changes.
01/01/09 – T. Jensen-No changes
02/01/09 – S. McAdams-Changed Owner title.
02/01/10 – T. Jensen-No changes.
10/01/10 – T. Jensen-Added privacy and security incidents as an item for corrective action would apply and streamlined procedure section.
10/01/11 – T. Jensen-No changes.
11/21/12 – S. McAdams-Reviewed with minor formatting changes.
02/12/13 – L. Slaughter-Added Health Alliance Medical Plans, Inc. (HAMP), Health Alliance Midwest, Inc. (HAMI) and Health Alliance Northwest Health Plan, Inc. (HANWHP) to Policy Applies To field.
03/14/13 – T. Jensen-Added Health Alliance Connect to Policy Applies to field.
04/24/14 – T. Jensen-Reviewed with no changes.
05/01/15 – S. McAdams-Reviewed with no changes.
04/11/16 – T. Jensen-Changed title Compliance Director to Executive Compliance Director and Compliance Officer to Chief Compliance and Risk Officer throughout the policy and updated Policy Applies To.
04/26/17 – S. McAdams-Updated Owner from Executive Compliance Director to VP, Chief Compliance & Risk Officer and updated entire policy; revised policy section.

APPROVED BY

Compliance Committee on 05/21/01; 05/06/02, 01/24/07
Compliance Officer 05/01/02, 04/03, 05/04, 12/05, 12/06, 02/08, 01/09, 02/09, 02/10, 02/11, 03/13, 04/14, 05/15, 04/16, 04/17
Privacy Officer 04/03, 05/04, 12/05, 12/06, 02/08, 01/09, 02/09, 02/10, 02/11, 11/12, 03/13, 04/14, 05/15, 04/16, 04/17

Signature(s): _______________________________
(Signature copies are kept in Compliance)

Date: __________________
PURPOSE OF THE POLICY

To comply with Center of Medicare and Medicaid Services (CMS) Medicare Managed Care and Part D guidelines set forth in Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Part D manual (Chapter 9/21) and 45 CFR 156.340 for Qualified Health Plans regarding oversight of Delegated Vendors.

DEFINITIONS

_Delegated vendor_ includes a vendor who meets the definition of a first tier or related vendor or provides services on behalf of Health Alliance for our Qualified Health Plan (QHP) product lines.

_First Tier entity_ means any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization (MAO) to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage (MA) program.

_Downstream entity_ means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between the MAO and the first tier vendor. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

STATEMENT OF THE POLICY

Health Alliance conducts initial and ongoing oversight activities to ensure that our delegated vendors comply with the Federal/State laws, regulations and CMS guidelines applicable to contracted entities.

As part of the oversight activities, Health Alliance has the following risk assessment, communication, auditing and monitoring processes in place.

**Risk Assessment**

*Initial Risk Assessment / Scoring Methodology:*
Health Alliance utilizes factors/criteria recommended by CMS to assess risk and assigns a risk level.

These factors include the following:

- Whether the delegated function is something the health plan and/or MAO is required to provide under our contract with CMS, the applicable federal/state regulations or CMS guidance and whether CMS significantly emphasizes as high risk.
- To what extent the function directly impacts beneficiaries or members.
- To what extent the delegated vendor has interaction with beneficiaries or members, either orally or in writing.
- Whether the delegated vendor has access to beneficiary information or member personal health information.
- Whether the delegated vendor has decision-making authority (e.g., UM vendor deciding time frames) or whether the entity strictly takes direction from health plan or MAO.
- The extent to which the function places the vendor in a position to commit health care fraud, waste or abuse (FWA).
- The risk that the vendor could harm enrollees or otherwise violate Program requirements or commit FWA.

The contracts/agreements with the delegated vendors will be analyzed against the above criteria and assigned a Risk Level utilizing a scoring method. The scoring is calculated by assigning points per delegated activity performed by each vendor, such as organizational determinations, coverage determinations, claims payments, credentialing, etc. Delegated vendors that have decision making authority, conduct activities that could potentially harm a member, pose an opportunity for fraud, waste and abuse, and provide services which CMS significantly emphasizes as high risk inherently receive a higher score. Risk-level is also determined on delegated vendor responses to the compliance questionnaire. High risk-level entities also include those with open corrective action plans or audit findings.

Total risk scoring is assigned as follows:

<table>
<thead>
<tr>
<th>Risk Level – High</th>
<th>Risk Level – Medium</th>
<th>Risk Level – Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score = 17+</td>
<td>Score = 12 - 16</td>
<td>Score = 11 or below</td>
</tr>
<tr>
<td>Potential for significant (if found deficient and/or noncompliant) direct member impact or interaction, decision making authority, opportunity for fraud, waste and abuse, and potential for member harm or CMS significantly emphasizes as high risk.</td>
<td>Potential for moderate (if found deficient and/or noncompliant) direct member impact or interaction, decision making authority, opportunity for fraud, waste and abuse, and potential for member harm.</td>
<td>Low to no direct member impact or interaction, decision making authority, opportunity for fraud, waste and abuse, and potential for member harm.</td>
</tr>
</tbody>
</table>

| Audit Bi-annual, monitor frequently and receives annual attestation of compliance | Monitor frequently and receives annual attestation of compliance | Receives annual attestation of compliance |

The delegated vendor must complete a Delegated Vendor Assessment Questionnaire. Responses to the questionnaire may result in a change of the risk score to a higher level.
Ongoing Re-evaluation of the Risk Assessment:
Compliance re-evaluates the risk score of the delegated vendor on an annual basis or as issues/concerns with vendor arise. These assessments allow for the identification of areas that have either increased their risk score due to newly opened audits, Corrective Action Plans (CAPs) or CMS notices or have reduced their risk score due to completed corrections to audits, CAPs, and CMS notices.

Communication
Internal employees have been assigned as the contract owner with the delegated vendor. The contract owners forward the appropriate new/revised guidance to the delegated vendor and ensure the delegated vendor has compliance processes in place.

Monitoring
As part of their contract, all delegated vendors are required to conduct their own routine monitoring, complete corrective actions in a timely manner and report to Health Alliance.

Health Alliance contract owner or their designee monitors the operational processes performed by the delegated vendor based on the risk level assigned.

The Health Alliance Fraud Investigator monitors for/conducts audits of Fraud, Waste and Abuse (FWA). Refer to the FWA Compliance Plan and associated policies for further details.

Corporate Relations performs initial and annual monitoring of OIG exclusion list to ensure contracted vendors are not on this list. Refer to the Contract/Amendment Review, Approval and Termination policy for further details.

Auditing
As part of their contract, all delegated vendors are required to conduct their own routine audits and complete corrective actions in a timely manner.

Health Alliance includes delegated vendors on the annual audit schedule and prioritizes audits based on risk level.

Follow-up and Corrective Action
Any deficiencies identified during auditing and monitoring activities must be corrected via a Corrective Action Plan (CAP) and must be implemented timely and/or as specified in accordance with the contractual and delegation agreements.

Reporting
When areas of non-compliance are self-identified by the delegated vendor outside monitoring or auditing efforts, the delegated vendor is required to notify Health Alliance immediately, no later than three (3) days from identification, and take prompt action to cure the deficiency and validate the cure to prevent future recurrence.

All auditing and monitoring reports and other reports of non-compliance will be reported to the Delegated Vendor Oversight Committee.

PROCEDURES
1. **Chief Compliance and Risk Officer and/or designee**

1.1 Upon onboarding, sends vendor the Delegated Vendor Assessment Form to complete.

1.2 Reviews completed form and supporting documents and determines vendor compliance.
   - Contact vendor if additional information is needed

1.3 Performs oversight based on the delegated vendor’s risk level.
   - Low risk – delegated vendor completes annual attestation
   - Medium risk – delegated vendor completes annual attestation and contract owner or designee provides ongoing monitoring.
   - High risk – delegated vendor completes annual attestation and Health Alliance or hired external auditor conducts periodic audits.

1.4 Delegated Vendor Oversight Committee reviews monitoring and audit findings and make recommendations for remediation plans and will monitor progress reports of those remediation plans.

1.5 Annually sends compliance attestation to be signed by delegated vendor.

**HISTORY**

Created: 04/16/13 – T. Jensen
Reviewed: 05/14/14 – S. McAdams-Reviewed with no changes.
          07/14/15 – S. McAdams-Reviewed with no changes.
          06/01/16 – T. Jensen-Added QHP.
          07/20/16 – T. Jensen-Revised to replace FDR with Delegated Vendor.
          10/05/16 – T. Jensen-Revised to add risk assessment process, removed links to other policies and included requirements within this policy.

**APPROVED BY**

Compliance Committee
2013

Signature(s): ______________________________________________________

*(Signature copies are kept in Compliance)*

Date: ______________