THE UNIVERSITY OF ARIZONA
HEALTH PLANS

SUBJECT: COMPLIANCE OFFICER RESPONSIBILITIES

POLICY: CP 6221

Department of Origin: Compliance Department
Responsible Position: Director of Compliance

Date(s) of Review and Revision: 04/08; 10/08; 04/09; 07/10; 04/11; 02/12; 05/13; 08/13; 01/14; 12/14; 12/15; 2/16; 09/16
Policy Replaces: AD 203; AD 221; AD 221 SNP; CP 221; CP 221 SNP

Department Approval:

Approval has completed on CP 622

PURPOSE

The University of Arizona Health Plans (Health Plan) Compliance Officer is responsible for ensuring Health Plan employees understand the Compliance Program, regulations, remain compliant with these regulations, and have access to reporting non-compliant actions of other employees, members, providers and vendors.

APPLICABILITY

This policy applies to all Lines of Business.

POLICY

To ensure that the Health Plan employees understand their roles in the Compliance Program and understand the duties of the Health Plan Compliance Officer.

DEFINITIONS

N/A

PROCEDURE

1.0 The Compliance Officer serves in an independent role as the primary focal point for compliance activities, with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection and reporting such as provider registration, prior authorization and contracts. This person has the primary responsibility of overseeing and monitoring the implementation of the Compliance Program, and ensuring that all policies and procedures are accurate and implemented and integrated into Health Plan's operations. Coordination and communication are key functions of the Compliance Officer.

2.0 The Compliance Officer must reside in the State of Arizona, be a full time employee of the Health Plan, and report directly to Health Plan's CEO, and has express authority to provide unfiltered, in-person reports to the Health Plan's Board of Directors at the Compliance Officer's discretion. The Board advises the Compliance Officer and assists in implementing the Compliance Program.

3.0 The Compliance Officer need not await approval of the Health Plan's Board of Directors to implement needed compliance actions and activities.

4.0 The Health Plan may use delegated subcontractors for compliance activities such as monitoring, auditing and training; however, the Health Plan does not delegate compliance program administrative functions to Health Plan subcontractors, including the role of Compliance Officer.

5.0 The Health Plan Compliance Officer has the following responsibilities:

5.1. Provide periodic reports directly to the Health Plan's Board of Directors on the activities and status of the Compliance Program, including issues identified, investigated and resolved by the Compliance Program.

5.2. Be vested with the day-to-day operations of the Compliance Program, define the Compliance Program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures and compliance expectations for all Health Plan employees, Board of Directors and subcontracted vendors.

5.3. Oversee and monitor the implementation of the Compliance Program.

5.4. Answer any employee, provider and subcontractor questions concerning compliance issues that cannot readily be answered by referencing the Compliance Program. Employees are directed to contact the Compliance Officer with any questions regarding compliance practices that are not adequately addressed by their immediate supervisor.

5.5. Develop and participate in educational and training programs that focus on compliance issues. Ensure employees and management, including Quality Management and Performance Improvement (QMPI) Committee members, are informed and comply with applicable federal and state regulations, standards, sub-regulatory guidance and the Health Plan's Code of Conduct. Ensure Compliance Program educational and training programs extend to

subcontractors and providers providing health and administrative services to Health Plan.

5.6 Ensure procedures are in place to screen monthly for ineligible providers, employees, Board of Directors and subcontractors. These individuals must not appear in the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), formerly EPLS, the National Plan and Provider Enumeration System (NPPES) and any other databases directed by AHCCCS or CMS. Coordinate any resulting personnel issues with the Health Plan's Human Resources, Security, Legal or other departments, as appropriate.

5.7 Create, periodically review and revise policies, reporting procedures, programs and communication materials that are well defined and published which encourage and prompt all employees to report program noncompliance and suspected fraud, waste and abuse and other improprieties to meet changing regulations and trends. This responsibility includes communication of non-retaliation policies and employee protection measures to all personnel.

5.8 To ensure that the most current government policies and procedures are reflected, annually review and/or revise the Compliance Program and Health Plan code of conduct.

5.9 Verify that all Health Plan policies reflect current coverage determinations or payment alerts and applicable regulations, statute and guidance.

5.10 Ensure the annual Compliance Program is reviewed and approved by the Compliance Committee and Board of Directors. Once approved, ensure distribution to all employees and required elements to subcontractors.

5.11 Ensure that all government and operational materials and manuals that Health Plan employees utilize are current and updated on a regular basis.

5.12 Objectively and independently investigate and act on compliance issues, and design and direct internal investigations and any subsequent corrective measures with all departments, subcontractors and providers providing health and administrative services to Health Plan.

5.13 Ensure that compliance reports are provided regularly to the Health Plan's CEO, Board of Directors and Compliance Committee. Reports should include the status of the Compliance Program implementation, solutions to reduce the health plans' exposure to fraud, waste and abuse, the identification and resolution of suspected, detected or reported instances of noncompliance, and the Health Plan's compliance oversight and audit activities.

5.14 Hold periodic meetings with Health Plan's management team to review the status of the Compliance Program.

5.15 Respond to reports of potential and observed instances of fraud, waste or abuse; coordinate internal investigation and oversee the development and monitoring of the implementation of appropriate corrective or disciplinary actions as necessary.

5.16 Immediately notify the Health Plan's Chief Executive Officer of any reportable event (self- disclosure).

5.17 Maintain documentation for each report of potential fraud, waste or abuse received through any reporting method that summarizes the initial report of

non-compliance, the investigation, the results of the investigation and all corrective and/or disciplinary action(s) taken as a result of the investigation.

5.18 Designated and recognized authority to access records and make independent referrals to the AHCCCS Office of Inspector General (OIG) and the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC).

5.19 Regularly attend and participate in AHCCCS, Office of Program Integrity work group meetings, CMS training, compliance meetings and fraud waste and abuse meetings.

5.20 Be aware of daily business activity by interacting with the operational units of the Health Plan.

5.21 Maintain the compliance reporting mechanism and closely coordinating with the internal audit and fraud, waste and abuse employees.

5.22 Collaborate with other programs, commercial payers and other organizations where appropriate, when a potential fraud, waste and abuse issue is discovered that involve multiple parties.

5.23 Have the authority to interview employees and other relevant individuals regarding compliance issues.

5.24 Review company contracts and other documentation pertinent to the AHCCCS and CMS programs.

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

5.26 Independently seek advice from legal counsel.

5.27 Report potential fraud, waste or abuse to AHCCCS, CMS its designee or law enforcement.

5.28 Conduct and/or direct audits and investigations of any subcontractors.

5.29 Conduct and/or direct audits of any Health Plan area or function involved with AHCCCS and Medicare Programs.

5.30 Recommend policy, procedure and process changes.

6.0 Routine Communication/Access to the Compliance Officer

6.1. An open line of communication between the Compliance Officer and personnel is critical to the success of the Compliance Program.

6.2. Employees are expected to report anything that violates the laws or regulations relating to AHCCCS, CMS or any other State or Federal law. Health Plan employees are required to report any concerns to a supervisor, the Compliance Officer or Health Plan's CEO. Any employee or agent who is either aware of a violation of the law or regulation and does not report it, or who is not aware of a violation of a law or regulation that the individual should have detected, is subject to disciplinary action, up to and including termination of employment.

6.2.1. Health Plan employees first discuss their questions or concerns with a supervisor. If they feel uncomfortable discussing the issue with a supervisor, or believe the supervisor has not properly addressed the concerns, they contact the Compliance Officer or Health Plan's CEO.

6.3. Health Plan employees seeking advice from the Compliance Officer have the option to remain anonymous and all inquiries are confidential subject to the limitations imposed by law.
6.4. Health Plan employees may make a report without fear of retaliation. Retaliation is prohibited against those who, in good faith, report inappropriate activities. Good faith is defined as a full, fair, accurate and timely disclosure.
6.5. The Health Plan maintains a toll-free hotline for individuals to ask questions or raise concerns in a confidential manner. If an employee or agent makes an anonymous report, they are provided with a reference number for future contact. The reported concern is then forwarded to Health Plan's Compliance Officer for investigation.

7.0 Compliance Committee Oversight
7.1. The Compliance Officer convenes and chairs the Compliance Committee in which the development, documentation, and periodic audit/review of internal controls and training of risk areas are reviewed. The Compliance Committee meets at least quarterly to ensure that compliance and compliance-related activity are consistently applied.
7.2. The Compliance Committee oversees the Compliance Program, advises the Compliance Officer and assists in implementing the Compliance Program. The Compliance Committee has the following responsibilities regarding compliance activities:
7.2.1. Evaluate the industry environment, the legal requirements with which it must comply, and the specific risk areas.
7.2.2. Assess existing policies and procedures that address these areas for possible inclusion in the Compliance Program.
7.2.3. Work with the appropriate departments to develop standards of conduct and policies to promote allegiance with Compliance Program.
7.2.4. Recommend and monitor, in conjunction with appropriate departments, the development of internal systems and controls to carry out the Health Plan's standards, policies and procedures as part of its daily operation.
7.2.5. Determine the best strategy to promote compliance with the Compliance Program and detect any potential violations.
7.2.6. Approve a system to solicit, evaluate and respond to complaints and problems.
7.2.7. Monitor internal and external audits and investigations to identify troublesome issues and deficient areas and implement corrective and preventive action.

8.0 The auditing and monitoring process is an ongoing evaluation process that is critical to having a successful Compliance Program. This includes monitoring; auditing, process improvement implementation and regular reporting to Health Plan Executives.
8.1. Compliance reports created by the monitoring process, including reports of noncompliance, are maintained by the Compliance Officer and reviewed by Health Plan's CEO.
8.2. Audits of the Compliance Program focus on at-risk areas and information that may affect payments from AHCCCS and Medicare. Monitoring techniques may

include sampling protocols that permit the Compliance Officer to identify and review variations from an established baseline. Any deviations are reported immediately and steps are taken to correct the problem. Health Plan reports any deviations that could affect AHCCCS immediately to AHCCCS and those that could affect CMS immediately to CMS.

8.3. Annual audits take place to determine the performance of the Compliance Program. 8.31 to 8.3.4.XX are example audits of such periodic reviews but do not represent all potential audits.

8.3.1. Procedures and practices are audited internally on a yearly basis by the Health Plan Compliance Officer. The audits include: Discussions with personnel involved in management, operations, customer care, medical delivery and other related operational areas.

8.3.2. Auditing and monitoring regarding underutilization and quality of care are conducted. Health Plan ensures quality of care remains high and there is no underutilization of services.

8.3.3. Auditing and monitoring of data collection and submission processes take place.

8.3.3.1. The Health Plan ensures there are random checks of encounter data to assure accuracy, completeness and truthfulness to the best of Health Plan's knowledge.

8.3.4. Auditing and monitoring for anti-kickback and other inducements is completed.

8.3.4.1. The Health Plan's legal department periodically performs a legal review of random contracts with marketing representatives to ensure adherence to anti-kickback and other applicable statues and regulations.

8.3.4.2. The Health Plan's legal department periodically performs a legal review of random contracts and assesses communications with providers to ensure compliance with anti-kickback and other applicable statutes and regulations.

8.3.4.3. The provider contracts require that Health Plan have access to member medical records as appropriate.

8.3.4.4. At the conclusion of any audit, the Compliance Officer and participating auditors may be requested to present the findings of the audit at the first regularly scheduled Health Plan Compliance Committee meeting after the conclusion of the audit.

8.3.4.5. Health Plan Compliance Committee members review the audit results and may recommend corrective action. The auditors also have pre-determined criteria based on AHCCCS and Medicare requirements and may issue a corrective action when audit results demonstrate non-compliance. Corrective action reports are provided to the Compliance Committee to ensure Committee awareness of all auditor-issued corrective actions.

8.3.4.6. These internal audits also incorporate periodic reviews of whether the program's compliance elements have been satisfied. The Health Plan Compliance Officer determines the areas upon which the audit focuses.

PERFORMANCE AND OUTCOME MEASURES

1.0 The Compliance Officer shall ensure the performance of all responsibilities as required by state and federal law, rule, regulation, policy and requirements.

REFERENCES

1.0 AHCCCS Contract; Paragraph 62 – Corporate Compliance
2.0 AHCCCS Contractors Operating Manual, Policy 103
3.0 Medicare Managed Care Manual – Chapter 11; Section 20
4.0 CFR 422.503 General Provisions

ASSOCIATED POLICIES AND PROCEDURES

1.0 Health Plan Policy – CP 6018; Fraud, Waste and Abuse
2.0 Health Plan Policy – AD 6003; New Employee Orientation and Ongoing Training
3.0 Health Plan Policy – CP 6001; Compliance Program
4.0 Health Plan Policy – CP 6227; Monitoring and Auditing
5.0 Health Plan Policy – CP 6019; Fraud, Waste and Abuse – FDR Awareness
6.0 Health Plan Policy – CP 6018; Fraud, Waste and Abuse – Employee Awareness
7.0 Health Plan Policy – CP 6230; Custodian of Records
8.0 Health Plan Policy – ND 6003; Provider Notification and Communication Methods
9.0 Health Plan Policy – ND 6002; New Provider Orientation
10.0 Health Plan Policy – ND 1112 A; Provider Office Visits
11.0 Health Plan Policy – QM 6009; QM/PI Committee

ATTACHMENTS

N/A