# Policy and Procedure

<table>
<thead>
<tr>
<th>Title:</th>
<th>Effective Monitoring and Auditing</th>
<th>Policy Number:</th>
<th>COM-MCR-16</th>
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<td>Originator:</td>
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<td>1/1/2013</td>
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<td>Michelle Watson, Medicare</td>
<td>Effective Date:</td>
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<td>Product:</td>
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<tr>
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<td>Chapter 9 and 21 Prescription Drug</td>
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<td>and Medicare Managed Care Manual,</td>
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<td>Compliance Program Guidelines,</td>
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<td>Sections 50.6.1, 50.6.3, 50.6.4</td>
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<td>and 50.6.5</td>
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<td>Approved By:</td>
<td>Dana Gryniuk, General Counsel</td>
<td>Signature:</td>
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**PURPOSE:**

To evaluate compliance, detect potential violations, and establish and implement an effective system for routine monitoring and identification of compliance risks. This includes:

- Routine internal monitoring of compliance risk areas by operational units
- Periodic internal audits to confirm results of monitoring
- External audits of first tier entities to evaluate compliance with requirements
- Evaluation of overall effectiveness of the Compliance Program
RESPONSIBILITY:
Medicare Compliance Officer
Internal Audit Department

DEFINITIONS:
Monitoring – Monitoring is an ongoing check and measurement of performance directed by management to ensure processes are working as intended. Although auditing techniques may be employed, monitoring is often less structured than auditing. Monitoring is typically performed by department staff and communicated to department management. Monitoring efforts are generally more frequent and closer to real time than audit activities.

Auditing – Auditing is a more formal, systematic review of past performance against applicable internal and external standards, using structured methodology and evaluation tools. Audits are typically performed by individuals outside of the department or function under review, such as the Compliance Department. SHP will utilize an auditor who is external of both SHP Operational units and the first tier entity being audited.

POLICY:
Simply Healthcare Plans (“SHP”) ensures compliance with Medicare regulations, sub-regulatory guidance, contractual obligations, applicable Federal and State laws, and internal policies and procedures through robust auditing and monitoring activities. In addition to department level performance monitoring conducted by various business units, SHP employs Internal Audit staff dedicated to auditing and monitoring the business for compliance with aforementioned legal and regulatory obligations.

The Internal Audit department utilizes an Audit Work Plan developed and maintained under the supervision of the Medicare Compliance Officer to guide its efforts. The Audit Work Plan includes both scheduled and ad hoc audits and is prioritized based on the severity of risk associated with each audit. (See COM-MCR- Risk Assessment P&P) The Audit Work Plan considers several elements, including but not limited to: CMS communications (e.g. CTMs, NONCs, Warning Letters), department self-reporting, risk-assessment tools, complaint trending, call trending and Fraud, Waste and Abuse reporting from the Special Investigations Unit (SIU).

Audit elements are based on regulatory, legal, and internal policy requirements, as well as guidance contained within the Program Audit Processes and Protocols issued via HPMS. SHP utilizes targeted sampling methodology to better measure the compliance of processes based on known risk factors. The Internal Audit department allows for a period of rebuttal to initial findings prior to drafting a final audit report and assigning a score. Audit results are delivered to the Medicare Compliance Officer, the Compliance Committee, Executive Leadership, and the appropriate business units along with an audit score and corrective action plans, where necessary.

The Medicare Compliance Officer is charged with ensuring the Internal Audit staff is qualified and knowledgeable of Medicare program requirements and auditors are objective and independent from
areas they are auditing.

- IA utilizes monitoring results provided from Operational areas to help identify risk areas for further auditing.
- IA utilizes risk assessments to guide the design of auditing activities.
- The audit work-plan includes focus on the evaluation of overall effectiveness of the Compliance Program.
- If any major findings are identified, Senior Leadership and/or the Board are notified as appropriate in a timely manner.
- When appropriate, CMS is notified of adverse findings in a timely manner.

### PROCEDURE:

#### I. Schedule

**A.** Each Operational Area is audited based on the Annual Audit Work Plan, which is developed and maintained by the Medicare Compliance Officer in conjunction with the Internal Audit Department.

**B.** The audit schedule listed in the Annual Audit Work Plan is prioritized based on a variety of inputs and contributing factors including:

1. CMS Communications (i.e., Corrective Action Plans (CAPs), Notices of Non-Compliance)
2. Annual Risk Assessments
3. Regulatory Updates
4. Department Self-Reporting
5. Complaint Trending (i.e., Grievances and Appeals)
6. CTM Trending
7. Call Trending
8. Special Investigations Unit Incident Reporting
9. FWA Alerts
10. Prior Audit Results
11. Available Resources

**C.** An overview of criteria to be tested for each audit is defined within the Audit Work Plan entry.

**D.** Each scheduled audit is assigned an auditor, start and end dates, methodology, business owner and necessary resources.

#### II. Scope and Methodology

**A.** Audit criteria must be objective, measurable, and defined per regulatory guidance and/or internal policies.

**B.** Supplemental criteria may be added if deemed necessary. (i.e., at the request of Senior Management or based on a NONC or CAP issued by a regulatory agency) All supplemental criteria must be objective and measurable.

**C.** Sample size will be determined based on universe size and guidance provided within the Program Audit Process and Protocols issued via HPMS.

**D.** Sample selection is targeted based on known risk factors.

**E.** Findings are deemed met, not met or met with notes.

#### III. Audit Notification

**A.** Each month the Internal Audit department compiles a Formal Audit Notification for each
area listed on the Annual Audit Work Plan to be audited during the month.

B. The Formal Audit Notification will provide the Business Owner with detailed steps and timeframes for each portion of the audit. (i.e., Universe due date, universe specifications, required sample documentation, etc.).

C. The Internal Audit department will also schedule an Audit Kickoff Meeting with each department prior to the start of the actual audit to discuss expectations and answer any questions the Business Area might have regarding the audit. If any changes need to be made to the due dates listed in the Audit Notification, it is discussed during this meeting.

IV. Reporting of Audit Findings

A. A report of initial findings is drafted upon completion of sample testing, including findings and recommendations for identified deficiencies.

B. Business Owners are afforded an opportunity for rebuttals, which are then considered by the Auditor and/or the Medicare Compliance Officer.

C. A final audit report is drafted including any modifications resulting from accepted rebuttals, and a final audit score if assigned. The final audit report is shared with the Medicare Compliance Officer, the Compliance Committee, executive Leadership and appropriate Business Owner.

D. Audit scores are posted with in a Medicare Compliance Scorecard housed on the Internal Audit SharePoint site and made available to all SHP employees.

E. Confirmed audit deficiencies are uploaded into the Remediation Tracker housed on the Internal Audit SharePoint site for ongoing monitoring with access being provided to those deemed necessary by each Operational Areas Leadership.

V. Corrective Action Plans (CAPs)

A. Audits resulting in scores lower than the acceptable threshold (currently 80%) will have a Corrective Action Plan(s) issued to the appropriate Business Owner(s).

B. The CAP document will clearly state the identified compliance deficiencies, along with the specific goals and deadlines for remediation.

C. The Internal Audit department will meet with the Business Owner(s) to discuss the required content of the CAP and the expectations for remediation. At this point, both Internal Audit and the Business Owner(s) sign the document indicating they have received and understand the expectations set forth with in the CAP document.

D. The Business Owner(s) will be responsible for defining planned remediation activities (i.e., process improvements and/or system enhancements) and expected dates of implementation. Each CAP is required to have the following information provided by the responsible Business Owner(s):
   - Impact Analysis
   - Root Cause Analysis
   - Process Improvement(s)
   - Anticipated and Actual Completion Dates

E. CAPs will be monitored by the Internal Audit department to ensure effective and timely implementation. Internal Audit and the Business Owner will sign the CAP document again upon successful completion and validation of the remediation. This closes the CAP.

F. Failure to comply with the CAP process or repeated incidents of similar non-compliance will be brought before the Medicare Compliance Officer and the Compliance Committee for further disciplinary actions as deemed necessary.
VI. Monitoring
   A. Internal Audit and the Medicare Compliance departments monitors the following items/areas on an ongoing basis:
      1. Remediation of issues identified within the Medicare Compliance Log and/or Medicare Risk Assessment Log
      2. Remediation of Corrective Action Plans
      3. Monthly trending reports supplied by each Business Unit
   B. Work Plan Audits receiving a failing score will have follow-up audits conducted to monitor improvements.
   C. Scope, Methodology, Reporting and Deficiencies are handled as described above.

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<tr>
<th>Date</th>
<th>Version Number</th>
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<td>1/1/2014</td>
<td>02</td>
<td>Keisha Pinnock</td>
<td>Updated to reflect current process</td>
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