

HEALTH PLAN POLICY	
Policy Title: Monitoring and Auditing	Policy Number: AC05 Revision: D
Department: Administration	Sub-Department: Compliance
Applies to Product Lines: <input type="checkbox"/> Medicaid <input checked="" type="checkbox"/> USFHP <input type="checkbox"/> Children's Health Insurance Plan <input checked="" type="checkbox"/> Commercial Insured <input checked="" type="checkbox"/> Health Insurance Exchange <input checked="" type="checkbox"/> Non-Insured Business <input checked="" type="checkbox"/> Medicare	
Origination/Effective Date: 12/09/14	
Reviewed Date(s):	Revision Date(s): 03/04/2016, 09/28/2017, 08/23/2018, 08/14/2019

SCOPE:

The purpose of this policy is to continuously evaluate compliance, detect potential violations, and establish and implement an effective system for routine monitoring and auditing of internal business units and first tier, downstream and related entities (FDRs).

DEFINITIONS AND ACRONYMS:

- **Audit** – A formal review of compliance with a set of standards (e.g., policies and procedures, laws and regulations) used as base measures.
- **Downstream Entity** – Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization (MAO) or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health plan and administrative services.
- **First Tier Entity** – Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage Program or Part D program.
- **Fraud, Waste, Abuse (FWA)**
- **Monitoring** – Regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

POLICY:

The health plan must undertake monitoring and auditing to test and confirm compliance with sub-regulatory guidance, contractual agreements and all applicable state and federal laws, as well as internal policies and procedures.

A. Monitoring¹

- Internal Risk Assessment
 - Compliance will conduct a formal baseline assessment of the organization's major compliance and fraud, waste and abuse areas.
 - Each operational area will be assessed for the types and levels of risks the area presents to the

¹ CMS Medicare Managed Care Manual, Chapter 21, Compliance Program Guidelines, 50.6.2.
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf>

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health plan.

- Factors considered in determining the risk associated with each area include, but are not limited to:
 - Size of department;
 - Amount of training that has taken place;
 - Past compliance issues;
 - Regulatory audits and oversight activities.
 - Risks identified by the risk assessment will be ranked to determine which risk areas will have the greatest impact on the health plan, and together with the operational areas, compliance will prioritize the monitoring and auditing strategy accordingly.
 - A risk assessment will be completed at least annually, or more often if business needs require. There will be an ongoing review of potential risks of non-compliance and fraud, waste and abuse (FWA).
 - Performance Indicators
 - Compliance will work with each operational area to identify appropriate performance benchmarks or indicators to assess compliance with applicable laws, regulations and company policies. This will include establishing a frequency appropriate to the nature of the process and relative risk it represents.
 - Examples of possible performance indicators include, but are not limited to:
 - Process cycle time;
 - Timeliness and appropriateness of member notices;
 - Compliance of contracted first-tier, downstream and related entities (FDR);
 - If a process involves more than one operational area, performance indicators must be developed to measure each area's compliance with the requirements for its portion of the process.
- B. Auditing²** - The compliance department will conduct or facilitate operational and first tier audits sufficient to evaluate the health plan's level of compliance with applicable laws, regulations and company policies. All compliance audits will be appropriately planned and structured according to established methodology and accepted tools and standards.
- Focused audits: The compliance officer will arrange focused audits of specific departments, FDRs or other areas as necessary. Focused audits may result from risk assessment results, departmental monitoring, regulatory concerns, associate incident reporting or any other credible indicators.
 - Routine Audits: The compliance officer will periodically schedule routine audits of the health plan departments or FDRs, as necessary and at a frequency to be determined by the compliance officer and compliance committee.
 - FDRs Audits³: The health plan's contractual agreements with FDRs provide for routine and random

² CMS Medicare Managed Care Manual, Chapter 21, Compliance Program Guidelines.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf>

³ CMS Medicare Managed Care Manual, Chapter 21, Compliance Program Guidelines.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf> , 50.6.6

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auditing. Where FDRs perform their own audits, the compliance department may request a copy of the FDRs audit work plan and request the audit results. When corrective action is needed, the compliance department will ensure that corrective actions are taken by the entity. Reports that the compliance department may review as part of FDR monitoring and auditing include, but are not limited to:

- Payment reports;
- Drug utilization reports;
- Provider utilization reports;
- Prescribing and referral patterns by physician's reports;
- Geographic zip reports.

C. Follow-up and Corrective Action⁴

- Corrective actions must be designed to correct the underlying problem that results in program violations, prevents future non-compliance and must include timeframes for specific achievements.
- When there are severe monitoring results, the compliance officer and the department manager/director will determine next steps, such as conducting a focused audit.
- Confirmed problems or cases of noncompliance must be remediated with appropriate corrective action. Refer to the corrective action policy.

D. Compliance Auditing and Monitoring Work Plan⁵ - The compliance officer, with input and approval of the compliance committee, will develop and publish an annual compliance monitoring and auditing work plan. The compliance work plan is subject to review and revision throughout the year as new indicators for focused audits may emerge. The compliance work plan includes:

- Audits to be performed;
- Audit schedules, including start and end dates;
- Announced and/or unannounced audits;
- Audit methodology;
- Necessary resources;
- Types of audit (desk or onsite);
- Number of FDRs that will be audited;
- Person(s) responsible;
- Final audit report due date; and
- Follow up activities or corrective action from findings.

⁴ CMS Medicare Managed Care Manual, Chapter 21, Compliance Program Guidelines.
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf> , 50.7.2

⁵ CMS Medicare Managed Care Manual, Chapter 21, Compliance Program Guidelines.
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf> , 50.6.3

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E. Reporting⁶

- Audit findings that represent significant risk to the organization will be reported immediately to the CEO and the governing board. If an issue contributes to any member impact or potential member impact, self-disclosure to the appropriate regulatory agency will occur.
- The compliance officer will prepare a quarterly report of the status of the compliance work plan. The report will summarize:
 - Audit objectives;
 - Scope and methodology;
 - Results of current audits included detected issues; and
 - Recommendations
- The report will be presented to the compliance committee at least quarterly.

REFERENCES:

- CMS Medicare Managed Care Manual, Chapter 21, Compliance Program Guidelines, with specific subsections as noted throughout the policy.
- 42 CFR §423.501

RELATED DOCUMENTS:

None

⁶ CMS Medicare Managed Care Manual, Chapter 21, Compliance Program Guidelines.
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf> , 50.6.4


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 Nancy Horstmann
 Chief Executive Officer Health Plans

8/23/19
 Date



 David Engleking, M.D.
 Medical Director Health Plans

8/23/19
 Date

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	12/09/2014	Initial release.	Board of Directors
A	03/04/2016	Yearly review – updated to current template. Updated Definitions and Acronyms.	Board of Directors
B	09/28/2017	Yearly review. No content changes. Changed signatory to reflect CEO.	Board of Directors
C	08/23/2018	Compliance review	Executive Leadership
D	08/14/2019	Annual review. Updated section E. Reporting, and miscellaneous verbiage throughout the policy.	Executive Leadership