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Monitoring and Auditing Fraud, Waste and Abuse

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC (NHP/NHIC/NHAS) proactively audits and monitors all allegations and risks for potential Fraud, Waste, and Abuse (FWA) across its Medicare and Commercial products. NHP/NHIC/NHAS reviews information regarding Fraud alerts and other credible resources to ensure timely and relevant awareness of potential FWA schemes for impact, NHP/NHIC/NHAS's Payment Integrity Special Investigations Unit (SIU) monitors and conducts investigational audits associated with daily plan operations to eliminate or reduce the risk of FWA.

Policy Detail:

I. NHP/NHIC/NHAS is committed to preventing, detecting, and deterring FWA, and identifying theft in compliance with all applicable state/federal rules, laws, regulations, and other requirements.

II. NHP/NHIC/NHAS's Payment Integrity SIU is responsible for identifying and investigating all suspected or known FWA and identifying potential theft by working with applicable internal departments and external agencies. The SIU is also responsible for making recommendations of process improvements for the Medicare Parts C and D programs aimed at increasing proactive detection of FWA.

III. The NHP/NHIC/NHAS fraud risk assessment has been incorporated into the Medicare Compliance Program's overall annual evaluation process, to assist in the identification of FWA across the health plan. The SIU also monitors prior reported Healthcare Compliance Core (HCC) forms to ensure that misconduct has been eliminated, and to identify if further action needs to be taken to address the issues.

Procedure Detail:

I. The NHP/NHIC/NHAS Payment Integrity manager and/or their designee will utilize the Office of Inspector General Annual Report, Centers for Medicare and Medicaid Services (CMS) Health Plan Monitoring System (HPMS) and other public and private industry resources to audit and monitor for FWA. In addition, the Compliance department annually sets an auditing schedule based on the results of the annual risk assessment processes. Other audit tools may also be utilized such as policies and procedures and any applicable department and/or subcontractor specific documentation. All managers and/or subcontractors/vendors will be notified prior to any audit of the specific audit tools that will be utilized.

II. NHP/NHIC/NHAS's contracted PBM for Medicare Part D will be audited annually to

ensure compliance with all Medicare Part D guidelines. NHP/NHIC/NHAS will notify its PBM of an upcoming audit and send an audit schedule to follow for auditing/reporting frequency with due dates. The results will be reported back to the NHP/NHIC/NHAS Compliance Officer for reporting to senior management and/or the Board of Directors.

III. All department managers are responsible for ensuring that his/her department meets all applicable statutory and regulatory requirements. NHP/NHIC/NHAS department managers are required to perform routine internal audits to assess the department's risk and/or successes. These quarterly audits will be maintained in the department and reported in the Compliance work plan. The results will be reported quarterly at NHP/NHIC/NHAS Compliance Committee meetings. Any findings of potential fraud will be reported to the NHP/NHIC/NHAS Payment Integrity and Recovery SIU for further investigation.

IV. The NHP/NHIC/NHAS Payment Integrity SIU will conduct random and targeted audits of suspected fraud to determine the level of impact to the Plan and members and make recommendations of necessary actions or report the findings to the Medicare Drug Integrity Contractor (MEDIC). The audit results are shared with the Medicare Compliance Officer and the department manager. Should any of the audits indicate areas of non-compliance; a Corrective Action Plan (CAP) will be implemented and monitored for completion by the Compliance Department.

Definitions:

Pharmacy Benefit Manager (PBM): An entity that provides pharmacy benefit management services, which may include contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; performing drug utilization review; and operating disease management programs. Many PBMs also operation mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies. A PBM is often a first tier entity for the provision of Part D benefits.

Special Investigations Unit (SIU): is an internal investigation unit responsible for conducting investigations of potential FWA.

Compliance Intake Form (CIF): reference was changed to new name from CSI (Compliance Safety Investigation) form.

Regulatory Citations:

CMS Part C Manual Chapter 21, section 50.6 – 50.6.2
CMS Part C Manual Chapter 21, section 50.6 – 50.6.2
42 CFR §422.503; 42 CFR §423.504

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