Title	Compliance Program Definitions	**P&P #:**	CC - 01
Product Line	All Products	**Effective Date**	July 1, 2016
Department	Compliance	**Next Review Date**	January 1, 2017
Initially Developed by	Elizabeth Andrews, MCO	**Date**	June 27, 2016
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Last Approved by	Stephanie Cook	**Date**	July 5, 2017

Policy: Dean Health Insurance, Inc. and Dean Health Plan, Inc. (collectively "Dean") maintains an effective compliance program. Dean's Corporate Compliance policies and procedures provide the framework for that compliance program. The definitions in this policy and procedure are intended to facilitate understanding of these policies and procedures.

Regulatory References: 42 CFR §422.2; 45 CFR §156.20; Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual Chapter 9 – Compliance Program Guidelines, §20.

Definitions:

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 not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.

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

BKD: Vendor that SSM has engaged to provide federal exclusion list testing.

Business Owner: The leader of a business unit responsible for the incident of non-compliance or responsible for the process in which the non-compliance occurred. In the case of non-compliance attributable to FDRs or other vendors, the leader of the business unit responsible for the relationship with that vendor.

Compliance Incident Management System (CIMS):	A ServiceNow tool used to report, manage and document compliance incidents and associated corrective action plans.
CMS:	Centers for Medicare & Medicaid services, the federal entity agency that oversees the Medicare and Qualified Health Plan (QHP) program.
CRMS:	Contract Request Management System is a tool used to manage and document Dean Health Plan's contract requests.
Delegated Entity (QHP):	Any party, including an agent or broker that enters into an agreement with a QHP issuer (Dean) to provide administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents relating to the QHP program.
Discrimination:	Any practice that distinguishes among individuals either directly or indirectly, in the type, quantity, quality or timeliness of program services, aids or benefits that they receive or the manner in which they receive them on the basis of race, color, national origin, sex, age, religion or disability.
Downstream Entity (Medicare):	Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a Medicare Advantage Organization (Dean) and a First-Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Downstream Entity (QHP):	Any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer (Dean). The term "downstream entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.
Employer Group Waiver Plan ("EGWP"):	Medicare Prescription Drug Plan whereby employers partner with a Medicare sponsor (Dean) and a Pharmacy Benefit Manager to offer prescription drug coverage to the employer's Medicare-eligible retirees and covered Medicare-eligible dependents.
FDR:	Acronym for First Tier Entities, Downstream Entities (Medicare), and Related Entities.
First Tier Entity:	Any party that enters into a written arrangement, acceptable to CMS, with Dean to provide administrative services or health care services for a

	Medicare eligible individual under the Medicare Advantage or Part D program.
Fraud:	Intentionally executing, or attempting to execute, a scheme to defraud any health care benefit program or to obtain any of the money or property owned by, or under custody or control of, any health care benefit program.
FWA:	Fraud, Waste and Abuse
Learning Management System (LMS):	Dean Health Plan's electronic system for tracking and distributing training activity.
Medicare Advantage Part D ("MAPD") Plan:	A type of Medicare health plan offered by a private company, such as Dean, that contracts with Medicare to provide beneficiaries with all Part A, Part B and Part D benefits.
Medicare Cost Plan:	An HMO with a cost-reimbursement contract under section 1876 of the Social Security Act ("Act"). Dean's Cost Plan is named DeanCare Gold.
Medicare Supplement Plan:	A Medigap plan that is governed by the State of Wisconsin, and specifically Wisconsin Administrative Code Ins. 3.39. Dean's Supplement Plan is named DeanCare Select.
Monitoring:	Regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
NBI Medic:	Stands for National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.
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. Some sponsors perform these functions in-house and do not use an outside entity as their PBM. Many PBMs also operate 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.

Qualified Health Plans ("QHP"):	A health plan that has in effect a certification that meets the standards described in 45 CFR §156 and is recognized by the Federally-Facilitated Exchange through which it is offered.
Related Entity:	Any entity that is related to the Medicare Advantage organization (Dean) by common ownership or control and: 1) Performs some of the organization's management functions under contract or delegation; 2) Furnishes services to Medicare enrollees under an oral or written agreement; or 3) Leases real property or sells materials to the organization at a cost of more than $2,500 during a contract period.
Remediation Owner:	The leader of a business unit responsible for completing tasks in order to remediate an incident of non-compliance. There may be multiple remediation owners for a single incident.
ServiceNow:	ServiceNow is an application in which Compliance has created tools to submit, record, and track compliance activity.
VCMS:	Vendor Contract Management System is a tool used to manage and document Dean Health Plan's vendor information and vendor contracting efforts.
Waste:	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.