AIDS Healthcare Foundation

Compliance and Anti-Fraud Plan 2024

Revised: November 2023
Compliance Committee Approved: April 1, 2024
EOC Approved: April 2, 2024

AIDS Healthcare Foundation
Compliance and Anti-Fraud Plan – 2024

Purpose

AIDS Healthcare Foundation "AHF") offer a number of managed care plans and programs for people with HIV and AIDS:

- PHP (Medicare Advantage Prescription Drug chronic disease special needs plan (C-SNP), Los Angeles County, California)
- PHC California (Medi-Cal Managed Care Plan, Los Angeles County, California)

AHF recognizes that, as a recipient of Medicare and Medicaid funds, AHF must comply fully with all applicable federal and state laws and regulations, as well as with the contractual requirements and instructions of the administering government agencies, including the Centers for Medicare & Medicaid Services ("CMS"), California's Department of Health Care Services ("DHCS"), and California's Department of Managed Health Care ("DMHC").

As required by law and its government contracts, and in furtherance of the commitment to prevent, detect, and report non-compliance and fraud, waste and abuse, AHF has developed this Compliance and Anti-Fraud Plan ("Compliance Plan" or "Plan"), which includes measures to detect, correct, and prevent non-compliance, fraud, waste, and abuse in connection with AHF's healthcare programs and plans. The Plan consists of seven statutorily required elements that together establish AHF's commitment to operating ethically and lawfully.

1. Written policies and procedures and standards of conduct;
2. Compliance Officer and Compliance Committee;
3. Training and education;
4. Effective lines of communication between the Compliance Officer and internal and external persons;
5. Enforcement of standards through well publicized disciplinary guidelines;
6. Internal monitoring and auditing;
7. Prompt detection and correction of noncompliance development of corrective action initiatives.

The Compliance and Anti-Fraud Plan is a living document that is updated on a regular basis to reflect organizational and external regulatory requirements. This 2024 Plan updates the 2023 Compliance and Anti-Fraud Plan. The Compliance Plan and Anti-Fraud Plan are integrated into this one document and incorporate AHF's Compliance and Anti-Fraud policies and procedures. The 2024 Plan is designed to provide a broad, narrative overview of AHF's Compliance and Anti-Fraud program, while the details about its operation can be found in the referenced policies and procedures. Finally, this Plan is intended to apply uniformly to all of AHF's plans and programs in California, except

where specific regulatory requirements (DHCS and CMS) require a distinct procedure. In that case, the exception is noted in the appropriate policy and procedure.

The Compliance and Anti-Fraud Plan and its policies and procedures are reviewed and updated annually and as needed, are approved by the Managed Care Compliance Committee and the Executive Oversight Committee ("EOC"). The Compliance and Anti-Fraud Plan reinforces the AHF's commitment to ethical standards of conduct.

AHF takes any potential conflict of interest seriously. On an annual basis, AHF sends out a conflict-of-interest survey to personnel. AHF will avoid any situation in which a conflict of interest could exist or appear to exist between our personal interests and the business interests of the company. AHF encourages all employees to support their communities. Employees should avoid outside jobs or activities that conflict with the employee's current AHF position or reflect poorly on the company. Regarding investigations, if there is a potential or confirmed conflict of interest with the investigator and/or personnel in the Compliance or Special Investigations Unit, the investigator or reporter are encouraged to go directly to the Compliance Officer or Legal Department. The Special Investigations Unit is comprised of a Compliance/SIU Manager, who has over a decade of health care fraud investigations is a Certified Fraud Examiner (CFE).

The Compliance Officer is responsible for carrying out the Compliance and Anti-fraud plan. The Compliance Officer has an extensive background in Fraud, Waste, and Abuse including overseeing and managing investigations and holds a certification in Health Care Compliance.

The Compliance Officer's contact information is:

Compliance Officer
6255 Sunset Blvd., 21st Floor
Los Angeles, CA 90028
(323) 337-9151 (phone
(888) 238-2385 (fax)
PHC-Compliance@ahf.org

Federal Government Exclusions Screenings

AHF ensures that the Department of Health and Human Services Office of the Inspector General DHHS OIG and Government Services Administration ("GSA") exclusion lists are checked with respect to all employees, contractors, EOC members, and FDRs upon hire, appointment or contracting and monthly thereafter, and coordinates any resulting personnel issues with the appropriate party.

1. Written Policies, Procedures, and Standards of Conduct

AHF has robust compliance policies and procedures that support the Code of Conduct and the Compliance and Anti-Fraud Plan. These policies and procedures are designed to reduce potential noncompliance and fraud, waste and abuse. In addition to compliance policies, the AHF has operational policies and procedures that partner with the compliance policies to ensure the operational implementation of and adherence to compliance requirements.

All policies and procedures are housed electronically. All employees, contractors, first-tier, downstream or related entities (FDRs) and EOC members are given access to policies and procedures no later than ninety (90) days from the date of hire, appointment or contracting and annually thereafter. Notification is sent out via electronic communications if there is a substantive change to those policies and procedures outside of the annual review period.

AHF expectations for compliance adherence are detailed in compliance-specific policies, including but not limited to policies regarding AHF's stance on non-intimidation, non-retaliation, privacy, security and applicable laws and regulations regarding potential non-compliance and FWA.

These policies along with the AHF's Code of Conduct set minimum conduct standards for employees, contractors, FDRs and EOC members. Specifically, compliance expectations outlined in the Code of Conduct consist of:

- Expectations for honest and ethical behavior
- Obligations to report potential/suspected non-compliance or fraud, waste and abuse
- How to report potential/suspected non-compliance or fraud, waste and abuse
- AHF's policy on non-retaliation and non-intimidation

All FDRs and operational areas are required to maintain functional, service-specific policies and procedures that support the service or function that they are responsible for. All internal and FDR policies and procedures are subject to review by AHF's Compliance Department.

All managed care employees, agents, contractors and FDRs are required to adhere to AHF's published, written standard of conduct ("Code of Conduct").

AHF conducts its managed care operations and compliance activities pursuant to written policies, procedures.

AHF's policies and procedures for creating, implementing and updating AHF's Standards of Conduct and its policies and procedures are set forth in our Compliance Policies and Procedures. A listing of those Compliance policies are listed below in this Compliance and Anti-Fraud Plan.

2. Compliance Officer and Compliance Committee

The Managed Care Department employs a full-time Compliance Officer who reports to the Chief of Managed Care. The Compliance Officer oversees AHF's compliance with federal and state laws and regulations (i.e., Medicare and Medicaid), government agency guidance (e.g., CMS), as well as with AHF's government contract requirements. The Compliance Officer has unrestricted access to report any fraudulent or otherwise

unlawful or unethical activity, including fraud[1] and abuse[2] and overpayment, directly to the EOC.

The Compliance Officer responsibilities include, but are not limited to:

- Ensuring that Compliance reports are provided regularly to AHF's EOC, CEO, and compliance committee.

- Involvement and awareness with departments on self-monitoring and potential non-compliance issues.

- Approving and developing educational training programs to ensure that the sponsor's officers, EOC members, managers, employees, FDRs, and other individuals are knowledgeable about AHF's compliance program, the written Code of Conduct, compliance policies and procedures, and all applicable statutory and regulatory requirements.

- Developing and implementing methods and programs that encourage managers and employees to report Medicare program noncompliance and potential FWA without fear of retaliation.

- Maintaining the compliance reporting mechanism and closely coordinating with the internal departments and the SIU, where applicable.

- Responding to reports of potential FWA, including the coordination of internal investigations with the SIU or other internal department and the development of appropriate corrective or disciplinary actions, if necessary.

- Coordination and oversight of internal investigations.

- Ensuring that the DHHS OIG and Government Services Administration ("GSA") exclusion lists have been checked with respect to all employees, EOC members and FDRs monthly and upon hire/prior to contract initiation.

- Maintaining documentation for each report of potential noncompliance or potential FWA received from any source, through any reporting method (e.g., hotline, mail, or in-person).

[1]"Abuse": Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. Recipient practices that result in unnecessary cost to the Medicaid program.

[2] "Fraud" means: An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

- Overseeing the development and monitoring of AHF's auditing, monitoring and delegation oversight program including the implementation of corrective action plans as needed.

- Coordinating potential fraud investigations/referrals with the SIU, where applicable, and the appropriate NBI MEDIC.

The Compliance Officer chairs AHF's Managed Care Compliance Committee, which assists the Compliance Officer in designing, implementing, and adapting AHF's Compliance Plan to AHF's needs and changing regulatory environment. The Managed Care Compliance Committee meets quarterly (four times/year) and reports to the Managed Care EOC. Specifically, responsibilities of the Compliance Committee include, but are not limited to:

- Meeting at least on a quarterly basis, or more frequently as necessary to enable reasonable oversight as determined by the Compliance Officer.

- Assisting in the development of strategies to promote compliance and the detection of any potential violations.

- Reviewing and approving compliance and FWA training and ensuring that training and education are effective and appropriately completed.

- Assisting with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work plan.

- Assisting in the creation, implementation and monitoring of effective corrective actions as needed.

- Developing innovative ways to implement appropriate corrective and preventative action as requested by the Compliance Officer.

- Reviewing effectiveness of the system of internal controls designed to ensure compliance with Medicare regulations in daily operations.

- Supporting the compliance officer's needs for sufficient staff and resources to carry out his/her duties.

- Ensuring that the AHF has appropriate, up-to-date compliance policies and procedures.

- Ensuring that AHF has an effective system for employees and FDRs to ask compliance questions and report potential instances of Medicare program noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation.

- Ensuring that the sponsor has a method for members to report potential FWA.

- Reviewing and addressing reports of monitoring and auditing of areas in which the sponsor is at risk for program noncompliance or potential FWA.

The Compliance Officer also oversees the Special Investigative Unit (SIU) activities, which include the detection, investigation, and follow-up actions related to potential overpayment, fraud, waste, and abuse occurrences. Specifics, including an organizational chart, related to the structure of the SIU and methodologies utilized are set forth in Compliance Policies and Procedures.

AHF's EOC receives quarterly reports on AHF's Managed Care compliance programs, including those involving managed care (i.e., status of Compliance Plan implementation; identification and resolution of potential or actual instances of noncompliance; oversight and audit activities.) The EOC is responsible for providing the Compliance Officer and Compliance Committee with adequate resources to operate the Compliance Plan. In addition, the EOC exercises reasonable oversight by, but not limited to:

- Annual review and approval of compliance policies and procedures.
- Review and approval of compliance and FWA training.
- Review and approval of compliance risk assessment.
- Review of internal and external audit work plans and audit results.
- Review and approval of corrective action plans resulting from audits.
- Review and approval of appointment and removal of the Compliance Officer.
- Review of dashboards, scorecards, self-assessment tools, etc., that reveal compliance issues.

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3. Compliance Training and Education

AHF Managed Care directors and managers are responsible for ensuring their staff is trained on how to perform their jobs lawfully and ethically. The Compliance Officer is responsible for developing and overseeing the implementation of formal compliance trainings specifically related to detecting, reporting, and preventing fraud, waste and abuse.

All AHF Managed Care staff, agents, and contractors receive compliance training within ninety (90) days of initial hire and are required to participate in formal compliance training at least annually thereafter. Training is launched through AHF's "AHF University". Additionally, informal compliance training shall go on throughout the year, for

example, at staff meetings, or through email updates from the Compliance Officer. Compliance trainings will educate participants on the various anti-fraud laws and penalties (i.e., Anti-Kickback, False Claims, Stark) and will emphasize AHF's non-retaliation policy as well as whistleblower protections. Training also includes an overview of the Compliance and Anti- Fraud Plan which reviews:

- An overview of how to ask compliance questions, request compliance clarification or report suspected or detected noncompliance.
- Requirements to report to AHF actual or suspected noncompliance or potential FWA;
- Provides examples of reportable noncompliance that an employee might observe;
- A review of potential conflicts of interest and AHF's system for disclosure of conflicts of interest;
- An overview of the monitoring and auditing process; and
- A review of the laws that govern employee conduct AHF's programs.
- Special Investigations Unit Role

4. Communication between the Compliance Officer, Compliance Committee, AHF Employees, AHF's First Tier and Downstream and Related Entities

AHF takes compliance seriously as evidenced by the implementation of strong lines of communication between employees, FDRs, AHF leadership, Compliance Officer, Compliance Committee and the EOC. Lines of communications are accessible to all and allow reports of potential non-compliance and fraud, waste and abuse to be reported anonymously or via a variety of mechanisms. There is a confidential and anonymous reporting line that operate twenty-four (24) hours a day, seven (7) days a week at 1-800-AIDS-HIV.

Mechanisms for reporting are available through:

- In-person reporting to management or any member of the Compliance team
- Directly to the Compliance Officer
- Telephonically via the Compliance Hotline, or
- Via E-mail to published user group e-mails

The above processes and mechanisms were put in place to receive, record, respond and track all potential reports of non-compliance and fraud, waste and abuse. These mechanisms are made available to FDRs and are reiterated on a regular basis to ensure

they have the information available. All reports of potential non-compliance and fraud, waste and abuse are investigated immediately and are remediated as soon as the issue warrants as described below. This process is overseen by the Compliance Officer. The Compliance Officer provides reports regularly to the Compliance Committee, Chief of Managed Care and the EOC.

The Compliance Officer has an open-door policy. AHF regularly instructs its directors, managers, employees, agents, and contractors on how they may ask compliance questions or report compliance issues such as suspected fraud. AHF provides a compliance hotline (1-800-AIDS-HIV), where employees, agents, and contractors may leave anonymous reports of noncompliance or fraud. AHF also received tips from its members, FDRs and other community partners.

5. Enforcement of standards through well publicized disciplinary action

AHF publishes disciplinary guidelines in its Employee Handbook. Employees and contractors are admonished in written, published policies that AHF will not tolerate any fraudulent or otherwise unlawful conduct, and such conduct will be subject to discipline up to and including termination.

The Director of Human Resources maintains and periodically reviews records of discipline in conjunction with the Director of Compliance to promote consistency and fairness in the administering of discipline.

AHF's policies and procedures for creating, publishing, and enforcing disciplinary guidelines are set forth in the Plan's Policies and Procedures.

6. Internal Monitoring and Auditing

AHF's managers are responsible for making sure their staff works according to legal requirements and AHF's policies and procedures. The Compliance Officer will oversee ongoing monitoring and auditing activities to check for continued compliance.

Each year, the Officer will present a formal Risk Assessment as well as monitoring/auditing work plans to the Managed Care Compliance Committee for review and approval. The plan will be developed based on an assessment of AHF's risk areas as well as on priorities established by regulatory agencies such as CMS or the Office of Inspector General ("OIG").

To ensure compliance with all applicable laws, regulations, sub regulatory guidance, contractual agreements and AHF policies and procedures as it relates to the Medicare program AHF utilizes several methods for our auditing and monitoring program such as:

- Active self-monitoring by departments and oversight conducted on an on-going basis that aligns with our work plans by the Compliance Department.

- Utilizes independent reviews and audits as another level of verification of compliance as needed.

The results of all auditing and monitoring conducted by Compliance are shared with appropriate leadership. Audit results, including any corrective action plans are reported to the Compliance Committee.

Specific to FWA, AHF utilizes tips, claims review and CMS Health Plan Management System (HPMS) Memos to proactively detect outliers and data mine claims for potential FWA. AHF has a number of practices and procedures for detecting fraud, waste or abuse including:

- Through its utilization management procedures and data mining activities, AHF is able to detect suspicious provider charges.
- Through its Explanation of Benefits, AHF informs PHP and PHC California members about their recent utilized services, allowing them an opportunity to question any unauthorized services and thereby detect possible fraud.
- A Compliance Hotline is available to AHF employees to report suspected fraud.
- Employees are given anti-fraud training and instructions in their Employee Handbook about detecting/reporting fraud.
- The Compliance Officer's duties include conducting periodic internal audits of AHF operations (including among other things claims processing, grievances and appeals, provider complaints), which will include looking for evidence of fraud, waste, and abuse.
- The Compliance Officer will conduct or oversee such activities as data mining, analysis and other data studies specifically designed to detect anomalous patterns that may be indicative of fraud, waste, or abuse.
- AHF educates providers and other contractors about fraud and abuse and provides them with the ability to report through the Compliance hotline.
- AHF's financials are audited annually by outside auditors using generally accepted accounting principles.
- Inventory systems in Information Technology ("IT") and Pharmacy account for AHF assets.

7. Prompt responses and corrective action initiatives

Any material deficiencies identified through the monitoring or auditing process or a reported incident of potential non-compliance or FWA will be remedied through corrective action plans that will be approved and monitored until completion by the Managed Care Compliance Committee. In the period between Committee meetings, approval and monitoring may be done at the quarterly Managed Care EOC meeting or at an ad hoc meeting.

If an AHF employee, agent or contractor reports suspected illegal conduct, including but not limited to misconduct related to payment or delivery of items or services, the Compliance Officer will immediately report the matter to AHF's Chief of Managed Care and will have the Special Investigative Unit (SIU) conduct a timely investigation. Upon notification of a report the SIU reviews the report and conducts a thorough investigation by certified coders, certified fraud examiners utilizing current guidelines, regulations and billing manuals.

In the event that an investigation of misconduct discloses misconduct by an AHF employee, agent, or subcontractor, AHF (through, for example, its Human Resources, Finance, or Provider Relations departments), will conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees). AHF's culture is foundationally based upon several principles of conduct and include:

- Follow AHF's Mission and live the Core Values in your daily work
- Provide high quality, skilled, and competent care
- Offer courteous, compassionate, reliable services to all
- Conduct yourself with professionalism, honesty, and integrity
- Treat all people with respect and dignity
- Treat co-workers, patients, and plan members fairly and equally, regardless of race, color, religion, sex, gender, national ancestry, age, physical or mental disability, sexual orientation, veteran status, or any other status protected by law.
- Safeguard the privacy and confidentiality of patient information entrusted to AHF
- Prevent, detect, and correct potential instances of fraud, waste, or abuse.

Typically, the Compliance Officer and Senior Leadership determine how we as individuals and as an organization support our members and business goals. Failure to comply with the standards by employees, agents or contractors may result in disciplinary action such as performance management but up to and including termination of employment or other relationship. All disciplinary actions are handled with oversight by the Compliance Officer and other senior leadership as appropriate.

AHF shall follow procedures for voluntarily self-reporting potential fraud or misconduct related to the appropriate regulatory agent (i.e., CMS or DHCS) and law enforcement. Examples of triggers that AHF employees, members, providers and contractors are expected to report are issues such as untimely cases, incorrect templates utilized, upcoding, billing for services not performed, unbundling etc.

8. Reporting to Regulatory Agencies

At a minimum, on an annual basis AHF will provide to appropriate regulatory agencies an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency.

References

Medicare Managed Care Manual Chapter 21
Prescription Drug Benefit Manual Chapter 9
Code of Federal Register 42 CFR 422 and 423

Policies and Procedures

1. PHC-CA Compliance and Anti-Fraud Plan
2. PHC-CA Compliance Officer and Managed Care Compliance Committee
3. PHC-CA Written Policies and Procedures
4. PHC-CA Compliance Training and Education
5. PHC-CA Effective Lines of Communication
6. PHC-CA Disciplinary Guidelines
7. PHC-CA Auditing and Monitoring
8. PHC-CA Response to Detected Offenses and Corrective Action Plans
9. PHC-CA False Claim Act
10. PHC-CA Provider False Claims Act
11. PHC-CA Data Certification Policy
12. PHC-CA Delegation Oversight
13. PHC-CA DHCS and DMHC All Plan Letters
14. PHC-CA U.S. Patriot Act
15. PHC-CA Annual Risk Assessment
16. DMHC Key Personnel and Business Administration Change
17. PHC-CA Enforcement Actions Administrative and Monetary Sanctions
18. DMHC Annual Antifraud Reports Requirements
19. PHP Compliance and Anti-Fraud Plan
20. PHP Compliance Officer and Managed Care Compliance Committee
21. PHP Written Policies and Procedures
22. PHP Compliance Training and Education
23. PHP Effective Lines of Communication
24. PHP Disciplinary Guidelines
25. PHP Auditing and Monitoring
26. PHP Response to Detected Offenses and Corrective Action Plans
27. PHP False Claims Act
28. PHP Provider False Claims Act
29. PHP Delegation Oversight
30. PHP Health Plan Management System (HPMS) Memorandums
31. PHP U.S. Patriot Act
32. PHP Annual Risk Assessment