Medicare Compliance Program
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### Definitions

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AHCCCS</td>
<td>Arizona Health Care Cost Containment System</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>CTM</td>
<td>CMS Complaints Tracking Module</td>
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<td>EPLS</td>
<td>Excluded Parties List System</td>
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<td>FDR</td>
<td>First Tier, Downstream and Related Entity</td>
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<td>FWA</td>
<td>Fraud, Waste, and Abuse</td>
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<td>GSA</td>
<td>General Services Administration</td>
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<td>HMO</td>
<td>Health Maintenance Organization</td>
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<td>LEIE</td>
<td>List of Excluded Individuals and Entities</td>
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<td>MAPD</td>
<td>Medicare Advantage Prescription Drug</td>
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<td>MCA</td>
<td>Mercy Care Advantage</td>
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<td>MEDIC</td>
<td>Medicare Drug Integrity Contractor</td>
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<td>MIPPA</td>
<td>Medicare Improvements for Patients and Providers Act</td>
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<td>MOC</td>
<td>Model of Care (required by CMS for SNP plans)</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<td>SCHN</td>
<td>South West Catholic Health Network</td>
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<td>SIU</td>
<td>Special Investigations Unit</td>
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<td>SNP</td>
<td>Special Needs Plan</td>
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Section 1. Introduction and Background of Sponsoring Organization

This document has been developed by the Medicare Compliance Officer to serve as a road map for the Southwest Catholic Health Network (SCHN) d/b/a Mercy Care Advantage, (a HMO SNP referred to as “Mercy Care”) to meet the obligations specified in regulations and guidance issued by the Centers for Medicare and Medicaid Services (“CMS”) and the Health and Human Services Office of the Inspector General (“OIG”) for compliance plans. For purposes of this document, the organization is referred to as “Health Plan”. There are (7) elements for compliance programs which are specifically defined within the CMS Compliance Program Guidelines found in Chapter 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

This document provides an overview of the Medicare Compliance Program (“Program”). The Program is designed to prevent, detect, and correct Part C and D Medicare Program non-compliance and fraud, waste and abuse (“FWA”). This Program is comprised of the following elements each of which are described in more detail within the subsections of this document:

- A Medicare Compliance Officer, a Medicare Compliance Committee, and oversight of the Compliance Program;
- Written policies, procedures and standards of conduct;
- Compliance training and education for employees and first tier, down steam and related entities (FDRs);
- Effective lines of communication;
- Internal monitoring, auditing and identification of compliance risks;
- Enforcement of standards through well publicized disciplinary guidelines;
- Responding promptly to detected offenses, development of corrective actions and reporting to Government; and
- A comprehensive fraud and abuse plan to detect, correct, and prevent fraud, waste, and abuse.

A first tier delegated Plan Management Service Agreement exists between Aetna and Southwest Catholic Health Network, the sponsoring organization contracted with the Centers for Medicare and Medicaid Services. Under the Plan Management Services Agreement, both Aetna and Aetna Medicaid Administrators, LLC, are responsible to provide daily operational plan management services for the Mercy Care and Mercy Care Advantage Plans. This Medicare Compliance Program along with the Medicare Compliance policies and procedures and the Aetna standards of conduct, Code of Conduct and the operational policies, desktops, procedural guides and tools maintained by Aetna and the Health Plan collectively comprise the Medicare Compliance Program.

Under the first tier delegated Plan Management Services Agreement, Aetna has implemented standards of conduct, referred to as the Aetna Code of Conduct and provides certain shared services such as the Special Investigations Fraud, Waste, and Abuse (FWA) Unit to assist in providing the services and support required for the daily administration of the Mercy Care Advantage contracting requirements. Aetna and the Health Plan are committed to conducting business in an ethical and professional manner and in full compliance with federal and state laws, regulatory and sub-regulatory guidance that are applicable to the Medicare Advantage Prescription Drug (MAPD) plans administered under contract with CMS.

The Medicare Compliance Officer and compliance staff is responsible for managing and implementing the Program and will work collaboratively with the Senior Management team, SCHN Audit and Compliance Committee and Aetna Corporate Compliance to monitor business activities, identify, and elevate compliance risks, and resolve identified concerns and risk issues. Medicare Compliance is responsible for the following:

- Interpret, distribute, and explain new and revised regulatory guidance
- Help identify and consult with business areas to resolve compliance risks and concerns
- Audit business activities where there are Medicare requirements for compliance and support these areas in the implementation of mitigating actions taken to achieve compliance
- Continuous assessment and reporting of compliance for key performance metrics
- Monitor timely development, implementation and employee completion of training program requirements
• Communicate and coordinate with Regulatory Agencies, Medicare business and Mercy Care Leadership
• Review business policies, procedures and practices for compliance

The Program is reviewed and revised annually to incorporate process changes and/or upon release of new regulations and law. When updated, the Program is distributed to the Medicare Compliance Committee and SCHN Audit and Compliance Committee, which includes members from the Board of Directors for review and approval. The Program is available to employees, temporary employees, and volunteers on the Medicare Compliance Share Point site. On an annual basis, the Medicare Compliance Officer will distribute an overview of the Medicare Compliance Program requirements electronically to all employees and explain how to contact Medicare Compliance with any questions about the Program. Contracted first tier, down steam and related entities (FDRs) receive a copy of the Program and compliance policies electronically at the time of contract and annually thereafter.

An annual evaluation of the Program is required to validate its effectiveness for timely identification and remediation of compliance risk issues. CMS recommends persons other than the Health Plan’s Compliance Officer and/or compliance department conduct this evaluation. The preferred method is use of an external reviewer and the outcome of the evaluation and any follow up actions must be shared with senior leadership, the Medicare Compliance and SCHN Audit and Compliance Committees and governing body.

Health Plan leadership and Aetna are committed to making Compliance a Core Competency throughout the company. Compliance as a Core Competency means creating and maintaining a company culture where employees at all levels are committed to:
• Meeting our legal and regulatory obligations
• Honoring commitments and keeping our promises
• Doing the right things for the right reasons, and asking for help when the choices aren't clear
• Behaving ethically
• Raising problems and concerns as soon as they come to light so they can be addressed

Because of this commitment, compliance is also an important measure used in employee performance evaluations.

Background of Sponsoring Organization

Southwest Catholic Health Network Corporation d/b/a “Mercy Care Plan” is a not-for-profit provider sponsored organization jointly sponsored by Dignity Health organization (through subsidiary St. Joseph’s Hospital and Medical Center) and Ascension Health (through Carondelet Health Network of Arizona). Mercy Care Plan was formed in 1985 to provide Medicaid services in the State of Arizona through a contract with the Arizona Health Care Cost Containment System (AHCCCS). Mercy Care Plan has three decades of experience in working the Medicaid funded programs and was one of the first AHCCCS health plans. Today, Mercy Care Plan actively participates in all of the AHCCCS programs, including Arizona Long Term Care Services (ALTCS), Acute Care, and Developmentally Disabled. Mercy Care Advantage (“MCA”) is a Coordinated Care Plan that integrates Medicare and Part D prescription drug coverage with Medicaid medical benefits. MCA began coordinating care for the specialized dual eligible population as of January 1, 2006.
Section 2. Medicare Compliance Officer, Compliance Committee, and Oversight Structure

The Medicare Compliance Officer (MCO) supporting Mercy Care Advantage is a full time, experienced employee of Dignity Health, one of the co-sponsoring organizations accountable for Mercy Care Plan. The MCO is primarily responsible to act as the principal leader in the oversight, development, and implementation of the Program. The MCO serves as the Chair of the Medicare Compliance Committee (MCC) to oversee implementation and monitor the execution of the Program with the MCC and support of compliance personnel. The MCO has “dotted line” reporting responsibility to the Chief Executive Officers of each health plan and the Head of Medicare Products. The MCO provides unfiltered reports to the Audit and Compliance Committee of the Board of Directors for Southwest Catholic Health Network. The MCO has access to company personnel, documents, legal counsel, operational units, first tier, downstream, and related entities (FDRs), as needed to support the Program activities.

I. Medicare Compliance Officer

The MCO is an executive manager in a senior-level position responsible for developing, operating and administering the day-to-day operations of the Program. The MCO supports the Health Plan staff and contracted FDRs in performing their respective job functions, operations and activities in compliance with all federal and State laws, meet applicable regulatory requirements and conduct themselves in conformity with the required standards of conduct described in the Aetna Code of Conduct as required.

The MCO has the following duties, including, but not limited to:

a. Regularly creating and delivering reports, as applicable, such as:
   • Monthly Medicare Compliance Report for CEO, COO and Medicaid Steering Committee
   • Medicare Compliance Report for SCHN Audit and Compliance Committee
   • Annual Compliance Program Effectiveness Report
b. Ensuring Executive Leadership, MCC, Audit and Compliance Committees, and the governing body is aware of Program activities including risk issues identified, investigated, and resolved as well as regulatory enforcement actions, audit results, and corrective action activities implemented.
c. Acting as the Medicare Compliance central point of contact for internal and external constituents.
d. Attending and providing compliance support for operational business sub-committees and meetings.
e. Providing timely and accurate responses to regulatory inquiries.
f. Oversee the creation and maintain Medicare specific compliance and FWA policies.
g. Collaborating with management on the development and implementation of effective training for employees who have responsibility for MCA operations and Model of Care requirements.
h. Ensuring new federal and state law and regulations applicable to the Medicare Advantage Prescription Drug (MAPD) program are reviewed and disseminated in an educational format to the appropriate operational staff on a timely basis and monitored for implementation. This includes the review of any issuance by government agencies such as the OIG and CMS including fraud alerts, special advisories, or proposed and final rules.
i. Coordinating, overseeing, and conducting regular compliance audits to monitor performance and compliance with applicable federal and state standards. Overseeing the development, implementation and monitoring of corrective action plans.
j. Requiring impacted departments, employees, and/or sub-contractors to implement corrective action(s), as appropriate, upon completion of internal investigation of identified compliance risk issues.
k. Monitoring Health Plan compliance with developing and submitting Part C and D reporting data reporting information in accordance the guidelines and timelines established by CMS.
l. Oversee and monitor that required training is completed at time of hire and annually to ensure that the Health Plan’s officers, directors, managers, employees (including temporary employees & volunteers) , FDRs, and other individuals working on the Medicare program are knowledgeable about the Compliance Program, Code of Conduct, FWA training, policies, procedures, and statutory and regulatory requirements.
m. Promote through education and other activities, the no-tolerance policy for retribution or retaliation against any good faith reporting conducted by employees and FDRs.

n. Oversee and monitor the completion of routine verification of employees, officers, directors, contractors and temporary employees and volunteers supporting MCA are checked against the Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS) exclusion lists prior to hire and monthly thereafter. Verify contracted FDR compliance during routine compliance audits.

o. Support the Health Plan efforts to monitor and oversee first tier, downstream and related entities (FDRS) contracted to perform functions on behalf of MCA plans.

p. Support and coordinate with Aetna’s Special Investigations Unit (“SIU”) through monitoring, coordination of reporting and data analysis to review reports of potential and confirmed instances of Medicare and Medicaid FWA. Support internal investigations and development of appropriate corrective or disciplinary actions, as required; including making necessary revisions to Health Plan policies and procedures.

q. Routinely participate in the MCP/MCA FWA Committee to discuss fraud or misconduct cases identified for the Health Plan’s Medicare and Medicaid lines of business to support timely reporting to the NBI MEDIC, AHCCCS, law enforcement and/or other applicable government authorities as required. Review actions implemented by the Health Plan and Aetna to resolve issues and keep senior management and the Audit and Compliance Committee apprised of identified and reported incidents.

II. Medicare Compliance Committee (MCC)

The MCC oversees the Program and is comprised of management staff from the various operational business units. Through the MCO, the MCC regularly reports its activities and findings to the CEO, Audit and Compliance Committee, and governing body. The MCC is chaired by the MCO and meets at least quarterly. An MCC Charter is maintained and describes the committee’s obligations. Please refer to the Reference Documents section for the Medicare Compliance Committee Charter.

III. Governing Body

Southwest Catholic Health Network (SCHN) has an established Board of Directors and several sub-committees to oversee Health Plan compliance with legal and regulatory requirements. The Health Plan’s Senior Leadership meets on a regular basis, but no less than quarterly with the Audit and Compliance sub-committees and the full Board of Directors. Several members of the Board of Directors attend the Audit and Compliance Committee. The Audit and Compliance sub-committee identifies standing agenda topics and reports prior to the beginning of each calendar year. The Medicare Compliance report is a required standing report.

The Medicare Compliance Officer develops a Medicare Compliance report for each Audit and Compliance Committee. Reports include details on the status of Program and related activities, including but not limited to: compliance or operational risk issues identified, investigated, and resolved, Non-Compliance Notices issued by CMS, results of internal and/or federal performance audits and corrective action activities implemented, and new regulatory requirements.

The Medicare Compliance report is included as part of the Audit and Compliance Committee agenda documents distributed to the each committee member in advance of the meeting for review. The MCO presents the Medicare Compliance report during the meeting and addresses questions raised. If the MCO is unable to attend a meeting, a representative from Compliance department will attend to present the report on behalf of the MCO. Additional actions requested by the committee are captured in the meeting minutes and status updates from the MCO are shared at the next scheduled meeting or via email depending on urgency of the issue. Issues raised by the MCO that require action or support from the Board, are documented in the meeting minutes, and presented to the governing body by the Chair of the Audit and Compliance Committee and the members of the Board who attended the Audit and Compliance committee. The Health Plan and Board maintain copies of the SCHN Audit and Compliance Committee agendas, reports, and minutes.
IV. Senior Leadership and Sub-Committee Engagement

Mercy Care Plan and Medicare Compliance work collaboratively to implement processes that provide effective oversight, monitoring, reporting, and corrective action for identified risks issues. Listed below are the key standing committees that support the monitoring and oversight efforts of the Program. Reports and information obtained from these committees are reported to the Medicare Compliance Committee and the Audit and Compliance Committees.

Executive Council
Executive Council consists of senior leadership staff that meets regularly to discuss new and existing business initiatives, operational and compliance issues. At this meeting, the MCO reports identified compliance risks and other compliance initiatives, audit activities and new regulatory guidance.

MCA Joint Operating Committee
The MCA Joint Operations Committee is a monthly sub-committee of the Medicare Compliance Committee and is chaired by the Director of Medicare Product. The committee includes Medicare Compliance and business management representatives. The objective of this committee is to:

- Discuss operational issues and identified compliance risks/concerns;
- Discuss existing and new business initiatives;
- Share performance metrics, recommend and monitor controls of daily Medicare operations and the Model of Care;
- Discuss internal compliance and external government audits for the purpose of identifying material compliance issues and implementing corrective actions
- Discuss new regulatory changes and monitor timely business implementation and policy development

Delegation Oversight Committee
The Delegation Oversight Committee meets at least six times per year or more often as deemed necessary to track, monitor, and oversee contracted FDR arrangements with existing and new FDRs. The Delegation Oversight Committee also validates performance results and compliance with applicable laws, rules, and regulations with respect to Medicare Part C and D programs. The Delegation Oversight Committee, with support from the Medicare Compliance Officer is responsible to train and educate internal designated staff on the FDR contracting requirements. The committee is responsible to review and evaluate new FDR proposals received for delegation to analyze if the function requested is appropriate for delegation to the FDR identified. If approved, the committee will oversee the pre-delegation audit and review the results to validate the FDR is able to comply with the performance and regulatory requirements for the functions that will be delegated. In addition, the committee will track and monitor that the Compliance and Fraud, Waste, and Abuse training requirements are communicated to contracted FDRs at time of contact and annually.

Aetna Medicare Compliance Support
Aetna’s Corporate Medicare Compliance Department provides the MCO with consultative services on an as needed basis, but the MCO retains control over and independent judgment on behalf of the MCA Compliance Program.
Section 3. Policies and Procedures, and Code of Conduct

I. Code of Conduct

The Health Plan and Aetna are committed to developing and implementing standards of conduct and related compliance policies and procedures that reflect a commitment to conduct business based on high ethical standards and strict compliance with federal and state laws and regulations. Under the Plan Management Services Agreement, the Health Plan utilizes Aetna’s standards of conduct, and the Aetna Code of Conduct (the “Code”), to define the high standards of ethics, values and principles to which each employee is held in carrying out the Health Plan’s business operations. The Aetna Code of Conduct reflects the company’s commitment to compliance with federal and state laws, regulations and sub-regulatory requirements, as well. The Code is reviewed and updated at least annually with any material revisions approved by the Aetna, Inc. Board of Directors and their Audit Committee. The Code includes:

a) Aetna’s commitment the highest standards of ethical business conduct and compliance with all applicable laws and regulations.
b) The expectation that employees perform their Aetna and Health Plan responsibilities in compliance with the Code, applicable laws and regulations, and company policies, as well as their obligation to immediately report any suspected violations of the Code, the law or company policies.
c) Expectations and resources for reporting, investigating, and resolving potential, detected, or reported compliance and/or Fraud, Waste and Abuse (“FWA”) concerns together with the assurance of non-retaliation.
d) The assurance that every reported compliance or FWA concern will be thoroughly investigated and the situation resolved/corrected.
e) Disciplinary Policy, including a policy of non-intimidation and/or non-retaliation for good faith participation in the Program or for reporting concerns to law enforcement or a government agency.


I. Policies and Procedures

The Medicare Compliance Policies and Procedures define and implement the Program. These policies articulate the specific Program requirements and ethical standards. In addition, the Health Plan’s business units are responsible to maintain departmental policies and desktop procedures to support the organization’s operations, business standards, and regulatory requirements. Aetna maintains a Special Investigation Unit that has developed a Health Care Anti-Fraud Plan and policies to facilitate prompt and appropriate actions for instances of potential FWA.

New departmental operational policies and desktop procedures go through the Health Plan’s Policy Committee for approval. Existing operational policies get reviewed annually or when new regulatory guidance is introduced and go through the Policy Committee for approval. Medicare Compliance participates in the Policy Committees and has the authority to reject any policy that does not comply or include the required Medicare Part C and D regulatory requirements. The policy committee tracks the status of all policies and desktops reviewed. Approved policies and desktops are retained on the Mercy Care SharePoint for applicable record retention. Medicare Compliance policies are available to employees on the Medicare Compliance SharePoint site. Each business unit is accountable to have a process for distributing approved policies and desktops to their front line staff and conduct appropriate employee training. Each employee is responsible for being well versed in the requirements of those portions of the particular policies and desktop procedures applicable to his or her job responsibilities.

First Tier, Downstream and Related Entities (FDRs): Medicare Compliance provide FDRs with copies of the Medicare Compliance Program and compliance policies in the Compliance and Fraud, Waste, and Abuse (FWA) communication packet distributed at the time of contracting and annually thereafter. FDRs are required to complete and return an attestation confirming their organization compliance with established policies and procedures and other Medicare Compliance program requirements.
Section 4. Training and Education

Mercy Care Plan and Aetna are committed to making Compliance a Core Competency for all employees and delegated entities. A key component to building and maintaining a culture of compliance is a strong education and training program. Medicare Compliance helps oversee training and education provided to all employees who support MCA, which includes General Compliance, FWA, new guidance distribution, and specialized training at the time hire and annually thereafter.

1. General Compliance and Fraud, Waste and Abuse Training

Aetna has instituted a robust compliance training program, comprised of two components, the Business Conduct & Integrity (“BCI”) training course, and the Code of Conduct Acknowledgment. Under the Plan Management Services Agreement, executive leadership, managers, employees, temporary employees, and contingent workers employed by Aetna, who support the daily administration and contract requirements associated to the plans offered by Mercy Care Plan must complete the Aetna Business Conduct and Integrity (“BCI”) Training. Completion of this training program is required of all Aetna employees and contingent workers within 90-days of hire and annually thereafter with completion tracked by Aetna Corporate Compliance to demonstrate fulfillment of this training requirement. This training consists of several elements to help employees understand why they must be committed to the highest standards of business conduct. The following are some of the topics included: ethical decision-making, conflicts of interest, reporting concerns, and how to report, confidentiality, non-retaliation and disciplinary action, safe guarding information and accurate record keeping, etc.

This training also includes required general compliance training and the Code of Conduct Acknowledgment affirms the employee’s having read, and agreement to comply with, the Code and related Privacy and Information Security Policies. Aetna’s BCI training is available to employees via the Aetna Learning Center.

Additionally, executive leadership, managers, employees, temporary employees, contractor, and contracted FDRs must also comply with all Federal laws and regulations designed to prevent fraud, waste, and abuse including, but not limited to, applicable provisions of the Federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq.), the anti-kickback statute (section 1128B(b)) of the Act and HIPAA privacy and administrative simplification rules at 45 CFR parts 160, 162 and 164. The Aetna BCI training program includes the required FWA information.

As an employee of Dignity Health, the MCO is required to complete the Code of Conduct provided by Dignity Health and Aetna’s BCI training on an annual basis.

Members of the Board of Directors complete the Code of Conduct applicable to the sponsoring organization they represent when appointed and annually thereafter. In addition, general compliance and FWA training is provided to the members of the governing body via a power-point training presentation prepared by the Center of Medicare and Medicaid Services (CMS). The Medicare Compliance Officer is responsible to distribute the CMS training presentation to the existing governing body members electronically at the time of appointment and annually thereafter. When changes to the members of the Board of Directors occur, the internal Board of Directors Liaison notifies Medicare Compliance. Medicare Compliance will provide newly appointed members with the required training electronically for completion within 90-days of appointment. Both existing and new governing body members are required provide a completed training attestation to Medicare Compliance within 30-days of receiving the annual training.

First Tier, Downstream and Related Entities (FDRs): The Health Plan communicates Compliance and Fraud, Waste, and Abuse expectations to FDRs by providing contracted FDRs with a Compliance and Fraud, Waste, and Abuse (FWA) communication packet. Effective January 1, 2016, CMS requires FDRs to use the CMS Medicare Parts C and D Fraud, Waste and Abuse and General Compliance training to meet general compliance and FWA training requirements. This training is accessible via CMS Medicare Learning Network available on CMS website. Medicare Compliance
provides FDRs with a compliance communication packet that includes copies of the Aetna Code of Conduct (COC), Medicare Compliance Program and compliance policies and contact information for the Medicare Compliance Officer. The packet also contains instructions explaining how FDRs can access CMS’ FWA and General Compliance training module available on the CMS Medicare Learning Network.


The Compliance and FWA training communication packet is provided to FDRs via electronic delivery at the time of contract and annually thereafter. FDRs must ensure their employees complete the CMS Medicare Parts C and D Fraud, Waste and Abuse and General Compliance training at time of hire and annually thereafter. Contracted FDRs will be required to submit a completed Compliance and FWA attestation to the Medicare Compliance mailbox within 30 days of receipt for existing FDRs and within 60 days of receipt for new FDRs.

Receipt of completed FDRs attestations are tracked as part of the Delegation Oversight Committee processes. Copies of the email communication sent to FDRs and completed attestations are retained on the Delegation Committee Share Point site. Audits of FDRs will be conducted to validate they are compliant with their contractual obligation to maintain and provide documentation requested to support required employee training.

Contracts executed with FDRs who will administer Medicare Part C and D benefits include a Medicare Advantage Addendum that contains the contract language requirements required by CMS. The addendum includes the following contract requirement: HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS’ contract with the MA organization) through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later (422.504(i)(2)(i) and (ii).

In addition to the requirements set forth by CMS and the OIG, Mercy Care Plan must abide by the applicable provisions under Title 42 of the Code of Federal Regulations, Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973 Genetic Information Nondiscrimination Act of 2008, and Americans with Disabilities Act.

Providers
Providers contracted with Mercy Care Plan must also utilize CMS’ Medicare Parts C and D Fraud, Waste and Abuse and General Compliance training available on the CMS Medicare Learning Network to conduct training for their staff.

Providers who have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and supplies (DMEPOS) are deemed to have met the FWA training and educational requirements, but are still required to complete the compliance training component.

III. Specialized Training

Specialized training may be developed, delivered, and required based on an employee’s job function and training needs as identified by Medicare Compliance and Management to address operational and procedure requirements or education on regulatory and sub-regulatory requirements or a combination of both.

Dual Eligible Special Needs Plan Model of Care (MOC) Training
As required under our Medicare Advantage Dual Eligible Special Needs Plan contract, MCA is required to implement a Model of Care describing the following:
• Define Model of Care, Special Needs Plan, Interdisciplinary Team, and other terminology used
• Describe the targeted populations that meet the criteria for the Model of Care
• Review the SNP quality requirements based upon Medicare Improvements for Patients and Providers Act “MIPPA” regulations
• Recognize the key components that comprise the Model of Care
• Describe the integrated complex case management program
• Identify departments responsible for the management of the program
• Outline the benefits of this program for enrollees

The MOC training is developed and managed by Medical Management and reviewed annually for required updates. All employees, producers, providers and delegates supporting the MCA plans are required to complete Model of Care Training within 90 days of hire and annually thereafter. This training is included as part of the MCA employee new hire training curriculum and is available via the Aetna Learning Center.

Network providers are educated on the MOC requirements and receive training via in-services conducted by Provider Relations Representatives. Additionally, the MCA Provider Manual contains information about the MOC and training requirement. Providers and their staff are able to access the MOC training via the MCA Provider website.

Delegated entities (FDRs) responsible to perform functions associated to the MOC requirements are provided with an electronic copy of the MOC training for completion at time of contracting and annually upon updating. Training must be completed by FDR employees within 90-calendar days of receipt.

**Regulatory Guidance Distribution**

The Medicare Compliance department is responsible for tracking, analyzing, and conveying new laws, regulations, and policies specific to the Medicare Program. Medicare Compliance facilitates timely distribution of all guidance memos issued by CMS to all appropriate parties. Medicare Compliance summarizes the memos received and conducts regular guidance summary meetings with the operational business staff to explain the new regulatory guidance issued, the business impact and implementation action/timeline required, including system enhancements that may require Information Technology (IT) funding and training needs.
**Section 5. Effective Lines of Communication**

Compliance risk issues can be identified by internal and external sources. Medicare Compliance and Aetna Corporate Compliance foster open lines of communication among all Program constituents (e.g., Health Plan employees, FDRs, business partners and Board members). Various methods of communication are used to ensure critical information is communicated timely across the organization and to external entities to ensure employees and business partners understand compliance, who to contact to ask compliance questions and how to report compliance concerns.

The following are the elements and methods of communication used:

- Identification of key data and information to be communicated to various constituents.
- Mechanisms for the MCO to communicate with various constituent groups.
- Ongoing communication of new/revised statutory, regulatory, or sub-regulatory guidance and/or other changes to compliance or business policies and procedures or standards of conduct including member communication and education to business partners.
- Tools and mechanisms (e.g., published MCO contact information, posters, Compliance mailboxes, etc.) for constituents to direct questions and concerns to Medicare Compliance and systems to track receipt and respond to questions and concerns in a timely manner.
- Education for members about identification and reporting of potential FWA through member materials, website postings, etc.

Formal mechanisms include the Aetna Corporate Compliance communications, Mercy Care management communications and the toll-free hotline-Aetna Alert Line. A no-tolerance policy for retribution or retaliation against any good faith reporting is strongly enforced by the Health Plan and Aetna.

**Alert Line**

Employees and delegated entities are educated about the availability of a toll free hotline phone number (AlertLine®) when taking Aetna’s BCI training. In addition, Aetna Corporate Compliance publicizes the AlertLine on the AetNet and Compliance website. Medicare Compliance publicizes the AlertLine information on the Medicare Compliance SharePoint site and on compliance posters. The AlertLine® 1-888-891-8910 is available 7 days a week, 24 hours a day.

**Aetna Corporate Compliance Communications**

Aetna’s Corporate Compliance department maintains a Compliance internet site on the AetNet at: [http://aetnet.aetna.com/compliance/index.htm](http://aetnet.aetna.com/compliance/index.htm). This site is available to all employees and contains Compliance contact information, policies and procedures, training information and communications. There is also a direct link to the Aetna Medicare Compliance internet site.

Aetna’s Corporate Compliance department produces monthly “Compliance First” communications on the AetNet. These compliance communications include videos, ethics, and business compliance articles to educate employees on the importance of conducting their job responsibilities in accordance with Aetna’s ethics and compliance standards.

**Mercy Care Senior Management Communications**

The Health Plan’s senior management team utilizes several communication strategies such as monthly newsletters and emails to disseminate information to employees to keep them apprised of new and existing business initiatives, training reminders, employee recognition, and other important plan information.

**Regulatory Guidance Distribution and Communication**

The Medicare Compliance department is responsible for tracking, analyzing and conveying new laws, regulations, and policies specific to the Medicare Program. Medicare Compliance summarizes CMS memos received and facilitates timely distribution to impacted business areas. In addition a guidance summary containing all memos issued is distributed twice a month to all business areas supporting MCA to promote general awareness. The regulatory guidance summaries are retained on the Medicare Compliance SharePoint site.
New regulatory guidance containing significant operational business impact and implementation timelines are discussed at Executive Council, Medicare Joint Operating Committee, and the Medicare Compliance Committee and in separate meetings held with the operational business managers to determine business impact, the implementation actions/timeline required, including system enhancements that may require Information Technology (IT) funding, testing, and training needs. Medicare Compliance communicates key regulatory guidance and actions required to the CEO, Medicare Executive Leadership, Medicare Compliance Committee, and SCHN Audit and Compliance Committee and governing body in the Medicare Compliance reports.

**Medicare Compliance Newsletters**
Medicare Compliance develops and distributes a quarterly MCA newsletter to employees and an FDR newsletters to promote education and awareness of the MCA Medicare Compliance Program objectives and our contractual regulatory requirements.
Section 6. Routine Monitoring & Identification of Compliance Risks

Immediate identification and remediation of compliance risk issues is critical. This is accomplished through on-going proactive operational processes and continuous monitoring activities conducted throughout the calendar year. This Compliance Program utilizes CMS requirements and audit protocols to conduct on-going risk assessment, monitoring and auditing of internal business areas and FDRs delegated for the Medicare Part C and Part D operational functions. These processes target risk areas, test compliance of operations against CMS requirements, implement corrective actions, and encourage business operations to test compliance of operations and support external monitoring projects and audits as they arise. The Medicare Compliance Officer and Medicare Compliance Committee play a key role in these processes.

Tracking of identified Compliance Risk and FWA Issues

When risk and/or suspected FWA issues are identified, through either internal discovery or external parties, Medicare Compliance tracks and investigates the issue. The issue and/or suspected fraud allegation is logged and tracked on the Medicare Compliance Risks/FWA Issues Tracking Log, which is maintained on the Compliance SharePoint. Within three business days of identification, Medicare Compliance begins conducting appropriate investigation of the issue received with the applicable business managers and/or FDRs. Medicare Compliance will assist in determining the corrective actions and timeframes required for resolution and monitors timely remediation. Medicare Compliance maintains updates to the tracking log until the issue is closed and retains documentation supporting the investigation and resolution actions on the Compliance shared drive for reporting and auditing purposes. Issues are categorizes by the month identified and name of issue.

Medicare Compliance determines if an issue requires CMS disclosure based on the type of issue, duration, and member impact (access to services/drugs). Identified potential FWA incidents are elevated to Aetna SIU for proper investigation and timely reporting to the MEDIC.

Risk Assessment

Medicare Compliance uses the following assessment methods to identify compliance risks and FWA issues:

- Annual and on-going risk assessment tool analysis and score rating of the risk (e.g., high, medium, low)
- Identifying internal and external operational risks area, based on changes in regulation and/or awareness of a material change in business operations, systems and consultation with business leaders
- Results from internal compliance audits and CMS monitoring projects and audits
- Participation in operational and FWA committees
- Trends identified through MCA complaints and grievances and CMS CTMs
- Centers for Medicare and Medicaid Services (CMS) audit protocols
- CMS website – Part C and Part D Compliance and Audits Overview and Annual Report
- The Office of Inspector General (OIG) Work Plan
- CMS Compliance Notices and Performance Points
- MCA Compliance Issues Log and internal Warning/Notices of Non-Compliance
- Internal Compliance Issues Log and Warning/Notice of Non-Compliance
- CMS STAR ratings performance measures
- CMS annual Part C and Part D data validation results
- Monitoring, including a review of monthly operational dashboard metric results for performance and compliance measures
- FDR oversight and monitoring and status of corrective actions
- Marketing oversight of agent and broker compliance (testing, certification, payment, etc.), and related grievances
- Complaints filed with State Department of Insurance
- Internal interviews with operational units, IT, managers, and key Compliance Program personnel (including personnel in Aetna Medicare Compliance), etc.
• FWA program performance and reports
• Industry information, including newsletters, CMS and/or other industry webinars & conferences hosted to support regulatory requirements, etc.

Business or FDR operations and processes identified as high risk will be subject to on-going routine audits, oversight, and monitoring. A corrective action plan will be required to remediate identified non-compliance. Medium risk areas are subject to increased oversight and monitoring, and audit. Low risk areas are routinely monitored and may be subject to ad-hoc focused audit. Medicare Compliance reserves the right to conduct ad-hoc focused audits as new risks are identified.

"Monitoring" vs. "Auditing": What is the Difference?

It is important to distinguish between monitoring activity and auditing activity. Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An audit is a formal review of compliance with a particular set of standards and elements (e.g., policies and procedures, laws and regulations) used as base measures.

Monitoring

Medicare Compliance monitors and works with the operational business areas and FDRs to identify and resolve problems before they escalate into a situation of non-compliance. This process includes the collection and analysis of Part C and Part D performance data (dashboards and other reporting data). In addition to issues identified through regular monitoring activities, issues worked at this stage may come to Compliance’s attention from others sources (the operational business area, FDR, CMS, CTM, Congressional correspondence, or other government agencies, etc.). If compliance risks are identified during routine monitoring activities, it is logged and tracked on the Medicare Compliance Risks/FWA Issues Tracking Log for proper investigation and resolution. Medicare Compliance reserves the right to issue a warning notice and/or notice of non-compliance depending on the level of risk and non-compliance identified.

In addition to the monitoring activities conducted by Medicare Compliance, each operational business area and FDR is accountable to conduct self-monitoring (e.g., metrics monitoring, quality assessments, etc.) and immediately communicate risks identified to the MCO. Medicare Compliance assists in monitoring the oversight and performance of functions delegated to FDRs through participation in the Delegation Oversight Committee. This committee evaluates the results of FDR onsite and/or desk audits for compliance with performance metrics and regulatory laws and requirements.

Audit Schedule and Methodology

Medicare Compliance develops an annual audit schedule each calendar year. The audit schedule captures internal and first tier FDR audits, audit timeframes, and person(s) responsible and is subject to change if new risk areas are identified during the calendar year. The audit schedule is presented to the SCHN Audit and Compliance Committee and Medicare Compliance Committee for approval.

Medicare Compliance conduct audits using the Medicare Part C and D program manuals and CMS audit protocols to test compliance with Medicare requirements, contractual agreements, and policies and procedures. Medicare Compliance coordinates and oversees each audit, which includes advance notification to the operational business area(s) or FDR scheduled for audit, pre-audit meeting to discuss audit scope, a detailed audit report summarizing results and a post-audit discussion of findings and corrective actions required (if applicable). When an audit identifies deficiencies the operational business area(s) and/or FDR will be required to provide a Corrective Action Plan describing the remediation action and timeframe required to correct identified deficiencies. Medicare Compliance will monitor timely receipt of the Correct Action Plan and will expect documentation to validate the corrective actions implemented have cured the deficiencies. Validation may include testing or other applicable methods to support required remediation. Following an audit, Compliance will assign a risk level to determine if another ad-hoc audit is needed in addition to on-going monitoring.
Medicare Compliance retains all audit documentation. Compliance audit reports are presented to the Medicare Compliance Committee, SCHN Audit and Compliance Committee, and Delegation Oversight Committee, as applicable. If any issues of potential fraud, waste, and abuse are identified during an audit, Medicare Compliance immediately refers to Aetna’s SIU for investigation.

Audits by CMS or CMS Designees

Mercy Care Plan is committed to cooperating with audits conducted by CMS or its designees for our MCA contract whether conducted as an onsite, webinar, or desk review. The MCO is the point of contact for CMS audits and may assign a designee for CMS audit activities. The MCO is responsible for ensuring the coordination of all CMS audit requests and deliverables. Contracted FDRs must also participate in regulator audits and are contractually required to comply with CMS access to records and maintain records to support audits.

Relationships

Under the Plan Management Services Agreement with Aetna, the following departments within Aetna help to support the efforts of this Compliance Program.

- Aetna’s Internal Audit Department may conduct enterprise-wide risk assessment that includes Medicare systems, process, or operational business areas. In these situations, Medicare Compliance will engage with Internal Audit to coordinate audit plans and assistance, as applicable.

- Aetna’s SIU is responsible for preventing, detecting, and correcting FWA activities. Medicare Compliance collaborates with SIU to support their activities. Aetna’s SIU maintains a Health Care Anti-Fraud Plan and FWA policies.

- Aetna’s Investigative Services and other units collaborate with Medicare Compliance on OIG and GSA exclusion screening results, as necessary.

CMS Annual Readiness Assessment

Each fall, CMS issues their annual Readiness Checklist summarizing the Part C and D regulatory requirements and guidance that Medicare Advantage Prescription Drug Plans must adhere to in the coming calendar year under their contractual obligation with CMS. MCA business managers must review their department’s current processes, policies, desktops and systems to determine compliance with the CMS checklist requirements. Medicare Compliance uses a log to track business readiness and requires a completed business attestation to confirm readiness and/or disclosure of any areas that will not be compliant by January 1. Medicare Compliance will engage with business managers and FDRs to discuss identified areas of risk and monitor timely implementation of new requirements and documentation supporting readiness. As required, Medicare Compliance will disclose to CMS any requirements that will have a delayed implementation and the expected remediation date.
Section 7. Disciplinary Standards and Enforcement

Mercy Care Plan and Aetna have implemented procedures that encourage good faith participation in the Program. These expectations are defined in the Code of Conduct and in Human Resource Workplace Policies. The Business Conduct and Integrity training articles are posted on the Aetna intranet site, and in various training courses required throughout the year to provide reminders about these expectations and the disciplinary standards for failure to comply.

I. Disciplinary Standards

Aetna’s Human Resource Workplace policies address the following:
• Aetna’s Code of Conduct
• Misconduct (includes definition, examples of misconduct, reporting expectations and types of disciplinary actions). Unethical, illegal and non-compliant behavior (e.g., not meeting training or reporting expectations, etc.) are considered acts of misconduct.
• Addressing Misconduct (guidance for managers to work with Human Resources or Investigative Services to investigate and take timely, consistent, effective and appropriate action for misconduct, details the type of disciplinary actions).

II. Methods to Publicize Disciplinary Standards

a. Embedded in the Code of Conduct
b. Policies are posted on Aetna’s intranet, in Access HR
c. Aetna Handbook provided to all new hires and available in Access HR
d. Medicare Compliance Posters
e. Publications of articles highlighting key compliance expectations
f. Leading with Integrity- quarterly compliance videos, that must be facilitated and discussed at staff meetings
g. Expectations and resources communicated annually through training courses available to employees and FDRs

III. Enforcing Disciplinary Standards

a. The Code of Conduct expresses that disciplinary actions, including loss of job, may occur if the employee does not follow the Code or Aetna policies, does not cooperate in an internal investigation, or neglects to report a violation of the Code, Aetna policies, a law or regulation.
b. Disciplinary actions may be taken for non-compliant business practices include, but are not limited to the following:
• Verbal or written consultations
• Internal Notices of Non-Compliance
• Internal Corrective Action Plans
• Mandatory Management Action Plans
• Notice to cure and contract termination for FDRs
c. Disciplinary actions that may be taken for non-compliant behavior for an employee include (but are not limited to) the following:
• Coaching
• Training (e.g., Code of Conduct, Sexual Harassment, Civil Treatment, Information Security)
• Policy reminder and notice
• One-time warning
• Suspension without pay
• Financial consequences (e.g., employee will be charged equipment replacement fees in negligent situations such as a laptop theft, restrictions in incentive compensation plan participation or reductions in bonus or merit payments)
• Reporting relationship change or transfer to another position
• Notification to external entities such as law enforcement/regulatory agencies and licensing boards
• Termination of employment

d. Misconduct situations and the manner in which they are addressed if substantiated depends upon:
  • Severity of behavior
  • Impact on employees and Aetna
  • Whether there was intent
  • Previous disciplinary history
  • Other facts specific to each situation

e. Aetna and the Health Plan enforce a no-tolerance policy for retaliation or retribution against any employee or FDR who in good faith reports suspected non-compliance or FWA.
f. Actions taken in response to non-compliant employee behavior may require approval from Employee Relations/Human Resources, the MCO, legal counsel, and/or the Ethics Council.
g. Aetna’s Employee Relations/Human Resources model is used to apply disciplinary actions to employees and provides for timely, consistent, and effective enforcement standards when non-compliance or unethical behavior is determined to have occurred.
h. Records are maintained in accordance with the Record Retention Policy for a period of no less than ten years and include the date the violation was reported, description of violation, dates of investigation, a summary of the findings, the disciplinary action taken and the date this action was applied.
Section 8. Procedures for Prompt Response to Compliance Issues

When an instance of non-compliance is suspected, detected, reported, or discovered internally or externally, a proper and thorough investigation will commence and action will be taken to cure the issue and prevent reoccurrence.

I. Conducting a Timely and Reasonable Investigation of Detected Offences

   a. The MCO acts promptly to investigate detected offences and may delegate duties associated to the investigation, as needed.
   b. Regardless of how the issue was identified, an investigation will begin within three business days of identification. The scope of the investigation is based on the evaluation of the initial and ongoing information with the goal of completing a timely and reasonable investigation based on the severity of the detected offense (see section 6 for tracking of identified risk issues).

II. Corrective Actions

   a. Confirmed instances of non-compliance result in the development of internal corrective and preventative action plans to resolve identified deficiencies, correct the underlying problem that led to the deficiency, and conduct follow-up monitoring/validation review to ensure the actions implemented are effective for ongoing compliance. Corrective action plans describe the actions steps that will be implemented, timeframes and responsible parties involved in addressing the problem, deficiencies or FWA identified and include ramifications for failure to implement effective corrective actions.
   b. The MCO has responsibility for overseeing corrective action plans and the authority to escalate to senior management for immediate intervention if the corrective action plan is determined to be insufficient or untimely. This type of escalation may include requests for disciplinary actions and/or contract termination for FDRs.
   c. Medicare Compliance maintains documentation of all deficiencies and corrective actions taken.
   d. All non-compliant activities, including action steps taken to resolve, are reported during the Medicare Compliance Committee and SCHN Audit and Compliance Committee.

III. Instances of Potential FWA

   a. With respect to fraud, waste, and abuse (FWA), Aetna’s Special Investigations unit (SIU) carries out the FWA prevention and detection activities for the plans offered by Mercy Care. SIU ensures a reasonable investigation is initiated within 2 weeks concerning potential FWA issues. Medicare Compliance reports all suspected healthcare fraud inquiries received to Aetna SIU.

Medicare Compliance provides information requested by SIU to investigate, track, and respond to all Medicare related fraud, waste, and abuse cases. Medicare Compliance attends the Health Plan’s monthly FWA Committee that is comprised of a charter that includes Medicaid Compliance, Aetna SIU, and internal Health Plan staff. This committee serves as a forum to review potential FWA activity in a timely manner, which includes misconduct related to payment or delivery of items or services under the contract to ensure timely referral of suspected FWA cases to both state and federal regulators.

Aetna SIU responsibilities include:

- Conduct thorough and prompt investigations of all potentially fraudulent claims to obtain the necessary information for use in making informed decisions on the validity of the claims;
- Support the Health Plan and Aetna’s reputation with members, plan sponsors, health care providers and law enforcement personnel as a carrier which is committed to combating the health care insurance fraud problem;
• Establish a professional liaison with other carriers, plan sponsors, health care providers, law enforcement agencies and other governmental agencies involved in the prevention of health care insurance fraud;
• Maintain a continuing database of information (derived from cases presented) relating to trends, insurance fraud practices and organizations involved in the review of completed cases.

All full-time, part-time, temporary employees, directors, contractors, and FDRs performing Medicare related work are required to complete Compliance and Fraud, Waste and Abuse training upon hire and annually thereafter. This required training provides examples of fraud, waste, and abuse and stresses the responsibility of every employee in identifying and reporting potential and/or suspected cases of healthcare fraud.

Employees may report suspected FWA via the following methods:
• Aetna Special Investigation Unit at aetnasiu@aetna.com or;
• Aetna SIU hot line 1-800-338-6361 or fax number: 1-860-975-9719
• Directly or anonymously to the Compliance Officer
• MercyCareAdvantageMedicareCompliance@aetna.com
• Via the fraud reporting tool in e.service
• Aetna AlertLine® at 1-888-891-8910 (available 7 days a week/24 hours a day)
• Aetna Internal Audit Services at InvestigativeServices@aetna.com
• Write to Compliance & Regulatory Affairs at P.O. Box 370205, West Hartford, CT 06137-0205

Employees are educated about the AlertLine and other avenues for reporting compliance and fraud, waste and abuse concerns through a variety of compliance communications, including the Code of Conduct, annual online Business Conduct & Integrity (BCI) training, “Real-Time Ethics” bulletins and monthly compliance articles posted on the AetNet. Aetna’s Compliance & Regulatory Affairs (C&RA) internet home page has a prominent section called “Raising Compliance Issues & Concerns”, which provides guidance and instructions for raising compliance matters.

Delegated entities (FDRs) may use the AlertLine to raise compliance concerns. Delegated entities receive a copy of the Aetna Code of Conduct that provides instructions and contact information for reporting compliance concerns.

Contracted providers (e.g., physicians, hospitals, medical facilities, laboratories, etc.) may raise fraud or compliance related concerns and questions through the toll-free Special Investigations Unit (SIU) hotline 1-800-338-6361 or directly to the Office of Inspector General HHS Tips Hotline 1-800-447-8477. These toll-free numbers are published in the Health Plan provider manuals and the provider websites.

Members may raise fraud or compliance related concerns and questions through the toll-free Special Investigations Unit (SIU) hotline 1-800-338-6361 or directly to the Office of Inspector General HHS Tips Hotline 1-800-447-8477, Medicare or AHCCCS. The Health Plan’s websites include a Fraud and Abuse page and online form available for reporting suspected fraud and abuse directly to Compliance.

b. Medicare Compliance, the Health Plan, and Aetna are committed to cooperating with the MEDICs to refer potential FWA and/or to provide information requested by the MEDICs within the timeframes specified. Medicare Compliance and the Health Plan also cooperate with other outside authorities (e.g., Medicaid Programs, Department of Insurances, CMS or its designees and law enforcement agencies, etc.) who are conducting FWA investigations, etc. (including compliance with requests regarding network providers identified as potentially abusive or fraudulent).

c. The SIU conducts thorough investigations, data analysis, internal reporting to the MCO and MCC and conducts referrals to outside agencies as necessary (e.g., MEDICs, CMS, law enforcement, etc.).
IV.  Self-Reporting Potential Fraud or Misconduct

Medicare Compliance, the Health Plan, and Aetna recognize the importance of voluntarily self-reporting potential FWA and/or significant incidents of non-compliance to CMS and regulatory authorities. Medicare Compliance discloses identified risk and FWA issues to CMS in a timely manner based on the severity and member impact of the issue identified. Risk issues identified that affect member access to benefits and services are immediately analyzed to identify root cause, duration, and number of members affected. If an issue impacts more than 100 members, the Medicare Compliance Officer will contact the CMS Regional Office Plan Manager to discuss the issue, corrective actions implemented and any additional action steps required by CMS. Medicare Compliance provides the CMS Regional Office Plan Manager with process updates as specified until the issue is fully resolved. Additionally, Medicare Compliance and the Medicare Product team meet monthly with the Health Plan’s assigned CMS Regional Office Managers to discuss MCA business initiatives, new regulations, and guidance and other topics requested by CMS.
Section 9. Medicare Compliance Committee Charter

Medicare Compliance Committee Charter
The Medicare Compliance Committee (the “Committee”) is primarily responsible for compliance strategy and oversight of the Mercy Care Advantage (MCA) Medicare Compliance Program in preventing, detecting, and correcting noncompliance and fraud, waste, and abuse (FWA). The Committee’s purpose is to assist the Southwest Catholic Health Network (SCHN) Audit and Compliance Committee and Board of Directors to oversee, guide, and evaluate the effectiveness of Medicare Compliance Program and help ensure that the plan operates in accordance with federal and state regulations and sub-regulatory issuances. These issuances may include, but are not limited to, requirements published by the Centers for Medicare and Medicaid Services, the Office of Inspector General of the Department of Health and Human Services, or a State Agency with applicable regulatory authority. It is also the commitment of the Medicare Compliance Committee to promote and support a culture of compliance within the Mercy Care Organization.

Charter Review and Approval
The SCHN Audit and Compliance Committee include members of the SCHN Board of Directors who are accountable to review the Medicare Compliance Committee Charter on an annual basis and approve any changes made to the MCA Medicare Compliance Program and charter.

Committee Membership and Chairperson
The Medicare Compliance Officer chairs the Committee. The Committee is comprised of senior management staff approved by the Chief Executive Officer, the Medicare Compliance Officer and SCHN Audit and Compliance Committee. The Committee also includes members from operational and administrative departments supporting the MCA line of business and Compliance Program to foster a culture of compliance and provide high quality services to health plan membership.

Committee membership is composed of voting and non-voting members as follows:

Voting Members
- Medicare Compliance Officer – Chair
- Chief Operating Officer
- Chief Financial Officer
- Chief Medical Officer
- Chief Pharmacist
- Director of Quality Management
- Head of Medicare Product

Non-voting Members
- Aetna Special Investigations Unit
- Customer Service Operations
- Health Plan Operations
- Long Term Care
- Medical Management
- Medicare Compliance
- Medicare Product Team
- Medicare Sales
- Quality Management

In addition, the Committee may have guests, such as invited presenters, who attend on a routine or ad hoc basis. Voting Committee Members must attend at least 75 percent of Committee meetings. There are no terms or term limits applicable to Committee Members.
Committee Conduct

A. Committee Meeting
The Committee will meet quarterly during each calendar year, unless otherwise agreed to by the Voting Members of the Committee. The Committee may meet more frequently, or convene a special meeting, if it is deemed necessary by the Chair or the Voting Members. Members of the Committee can attend in person or by telephone using WebEx meeting technology.

B. Meeting Agenda
The Chair will develop an agenda for each Committee meeting and distribute prior to each meeting. Included with the agenda will be the minutes from the prior meeting and other materials for discussion. Meeting agendas will be integrated with the meeting minutes as part of the Committee retained records.

C. Call to Order, Quorum, and Voting
The Medicare Compliance Officer will convene the Committee. If the Medicare Compliance Officer is not able to attend a Committee meeting, another member of Medicare Compliance will be designated to conduct the meeting and the Committee will proceed in completing its business as scheduled.

In order for the Committee to conduct its business, a quorum of Voting Members is necessary. The required quorum is the attendance of at least 50% of all Voting Members in person, by phone, or by other accepted means of communication. If the number of Voting Members is less than the 50% required, the lack of a quorum will be noted in the minutes and the Chair will terminate the meeting.

If a Voting Member is unable to attend the meeting, they may designate an alternate however, the alternate must be approved in advance by the Chair. The designated alternate will count toward the quorum and be able to vote. All Voting Members have equal voting privileges. Decisions are made by majority vote, once a quorum is present. The Chair will decide votes resulting in a tie.

Voting on matters presented to the Committee will take place after matters requiring a vote are discussed, and a motion to approve initiated. Voting will take place verbally, or if outside of scheduled meetings, using an alternative electronic polling mechanism as determined by the Chair. At the discretion of the Chair, the recording of the outcome of a vote on a matter before the committee may be delayed for a reasonable time until the votes of Members unable to attend a regular meeting are polled by the Chair. Regardless of the means used, the Committee Chair must take measures to assure that all Voting Members have had an opportunity to review matters and motions, and register their votes.

D. Reports to the Committee
As part of its work, the Committee receives and reviews a number of routine and ad hoc reports. The Medicare Compliance Officer, various operational departments, committees, or work groups who have a role in the Medicare Compliance Program may also generate reports. These reports include, but are not limited to the following:

- The detection of breaches in compliance, privacy, confidentiality, and Code of Conduct; the corrective and disciplinary actions taken; and issues deemed reportable to CMS and the status of such reporting.
- CMS notices, report data, and/or other CMS communications regarding MCA compliance including notices of non-compliance, audits, monitoring programs.
- Audit updates including activity and status resulting from internal compliance audits and CMS audits, findings and subsequent corrective action plans.
- Internal monitoring of MCA operations, identified risk issues, and actions taken for remediation, and effectiveness of these actions.
- Compliance and FWA program requirements, required training, monitoring, and reporting activities.
- Activity and updates on the oversight of first tier, downstream, and related entities.
- Operational or staffing changes deemed a “material change” that affects the MCA line of business.
- Status of policies and procedures (P&Ps) for Compliance and operational areas, including updates and annual reviews.
- Market conduct issues, compliance oversight, corrective actions, and effectiveness of these actions, as well as status of agent/broker training.
- Reports and data supplied by Quality Improvement Committee.
- Ad hoc reports and ad hoc compliance work group activity.

E. Meeting Minutes and Committee Records
The proceedings of Committee meetings are documented in written minutes that include, but not limited to, meeting attendance, information on the presentation of routine and ad hoc reports, a summary of the discussions by Committee members (Voting and Non-voting) and guests, and a record of any votes or resolutions for action adopted by the Committee.

The Chair will appoint an individual to record the minutes of each Committee meeting, ensure that the minutes are distributed before the next Committee meeting for review and comment, and will call for adoption by the Committee. The official record of a Committee meeting includes the agenda, the adopted minutes, and copies of reports and other materials presented to the Committee. The Medicare Compliance Officer will oversee the secure storage of the meeting agenda, minutes, and meeting materials for no less than ten years in accordance with CMS record retention requirements.

F. Reporting Responsibilities
The Chair provides routine Compliance reports the Chief Executive Officer (CEO), Chief Operating Officer (COO) and Executive Leadership as well as to the SCHN Audit and Compliance Committee Board of Directors.

Committee responsibilities:

1. Annually review and approve the MCA Compliance Program, Charter, Risk Analysis, Audit Schedule, and other key supporting documents of the Program (e.g., Standards of Conduct, Charters, and training plans).

2. On an ongoing basis, monitor, and assess internal operational policies and procedures, systems, and controls used as part of daily operations for areas of risk and the possible need for additional Compliance oversight or business policies that coincide and support compliant operations.

3. Assist in the analysis of the regulatory environment and legal requirements with which MCA must comply and identify areas of risk. Oversee the implementation of new regulatory and sub-regulatory requirements.

4. Regularly review ongoing activities of the Compliance Program, performance reports (e.g. dashboards) and other reports identifying risks and trends to assist in the identification of information for reporting to the CEO’s, Executive Management and the SCHN Audit and Compliance Committees and Boards.

5. Monitor internal and external audits results and investigations for the purpose of identifying risk and deficient areas and implement corrective and preventive actions. Review concerns encountered by persons conducting formal audits and investigations, regarding significant difficulties or non-compliance encountered.

6. Support and conduct monitoring and oversight of operational functions delegated to first tier, down steam, and related entities (FDRs) to help ensure regulatory and contract performance requirements are met. Support recommendations from the Delegation Oversight Committee when corrective action plan is required for identified FDR non-compliance.
7. Support and promote employee and FDR education and timely completion of Code of Conduct, Compliance and fraud, waste, and abuse training and any other training activities identified to support compliance and adherence to pertinent laws, regulations, policies, procedures, and practices.

8. Conduct a review of analysis completed for the development of new business initiatives applicable to MCA to help identify any compliance risks with Medicare laws and regulations.

9. Assist the Medicare Compliance Officer and SCHN Board of Director to foster and maintain a culture of compliance. Work with appropriate business departments and affiliated FDRs to develop support for the standards of conduct, policies and procedures, and the Compliance Program.

10. Determine the appropriate strategy to promote compliance with the Program and detection of any potential violations, such as hotlines and other fraud reporting mechanisms. Monitor the processes and systems in place to identify, solicit, research, investigate, evaluate, report (to appropriate internal and external authorities), remediate, and respond to compliance concerns/complaints and allegations of FWA.

11. Participate in the annual evaluation of the effectiveness of the Medicare Compliance Program and make recommendations.

12. Provide a forum for communication among the various business entities and FDRs who support the MCA line of business for issues relevant to audit and compliance.

13. Maintain a process that may be used, with consensus from the Committee, to assign responsibility to Committee members to assure reported deficiencies or concerns have appropriate corrective actions and appropriate oversight.

14. Perform any other activities consistent with this Charter and other governing laws, as this Committee or the SCHN Audit and Compliance Committees deems necessary or appropriate.

**Medicare Compliance Program and Committee Charter Approvals**

- SCHN Audit and Compliance Committee on November 16, 2016
- Medicare Compliance Committee on December 9, 2016