GOVERNMENT PROGRAMS COMPLIANCE POLICY

Title: Medicare Prompt Responses to Compliance Issues and Corrective Actions	**Policy No**:012
	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 Programs Compliance Officer	Government Programs Compliance
Approved:		
HCSC Board of Directors		

Purpose

The purpose of this policy is to articulate HCSC's commitment to compliance with the Center for Medicare and Medicaid Services (CMS) guidelines that require HCSC to establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements..

Scope

This policy applies to HCSC employees who administer or deliver 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 is committed to complying with all CMS guidelines requiring the establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.

Identification and Investigation

In collaboration with Medicare Line of Business, Delegation Oversight (DO), Customer Service (CS) and appropriate business areas, Government Programs Compliance (GPC) will maintain procedures for promptly responding to compliance issues, investigating potential compliance problems as identified, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.

Issues of Government Programs' noncompliance or Fraud, Waste and Abuse (FWA) may be identified through numerous sources including, but not limited to monitoring activities, the Fraud Hotline, Corporate Integrity Hotline or mailbox, emails to HISCCompliance@bcbsil.com or through communications directly to the Government Programs Compliance Officer (GPCO) or Government Programs Compliance staff.

Generally, the Special Investigations Division (SID) manages investigations and corrective actions for FWA issues; the Ethics and Compliance Department (ECD) manages commercial issues, and GPC manages government program-related issues.

Conducting Timely and Reasonable Inquiry of Detected Offenses

A reasonable inquiry will be initiated into apparent FWA or program noncompliance at either the Government Contract Holders or their FDRs as quickly as possible, but no later than 14 days after the date the potential noncompliance or potential FWA incident was identified.

A reasonable inquiry will include a preliminary review of the facts by GPC, ECD, SID, and/or Medicare Line of Business, in consultation with other areas of HCSC, as appropriate.

- For Government Programs issues, if the preliminary review reveals a further investigation is necessary, GPC, SID, or business areas may conduct the investigation, and they agree to keep the GPCO informed throughout the process.
- If the issue appears to involve fraud or abuse, and GPC, SID, or the business areas do not have the time or resources to conduct the investigation, the matter will be referred to the I-MEDIC within 30 days of the date the potential fraud or abuse is identified so that the activity does not continue. For more information about the I-MEDIC referrals, see below.
- Significant noncompliance or FWA issues will be reported to CMS or its designee or to state agencies according to CMS guidelines.

Investigations shall include, but are not limited to:

- A determination of the facts, with relevant dates
- A determination of individuals (if possible, as reporter and/or individuals could be kept anonymous) and/or departments affected
- A full root cause analysis
- A beneficiary impact analysis that meets the requirements of CMS Audit Protocols

All investigations are thoroughly documented.

Remediation

HCSC and all Government Contract Holders will undertake appropriate remediation in response to identified issues. Remediation will be tailored to address the particular circumstances, the identified root cause(s), and may include, but are not limited to, any or all of the following:

- Immediate remediation of member access or other urgent issues
- Process improvements
- Policy and/or procedure development or updates
- Plans for ongoing monitoring
- Training of employees/management
- Disciplinary action

ECD, SID, the business areas, and GPC will maintain complete documentation of all deficiencies identified, and corrective actions taken.

DO will ensure that FDRs have corrected significant deficiencies by developing written Corrective Action Plans (CAPs) that include timelines for specific achievements as well as ramifications if the FDR fails to implement the corrective action satisfactorily. The GPCO or his/her designee will oversee the development and monitoring of the implementation of formal CAPs. DO will also ensure that appropriate monitoring of the FDRs is performed to ensure that the CAPs have remediated the issue.

Self-Reporting Potential FWA and Significant Noncompliance

SID will investigate potential FWA activity within 14 days of discovery and determine whether FWA has occurred. If FWA is confirmed, SID will report the matter to the I-MEDIC within 7 days, and if warranted, to the Office of Inspector General and Department of Justice.

Referrals to the I-MEDIC

GPC and/or SID will refer cases involving potential fraud and abuse that meet the following criteria to the I-MEDIC:

- Suspected, detected or reported criminal, civil or administrative law violations
- Allegations that extend beyond HCSC's Parts C and D plans, such as those involving multiple health plans, multiple states, or widespread schemes
- Allegations involving know patterns of fraud, including abuse threatening the life or well-being of beneficiaries
- Schemes with large financial risk to the Medicare Program or beneficiaries

Referrals to the I-MEDIC contain specifics that will allow an investigator to follow up on a case including basic identifying information and contacts as well as a description of the allegations. If the I-MEDIC requests additional information, HCSC shall, to the best of its ability, furnish additionally requested information within 30 days, unless the I-MEDIC specifies otherwise.

Responding to CMS-Issued Fraud Alerts

HCSC and all Government Contract Holders will review fraud alerts for compliance with any contracted parties affected. Appropriate action, including terminating the contract with the affected party, will be considered based on the facts involved, along with coordination from the appropriate business operations area.

Claims activity will be assessed based on information contained in the fraud alert, including denying or reversing affected claims. Past paid claims identified from entities in the fraud alert will be reviewed to meet the "best knowledge, information and belief" standard of certification.

Identifying Providers with a History of Complaints

HCSC and all Government Contract Holders will maintain files for a period of 10 years plus current contract year for both in-network and out-of-network providers who have been the subject of complaints, investigations, violations and prosecutions.

This includes:

- enrollee complaints,
- I-MEDIC investigations,
- Office of Inspector General (OIG) and/or Department of Justice (DOJ) investigations,
- US Attorney prosecution, and
- any other civil, criminal, or administrative action for violations of Federal health care program requirements.

HCSC and all Government Contract Holders will also comply with requests by law enforcement, CMS, and CMS' designee regarding monitoring of providers within the sponsor's network that CMS has identified as potentially abusive or fraudulent.

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.

Compliance Program: HCSC Corporate Integrity and Compliance Program, including the Government Programs Section.

DHHS: Department of Health and Human Services. CMS is the agency within DHHS that administers the Medicare program.

DOJ: Department of Justice.

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)

ECD: HCSC Ethics and Compliance Department

Employees: those persons employed by the sponsor or First Tier, Downstream or Related Entity (FDR), who provide health or administrative services for an enrollee.

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 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.

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."

GPC: Government Programs Compliance

GPCO: Government Programs Compliance Officer

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

Medicare: the health insurance program for people:

- 65 or over,
- under 65 with certain disabilities, or
- of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

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

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.

OIG: Office of the Inspector General within DHHS. The Inspector General is responsible for audits, evaluations, investigations, and law enforcement efforts relating to DHHS programs and operations, including the Medicare program.

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: 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.

Governing Authorities

42 C.F.R. §§ 422.503(b)(4)(vi)(G)
42 C.F.R. §§ 423.504(b)(4)(vi)(G)
42 C.F.R. §§ 422.503(b)(4)(vi)(B)
42 C.F.R. §§ 423.504(b)(4)(vi)(B)
42 C.F.R. § 438.608(a)(1)(iv)
Prescription Drug Benefit Manual. Chapter 9

Medicare Managed Care Manual. Chapter 21

HCSC GPC "Communication and Reporting Mechanisms" Policy #004

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 references to Service Delivery Operations and replaced with Customer Service. Updated title to include "Medicare", updated references to the I-MEDIC and added regulatory reference for MMP.
09/04/2020	12/08/2020	Angela Broadway	Updated Government Contracts Holders to include new subsidiary IBCBSIC. Removed references to Government and Consumer Solutions department and replaced with appropriate terms.
07/03/2019	12/03/2019	Kim Tulsky	Removed Medicaid Plans – created new Medicaid specific GPC Policy. Added section headings. Minor grammatical corrections.
8/6/18	12/04/2018	Kim Tulsky	Changes to reflect corporate changes.
06/06/2017	12/05/2017	Kim Tulsky	Changed owners, added approver, added Service Delivery Operations. Deleted details about GPC documentation in PeopleSoft. Minor punctuation edits. Update name of IL Medicaid Plans.
09/09/2016	12/06/2016	Charles Pickett	Minor editing for clarity and formatting changes
08/27/2015	12/08/2015	Charles Pickett	Minor revision to include joint investigations with Ethics & Compliance Investigator.
06/27/2014	12/09/2014	Charles Pickett	No changes required.

04/14/2014	05/06/2014	Charles Pickett	Policy extracted from 02/26/2013 approved Policy 005, Investigations of Medicare Inquiries/Allegations and updated and expanded based on Medicare regulations.
02/26/2013	02/26/2013	Dennis Klopfle	Reflects Board Approval Date
01/23/2013	01/29/2013	Dennis Klopfle	Changed “subsidiary” reference to “Government Contract Holders (as defined in the Health Care Service Corporation Corporate Integrity & Compliance Program Government Programs Section).”
02/02/2012	02/20/2012	Ren Herr	Modified to reflect HCSC ownership and to include application to MA-PD
10/14/2011	11/07/2011	Charles Pickett	Reviewed and revised to include comments from Legal and Government Contracts Compliance.
03/15/2011	04/21/2011	Fran Free	Developed a HISC P&P for addressing government programs related investigations.