HEALTH PLAN POLICY	
Policy Title: Annual Compliance Program Effectiveness Assessment – Medicare Advantage	**Policy Number:** AC11 **Revision:** E
Department: Administration	**Sub-Department:** Compliance
Applies to Product Lines: ☐Medicaid ☐USFHP ☐Children's Health Insurance Plan ☐Commercial Insured ☐Health Insurance Exchange ☐Non Insured Business ☒Medicare	
Origination/Effective Date: 04/01/2015	
Reviewed Date(s):	**Revision Date(s):** 03/04/2016, 09/28/2017, 09/20/2018, 04/15/2020, 04/06/2021

SCOPE:

This policy applies across the Medicare Advantage lines of business to ensure that the Medicare Advantage (MA) Plan and Prescription Drug Plan (MAPD) complies with all Centers for Medicare and Medicaid Services (CMS) rules and Annual Compliance Program Effectiveness Assessment.

DEFINITIONS AND ACRONYMS:

- **Abuse -** Payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.
- **Centers for Medicare and Medicaid Services (CMS)** – The federal agency responsible for administering the Medicare and Medicaid programs.
- **Downstream Entity –** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization (MAO) or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health plan and administrative services.
- **FDR** – First Tier, Downstream or Related Entity.
- **First Tier Entity** – Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage Program or Part D program.
- **Fraud -** is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.
- **FWA -** Means fraud, waste and abuse.
- **Medicare Advantage (MA) Plans -** (like an HMO or PPO) also called "Part C" are health plans run by Medicare-approved private insurance companies. Medicare Advantage Plans include Part A, Part B, and usually other coverage like Medicare prescription drug coverage (Part D), sometimes for an extra cost.
- **Medicare Advantage Prescription Drug (MA-PD) Plan** - A MA plan that provides qualified prescription drug coverage.

- **Related Entity –** Any entity that is related to an MAO or Part D sponsor by common ownership or control, and
  - Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;
  - Furnishes services to Medicare enrollees under an oral or written agreement; or
  - Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period. (See, 42 C.F.R. §423.501).
- **WASTE -** The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

POLICY:

A. The compliance officer and committee ensures implementation of an audit function appropriate to the size, scope and structure of the health plan. The audit function is performed by an internal audit team, or by the compliance department.

B. The staff dedicated to the audit are responsible for monitoring and auditing operational areas to ensure compliance with Medicare.

C. Adequate resources are devoted to the audit function, and considers factors such as health plan size, risk areas, compliance history, and goals needed for oversight of the annual work plan.

D. The associates completing the audit are knowledgeable about CMS operational requirements for areas under review (FDR Oversight, FWA, Internal Monitoring and Auditing). CHRISTUS Health Plan ensures that auditors are independent and do not engage in self-policing. Operations staff participates in the audit activities, as well as individuals in other business areas.

E. The health plan shares the audit results with executive leadership, compliance committee, and the Board of Directors.

REFERENCES:

Medicare Managed Care Manual Chapter 21, Section 50.6.5

RELATED DOCUMENTS:

None

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REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	04/01/2015	Initial release.	Board of Directors
A	03/04/2016	Yearly review – updated to current template.	Board of Directors
B	09/28/2017	Yearly review – corrected typographical errors. Changed signatory to reflect CEO.	Board of Directors
C	09/20/2018	Compliance review. Updated Definitions and Acronyms.	Executive Leadership
D	04/15/2020	Yearly review. Updated title, Scope, References, and verbiage throughout policy.	Executive Leadership
E	04/06/2021	Yearly review. No change to policy content.	Executive Leadership