GOVERNMENT PROGRAMS COMPLIANCE POLICY

Title: Medicare System to Identify Medicare Compliance Risks				**Policy No**: 006	
				Effective Date: 4/21/11	
Policy Applies to the Following Products with an "X";					
X	Medicare Part D (PDP) (as applicable includes Group)	X	Medicare Advantage and Part D (MAPD) (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 Health Care Service Corporation's (HCSC) commitment to compliance with the Centers for Medicare & Medicaid Services (CMS) guidelines that require HCSC to adopt and implement an effective system for routine monitoring and identification of compliance risks. This system includes internal monitoring and audits and external audits to evaluate HCSC's compliance with CMS requirements and the overall effectiveness of the compliance program. This system extends to HCSC's first-tier, downstream, and related entities (FDRs).

Scope

This policy applies to HCSC employees who are involved in the administration or delivery of the government programs referenced in the Policy Application section above, including the chief executive and senior administrators, managers, governing body members, and FDRs.

Policy

HCSC is committed to complying with all CMS guidelines, including but not limited to those that relate to establishing and implementing an effective system for routine monitoring and identification of compliance risks.

Risk Assessment

The Government Programs Compliance (GPC) Department performs formal Risk Assessments for Medicare and Medicare Medicaid Plan (MMP) products at least annually.

As risks change and evolve with changes in the law, regulations, CMS requirements, and operational matters, GPC will re-evaluate the potential risks of non-compliance and fraud, waste, and abuse (FWA) within the Medicare and MMP functions and will adjust the monitoring and/or auditing work plans as appropriate. Significant changes to the Risk Assessment, as determined by the Government Programs Compliance Officer (GPCO), will be reported to the Government Programs Compliance Committee (GPCC), the Corporate Compliance Committee (CCC), and the Audit, Compliance, and Finance Committee.

This Risk Assessment accounts for all Medicare and MMP business operational areas, including those performed by FDRs, for all Government Contract Holders. These operational areas will be assessed for the types and levels of risks they present to the Medicare and MMP programs and to HCSC.

At a minimum, GPC considers the following factors when formally assessing risk on an ongoing basis:

- External Factors
  - Risks of potential FWA,
  - Access to personally identifiable information/Probability of privacy or security breaches,
  - Regulator priorities and risk areas, and
  - Changes in laws or regulations.
- Structural Components
  - Designated ownership,
  - FDR relationship, and

    - Budget/Resources.
- Operations and Process Components
    - Policies and procedures,
    - Training,
    - Monitoring, and
    - Regulatory change management.
- Outcomes
    - Regulator actions imposed, and
    - Internal compliance history.

The GPCO or her/his designee(s) develop and regularly update procedures to score each Medicare and MMP function based on objective and subjective criteria. The Medicare and MMP operational areas are then ranked according to the resulting risk scores to determine which will present the most significant risks to the Medicare and MMP programs and impact on the respective Plan. Adjustments are made, as necessary, to the Risk Assessment and the Compliance Program monitoring activities. See Policy 007, Routine Monitoring and Auditing of Medicare Programs, for more detail regarding how the Risk Assessment results are used to drive the GPC monitoring and auditing activities and work plan for the coming year.

GPC works closely with Audit Services and other key business areas to develop appropriate monitoring, auditing, and other mitigation strategies based on the results of the Government Programs Compliance Risk Assessment and the Audit Services Risk Assessment.

The GPCO presents the results of the Risk Assessment to the GPCC, the CCC, and the Audit, Compliance, and Finance Committee at least annually, or more often as deemed necessary by the GPCO.

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 & Medicaid Services.

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization 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).

First-Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare-eligible individual under the Medicare Advantage 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.

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: Operations of any Medicare Advantage, Medicare Part D, MMP, or Medicaid contracts.

GPC: Government Programs Compliance.

GPCO: Government Programs Compliance Officer.

MA: Medicare Advantage. A health plan offered by a private health insurance company as an alternative to traditional Medicare Part A and Part B services, plus Part D. Additional benefits are often added to the plan, such as dental, vision, and wellness services. Sometimes referred to as Medicare Part C since it combines Part A, Part B, Part D, and any additional benefits into a single plan.

MAO: Medicare Advantage Organization. Medicare-approved private health insurance company (subject to following the same rules set for traditional Medicare) offering a Medicare Advantage plan.

MAPD: Medicare Advantage and Part D (prescription drugs) combined benefit plan offered by a private health insurance company.

Medicare: The health insurance program for people:

- 65 or older,
- Under 65 with certain disabilities, or
- Of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

PDP: Prescription Drug Plan. Medicare insurance plan covering prescription drug costs offered by a private health insurance company. Available as a stand-alone service.

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).

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)(F)
42 C.F.R. §§ 423.504(b)(4)(vi)(F)
42 C.F.R. § 438.608(a)(1)(iv)

Prescription Drug Benefit Manual, Chapter 9 – Compliance Program Guidelines

Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines

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
08/21/2024	11/21/2024	Angela McCullough	No recommended changes.
09/30/2023 08/17/2023	11/14/2023	Denise Anderson Angela McCullough	Standardization of language used in all GPC policies, updated Definitions section to ensure inclusion of applicable words/phrases, and minor clarification of language in content. Updated description of risk factors used in risk assessment.
8/16/2022	11/15/2022	Angela Broadway	Updated references of MAPD to Medicare and the risk assessment factors categories. Added references to the Audit, Compliance and Finance Committee.
07/13/2021	12/07/2021	Angela Broadway	Updated title to include “Medicare” and added regulatory reference for MMP.
08/27/2020	12/08/2020	Angela Broadway	Updated Risk Assessment factors to align with current procedure, updated Government Contracts Holders to include new subsidiary IBCBSIC and added verbiage for state and federal disasters or public health emergencies.
07/03/2019	12/03/2019	Kim Tulsky	Added section headings. Minor grammatical corrections.
8/6/18	12/04/2018	Kim Tulsky	Minor wording changes to paragraph 2 for clarity. Updated factors considered and removed references to Medicaid.
06/5/2017	12/05/2017	Kim Tulsky	Change of owner. Update name of IL Medicaid Plans. Revised the sentence listing major Medicare and Medicaid functions to align with the risk categories in the risk assessment. Changed verb tense. Minor wording changes.
08/31/2016	12/06/2016	Ren Herr	Minor wording changes for clarity.
08/27/2015	12/08/2015	Ren Herr	Change in owner and the addition of a resource.
06/19/2015	06/19/2015	Ren Herr	No changes recommended.
06/27/2014	12/09/2014	Ren Herr	No changes recommended.
04/14/2014	05/06/2014	Ren Herr	Policy extracted and updated from 02/26/2013 approved Policy 002, Medicare Monitoring and Auditing.
02/26/2013	02/26/2013	Dennis Klopfle	Reflects Board Approval Date
01/23/2013	01/29/2013	Dennis Klopfle	Reflect consolidation of Medicare and Government Programs Compliance Program into the HCSC Compliance Program and other minor changes.

			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.
03/29/2011	04/21/2011	Ren Herr	Developed to specifically address Medicare Part D.