24. PROGRAM DESCRIPTIONS

E. Compliance Program Description

Introduction

A. IEHP is committed to conducting its business in an honest and ethical manner and in compliance with the law. IEHP has established and implemented a Compliance Program to promote our culture of ethical conduct and compliance. The Compliance Program Description sets forth the principles, policies, and procedures for how IEHP Team Members, Governing Board Members, as well as subcontracted entities (First Tier, Downstream, and Related Entities (FDRs)) are required to conduct business and themselves. IEHP's Compliance Program is built upon and implemented in accordance with applicable Federal and State laws, regulations and guidelines, including those set forth by the Federal Sentencing Guidelines (FSG) and Office of Inspector General (OIG) Seven Elements of an Effective Compliance Program. This Compliance Program Description sets forth the requirements in which IEHP expects the Delegated entities to develop their Compliance Programs.

Mission and Vision

A. The mission of IEHP is to organize and improve the delivery of quality, accessible and wellness-based healthcare services for our community. The organization prides itself in six (6) core values:

1. *Health and Quality before Costs:* We believe in placing Member's health care needs above all else.
2. *Team Culture:* We are a dedicated and cohesive team focused on Member care and supporting our Providers.
3. *Think and Work LEAN:* We strive to continuously improve our daily operations and delivery of health care services.
4. *Partner with Providers:* We recognize the necessity of a strong working relationship with our Providers based on mutual respect and collaboration.
5. *Stewardship of Public Funds:* We are accountable to the public and strive for transparency and prudent fiscal management.
6. *Foster Innovation:* We are thinking about the future of health care in terms of digital access, use of data, creative initiatives and other innovations that will improve that will improve the lives of our Members, Providers, the Community, and our Team Members.

Compliance Program Scope

A. Delegated entities must implement a Compliance Program to provide a systematic process dedicated to ensure that management, employees, business associates, First Tier, Downstream, and Related Entities (FDRs) and other associated individuals/entities comply with applicable health care laws, Federal and State requirements, and, all applicable regulations and standards.

B. The Compliance Program must include:

1. Standards of conduct, policies and procedures to support and sustain Compliance Program objectives.
2. Be overseen by the Board Directors and senior management levels.
3. Process to reporting compliance activities and outcomes to the Board of Directors/Governing Board ("Board"), senior management, IEHP Employees and applicable regulatory agencies.
4. Screening of employees, Board Members, business associates, FDRs, and other affiliated individuals/entities for the presence/absence of program- related adverse actions and/or sanctions.
5. Education and training: General training on health care regulatory requirements; specific training on job functions; and, training to business associates, FDRs and other external affiliates.
6. Ongoing auditing and monitoring of the organization's compliance performance, including preventive practices identifying potential compliance issues.
7. Enforcement measures, including implementation of corrective action plans (CAP), enacted when issues of non-compliance are identified.
8. Preventive practices to identify potential compliance issues and to implement actions that lower or mitigate risk.
9. Evaluation to determine the effectiveness of the compliance program.

C. Delegated entities must implement an effective compliance program that meets regulatory guidelines.

Written Policies, Procedures, and Standards of Conduct

A. Code of Conduct – All Delegated entities are required to have a Code of Conduct that demonstrates their commitment to compliance and articulates the core values and principles that guide the organization's business practices and ensures that Compliance with all state and federal laws is the responsibility of all employees. The code should be communicated to Employees, (Temporary and Permanent), Providers, Contractors, Board Members, and Volunteers.

1. The Code can be communicated by various methods, including:
   a. Provided to new Employees in the Employee Handbook upon initial employment.
   b. Discussed during Compliance New Hire and Annual Training.

2. Employees are required to acknowledge their understanding of the Code of Conduct and their commitment to comply with its intent within ninety (90) days of initial employment and annually thereafter.

3. Delegated entities should also provide a Vendor Code of Conduct to their business associates that address their obligations toward conducting business at the highest level of moral, ethical and legal standards.

   a. The Vendor Code of Conduct should include reporting requirements for any issue of non-compliance.

B. Policies and Procedures – All Delegated entities should develop Policies and Procedures that:

1. Address commitment to complying with all Federal and State standards;

2. Provide direction on dealing with suspected, detected or reported compliance issues;

3. Provide guidance on reporting compliance issues;

4. Include a policy of non-intimidation and non-retaliation for good faith efforts to reporting potential non-compliance issues; and

5. Are reviewed on an annual basis, or more often to incorporate changes in applicable laws, regulations or other program requirements.

Compliance Officer, Compliance Committee, and High-Level Oversight

A. Compliance Officer.

1. The Compliance Officer is an employee of the Delegated entity, or the Management Services Organization (MSO) acting on behalf of the Delegated entity, and should report directly to the highest level of the organization. The responsibilities may include, but are not limited to:

   a. Advising the organization and FDRs on policy requirements and the development, distribution and implementation of policies.

   b. Ensuring that policies accurately and effectively communicate compliance and regulatory requirements.

   c. Periodically reviewing policies and initiating needed updates.

   d. Notifying Senior Management and IEHP of non-compliance issues.

   e. Preparing an update on a periodic basis of the Compliance Program for presentation to the Governing Board, which includes at a minimum:

      1) Policy updates.

      2) Issues of Non-Compliance.

3) Fraud, Waste and Abuse detection, monitoring and reporting.

4) Auditing and Monitoring Program Updates.

B. High Level Oversight – The Delegated entity's Governing Body should be responsible for:

1. The annual review and approval of the Compliance, Fraud, Waste and Abuse, and HIPAA Programs;
2. Adoption of written standards including the Delegated entity's Code of Conduct;
3. Monitoring and support of the compliance program; and
4. Understanding regulatory and/or contract changes, policy changes and health reform and the impact on the Delegated entity's Compliance Program.

Effective Training and Education

A. IEHP requires FDRs to provide Compliance Training to all Employees (Temporary and Permanent), Providers, Governing Body, contractors, vendors, and volunteers.

1. Compliance Training must be provided within ninety (90) days of initial employment/start, whenever significant changes are made to the Compliance Program, upon changes in regulatory or contractual requirements related to specific job responsibilities or when legislative updates occur and on an annual basis.

   Training should include, at a minimum:

   a. Reinforcement of the organization's commitment to compliance.

   b. Privacy/confidentiality issues, as well as regulatory updates and recent health care compliance related adverse actions such as penalties and settlements.

   c. Fraud, waste and abuse issues as well as regulatory updates and recent health care compliance related adverse actions such as penalties and settlements.

   d. HIPAA Privacy and Security and the Health Information Technology for Economic and Clinical Health (HITECH) Act regulations.

   e. Laws that may directly impact job related functions such as anti- kickback laws, privacy breaches, the False Claims Act, and, the consequences of non-compliance.

   f. Changes in compliance and regulatory requirements and updates on the consequences of non-compliance with these requirements.

   g. Responsibilities to report concerns, misconduct, or activities related to non-compliance.

2. Delegated entities may use a written test, or develop other mechanisms to assess effectiveness of the training.

3. FDRs who have met the Fraud, Waste and Abuse (FWA) certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and supplies (DMEPOS), or through the Medicare Learning Network (MLN), are deemed to have met the training and educational requirements for FWA, but must provide an attestation to IEHP of deemed status.
4. Documentation of education/training activities must be retained for a period of ten (10) years. Documentation may include sign-in forms, signed attestations and the completion of testing results.

Effective Lines of Communication

A. IEHP requires all FDRs, vendors, and other business associates to report compliance concerns and suspected, or actual, misconduct regarding delegated functions, IEHP Members and Providers. This requirement is communicated through:
   1. Provider Manuals, newsletters and bulletins. Providers and Delegated entities are required to submit signed acknowledgement of their receipt of the Provider Manual which delineates compliance reporting responsibilities;
   2. Annual Compliance training for all FDRs; and
   3. The Vendor Code of Conduct applicable to business associates, FDRs, and those with whom IEHP has a business relationship (See Attachment, "IEHP Vendor Code of Conduct" in Section 23).

B. IEHP has the following mechanisms available for reporting Compliance issues:
   1. Compliance Hotline - (866) 355-9038;
   2. E-mail - compliance@iehp.org;
   3. Secure fax - (909) 477-8536; or
   4. Mail - Compliance Officer, PO Box 1800, Rancho Cucamonga, CA 91729.

C. Delegated entities are expected to develop similar mode of referring compliance issues, including reporting non-compliance issues to IEHP.

Well Publicized Disciplinary Standards

A. Delegated entities must develop and implement disciplinary policies that reflect the organization's expectations for reporting compliance issues including non-compliant, unethical or illegal behavior.

B. Policies should provide for timely, consistent and effective enforcement of established standards when non-compliance issues are identified.

C. Disciplinary standards should be appropriate to the seriousness of the violation.

Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks

A. Delegated entities must develop a monitoring and auditing component of the Compliance Program to test and confirm compliance across functional areas with contractual, legal and regulatory requirements. The monitoring and auditing processes must be documented to show subject, method and frequency.

B. Definitions:

1. Audit - a formal review of compliance with a set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

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

3. Risk assessments - broad based audits used to identify opportunities for improvement.

C. IEHP utilizes both internal and external resources to conduct the audit program. It is IEHP's expectation that the individual or Delegated entity responsibility for the audit content cooperate with the audit process by providing access to documents and other information requested.

1. Methods of review include, but are not limited to:

a. Provider/Contractor initial contract and annual Delegation Oversight Audits;

b. Quarterly Reporting;

c. External reviews of medical and financial records that support claims for reimbursement and Medicare cost reports; and

d. Trend analysis and studies that identify deviations in specific areas over a given period.

D. Delegated entities must implement a screening program for employees, Board Members, contractors, and business partners to avoid relationships with individuals and/or entities that tend toward inappropriate conduct. This program includes:

1. Prior to hiring or contracting and monthly thereafter, review of the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) that are excluded from participation in government health care programs (42 CFR §10011901).

2. Prior to hiring or contracting and monthly thereafter a monthly review of the GSA System for Award Management (SAM).

3. A monthly review of the Department of Health Care Services Medi-Cal Suspended and Ineligible list.
4. Criminal record checks when appropriate or as required by law.
5. Standard reference checks, including credit for Employees.
6. Review of the National Practitioner Databank (NPDB).
7. Review of professional license status for sanctions and/or adverse actions.
8. Reporting results to Compliance Committee, Governing Body, and IEHP as necessary.

Procedures and System for Prompt Response to Compliance Issues

A. Adverse findings routinely require corrective action plans, designed to identify the root cause of compliance failures; to implement actions directed at improving performance and/or eliminating risk; and, to ensure that desired results are being sustained. Follow-up auditing and/or monitoring is conducted to assess the effectiveness of these processes.

B. Delegated entities must develop and implement a system for reporting and prompt response to non-compliance and detected offenses.

1. When potential and/or actual non-compliance is reported or suspected, the following steps should be taken:

a. The activity causing the non-compliance should be promptly halted and/or mitigated to the extent possible to prevent harm to individuals, entities and/or IEHP.

b. Investigations should be promptly initiated in accordance with the Fraud, Waste and Abuse Plan; the HIPAA Plan, the Compliance Plan, and, or, in consultation with the IEHP Special Investigations Unit (SIU) or the Compliance Officer who has the authority to open and close investigations.

c. The implementation of Corrective Action Plans (CAP) should be based on the policy guidance that address the issue of non-compliance, as appropriate. These may include, but are not limited to:

1) Initiation of corrective action plans and/or agreements.

2) Repayment of identified over-payments.

3) Initiation of Task Forces to address process and/or system deficiencies that may have caused or contributed to the non-compliance.

4) Additional education and training.

5) Modification of policies and procedures.

6) Discipline or termination of Employees or contracts.

d. Preventive measures should be implemented to avoid similar non-compliance in the future, including monitoring of corrective action plans.

1) Investigations may consist of an informal inquiry or involve formal steps such as interviews and document collection, depending on the circumstances involved.

2) Investigations should be conducted in consultation with the Compliance Officer who has the final authority to determine this process.

3) External investigations should be performed by the Special Investigation Unit (SIU) Team or related unit. Referrals to legal counsel and/or other external experts should be utilized as deemed appropriate by the Compliance Officer.

4) The timeliness and progress of the investigation should be documented by the SIU Team or related unit.

5) Documents and evidence obtained during investigations should be retained for a period of no less than ten (10) years.

e. Reporting of these activities and their results should be provided to:

1) The Compliance Officer;

2) The Compliance Committee;

3) Chief Executive Officer;

4) The Governing Body, if the Compliance Officer in consultation with the Chief Executive Officer deems there is a significant non-compliance finding;

5) Governmental authorities, as determined by the Compliance Officer, if there is an obligation to report misconduct that violates criminal, civil or administrative law within a reasonable time of discovery;

6) Responses to government inquiries and investigations should be coordinated by the Compliance Officer; and

7) IEHP Compliance Department.

Assessment of Compliance Effectiveness

A. On an annual basis, Delegated entities must conduct a review of the Compliance Program to ensure the Program is effective in meeting applicable State and Federal regulations, and preventing Fraud, Waste and Abuse (FWA). The assessment should include, but is not limited to:

1. Written Policies and Procedures and Standards of Conduct;
2. Designation of a Compliance Officer and High Level Oversight;
3. Effective Lines of Communication;
4. Well Publicized Disciplinary Standards;
5. Ongoing Education and Training;
6. Effective System for Routing Auditing, Monitoring, and Identification of Compliance Risks; and
7. Reporting and Prompt Response for Non-Compliance, Potential FWA, and Detected Offenses.

REFERENCES:

A. Medicare Managed Care Manual, Chapter 21(42 C.F.R. §§422.503(b)(4).

B. Prescription Drug Benefit Manual, Chapter 9 (42 C.F.R. §423.503(b)(4).

C. 42 CFF 438.608.

24. PROGRAM DESCRIPTIONS

E. Compliance Program Description

Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2015
Chief Title: Chief Executive Officer	**Revision Date:**	January 1, 2019