DEPARTMENT: Compliance **POLICY TITLE:** CMP05 Fraud, Waste and Abuse and Compliance Plan		
REVIEWED BY: AZPC Compliance Officer	**REVIEW DATE: 11/08/2019**	**EFFECTIVE DATE: 12/01/2019**
APPROVED BY: Compliance Committee	**APPROVAL DATE:** 11/11/2019	

POLICY:

Arizona Priority Care complies with The Centers for Medicare and Medicaid Services (CMS) annual requirement of training fraud, waste and abuse (FWA) for organizations providing health or administrative services to Medicare Advantage (MA) enrollees on behalf of a health plan. AZPC also complies with distributing training to all downstream entities, and documenting such distribution.

AZPC also complies with CMS requirement that MA sponsors have a compliance plan that guards against potential fraud, waste and abuse. An MA or Part D Sponsor must:

1. Create a Compliance Plan that incorporates measures to detect, prevent, and correct fraud, waste and abuse.
2. Create a Compliance Plan that must consist of training, education, and effective lines of communication.
3. Apply such training, education, and communication requirements to all entities, which provides benefits or services under MA or PDP programs.
4. Produce proof from first-tier, downstream and related entities to show compliance with these requirements.

PROCEDURE:

1. AZPC's Compliance Plan complies with the following 7 elements:
    a. Written policies, procedures and standards of conduct.
    b. The designation of a Compliance Officer and Compliance Committee who report directly and are accountable to the organization's senior management.
    c. Establishment and implementation of effective training and education between the Compliance Officer and the organization's employees, the organization's senior administrators, managers and governing body members, and organization's first tier, downstream, and related entities (FDRs).
    d. Establishment and implementation of effective lines of communication, ensuring confidentiality, between the Compliance Officers, members of the compliance committee, employees, managers, governing body, and FDRs.
    e. Well-publicized disciplinary standards through the implementation of procedures, which encourage good faith participation in the compliance program by all affected individuals.
    f. Establishment and implementation of an effective system for routine monitoring and identification of compliance risks.

   g. Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

2. AZPC requires a signed attestation form from each of the FDRs that they have obtained written or electronic certifications from their employees and that, as a condition of employment, they have received, read, understood and will comply with all written Standards of Conduct.
3. AZPC requires all of its and employees and the employees of the FDRs to receive Compliance and FWA training upon hire (during orientation, within 90 days after hire) and annually thereafter. FDRs must complete the AZPC training modules or equivalent. The effectiveness of AZPC's training is confirmed by a passing score of 80% or better.
4. AZPC's employees and the employees of the FDRs have the obligation to report any known or suspected violations of the policies and procedures or laws and regulations. AZPC reports allegations of fraud, waste, and abuse to the health plans within 10 days of becoming aware of suspected violations, prior to conducting an investigation, and within 10 days of the conclusion of the investigation.
5. AZPC establishes and implements an effective system for routine monitoring and identification of compliance risks. This system includes both internal and external monitoring and audits, performed annually but no later than the fourth quarter, which evaluate the organization's and FDR's compliance with CMS requirements, and the overall effectiveness of the compliance program.
6. AZPC monitors 100% of its FDRs by requiring compliance attestations upon contracting and annually thereafter. AZPC consistently audits, monitors, and maintains documentation regarding adherence to this AZPC requirement.
7. AZPC establishes and implements procedures and a system for promptly responding to compliance issues as they are raised. AZPC investigates potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and to ensure ongoing compliance with CMS requirements.
8. Employees/FDRs deemed to have violated AZPC's compliance policies or any federal and state law or regulations, will be sanctioned according to company's discipline guidelines promptly, but not later than 10 days after determination. See also Actions to Mitigate Breach Risk policy.
9. AZPC's Human Resources department complies with CMS requirement of checking the Office of the Inspector General (OIG) and General Services Administration (GSA) exclusion lists for all new employees and every month thereafter to validate that employees and other entities that assist in the administration or delivery of services to Medicare beneficiaries are not included on such lists:
   a. OIG List of Excluded Individuals/Entities (LEIE): http://exclusions.oig.hhs.gov/search.html

   b. GSA database of excluded individuals/entities: www.sam.gov
10. Any providers found to be on the CMS Preclusion list will be excluded in accordance to the CLP-0060 CMS Preclusion List policy.
11. AZPC has the right and responsibility to report possible fraud, waste, or abuse. Employees, FDRs, and enrollees may address issues or concerns to:
    a. AZPC's Compliance Office or the corporate compliance hotline 1-855-625-7894 and/or;
    b. The Compliance Officer or compliance hotline of the applicable Medicare Advantage Organization Sponsor(s) with whom AZPC's participates; compliance hotline numbers are available on each of the organization's websites.
    c. 1-800 MEDICARE.
    d. AZPC reports any possible Fraud, Waste and Abuse to the National Benefit Integrity Medicare Drug Integrity Contractor (NBI Medic).
12. System generated reports, such as claim adhoc reports or those from PCG (Virtual Examiner) or iCode software, are routinely utilized to identify possible fraud, waste, and abuse. These reports, along with the findings from routine monitoring, auditing, and identification of risks, are analyzed and routinely reported to the appropriate departments, the Compliance Committee, AZPC and HPN's Board of Directors, and to health plans, as required.
13. AZPC's Compliance Officer ensures compliance with CMS' requirements on a quarterly basis or as required by the Compliance Committee.

DEFINITIONS:

Medicare:

1. Part A- Hospital Insurance: pays for inpatient care, skilled nursing facility care, hospice, and home health care.
2. Part B- Medical Insurance: pays for doctor's services, and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs.
3. Part C –Medicare Advantage Plans (MA): combines Part A and Part B health benefits through managed care organizations. Some plans include Part D (MAPD plans).
4. Part D – Prescription Drug Insurance: helps pay for prescription drugs, certain vaccines and certain medical supplies (e.g. needles and syringes for insulin). This coverage is available as Prescription Drug Plan (PDP). While referenced, Heritage Provider Network does not participate in Medicare Part D.

First Tier Entity: A party that enters into a written agreement with a MA Organization or Part D plan Sponsor to provide administrative services or health care services to a Medicare eligible individual under the MA or Part D programs. Examples include IPA's Medical Groups, Pharmacy Benefit Manager (PBM), contracted hospitals, clinics, and allied providers.

Downstream Entity: A party that enters into a written arrangement, with persons or entities involved in the MA or Part D benefit, below the level of the arrangement between a MA Organization or Part D sponsor mad a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include pharmacies, marketing firms, and quality assurance companies, claims processing firms, and billing agencies.

Related Entity: An entity that is related to the MA Organization or Part D Plan Sponsor by common ownership or control and performs some of the MA Organization or Part D Plan Sponsor's management function under or delegation; furnishes services to Medicare enrollees under an oral agreement; or leases real property or sells materials to the MA Organization or Part D Sponsor at a cost of more than $2,500.00 during a contract.

Fraud: An intentional act of deception, misrepresentation or concealment in order to gain something of value.

Waste: Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practice. Refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss.

REFERENCES:

Heritage Provider Network Policies
42 CFR §422.503(b)(4)(vi)(A-G)
Medicare Managed Care Manual, Chapter 21

APPENDICES:

CMS Elements Mapping to HPN Compliance Program
FDR Compliance Attestation
Compliance Training Location
Incident Notifcation Log
Internal Audit Tool
Privacy Confidentiality Walk-Through Checklist

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DOCUMENT REVISION LOG

Date	Document Modification (including deletions)	Page(s)	Location
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