GOVERNMENT PROGRAMS COMPLIANCE POLICY

Title: Routine Monitoring and Auditing of Medicare Programs					**Policy No**:007
					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 establish and implement an effective system for routine monitoring, auditing, and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate HCSC's and first-tier, downstream, and related entities' (FDRs) compliance with CMS requirements.

Scope

This policy applies to HCSC employees who are involved in 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 specific to establishing and implementing an effective system for routine monitoring, auditing, and identification of compliance risks.

Accordingly, this policy establishes an effective system for internal monitoring and auditing and, as appropriate, external audits, of:

- HCSC's compliance with CMS guidelines,
- FDRs' compliance with CMS guidelines, and
- Overall effectiveness of the Compliance Program.

This policy and system meet the following requirements:

- Monitoring performed by business areas as part of normal operations,
- Monitoring performed by Government Programs Compliance (GPC) to test specific, identified risks of non-compliance, and
- Audits performed by Audit Services.

Identification of Compliance Risks

GPC conducts a formal baseline assessment of HCSC's major compliance and fraud, waste, and abuse (FWA) risk areas ("Risk Assessment"). The Risk Assessment considers all Medicare and MMP business operational areas, and each operational area is assessed for the types and levels of risk the area poses to the Medicare program and to the Government Contract Holders. See Policy 006, System to Identify Medicare Compliance Risks, for additional detail regarding conducting the Risk Assessment. The results of the Risk Assessment inform the development of the monitoring and audit work plans described below. GPC coordinates with Audit Services and other stakeholders to develop monitoring and auditing work plans that include schedules of all planned monitoring and auditing activities for the calendar year. The most significant risks identified in the Risk Assessment are scheduled in the annual monitoring and/or auditing work plans.

Routine Monitoring Activities and Auditing

HCSC undertakes routine monitoring activities and auditing to test and confirm compliance with Medicare regulations, sub-regulatory guidance, contractual agreements, and applicable federal and state laws. Additionally, applicable HCSC policies and procedures are reviewed in conjunction with these activities to protect against Medicare program non-compliance and potential FWA.

Audit Services, in conjunction with and at the direction of the Government Programs Compliance Officer (GPCO), develops an Annual Audit Work Plan for audits of Medicare and MMP processes.

GPC monitors significant federal and state disasters and public health emergency declarations. Adjustments are made, as necessary, to the Compliance Program monitoring activities.

GPC and Audit Services have procedures for responding to monitoring and auditing results. Those procedures include follow-up reviews of areas found to be non-compliant to determine if the corrective actions implemented have fully addressed the underlying problems. The GPCO leads or oversees formal Corrective Actions.

The GPCO, assisted by the GPC staff and/or the Compliance Committee(s) if desired, coordinates, oversees, and/or executes all the monitoring and auditing activities.

The GPCO or his/her designee regularly provides updates regarding the results of the monitoring and auditing activities to the Government Programs Compliance Committee, the Corporate Compliance Committee (CCC), CEO, senior leadership, and the governing bodies.

In situations where the Medicare Delivery, Performance, and Integrity (DPI) Department has specific responsibilities related to CMS Compliance Program Requirements (such as reviewing and overseeing the implementation of new regulations and guidance, FDR oversight, policies and procedures, etc.), GPC and Audit Services may include in the monitoring or auditing work plans activities designed to ensure that these activities are performed effectively and in accordance with CMS Compliance Program requirements.

Annual Auditing of the Compliance Program

HCSC senior leadership, the Chief Ethics, Compliance, and Privacy Officer, and the CCC ensure the implementation of an audit function appropriate to the sponsor's size, scope, known risks, and structure. HCSC, on at least an annual basis, audits the effectiveness of the Compliance Program and shares the results with the governing body. The GPCO and the Chief Audit Executive ensure the audit function incorporates CMS operational requirements. In addition, the GPCO will ensure the audit function is independent of, and has appropriate access to, the personnel, information, records, and operational areas under review.

Routine Monitoring and Auditing of FDRs

GPC will coordinate with the Audit Services department and other stakeholders to ensure that the monitoring and auditing work plans address functions performed by FDRs.

It is HCSC's policy to ensure than any function delegated to an FDR is performed in accordance with all applicable laws and regulations. This includes functions performed by entities considered downstream to HCSC. In accordance with requirements, HCSC uses the FDR risk assessment process to rank the entities from highest to lowest risk for purposes of focusing monitoring and auditing efforts.

GPC coordinates with Delegation Oversight and Audit Services to ensure a reasonable number of FDRs are monitored and audited on an ongoing basis. At a minimum, these auditing and monitoring efforts will include an assessment of the Compliance Program requirements and key operational requirements.

The FDR monitoring and auditing work plans will include processes for responding to all monitoring and auditing results and for conducting follow-up reviews of areas found to be non-compliant to

determine if the corrective actions implemented have fully addressed the underlying problems. At a minimum, all corrective actions will be overseen by the GPCO.

Tracking and Documenting Compliance and Compliance Program Effectiveness

GPC coordinates with Audit Services and DPI to ensure the results of routine monitoring and internal audits, including any potential FWA, are tracked and disseminated on a regular basis.

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.

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

CMS: Center 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.

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."

GPCO: Government Programs Compliance Officer.

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

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

Related Entity: Any entity that is related to a Medicare Advantage Organization (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).

Routine Monitoring: Monitoring Activities documented and reported through the System of Controls.

Targeted Monitoring: Ad hoc monitoring activities performed by GPC to test specific, identified risks of non-compliance.

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 Guidelines

Government Programs Policy 006: System to Identify Medicare Compliance Risks

Government Programs Policy 009: Identifying Excluded Individuals and Entities

Government Programs Policy 010: Government Programs FWA policy

Government Programs Fraud, Waste, and Abuse Program

Corporate Policy 3.01: Audit and Performance Services.

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 Policy Purpose statement to align with CMS requirements. Removed outdated references to routine vs. targeted monitoring. Updated references to GPC Procedures to Job Aids and updated titles for the Chief Ethics, Compliance and Privacy Officer and the Chief Audit Executive.
8/16/2022	11/15/2022	Angela Broadway	Updated references to Medicare Delivery, Performance and Integrity department.
07/13/2021	12/07/2021	Angela Broadway	Updated references to ROM to Medicare Performance and Delivery, updated title to include “Medicare” and added regulatory reference for MMP.
08/27/2020	12/08/2020	Angela Broadway	Added Delivery, Performance and Integrity department, where applicable, 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	Edits to reflect change from GPD. Removal of references to Medicaid and other minor edits.
06/05/2017	12/05/2017	Kim Tulsky	Minor grammatical, update name of IL Medicaid Plans and wording changes.
08/29/16	12/06/2016	Kim Tulsky	Revised to reflect the Routine Monitoring Activity documented in the System of Controls and the respective roles of GPC, GPD and Audit Services.
08/28//2015	12/08/2015	Kim Tulsky Ren Herr	Annual Update, Minor Revisions
06/24/2014	12/09/2014	Andrew Massura	Annual Update, Minor Revisions
04/14/2014	5/06/2014	Andrew Massura	Policy language extracted and updated from the 2/26/2013 approved Policy and Procedure. Government Programs Compliance (GPC) will now be maintaining a separate policy and a separate procedure on each government requirement.
01/23/2013	02/26/2013	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	04/21/11	Ren Herr	Developed to specifically address Medicare Part D.