Policy and Procedure No: CO 101.4	**Revision No: 4**
Division: Care Management	
Department: Compliance	
Title: PHP Compliance and Anti-Fraud Plan	
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Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 12/2/2025**
Approving Committee: Compliance Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To describe the elements of PHP's (the Health Plan) Compliance and Anti-Fraud Plan and its measures to detect, correct, and prevent fraud, waste, and abuse (FWA).

Policy:

All Health Plans are required to adopt and implement an effective compliance program, which must include measures to prevent, detect and correct Part C or D program noncompliance as well as FWA. The compliance program must, at a minimum, include the following core requirements:

1. Written Policies, Procedures and Standards of Conduct;
2. Compliance Officer, Compliance Committee and High Level Oversight;
3. Effective Training and Education; 4. Effective Lines of Communication;
4. Well Publicized Disciplinary Standards;
5. Effective System for Routine Monitoring and Identification of Compliance Risks; and
6. Procedures and System for Prompt Response to Compliance Issues.

In order to be effective, the Health Plan's compliance program must be fully implemented, and should be tailored to each sponsor's unique organization, operations and circumstances. A compliance program will not be effective unless the Health Plan devotes adequate resources to the program. Adequate resources include those that are sufficient to do the following:

1. Promote and enforce its Standards of Conduct
2. Promote and enforce its compliance program;
3. Effectively train and educate its governing body members, employees and first-tier, downstream, and related entities (FDRs);
4. Effectively establish lines of communication within itself and between itself and its FDRs;
5. Oversee FDR compliance with Medicare Part C and D requirements;

6. Establish and implement an effective system for routine auditing and monitoring; and

7. Identify and promptly respond to risks and findings

The Health Plan must undertake monitoring and auditing to test and confirm compliance with Medicare regulations, sub-regulatory guidance, contractual agreements, and all applicable Federal and State laws, as well as internal policies and procedures to protect against Medicare program noncompliance and potential FWA.

Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An audit is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

The Health Plan must have monitoring and auditing work plan that addresses the risks associated with the Medicare Parts C and D benefits. The Compliance Officer and Compliance Committee are key participants in this process. The Health Plan must have a system of ongoing monitoring and auditing that is reflective of its size, organization, risks and resources to assess performance in, at a minimum, areas identified as being at risk. The monitoring and auditing work plan must be coordinated, overseen and/or executed by the Compliance Officer assisted if desired by the compliance department staff and/or the compliance committee. The Compliance Officer must receive regular reports from those who are conducting the audits regarding the results of auditing and monitoring and the status and effectiveness of corrective actions taken. It is the responsibility of the Compliance Officer or his/her designee to provide updates on monitoring and auditing results to the compliance committee, the CEO, senior leadership and Executive Oversight Committee of the Board of Directors (EOC).

Procedure:

1. The Health Plan has a written Compliance and Anti-Fraud Plan ("Compliance Plan") with the following elements:

    a. Written policies, procedures, and standards of conduct that articulate the Health Plan’s commitment to comply with all applicable federal and state standards.

    b. The designation of a Compliance Officer and a Compliance Committee that are accountable to Senior Management. The Health Plan has adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Health Plan in preventing and detecting potential Fraud and Abuse activities.

    c. Effective training and education between the Compliance Officer and Health Plan employees, managers and directors, and the Health Plan 's first tier, downstream, and related entities.

    d. Effective lines of communication between the Compliance Officer, members of the Compliance Committee, the Health Plan employees, managers and directors, and the Health Plan’s first tier, downstream, and related entities.

    e. Enforcement of standards through well-publicized statutory and contractual requirements and disciplinary guidelines.

    f. Procedures for internal monitoring and auditing.

g. Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to Health Plan contracts with the respective government agency (i.e., CMS, DHCS, OIR, etc.). Specifically, procedures for:

    1. In the event the Health Plan discovers evidence of misconduct related to payment or delivery of items or services under one of its government contracts, conducting a timely, reasonable inquiry into that conduct.

    2. Taking appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation.

    3. Voluntarily self-reporting potential fraud or misconduct related to the Health Plan, to the appropriate government agency (i.e., CMS, OIR, DHCS) or its designee).

2. The Compliance Plan is prepared by the Compliance Officer and Compliance Committee. The Compliance Plan shall be submitted to the Executive Oversight Committee of the Board of Directors for its review and approval.

3. The Compliance Officer and the Compliance Committee periodically review the Compliance Plan, no less than once a year, and update it to conform to current regulatory and contractual requirements. If the Compliance Plan is revised, the revised Compliance Plan is submitted to the EOC for approval.

Definitions:

1. Abuse: includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

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

3. Downstream Entity: is 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).

4. FDR means First Tier, Downstream or Related Entity.

5. First Tier Entity is 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).

6. Fraud: is 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.

7. FWA: means fraud, waste and abuse.

8. Governing Body; means that group of individuals at the highest level of governance of the sponsor, such as the Board of Directors or the Board of Trustees, who formulate policy and direct and control the sponsor in the best interest of the organization and its enrollees. As used in this chapter, governing body does not include C-level management such as the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, etc., unless persons in those management positions also serve as directors or trustees or otherwise at the highest level of governance of the sponsor.

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

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

    a. Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;

    b. Furnishes services to Medicare enrollees under an oral or written agreement; or

    c. 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).

11. Waste: is 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.

Monitoring:

This policy is updated, as necessary, and reviewed and approved annually by the Compliance Committee.

Reference(s):

1. 42 C.F.R. § 422.503(b)(4)(vi)

2. 42 C.F.R. § 423.504(b)(4)(vi)

3. Medicare Managed Care Manual Chapter 21 Compliance Program Guidelines

4. Prescription Drug Benefit Manual Chapter 9 Compliance Program Guidelines