National Policy Library Document

Policy Name:	**Medicare Programs: Compliance Element I Written Policies and Procedures and Standards of Conduct**	**Policy No.:**	**PS729-65015**

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This Policy is applicable to the following:

Department(s):	All Departments
Business Unit(s):	HN Life, HNAZ, HNCA, HNCS, HNCSAZ, HNI, HNOR, HNPS
Products/LOB's:	Medicare Advantage and Medicare Part D, Dual Eligible

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Policy Statement:

Health Net, Inc. has written policies, procedures, and standards of conduct clearly stating its strong commitment to prevent, detect and correct fraud, waste and abuse and to comply with all applicable Federal and State standards, which include, but are not limited to:

· Medicare Part C and D statute, regulations and program manuals;
· Federal False Claims Act;
· Anti-Kickback Statute;
· Physician Self-Referral (“Stark”) Statute;
· Beneficiary Inducement Statute;
· Fraud Enforcement and Recovery Act of 2009,and
· Health Insurance Portability and Accountability Act (HIPAA).

Note for purposes of this policy and procedure, the term “Medicare programs” includes the Medicare Advantage (“MA”), Part D Prescription Drug (“Part D”), and Medicare-Medicaid Plan (“MMP”) lines of business.

A. Policies and Procedures

The Health Net enterprise-wide compliance program includes written policies and procedures

that:
1. Articulate Health Net's commitment to comply with all applicable Federal and State statutory and regulatory requirements;
2. Describe compliance expectations as embodied in the Code of Business Conduct and Ethics;
3. Implement operations of the compliance program;
4. Describe ramifications and/or penalties for failing to comply with standards of conduct, policies, and procedures, and the failure to act in an ethical manner.
5. Ensure continued operation and maintenance of the compliance program and Medicare Compliance Plan and Medicare-Medicaid Plan Compliance Plan;
6. Provide guidance to associates and others on dealing with potential compliance issues, including fraud, waste and abuse and avoidance of conflicts of interests;
7. Describe obligations of Health Net employees, management, members of the Health Net, Inc. and subsidiary Boards of Directors, and first tier, downstream and related entities (FDRs) to report violations of law and policy to Health Net, the Centers for Medicare & Medicaid Services (CMS), CMS' designate, the Department of Health Care Services (DHCS), law enforcement, and/or other regulatory agencies as appropriate and the process to communicate compliance issues to appropriate compliance personnel;
8. Describe how potential compliance issues, including fraud, waste, and abuse are investigated and resolved by Health Net;
9. Specify the disciplinary actions that can be imposed for violations of law and ethics, Compliance Program noncompliance and fraud, waste and abuse; and
10. Include a policy of non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential compliance and fraud, waste, and abuse issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

Each Health Net Business Unit and FDR is required to have policies and procedures in place that specify the duties that employees must perform in their day-to-day work in order to ensure that applicable regulations and laws are followed and to avoid fraud, waste and abuse. Policies and procedures are reviewed annually and updated to reflect changes to requirements, as applicable. Necessary revisions are made promptly if there is a change in the law or circumstance which materially affects policies and/or procedures.

The Executive Owner is responsible for ensuring the policy is compliant with federal and state laws, regulations, accreditation standards, and other Health Net policies. The Executive Owner must be a Vice President or above and has final approval authority for a policy.

Health Net maintains policies and procedures that support the Medicare and MMP Compliance Plans and the seven elements of an effective compliance program. The Medicare Compliance department reviews these policies and procedures on an annual basis for possible revisions that may result from a change in company policy or changes in applicable laws or regulations. The Medicare and MMP Compliance Committees review and approve substantive changes to the policies and procedures that support the Medicare and MMP Compliance Plans prior to such changes becoming effective.
In general, Health Net policies are stored in the National Policy Library (NPL) on the Health Net intranet site, Health Net Connect, and are available to all associates. The Medicare Compliance Plan and Medicare-Medicaid Plan Compliance Plan are stored on the Medicare Compliance page of Health Net Connect. New associates are directed to the policies and procedures on the NPL during new hire training. Associates are notified of changes to the Medicare Compliance Plan and the Medicare compliance program policies and procedures via

articles published on the Medicare Compliance page of Health Net Connect. Electronic copies of the policies and procedures that support the Medicare programs compliance program are made available to all associates, Directors and FDRs within 90 days of hire or contracting and within 60 days after a material change.

B. Standards of Conduct
All Health Net associates, Directors, and FDRs are required to familiarize themselves with the laws, regulations, and guidelines applicable to their jobs and to put forth their best efforts to follow the laws, rules, and regulations.

The Health Net Code of Business Conduct and Ethics establishes the standards of conduct that all Health Net officers, directors, managers, and associates are required to follow. Those who violate the standards in the Code of Business Conduct and Ethics are subject to disciplinary action up to and including termination of employment or contract.

Health Net reviews the Code of Business Conduct and Ethics on an annual basis for possible revisions that may result from a change in Company policy or changes in applicable laws or regulations.

The Code of Business Conduct and Ethics is endorsed by the Chief Executive Officer and Chief Operating Officer of the company and approved by the Health Net, Inc. Board of Directors.

The Health Net Code of Business Conduct and Ethics is available to all associates via HR Link and the Health Net Connect intranet site. New associates receive a hardcopy version of the Health Net Code of Business Conduct and Ethics during new hire training. Associates are notified of changes to the Health Net Code of Business Conduct and Ethics via articles published on the Compliance page of Health Net Connect. An electronic copy of the Code is made available to all associates, Directors and FDRs within 90 days of hire or contracting and within 60 days after a material change.

C. FDRs
FDRs have the option to:

1) Adopt Health Net's Code, Medicare Compliance Plan or Medicare-Medicaid Plan Compliance Plan, as applicable, and associated compliance policies and procedures;
2) Develop and follow their own code of conduct, compliance plan, and/or equivalent policies and procedures that describe their commitment to comply with applicable laws and regulations; or
3) Adopt the code of conduct, compliance plan, and/or equivalent compliance policies and procedures of another entity contracted with CMS for the MA, Part D, and/or MMP line(s) of business.

If an FDR follows a code of conduct, compliance plan, and/or equivalent policies and procedures not developed by Health Net, the Company reserves the right to review and approve these documents.

Health Net's Code of Business Conduct and Ethics is available through the Health Net provider website at www.healthnet.com/provider > Working with Health Net > Medicare Information > Code of Business Conduct and Ethics.

Health Net's Medicare compliance policies and procedures are available through the Health Net Provider website at www.healthnet.com/provider > Working with Health Net > Medicare Information > Medicare FWA, SNP Model of Care and Provider Marketing Training

D. Maintenance of Records
Records of compliance and fraud, waste, and abuse investigations, corrective actions, meeting minutes, and other pertinent information pertaining to Health Net's compliance are maintained for a minimum of ten (10) years.

Policy Purpose:
To ensure written policies, procedures, and standards of conduct are in place.

Scope/Limitations:
This policy applies to all individuals employed, contracted, or otherwise representing Health Net, Inc. and its subsidiaries and those of any FDRs who participate in the administration of Health Net's Medicare programs.

Related Policies:
· Associate Policy: Preventing and Detecting Fraud, Waste and Abuse of Government Programs (Policy MP27-72938)
· Associate Policy: Reporting and Investigating Violations / Non-Retaliation (Policy MP86-145819)
· Medicare Programs: Medicare Compliance Plan (Policy HR328-1543)
· Medicare Programs: Medicare-Medicaid Plan Compliance Plan (Policy PS69-115231)
· Medicare Programs: Compliance Element II Compliance Officer and Compliance Committee (Policy HR328-133757)
· Medicare Programs: Compliance Element III Training and Education (Policy HR329-83615)
· Medicare Programs: Compliance Element IV Effective Lines of Communication (Policy HR329-81145)
· Medicare Programs: Compliance Element V Enforcement of Standards (Policy HR329-83126)
· Medicare Programs: Escalation of Compliance Issues (Policy SN37-112439)
· Medicare Programs: Compliance Element VI Monitoring and Auditing (Policy HR810-84520)
· Medicare Programs: Compliance Element VII Prompt Responses to Detected Offenses (Policy EJ44-83932)
· Special Professional Associate Policy: Designation of Chief Compliance Officers and Obligation of Associates to Support the Compliance Mission (SS1112-94822)

References:
Title 42 Code of Federal Regulations (CFR)
422.503(b)(4)(vi)(A)423.504(b)(4)(vi)(A)

CMS Medicare Managed Care Manual
Chapter 21 – Medicare Compliance Program Guidelines – Section 50.1

Prescription Drug Benefit Manual
Chapter 9 – Medicare Compliance Program Guidelines – Section 50.1

Health Net's Medicare Compliance Plan

Health Net's Medicare-Medicaid Plan Compliance Plan
Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with California Department of Health Care Services and Health Net Community Solutions,

Inc. - §2.1.2

Definitions:

Anti-Kickback Statute
A Federal law that prohibits individuals or entities from knowingly and willfully offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by any federally funded program. A violation of the anti-kickback law is a felony offense that carries criminal fines of up to $25,000 per violation, imprisonment for up to five years and exclusion from government health care programs. The Balanced Budget Act of 1997 created an alternate sanction. The government may levy a civil fine of up to $50,000 for each violation of the statute and an assessment of three times the amount of the kickback.

Associate
For purposes of this policy and procedure, the term “associate” includes regular employees, temporary employees, volunteers, and interns.

Beneficiary Inducement Statute
A Federal law that prohibits offering a remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier. Sanctions for violations of the Beneficiary Inducement Law include civil monetary penalties of up to $10,000 for each wrongful act.

Business Unit
Health Net operational units, entities, or departments with specific business functionality.

Centers for Medicare & Medicaid Services (CMS)
The Federal agency within the U.S. Department of Health and Human Services (HHS) that administers the Medicare and Medicaid programs.

Compliance Officer
A Health Net associate responsible, either directly or through delegation, for overseeing the company’s compliance program.

Compliance Plan
A written document that defines the specific manner in which the compliance program is implemented across the organization.

Compliance Program
A program that promotes regulatory compliance and legal conduct to provide guidance to prevent, detect and help resolve non-compliant and illegal conduct, including fraud, waste or abuse.

Downstream Entity
Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between Health Net and a first tier entity. These written arrangements continue down to the level of ultimate provider of health, pharmacy and/or administrative services to members.

Federal False Claims Act
Also called the Lincoln Law. A Federal law that prohibits knowingly presenting, or causing to be presented a false claim for payment or approval. It also prohibits knowingly making, using,

or causing to be made or used, a false record or statement material to a false or fraudulent claim. Sanctions for violations of the Federal False Claims Act include civil penalties between $5,000 and $10,000 plus three times the total damage per claim.

First Tier Entity
Any party that enters into a written arrangement acceptable to CMS with Health Net to provide administrative services or health care or pharmacy services for a Medicare eligible individual under a MA or Part D Plan.

Fraud Enforcement and Recovery Act of 2009 (FERA)
A Federal law that modified and clarified certain provisions of the Federal False Claims Act. FERA enhanced criminal enforcement of federal fraud laws, especially regarding financial institutions, mortgage fraud, and securities fraud or commodities fraud.

Health Net
The term Health Net for the purpose of this policy and procedure is applicable for Health Net, Inc. and its various subsidiaries. The term will also include delegates, such as providers, third party administrators, or other entities who have been delegated responsibility for activities defined in this policy. Health Net Inc. is the ultimate parent company of all Health Net subsidiaries.

Medicaid
A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state as each state manages its own program, and is able to set different requirements and other guidelines.

Medicare
The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).

Medicare Advantage (MA)
A program offered to Medicare beneficiaries by private companies that work in conjunction with Medicare and cover the full range of hospital and doctor services covered under Original Medicare. Also referred to as Medicare Part C.

Medicare-Medicaid Plan (MMP)
A managed care organization that enters into a three-way contract with CMS and the State to provide covered services and any chosen flexible benefits and be accountable for providing integrated care to Medicare-Medicaid enrollees. Also known as Capitated Financial Alignment.

Medicare Programs
For purposes of this policy and procedure, the term “Medicare programs” includes the Medicare Advantage, Part D Prescription Drug, and Medicare-Medicaid Plan lines of business

Part D
Also referred to as Medicare prescription drug coverage, is a voluntary program offered to Medicare beneficiaries by private companies to subsidize the cost of prescription drugs.

Physician Self-Referral (“Stark”) Statute
Federal legislation that prohibits physicians from referring Medicare and Medicaid patients to entities for certain designated services with which the physician has a financial relationship

with and is billing these services unless specific exceptions apply. Sanctions for violations include, but may not be limited to: the denial of payment of a claim; refunds of amounts collected in violation of the statute; and civil monetary penalties up to $15,000 for each claim submitted in violation of the statute.

Related Entities
Any entity that is related to Health Net by common ownership or control and performs some of Health Net's management functions under contract or delegation, and furnishes services to Medicare Member under a written agreement.

Subsidiaries
Legal entities that report to, or are owned by, a parent company.

U.S. Department of Health and Human Services (HHS)
The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. CMS is a federal agency within the HHS.

Disclaimer:

Deviations:

Approvers:
Policy Author: Jamee E Sunga - Approved on 02/24/2016
Functional Owner: Sheryl D Pessah - Approved on 02/24/2016
Executive Owner: Donovan L Ayers - Approved on 02/24/2016
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