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Policy Name:	**Medicare Programs: Compliance Element VI Monitoring and Auditing**	**Policy No.:**	**HR810-84520**

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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, MHN
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.

Health Net has established protocols to ensure 1) compliance risks are identified and investigated, and 2) effective monitoring and auditing of its internal business units as well as first-tier, downstream, and related entities (FDR) responsible for administering the Medicare programs.

Risk Assessment

On an annual basis, the Medicare Compliance department performs a baseline assessment of Health Net’s major compliance and fraud, waste, or abuse (FWA) risk areas related to Medicare programs. Identified risks are ranked in order to determine which risk areas will have the greatest impact to Health Net. The baseline risk assessment is reviewed on a periodic

basis throughout the year and updated as deemed appropriate.

Auditing and Monitoring Work Plan

The Medicare Compliance department uses the results of the risk assessment to inform the development of the Health Net Medicare Programs Compliance Auditing and Monitoring Work Plan ("Work Plan"). The Work Plan lists the auditing and monitoring activities to be conducted by or on behalf of the Business Units and first tier entities responsible for administration of Medicare programs.

The activities included in the Work Plan are designed to test and confirm compliance with the MA, Part D, and MMP regulations, sub-regulatory guidance, contractual arrangements, and applicable State and Federal laws, as well as associated internal policies and procedures. Auditing and monitoring activities designed to test and confirm operational components that are not specifically tied to MA, Part D, or MMP regulatory requirements are not included in the Work Plan. Where applicable, the Work Plan includes activities designed to test areas previously found non-compliant to determine if the implemented corrective actions have fully addressed the underlying problem.

The Work Plan includes the following elements for each activity listed:

- The Business Unit or external audit firm responsible for conducting the activity;
- The component, Business Unit, or first tier entity that will be audited or monitored;
- A brief description the responsibilities the component, Business Unit, or first tier entity conducts on Health Net's behalf;
- The date the activity is scheduled to be initiated, started, or reopened;
- The frequency of the activity (ad-hoc, daily, monthly, etc.);
- A brief description of what the auditing or monitoring activity will be focused on;
- Whether or not the activity was initiated based on being identified through a risk analysis or assessment;
- The type of activity (i.e., ad-hoc or routine);
- The audit methodology (i.e., process, outcome, data vs sample review, targeted vs random, etc.);
- Which individuals and/or committees receive reports of the results; and
- When results will be reported.

Auditing and monitoring methodology is determined on a case-by-case basis. As warranted, Health Net uses appropriate methods in:

- Determining sample size;
- Extrapolating audit findings using statistically valid methods that comply with generally accepted auditing standards to the full universe; and
- Applying targeted or stratified sampling methods driven by data mining and complaint monitoring.

FDR Auditing and Monitoring

Various departments within Health Net are responsible for overseeing the ongoing compliance of FDRs responsible for the administration and delivery of Medicare program benefits. These departments include: Delegation Oversight, Health Net Pharmaceutical Services, Provider Network Management, Quality Assurance, Sales, and the Vendor Management Office. Multiple methods are used to monitor and audit FDRs including on-site audits, desk reviews, and monitoring of self-audit reports.

Health Net requires all FDRs to take corrective actions when deficiencies are identified through compliance audits, ongoing monitoring, or self-reporting. Health Net will take administrative action, which may include termination of the contract, if a FDR does not take appropriate corrective action when a deficiency is identified or does not meet its regulatory obligations as outlined in the contract.

Auditing and Monitoring of the Medicare Compliance Program
The Medicare Compliance Officer ensures an annual audit is conducted of the effectiveness of the Medicare compliance program. The audit may be conducted by internal staff other than compliance department staff or under contract with a third party vendor. The results of the Medicare compliance program effectiveness audit are shared with the Medicare Compliance Committee, MMP Compliance Committee, and the Heath Net Board of Director's Audit Committee.

The Medicare Compliance department administers less formal measures of Medicare compliance program effectiveness through completion of a self-assessment tool and other monitoring activities in support of the compliance program effectiveness audit. In addition, the Medicare Compliance department uses the Online Monitoring Tool (OMT) to track and document compliance related activities specific to the Medicare programs including:
- Auditing and monitoring activities conducted by the Medicare Compliance department;
- Issues self-reported to Medicare Compliance by the Business Units responsible for administration of the Medicare programs;
- Auditing and monitoring activities conducted by or on behalf of regulatory agencies;
- Notices of Non-Compliance and other enforcement actions taken by regulatory agencies; and
- Distribution and implementation of new or revised MA and Part D regulatory requirements.

Reporting Results of Auditing and Monitoring Activities
Results of auditing and monitoring activities described in the Work Plan are reported to one or more of the following individuals or committees:
- Applicable Business Unit owner(s);
- Medicare Compliance Officer;
- Chief Compliance Officer;
- Medicare Compliance Committee;
- MMP Compliance Committee;
- Executive Management, and/or
- Health Net Board of Directors' Audit Committee.

Health Net may refer findings indicative of fraud, waste, or abuse to CMS, the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), or law enforcement.

Policy Purpose:
To ensure processes are in place to:
- Conduct a formal baseline assessment of Health Net's compliance risk areas related to Medicare programs;
- Rank the risks to determine which risk areas have the greatest impact to Health Net;
- Prioritize the monitoring and auditing strategy accordingly; and

Conduct monitoring and auditing to test and confirm compliance with MA, Part D, and MMP regulations, sub-regulatory guidance, contractual arrangements, and applicable State and

Federal laws, as well as associated internal policies and procedures.

Scope/Limitations:
This policy 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:

- Delegated Entity Evaluation and Delegation Determination (WB106-104247)

- Delegation Oversight: Corrective Action Plan (GS318-114855)

- Internal Audit Department Policy and Procedure (IAD Charter) (MP38-75840)
- Medicare Compliance: Monitoring Medicare Part D Program Administration (CA913-142334)
- Medicare Compliance - Auditing by CMS or its Designee (HR328-152533)
- 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)
- SIU Oversight & Monitoring (PW323-123443)
- SIU Initial Intake and Assessment of Referrals (PW323-10182)

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

CMS Medicare Managed Care Manual
· Chapter 21 – Medicare Compliance Program Guidelines – Section 50.6

Prescription Drug Benefit Manual
· Chapter 9 – Medicare Compliance Program Guidelines – Section 50.6

Health Net's Medicare Compliance Plan

Health Net's Medicare-Medicaid Plan Compliance Plan

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

Addendum List:
A. Medicare Programs Identified Risk Areas Template
B. Medicare Programs Risk Ranking Tool
C. Medicare Programs Compliance Auditing and Monitoring Work Plan Template

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

Audit

A formal review of compliance with a particular set of internal or external standards used as base measures and performed by someone who has no vested interest in the outcomes or business unit being reviewed.

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.

Business Unit
Health Net operational units, entities, or departments with specific business functionality.

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 and Medicaid programs.

Compliance Contact
A Compliance Department associate responsible for providing guidance and overseeing a wide range of compliance activities for an assigned Business Unit to assure operational and procedural compliance with legislative and regulatory requirements.

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

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

Comptroller General
The director of the Government Accountability Office (GAO), a legislative branch agency established to ensure the fiscal and managerial accountability of the federal government.

Corrective Action Plan (CAP)
A description of the actions to be taken to correct identified deficiencies and to ensure future compliance with the applicable requirements. A CAP usually contains accountabilities and set timelines to return to a compliant state.

Corrective Action Request (CAR)
Notification issued when deficiencies are identified. A CAR typically contains: a description of the deficiencies identified; a description of what is required in order to achieve and maintain compliance; and a request for a CAP

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.

Executive Management
For purposes of this policy and procedure, the term "Executive Management" refers to any of the following officers of Health Net, Inc. or subsidiaries that hold MA, Part D, or MMP contracts

with CMS: Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Compliance Officer (CCO), President, or their designee.

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.

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.

Internal Audit
A department within Health Net that provides independent, objective and comprehensive reviews designed to evaluate and assess the adequacy and effectiveness of various areas of the company.

Medicaid
A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state as each state manages its own program, and is able to set different requirements and other guidelines.

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-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.

Monitoring
Surveillance activities conducted during the normal course of operations and which may not necessarily be independent of the business area being monitored (e.g., self reviews, peer reviews, etc.) Monitoring activities may occur to ensure corrective actions are being implemented and maintained effectively or when no specific problems have been identified to confirm ongoing compliance.

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)

An organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.

Office of the Inspector General (OIG)
The OIG conducts and supervises audits and investigations relating to programs and operations of the DHHS.

Online Monitoring Tool (OMT)
A web-based, hosted oversight and compliance management tool used by the Medicare Compliance department to track Issue Write-Ups, CAPs, regulatory audits, monitoring, and other activities.

On-Going Monitoring
Monitoring activities performed on a scheduled and/or routine basis.

Outcome Monitoring Review
A monitoring activity that confirms if the end result of a process or function is compliant.

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.

Process Monitoring Review
A monitoring activity that examines one or more processing steps, providing assurance that the process is being implemented as planned.

Related Entities
Any entity that is related to Health Net by common ownership or control and
(1) Performs some of Health Net'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 Health Net at a cost of more than $2,500 during a contract period.

Risk Assessment
The identification, measurement and prioritization of likely relevant events or risks that may have material consequences on Health Net's ability to maintain compliance with Medicare program requirements.

Special Investigations Unit (SIU)
A department within Health Net that responsible for detecting, investigating and deterring issues of possible Fraud, Waste and/or Abuse (FWA) in compliance with the laws, rules and regulations applicable to healthcare.

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.

Policy/Procedure:
Medicare Programs Risk Assessment and Work Plan

The Medicare Compliance department:
- Identifies risks to the Medicare program by reviewing, at a minimum:
  - CMS guidance relating to regulatory risks;
  - The OIG work plan;
  - Audit findings from external reviewers (e.g., CMS, OIG, etc.);
  - Enforcement notices from CMS;
  - Complaints filed with CMS (i.e., CTMs)
  - Audit and monitoring findings from internal reviewers (e.g., Business Units, Internal Audit department, Special Investigations Unit (SIU), etc.)
  - Internal operational dashboards, metrics and/or scorecards;
  - Member "touch points" including the Appeals & Grievances, Claims, Customer Contact Center, Membership, Sales, and Marketing departments;
  - Self-identified issues reported by the Business Units;
  - New or revised regulatory requirements;
  - New operational systems or practices; and
  - Corrective Action Plans.
- Adds identified potential risks to the Medicare Programs Identified Risk Areas document (Attachment A);
- Assesses the likelihood of occurrence, possible consequence of each of the identified potential risks, and the current management control level using the Medicare Programs Risk Ranking Tool (Attachment B);
- Assists the Medicare Compliance Committee and the MMP Compliance Committee in prioritizing the high risk areas to determine which will be referred to the Internal Audit department for consideration of inclusion in their audit work plan;
- Determines which risk areas ranked as highest priority and enhanced focus warrant auditing or monitoring by Medicare Compliance, either directly or through delegation to another internal Business Unit or a third party vendor, to supplement or validate existing management controls;

- Coordinates development of the Work Plan with Business Units responsible for auditing and monitoring of Medicare programs related functions;
Note: Risk areas not incorporated into the Work Plan are included in future risk assessments until or unless it is confirmed there are no potential risks remaining.
- Submits the Work Plan to the Medicare and MMP Compliance Committees for review; and
- Tracks activities listed in the Work Plan to ensure they are conducted and reported as scheduled.

<u>Auditing and Monitoring Activities</u>
The Medicare Compliance department:
- Reviews internal operational dashboards, metrics, and/or scorecards received from Business Units to ensure compliance with CMS requirements;
  - Where operational dashboards, metrics, and/or scorecards do not exist or are not adequate, the Medicare Compliance department works with the applicable Business Unit to ensure these are developed;
- Conducts ad-hoc or routine auditing or monitoring activities in situations where internal operational dashboards, metrics, and/or scorecards are not available or to validate self-monitoring results reported by Business Units;
- Uses applicable laws, regulations, and CMS guidance as well as associated internal policies and procedures when developing auditing and monitoring methodology;

- Reviews new and revised policies and procedures;
- Enters and tracks auditing and monitoring results within the OMT;
- Submits a Corrective Action Request to the Business Unit when deficiencies are identified;
- Tracks Corrective Action Plans to completion within the OMT;
- Reports monitoring and auditing results to applicable Business Unit owner(s), Medicare Compliance Officer, and applicable compliance committees; and

As deemed applicable, performs follow-up activities to determine if the implemented corrective actions have fully addressed the underlying problem.

Disclaimer:

Deviations:

Addendum A

Medicare Programs Identified Risk Areas Template

HR810-84520 Addendum A.xlsx

Addendum B

Risk Assessment Ranking Document

HR810-84520 Addendum B.doc

Addendum C

Medicare Programs Compliance Auditing and Monitoring Work Plan Template

HR810-84520 Addendum C.xlsx

Approvers:
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