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Policy Name:	**Medicare Programs: Compliance Element II Compliance Officer and Compliance Committee**	**Policy No.:**	**HR328-133757**

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This Policy is applicable to the following:

Department(s):	All Departments
Business Unit(s):	HN Life, HNAZ, HNCA, HNCS, HNCSAZ, HNI, HNOR, HNPS
Products/LOB's:	Medicare Advantage and Medicare Part D, Dual Eligible

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Policy Statement:

Health Net, Inc. follows the Centers for Medicare & Medicaid Services (CMS) requirements contained in the Medicare Compliance Program Guidelines as well as Parts 422 and 423 of Title 42 of the Code of Federal Regulations (CFR).

Note for purposes of this policy and procedure, the term “Medicare programs” includes the Medicare Advantage (“MA”), Part D Prescription Drug (“Part D”), and Medicare-Medicaid Plan (“MMP”) lines of business.

A. Compliance Officer

The Compliance Officer:

· Is a full time employee of Health Net, Inc.;

· Reports to the Chief Compliance Officer;

· Is accountable to the Chief Executive Officer (CEO);

· Has express authority to provide unfiltered, in-person reports to the CEO, Health Net, Inc. and subsidiary Boards of Directors, and the Health Net, Inc. Board of Director's Audit Committee at her discretion;

· Is a member of Health Net, Inc., senior management;

· Is dedicated principally to the Health Net compliance program;

· Has detailed involvement in and familiarity with the operational and compliance activities of the Health Net subsidiaries that hold contracts with CMS;

· Does not serve dual roles in both compliance and in operational areas;

· Is responsible for implementation of the Medicare compliance programs; and

· Defines the compliance program structure, educational requirements, reporting, and complaint mechanisms, response and correction procedures, and compliance expectations of all personnel and first-tier, downstream and related entities (FDR).

The Compliance Officer, at his or her discretion, does not await approval of the Health Net, Inc. or subsidiary Boards of Directors or the Audit Committee to implement needed compliance actions and activities. Compliance actions and activities implemented at the Compliance Officer's direction are reported to the Health Net, Inc. or subsidiary Boards of Directors or Audit Committee, as appropriate, at the next scheduled meeting.

Duties of the Compliance Officer include, but are not limited to:

· Developing and monitoring the implementation of and compliance with Medicare programs related policies and procedures through the creation and implementation of a monitoring and auditing program;

· Reporting, at least on a quarterly basis, or more frequently as necessary, to the Health Net, Inc. or subsidiary Boards of Directors or the Audit Committee, on the status of Health Net's Medicare programs compliance program, the identification, investigation, and resolution of potential or actual instances of noncompliance, and Health Net's oversight and audit activities, and such reports will be documented in meeting minutes;

· Creating and coordinating, or appropriately delegating, compliance related educational training programs to ensure that associates, Directors, and first tier, downstream, and related entities (FDR) working in the Medicare programs are knowledgeable of Health Net's compliance program; the Code of Business Conduct and Ethics, Medicare programs compliance policies and procedures; and applicable statutory, regulatory, and other requirements;

· Developing and implementing methods and programs that encourage associates, Directors, and FDRs to ask compliance questions, and report instances of Medicare program non-compliance and suspected fraud, waste or abuse and other misconduct without fear of retaliation;

· Maintaining the compliance reporting mechanism and closely coordinating compliance

activities with other Health Net associates and departments, such as:

o The Health Net Ethics Officer for matters related to the Code of Business Conduct and Ethics;

o The Health Net Privacy Officer for matters related to HIPAA and the privacy program;

o The SIU and Legal department, as applicable, for matters related to investigations of Medicare programs fraud, waste, and abuse;

o The Vendor Management Office for compliance matters related to FDRs; and

o Organization Effectiveness for matters related to associate disciplinary actions and standards.;

· Responding to reports of potential instances of Medicare programs fraud, waste or abuse, including the coordination of internal investigations and the development of appropriate corrective or disciplinary actions, if necessary. To that end, the Compliance Officer has the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and execute any resulting corrective action (e.g., making necessary improvements to policies and practices);

· Ensuring processes are in place to check the HHS OIG exclusion list and GSA debarment list with respect to all associates, Directors, and FDRs monthly and coordinating any resulting personnel issues with Organization Effectiveness, Corporate Compliance, Legal, Provider Network Management, or other departments as applicable;

· Ensuring documentation is maintained for each report of potential Medicare programs non-compliance, fraud, waste, or abuse received through any source, including any of the reporting methods (i.e., the Health Net Integrity Line, the Health Net Fraud Hotline, mail, in-person);

· Overseeing the development, implementation and monitoring of corrective action plans;

· Ensuring collaboration with other applicable organizations (e.g., other sponsors, State Medicaid programs, Medicaid Fraud Control Units (MCFUs), commercial payers, etc.) when a fraud, waste, or abuse issue is discovered that involve multiple parties; and

· The Compliance Officer has the authority to:

o Escalate compliance issues directly to Health Net’s executive management team, the CEO, the chief operating officer, or the Health Net, Inc. or subsidiary Boards of Directors;

o Interview or delegate the responsibility to interview Health Net’s employees and other relevant individuals regarding compliance issues;

o Review company contracts and other documents pertinent to the Medicare program;

o Review or delegate the responsibility to review the submission of data to CMS to ensure that it is accurate and in compliance with CMS reporting requirements;

o Independently seek advice from legal counsel;

o Report potential fraud, waste, abuse, or other misconduct to CMS, its designee, and/or law enforcement;

o Conduct and/or direct internal audits and investigations of any FDR;

o Conduct and/or direct audits of any area or function with MA, Part D, or MMP plans; and

o Recommend policy, procedure, and process changes.

As some duties of the Compliance Officer are delegated, the Compliance Officer maintains appropriate oversight of those delegated duties.

The Health Net Medicare and Medicaid Compliance departments report to the Compliance Officer and assist in promoting ethical conduct, instilling a company-wide commitment to Medicare programs compliance, and exercising diligence in detecting and preventing misconduct.

Responsibilities of the Medicare and Medicaid Compliance departments include, but are not limited to:

· Maintaining the Health Net Medicare Compliance Plan and the Medicare Medicaid Plan Compliance Plan;

· Interacting with Health Net's operational business units responsible for administration of the Medicare programs and being involved in and aware of their daily business activities;

· Interpreting applicable regulatory policy and providing guidance to the Health Net business units responsible for administering the Medicare programs;

· Analyzing new or revised regulatory guidance and ensuring distribution of such notices to the Health Net business units responsible for administering the Medicare programs;

· Tracking to ensure appropriate actions are taken by the applicable business unit(s) in response to new or revised regulatory guidance;

· Conducting routine monitoring and focused reviews of high-risk areas;

· Maintaining the Medicare and Medicaid Compliance intranet sites on Health Net Connect as sources of education and information to all associates;

· Developing training products to educate associates about the compliance program and associates' responsibility for administering Medicare programs in a compliant and ethical manner;

· Reporting significant and material compliance issues to the Medicare Compliance Officer; and

· Developing, implementing, and maintaining Medicare programs compliance policies and procedures.

B. Compliance Committee

The Health Net Medicare Compliance Committee and the MMP Compliance Committee are charged with assisting the Health Net, Inc., and subsidiary Boards of Directors and senior management in overseeing the Company's compliance program and serves to advise the Compliance Officer.

The Medicare Compliance Committee and the MMP Compliance Committee are composed of the Medicare Compliance Officer, Ethics Officer, Vendor Management Officer, and Legal Counsel. At a minimum, the Committees also include senior management representing the following departments: Appeals and Grievances, Claims Operations, Customer Contact Center, Delegation Oversight, Health Net Pharmaceutical Services, Information Technology, Marketing, Medical Management, Medicare Operations, Membership Accounting, Organizational Effectiveness, Privacy, Provider Network Management, Quality Improvement, Sales, and the Special Investigations Unit.

The Compliance Committees are chaired by the Compliance Officer or a designee of the Compliance Officer.

The Compliance Committees meets at least quarterly, or more frequently as the Committee members may determine to enable reasonable oversight of the Medicare programs compliance program.

The Compliance Committees are accountable to and provide Medicare programs compliance reports, through the Compliance Officer, to the CEO and Health Net, Inc. Board of Director's Audit Committee regularly, but no less than once per quarter.

Duties of the Compliance Committees include, but are not limited to:

· Reviewing and approving the Medicare Compliance Plan or Medicare Medicaid Compliance Plan including the policies and procedures that support the seven elements of an effective compliance program at least annually, or more frequently depending upon business needs or changes to Medicare program requirements;

· Developing strategies to promote compliance and the detection of any potential violations;

· Ensuring that compliance training and education are effective and appropriately completed;

· Authorizing and reviewing a Medicare programs compliance risk assessment at least annually, or more frequently as needed;

· Assisting with creation and implementation of the Medicare programs monitoring work plans;

· Assisting in the creation, implementation, and monitoring of effective corrective actions;

· Developing innovative ways to implement appropriate corrective and preventive actions;

· Reviewing a system of internal controls designed to ensure compliance with Medicare programs regulations in daily operations;

· Supporting the Compliance Officer's needs for sufficient staff and resources to carry out her duties;

· Ensuring Health Net has appropriate, up-to-date Medicare programs compliance policies and procedures;

· Ensuring Health Net has a system for associates, and FDRs to ask compliance questions, and report potential instances of Medicare program non-compliance and fraud, waste or abuse confidentially or anonymously (if desired) without fear of retaliation;

· Ensuring Health Net has a method for enrollees and other interested parties to report potential fraud, waste, or abuse;

· Reviewing and addressing reports of monitoring and auditing of areas in which Health Net is at risk for program non-compliance or fraud, waste or abuse and ensures corrective action plans are implemented and monitored for effectiveness; and

· Providing regular and ad-hoc reports on the status of compliance with recommendations to the Audit Committee.

C. Governing Body

The Health Net, Inc. Board of Directors exercises reasonable oversight with respect to the implementation and effectiveness of the Medicare programs compliance program.

The Health Net, Inc. Board of Directors delegates Medicare programs compliance program oversight to the Audit Committee, but the Board of Directors as a whole remains accountable for reviewing the status of the Medicare programs compliance program.

The Board of Directors for each of the Health Net subsidiaries that hold contracts with CMS are also obligated to oversee the Medicare compliance program for the MA, Part D, and MMP contracts under their purview. When compliance issues are presented to the Health Net, Inc., or subsidiary Boards of Directors or the Audit Committee, further inquiries are made and appropriate action is taken to address and satisfactorily resolve those issues.

The Compliance Officer has unfettered access to the Health Net, Inc. and subsidiary Boards of Directors and the Audit Committee.

As required by Federal regulations, the Health Net, Inc. and subsidiary Boards of Directors are knowledgeable on the content and operations of the Medicare programs compliance program. The Health Net, Inc. and subsidiary Boards of Directors and the Audit Committee receive compliance training and education as to the structure and operation of the Medicare compliance and FWA program to enable them to be engaged, to ask questions and to exercise independent judgment over the compliance issues with which it is presented. The Health Net, Inc. and subsidiary Boards of Directors and the Audit Committee are knowledgeable about compliance risks and strategies, understand the measurements of outcome, and are able to gauge effectiveness of the Medicare programs compliance program.

Responsibilities of the Health Net, Inc. Board of Directors, directly or through delegation to the Audit Committee, include, but are not limited to:

· Reviewing and approving the Health Net Code of Business Conduct and Ethics;

· Endorsing the Medicare Compliance Plan and the MMP Plan Compliance Plan;
· Reviewing and approving internal audit work plans;
· Reviewing outcomes from internal audits;
· Remaining informed about governmental compliance enforcement activities such as Notices of Non-Compliance, Warning Letters, and more formal sanctions;
· Review of dashboard, scoreboards, self-assessment tools, etc., that reveal compliance issues;
· Approving corrective action plans resulting from internal audits;
· Regularly scheduling updates from the Compliance Officer; and

· Overseeing the senior management team's commitment to ethics and the Medicare programs compliance program.

Responsibilities of the subsidiary Boards of Directors include, but are not limited to:

· Reviewing and approving the Health Net Code of Business Conduct and Ethics;

· Reviewing and approving the Medicare Compliance Plan or MMP Compliance Plan, as applicable;

· Regularly scheduling updates from the Compliance Officer;

· Reviewing and approving the Compliance Officer's performance goals; and

· Reviewing and evaluating and reporting to the Audit Committee on the performance of the Medicare programs compliance program on at least an annual basis.

The Health Net, Inc. and subsidiary Boards of Directors and Audit Committee meeting minutes document the level of their engagement in oversight of the Medicare programs compliance program. Minutes reflect that members of the Boards of Directors ask questions, follow-up on issues, and take action when necessary.

D. Senior Management

The CEO and other senior management are engaged in the Medicare programs compliance program. The CEO and senior management ensure the Compliance Officer is integrated into the organization and has the resources necessary to operate a robust and effective Medicare programs compliance program. The CEO receives regular reporting from the Compliance Officer and/or Corporate Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies. The CEO receives regular reporting of all compliance enforcement, from Notices of Noncompliance to formal enforcement action.

Policy Purpose:

A. To ensure the designation of a Compliance Officer responsible for developing, operating and monitoring the Medicare programs compliance program.
B. To ensure a Medicare Compliance Committee and MMP Compliance Committee are in place.

Scope/Limitations:
This policy and procedure applies to all individuals employed, contracted, or otherwise representing Health Net, Inc. and its subsidiaries and those of any FDRs who participate in the administration of Health Net's Medicare programs.

Related Policies:
· Associate Policy: Designation of Chief Compliance Officers and Obligation of Associates to Support the Compliance Mission (MP927-9829)
· Medicare Programs: Compliance Element I Written Policies and Procedures and
· Medicare Programs: Compliance Element III Training and Education (HR329-83615) Standards of Conduct (PS729-65015)
· Medicare Programs: Compliance Element IV Effective Lines of Communication (HR329-81145)
· Medicare Programs: Compliance Element V Enforcement of Standards (HR329-83126)
· Medicare Programs: Compliance Element VI Monitoring and Auditing (HR810-84520)
· Medicare Programs: Compliance Element VII Prompt Response to Detected Offenses (EJ44-83932)
· Medicare Programs: Medicare Compliance Plan (HR328-1543)
· Medicare Programs: Medicare-Medicaid Plan Compliance Plan (PS69-115231)
· Special Professional Associate Policy: Designation of Chief Compliance Officers and Obligation of Associates to Support the Compliance Mission (SS1112-94822)

References:
Title 42 Code of Federal Regulations (CFR)
· 42 CFR § 422.503(b)(4)(vi)(B)
· 42 CFR § 423.504(b)(4)(vi)(B)

CMS Medicare Managed Care Manual
· Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements – §20.1
· Chapter 21 – Medicare Compliance Program Guidelines §50.2

Prescription Drug Benefit Manual
· Chapter 9 – Medicare Compliance Program Guidelines §50.2

Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with California Department of Health Care Services and Health Net Community Solutions, Inc. - §2.1.2

Health Net Medicare Compliance Plan

Health Net Medicare-Medicaid Plan Compliance Plan

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

Audit Committee
The Committee of the Health Net, Inc., Board of Directors directly responsible for, among other

things, monitoring reports of compliance activities reported by the Chief Compliance Officer.

Centers for Medicare & Medicaid Services (CMS)
The Federal agency within the U.S. Department of Health and Human Services (HHS) that administers the Medicare and Medicaid programs.

Compliance Officer
A Health Net associate responsible, either directly or through delegation, for overseeing the company's compliance program and operations.

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

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

Downstream Entity
Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between Health Net and a first tier entity. These written arrangements continue down to the level of ultimate provider of health, pharmacy and/or administrative services to members.

First Tier Entity
Any party that enters into a written arrangement acceptable to CMS with Health Net to provide administrative services or health care or pharmacy services for a Medicare eligible individual under a MA, Part D, or MMP Plan.

General Services Administration's (GSA)
A centralized authority for the acquisition and management of federal government resources. Among other things, the GSA maintains an electronic, web-based system that identifies parties suspended, debarred, proposed for debarment or otherwise excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits.

Health Net
The term Health Net for the purpose of this policy and procedure is applicable for Health Net, Inc. and its various subsidiaries. The term will also include delegates, such as providers, third party administrators, or other entities who have been delegated responsibility for activities defined in this policy. Health Net Inc. is the ultimate parent company of all Health Net subsidiaries.

Medicaid
A health care program for families and individuals with low income and resources. Medicaid is jointly funded by the state and federal governments and managed by the states, with the states having broad leeway on eligibility determination and implementation of the programs.

Medicare
The federal health insurance program for people 65 years of age or older, certain younger

people with disabilities, and people with End Stage Renal Disease (ESRD).

Medicare Advantage (MA)
A program offered to Medicare beneficiaries by private companies that work in conjunction with Medicare and cover the full range of hospital and doctor services covered under Original Medicare. Also referred to as Medicare Part C.

Medicare Advantage (MA) Organization
An organization that is a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the requirements to offer an MA plan.

Medicare-Medicaid Plan (MMP)
A managed care organization that enters into a three-way contract with CMS and the State to provide covered services and any chosen flexible benefits and be accountable for providing integrated care to Medicare-Medicaid enrollees. Also known as Capitated Financial Alignment.

Medicare Programs
For purposes of this policy and procedure, the term “Medicare programs” includes the Medicare Advantage, Part D Prescription Drug, and Medicare-Medicaid Plan lines of business

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
An organization that the CMS has contracted with to perform specific program integrity functions for Part D under the Medicare Integrity Program. The MEDIC is CMS’ designee to manage CMS’ audit, oversight, and anti-fraud and abuse efforts in the Part D benefit.

Office of the Inspector General (OIG)
The OIG conducts and supervises audits and investigations relating to programs and operations of the DHHS. The OIG has the authority to exclude individuals and entities from Federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE), which provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other Federal health care programs.

Part D
Also referred to as Medicare prescription drug coverage, is a voluntary program offered to Medicare beneficiaries by private companies to subsidize the cost of prescription drugs.

Part D Plan Sponsor
An entity that has a contract with the Federal Government to offer Medicare prescription drug coverage.

Related Entities
Any entity that is related to Health Net by common ownership or control and performs some of Health Net’s management functions under contract or delegation, and furnishes services to Medicare enrollees under an oral or written agreement.

Subsidiaries
Legal entities that report to, or are owned by, a parent company.

U.S. Department of Health and Human Services (HHS)

The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. CMS is a federal agency within the HHS.

Disclaimer:

Deviations:

Approvers:
Policy Author: Jamee E Sunga - Approved on 02/24/2016
Functional Owner: Sheryl D Pessah - Approved on 02/24/2016
Executive Owner: Donovan L Ayers - Approved on 02/24/2016
Mgr Compliance & ReportingCorp: Sheryl D Pessah - Approved on 02/24/2016

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