KS Plan Administrators		POLICY NO: CP 8
SUBJECT: Monitoring and Auditing	**Date: October 2012** **Last Revised: November 2023** **Last Reviewed: December 2023**	
DISTRIBUTION: All Departments	**FUNCTIONAL AREAS:** All Departments	
SUPERCEDES POLICY: N/A	**REFERENCE/ATTACHMENT:** Medicare Managed Care Manual Ch 21 Compliance Program Guidelines	
PREPARED BY: Thomas Wilson **Revised by** Thomas Wilson	**DATE APPROVED: October 2012**	

I. Goal

KS Plan Administrators, LLC d/b/a KelseyCare Advantage ("KCA") continuously evaluates compliance of statutory and subregulatory guidance issued by the Centers for Medicare & Medicaid Services (CMS). KCA Compliance uses detective and preventive audits and monitoring to identify potential violations, including fraud, waste, and abuse (FWA) that may occur within the company or with its contracted first tier, downstream or related (FDRs) entities (See: 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F)). This includes:

- Routine monitoring and auditing of compliance risks within the company.
- Routine monitoring and auditing of FDRs.
- Audits of FDRs to determine compliance with a newly enacted regulation.
- External audit of the Compliance Program by an independent third-party with sufficient expertise to determine the overall effectiveness of the program.
- External audit of the company initiated by CMS or its designee.

II. Definitions

Auditing: means a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures.

Centers for Medicare & Medicaid Services (CMS): means a federal agency within the Department of Health and Human Services that is responsible for the administration of the Medicare program.

Corrective Action Plan (CAP): means a step-by-step plan that is developed to resolve and prevent identified errors. A corrective action plan includes a root cause analysis, an impact analysis, corrective actions, potential testing, and retraining of staff to ensure corrective actions are effective. CAPs may be formal or informal.

Downstream Entity: means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an 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 and administrative services. (See, 42 C.F.R. §, 423.501).

Employee(s): means those persons employed by the sponsor or a First Tier, Downstream or Related Entity (FDR) who provide health or administrative services for an enrollee.

FDR: means First Tier, Downstream or Related Entity.

First Tier Entity: means 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 MA program or Part D program. (See, 42 C.F.R. § 423.501).

Formal Corrective Action Plan: means identified errors that have adversely impacted the member and/or the plan or are considered to have high to medium risk potential to pose adverse effects to the member and/or the plan, or errors that do not comply with CMS regulations and requirements. A formal corrective action must be documented on the KCA CAP Form or on an equivalent form that meets all requirements of a formal corrective action plan (i.e., issue description, root cause description, deficiency identified, impact and target completion date).
A formal corrective action plan may be requested if self-reported, monitored, audited, or investigation identified any of the following:

- **Immediate Corrective Action(s) Required (ICAR):** means findings that delay, restrict, and/or limit the member's access to required services and/or medications.
- **Corrective Action(s) Required (CAR):** means findings that do not have an immediate impact on the member's access to services and/or medications but are found to be significant.

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.

Informal Corrective Action Plan: means identified errors with no adverse impact or low risk to the member and/or the plan and errors that are not a direct violation of CMS regulations and requirements. Informal corrective action must be documented, include the errors identified, steps to correct, education to prevent a recurrence and that is easily understood by the recipient. Informal corrective action plans may be completed if any of the following are identified:

- **Observation Requiring Corrective Action (ORCA):** means findings that are limited in scope or have been mitigated. Observations that require a corrective action are generally less significant but require attention to ensure the impact

to member and/or plan is resolved to prevent a recurrence.

- **Observation:** means findings that are found to be insignificant, have no direct impact to the member and/or plan, are not in violation of any specific CMS regulation and/or requirement. Observations generally do not require a corrective action. Observations may include recommendations for improvement.

Monitoring Activities: means regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Related Entity: means any entity that is related to an MAO or Part D sponsor by common ownership or control and

(1) Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;

(2) Furnishes services to Medicare enrollees under an oral or written agreement; or

(3) 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: 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.

III. Policy

KCA has appropriate monitoring and auditing processes to evaluate compliance with applicable laws, regulations, and policies, and to detect potential issues, or violations. KCA business operations perform ongoing monitoring of appeals, grievances, claim processing, customer service call handling, enrollments, disenrollments, organization determinations, coverage determinations, sales inbound calls, and performance of its FDRs to ensure the company meets regulatory requirement issued by CMS. The Compliance Department conducts targeted audits to prevent, detect, and respond to FWA issues.

IV. Procedure

1. KCA Compliance conducts an annual risk assessment of internal business operations and with its key FDRs. Risk assessment results are categorized, tabulated, and scored. Final auditing and monitoring activities are included on the Compliance Work Plan and Performance Scorecard which is submitted to the Compliance Committee and KCA Operating Committee (e.g., "Local Board") for review and approval (See: 42 C.F.R. §§

422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F)). On a quarterly basis the KCA Compliance reviews the work plan and may make updates to the number of audits or change monitoring activities based on business need or revised regulations.

2. KCA Compliance conducts ongoing monitoring and auditing activities (e.g., enrollment, disenrollment, claim processing, customer service, appeals and grievances, utilization management, etc.) to confirm compliance with CMS regulations. Internal and external business operations submit periodic reports to KCA Compliance regarding its monitoring and/or auditing activities. KCA Compliance monitors these reports and initiates CAPs as applicable. KCA Compliance issues periodic reports to senior leadership regarding the total number of formal open and closed CAPs. Informal CAPs are tracked and monitored and will convert to a formal CAP if the issue should rise to the level of a formal CAP.

3. The Compliance Work Plan and Performance Scorecard includes the number of audits it will conduct of business operations and of its FDRs (See: 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F)). The audit is a formalized process that describes the summary of the audit, regulatory guidance, methodology and sample size, and the results. Audits are considered closed when signed by the appropriate business owner. Audit results are presented to the respective business leader and, if applicable, shared with the FDR. If the audits identify errors that result in a formal ICAR or CAR, KCA Compliance strives to conduct a follow up audit within 90 days following the closure of the formal CAP. Audit results are shared with the Compliance Committee and Local Board.

4. KCA Compliance undergoes an annual audit of the Compliance Program. The annual audit is administered by an external third party. The purpose of the audit is to review policies, procedures and supporting documents to ensure they support the Compliance Program and tests controls through selected “tracer” presentations. The tracer describes how and when an issue was identified, the root cause, steps to correct the issue, escalation to senior leadership and Local Board, and controls to prevent a recurrence. Audit results are shared with the Compliance Committee and the Local Board.

5. KCA Compliance monitors all issues and self-reports applicable issues to the CMS Account Manager when there is significant harm to members that cannot access health care and/or prescription drugs, undo financial burden, significant impacts to providers, or reputational harm to KCA. The decision to self-report is case specific and may include other variables. Generally, if no significant harm or adverse impacts are determined, the issue is not reported to the CMS Account Manager.

6. CMS has the discretionary authority to perform audits under 42 C.F.R. 44 422.504(e)(2) and 423.505(e)(2), which specify the right to audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of sponsors or FDRs. KCA must allow access to any auditor acting on behalf of the federal government

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or CMS to conduct an on-site audit. On-site audits require a thorough review of required documentation. CMS audits are shared with the Compliance Committee and the Local Board.