GOVERNMENT PROGRAMS COMPLIANCE POLICY

Title: Medicare Programs Fraud, Waste and Abuse	**Policy No**: 010
	Effective Date: 4/21/11

Policy Applies to the Following Products with an "X":

X	Medicare Part D (as applicable includes Group)	X	Medicare Advantage and Part D (as applicable includes Dual-Special Needs Plan (D-SNP) and Group)	X	Medicare Medicaid Plan (MMP)

Owners:		
Kim Green	Government Program Compliance Officer	Government Programs Compliance
Approved:		
HCSC Board of Directors		

Purpose

The purpose of this policy is to articulate HCSC's commitment to comply with all the CMS and federal regulatory guidelines related to the prevention, detection, and correction of fraud, waste, and abuse.

Scope

This policy applies to HCSC employees who are involved in administering or delivering a benefit of the Government Programs referenced above, including the chief executive and senior administrators, managers, governing body members and first tier, downstream and related entities (FDRs).

Policy

HCSC and all Government Contract Holders are committed to the prevention, early detection, investigation, and elimination of fraud, waste and abuse (FWA) within their Government Programs.

HCSC implements a comprehensive FWA Program describing the efforts taken to detect, correct, and prevent fraud, waste and abuse. The Government Programs FWA Program applies specifically to the operations of any Medicare Advantage or Medicare Part D contract.

HCSC's Special Investigations Department (SID) reviews and investigates potential FWA complaints and conducts health care fraud investigations associated with the government programs. If a complaint is found to be potential fraud or misconduct related to the Medicare programs, the SID refers the case to appropriate federal agencies, law enforcement and state agencies. SID also shares information about potential fraud schemes with other stakeholders via multiple mechanisms. SID mines data through its Data Intelligence Unit (DIU), developing individualized analytical programs and detection routines which can be modified to address new and emerging fraud schemes. Government Programs Compliance (GPC) is responsible for review of the FWA Program, participating in FWA activities in an advisory role and conducting monitoring of SID activities.

Development and Maintenance of the FWA Program

HCSC has built its Government Programs Compliance and FWA programs around the seven elements of an effective compliance program as defined in Chapter 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual. The FWA Plan includes the following sections:

I. Written Policies, Procedures and Standards of Conduct
II. Compliance Officer, Compliance Committee and High-Level Oversight
III. Training and Education
IV. Effective Lines of Communication
V. Well Publicized Disciplinary Standards
VI. Effective Systems for Routine Monitoring, Auditing and Identification of Compliance Risks
VII. Procedures and System for Prompt Response to Compliance Issues

Development and Maintenance of the FWA Program

The FWA Program is created and maintained by the HCSC SID with collaboration from GPC and various business functional areas. The Government Programs FWA Program is reviewed at least annually or when the rules change.

Per the HCSC Code of Ethics and Conduct (the Code), everyone working in or with these government programs is responsible for recognizing, preventing, and reporting potential FWA. However, there are specific departments and FDRs that conduct day-to-day work specifically designed to identify potential FWA. These areas are outlined in the Government Programs FWA Program. ,

Definitions

Abuse: actions that may, directly or indirectly, result in: unnecessary costs to a Government 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.

CMS: Centers for Medicare and Medicaid Services.

Downstream Entity: 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. (42 C.F.R. §, 423.501).

FDR: First Tier, Downstream or Related Entity.

First Tier Entity: 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. (42 C.F.R. § 423.501).

Fraud: 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).

FWA: fraud, waste and abuse.

Governing Body: 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 Government Contract Holder in the best interest of the organization and its enrollees. Governing body dos 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.

Government Contracts Holders: Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the following entities: HCSC Insurance Services Company, a wholly-owned subsidiary of HCSC ("HISC"); GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO a wholly-owned subsidiary of HCSC ("BlueLincs HMO"); GHS Insurance Company (formerly known as GHS Property and Casualty Insurance Company), a wholly-owned subsidiary of HCSC ("GHS"); Illinois Blue Cross Blue Shield Insurance Company, a wholly-owned subsidiary of HCSC ("IBCBSIC") or any other HCSC subsidiary or affiliate that holds a Government Programs contract. HCSC, HISC, BlueLincs HMO, GHS and IBCBSIC are each referred to as a "Government Contract Holder" and collectively as "Government Contract Holders."

Government Programs: the operations of any Medicare Advantage, Medicare Part D, MMP or Medicaid contracts.

I-MEDIC: Investigations 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 I-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.

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

- performs some of the MAO or Part D plan sponsor's management functions under contract or delegation,
- furnishes services to Medicare enrollees under an oral or written agreement, or
- 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 (42 C.F.R. §423.501).

SID: Special Investigations Department, HCSC's Special Investigations Unit.

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.

Governing Authorities

42 C.F.R. §§ 422.503(b)(4)(vi)(D), (F) and (G)
42 C.F.R. § 455.1 et seq.
42 C.F.R. § 438.608(a)(1)(iv).

Prescription Drug Benefit Manual. Chapter 9

Medicare Managed Care Manual. Chapter 21

HCSC Government Programs Fraud, Waste and Abuse Program

Prime Therapeutics Fraud Plan

TMG Fraud Policy and Procedures
United States Department of Health and Human Services Centers for Medicare & Medicaid Services Contract in Partnership with State of Illinois Department of Healthcare and Family Services and Health Care Service Corporation (Illinois Medicare Medicaid Alignment Initiative Contract)

Review Date	Board Ratification Date	Author	Description of Changes
07/13/2021	12/07/2021	Angela Broadway	Removed list of departments whose day to day work involves identification of FWA to align with the current FWA Program, updated title to include "Medicare", updated I-MEDIC and added regulatory reference for MMP.
08/27/2020	12/08/2020	Angela Broadway	Updated list of departments whose day to day work involved identification of FWA to align with the FWA Program and updated Government Contracts Holders to include new subsidiary IBCBSIC.

07/03/2019	12/03/2019	Melissa Lupella	Removed Medicaid Plans – created new Medicaid specific GPC Policy. Added section headings. Minor grammatical corrections.
7/30/2018	12/04.2018	Melissa Lupella	Removed reference to Montana HELP program. Updated IL Medicaid contract references.
06/14/2017	12/05/2017	Melissa Lupella	Clarified reference to the Medicaid Managed Care regulations and update name of IL Medicaid Plans.
09/08/2016	12/6/2016	Mike Szott	Revised policy language, removed reference to Argus.
08/27/2015	12/08/2015	Melissa Lupella	Deleted list of FWA items.
04/8/2015	07/23/2015	Melissa Lupella	Revised owner of policy from Fran Free to Melissa Lupella. Removed Deb Coleman.
08/05/2014	12/09/2014	Deb Coleman	Deleted State references since Special Investigations has procedures covering this process.
04/14/2014	05/06/2014	Deb Coleman Fran Free	Policy language extracted and updated from the 2/26/2013 approved Policy and Procedure. GPC will now be maintaining a separate policy and a separate procedure on each government requirement.
01/23/2013	02/26/2013	Dennis Klopfle	Revised the title and incorporate language to include all government program FWA activity. Added Enterprise Health Care Management as key area involved in preventing and detecting FWA. Added regulation to the Resource section.
02/02/2012	02/20/2012	Ren Herr	Modified to reflect HCSC ownership and to include application to MA-PD
10/11/2011	11/07/2011	Fran Free	Added reference to TMG Health and Trover Solutions FWA activities and other minor changes.
03/15/2011	04/21/2011	Fran Free	Developed a high-level P&P to describe the HISC FWA Program process.