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 (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 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 in the Policy Application section above, including the chief executive and senior administrators, managers, governing body members, and first-tier, downstream, and related entities (FDRs).

Policy

To support the purpose of this policy, Government Programs Compliance (GPC) works in collaboration with Medicare Line of Business area, Delegation Oversight (DO), and appropriate business areas. HCSC workers are required to promptly respond to GPC, the Special Investigations Department (SID), or the Ethics and Compliance Department (ECD), as applicable.

Identification and Investigation

Issues related to government programs non-compliance 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 GPC staff.

Generally, GPC manages government programs-related issues, SID manages investigations and corrective actions for FWA issues, and ECD manages commercial and Individual and Family Markets issues.

Conducting Timely and Reasonable Inquiry of Detected Offenses

A reasonable inquiry will be initiated into apparent FWA or program non-compliance at either the Government Contract Holders or their FDRs as quickly as possible, but no later than 2 weeks after the date the potential non-compliance 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 FWA, 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, or

- Significant non-compliance 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, and
- 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 is not limited to, any or all of the following:

- Immediate corrective action of member access or other urgent issues,
- Process improvements,
- Policy and/or procedure development or updates,
- Plans for ongoing monitoring,
- Training of employees/management, or
- 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 FDRs is performed to ensure that the CAPs have remediated the issues.

Self-Reporting Potential FWA and Significant Non-compliance

SID will investigate potential FWA activity within 2 weeks 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 Department of Health and Human Services (DHHS) Office of Inspector General (OIG), and Department of Justice (DOJ).

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 Medicare Advantage and Part D plans, such as those involving multiple health plans, multiple states, or widespread schemes,
- Allegations involving known patterns of fraud, including abuse threatening the life or well-being of beneficiaries, and
- 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 or completion of audit, whichever is later, 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,
- DHHS OIG and/or 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 & Medicaid Services.

Compliance Program: Compliance Program Charter, 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 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).

ECD: HCSC Ethics and Compliance Department.

Employees: For the purposes of this policy, those persons employed by the HCSC or first-tier, downstream, or related entity (FDR), who provide health or administrative services for an enrollee.

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."

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 Medicare Advantage (Part C) and Part D plans 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 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).

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 – Compliance Program Guidelines

Medicare Managed Care Manual, Chapter 21 – Compliance Guidelines

HCSC Government Programs Policy 004: Communication and Reporting Mechanisms

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 08/18/2023	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 SID department name, added reference to individual and family markets and changed 14 days to 2 weeks to align with Chapters 9 and 21 language.
08/16/2022	11/15/2022	Angela Broadway	Updated Compliance Program name and reference to FWA and language for workers to promptly respond to Compliance.
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.