KS Plan Administrators, LLC	Compliance Policy Manual	POLICY NO: CP ## 001
SUBJECT: Medicare Advantage and Part D Fraud, Waste, and Abuse	**DATE:** 11/30/2022 **Last Revised Date:** New Policy **Last Review Date:** New Policy	
DISTRIBUTION: KSPA	**FUNCTIONAL AREAS:** KSPA	
SUPERCEDES POLICY: N/A	**REFERENCE/ATTACHMENT:** N/A	
PREPARED BY: Thomas Wilson, Medicare Compliance Officer	**Last Approved Date:** N/A	

I. PURPOSE:

The Company recognizes that violations of its compliance and integrity program, applicable federal and state laws and regulations and other types of noncompliance impact the Company's status as a reliable and trustworthy organization. This policy outlines the fraud, waste and abuse program of KS Plan Administrators, LLC d/b/a KelyseyCare Advantage ("KCA") and the Company's dedication to helping reduce or eliminate fraud, waste, and abuse, preventing illegal activities, referring potential cases to and supporting the Centers for Medicare & Medicaid Services (CMS) in investigations.

II. SCOPE:

This policy applies to KCA employees, contractors, consultants, volunteers, vendors, and members of the KCA Operating Committee ("Local Board").

III. DEFINITIONS:

Abuse: means actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Downstream Entity: means any party that enters into a written agreement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between the Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity.

First Tier Entity: means any party that enters into a written arrangement, acceptable to CMS, with an Medicare Advantage Organization 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: means 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. 18 U.S.C. § 1347.

FWA: means fraud, waste, and abuse.

NBI MEDIC: means the National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.

Related Entity: means any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and performs some of the Medicare Advantage 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 Medicare Advantage Organization 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: means 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.

IV. POLICY

KCA has established and implemented procedures and a system for promptly responding to compliance issues, including those involving fraud, waste, or abuse (FWA) as they are raised, investigating potential problems as identified in the course of self-evaluations and audits (preventive and detective), correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.

KCA works to prevent FWA through education (e.g., our compliance plan, compliance risk assessment, and compliance helpline) and through provider contracts, provider training, member newsletters, and the Evidence of Coverage.

KCA works to detect, correct, and prevent FWA through reports from members, internal staff, providers and by conducting internal audits.

V. PROCEDURE / ACTION

1. If KCA discovers evidence of misconduct related to payment or delivery of items or services under the contract, it will conduct a reasonable inquiry into that conduct.
2. KCA will initiate a reasonable inquiry as quickly as possible, but no later than 2 weeks after the date the potential noncompliance or potential FWA incident was identified.
3. KCA will conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible individuals) in response to the potential violations.
4. KCA has established and maintains procedures to voluntarily self-report potential fraud or misconduct related to the Medicare program to CMS or its designee (such as the NBI MEDIC).
5. If the issue appears to involve potential fraud or abuse and the Company does not have either the time or the resources to investigate the potential fraud or abuse in a timely manner, it should refer the matter to the NBI MEDIC within 30 days of the date the potential fraud or abuse is identified so that the potentially fraudulent or abusive activity does not continue.

6. KCA will refer cases involving potential fraud or abuse that meet any of the following criteria to the NBI MEDIC:
    a. Suspected, detected, or reported criminal, civil, or administrative law violations;
    b. Allegations that extend beyond the Medicare Advantage and Part D plans, involving multiple health plans, multiple states, or widespread schemes;
    c. Allegations involving known patterns of fraud;
    d. Patterns of fraud or abuse threatening the life or wellbeing of beneficiaries; and
    e. Schemes with large financial risk to the Medicare Program or beneficiaries.

RESPONSIBILITIES

KCA's Compliance Department has established and implemented procedures to promptly respond to FWA and significant Medicare noncompliance. It is responsible for the identification, timely investigation, and, where potential FWA and significant Medicare program noncompliance is identified, reporting such to the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), law enforcement as warranted, and CMS. Self-reporting of FWA and Medicare program noncompliance is voluntary. (See: 42 C.F.R. §§ 422.503(b)(4)(vi)(G), 423.504(b)(4)(vi)(G)).

There are no regulatory requirements for reporting issues to the CMS Account Manager. It is a subjective and iterative process that involves various stakeholders. KCA strives to provide transparent reporting to the CMS Account Manager as applicable. The Compliance Department provides various methods for reporting of FWA or significant noncompliance concerns.

Criteria used in the evaluation process include, but are not limited to:

- Number of members adversely affected obtaining care or prescription drugs;
- Number of members adversely impacted by the issue;
- Number of members financially impacted by the issue; and
- Scope of FWA or significant Medicare noncompliance concern and harm to the Company.

KCA will take the appropriate corrective action in response to the issues. Each KCA referral to the NBI MEDIC is made based on unique circumstances and shall contain specifics that will allow an investigator to follow-up on a case including basic identifying information and contacts as well as a description of the allegations. The Company will utilize the NBI MEDICs Complaint Form (please see references to form file path).

The NBI MEDIC may request additional information in order to fully investigate and resolve the matter. The Company shall furnish additionally requested information within 30 days, unless the NBI MEDIC specifies otherwise. In instances where the NBI MEDIC requires information in less than 30 days, all parties involved will be notified as soon as possible. The Company will provide updates to the NBI MEDIC when new information regarding the matter is identified.

The Compliance Department shall retain all documents and relevant communications regarding potential noncompliance or potential FWA incidents.

VI. DOCUMENTATION / REFERENCES:

- 42 CFR § 422.503(b)(4)(vi)
- 42 CFR § 423.504(b)(4)(vi)(H)
- Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines and

Prescription Drug Benefit Manual, Chapter 9 – Compliance Program Guidelines
- Anti-kickback Regulations
- Stark Law Amendments
- False Claims Act
- HIPAA/HITECH

VII. HISTORY:

DATE	REVISED BY	REASON FOR REVISION/CONTENT CHANGED
11/16/2022	N/A	New Policy. Approved by the Compliance Committee on 11/30/2022.