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Policy Name:	**Medicare Programs: Compliance Element VII Prompt Response to Detected Offenses**	**Policy No.:**	**EJ44-83932**

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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, MHN
Products/LOB's:	Dual Eligible, Medicare Advantage and Medicare Part D

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Policy Statement:

Health Net follows the Centers for Medicare & Medicaid Services (CMS) requirements contained in the Medicare Compliance Program Guidance as well as Parts 422 and 423 of Title 42 of the Code of Federal Regulations (CFR).

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.

It is the policy of Health Net to comply with all applicable regulations and guidance related to MA, Part D, and MMP lines of business and to implement appropriate corrective actions in response to potential or identified non-compliance with applicable requirements.

Non-compliance with regulations or guidance applicable to Medicare programs may be identified through:
· Internal Audit department auditing;
· Medicare Compliance department risk reviews or other monitoring;
· Special Investigations Unit (SIU) activities;
· Business Solutions Quality Assurance Team auditing;

· Business Unit self-monitoring;
· Delegation Oversight department auditing;
· First tier, downstream or related entity (FDR) or other business partner self-monitoring; or
· Auditing and/or monitoring by the U.S. Department of Health and Human Services, the Comptroller General, CMS, or any auditor acting on their behalf.

There are four basic forms of potential non-compliance related to Medicare programs:
· Fraud, waste, and abuse (FWA);
· Security breaches;
· Employee misconduct; and
· Other non-compliance.

Potential FWA compliance issues are investigated by the Special Investigations Unit (SIU) in conjunction with the Legal department, as appropriate. Refer to the Health Net Compliance Plan(s) and P&P HR329-81145, *Medicare Compliance - Effective Lines of Communication*, for more information.

Potential privacy and security incidents are investigated by the Privacy Office and the Information Security Office. If it is determined a breach has occurred, the Privacy Office manages the applicable regulatory reporting and notifications processes. Refer to P&P MP628-152752, *Privacy Program - Policies and Procedures,* for more information.

Potential employee misconduct is investigated by the Chief Ethics Officer, the Organization Effectiveness department, and/or the applicable Compliance Officer. Refer to the Health Net Code of Business Conduct and Ethics and P&P MP86-145819, *Associate Policy: Reporting and Investigating Violations / Non-Retaliation,* for more information.

Other potential non-compliance related to administration of the Medicare programs is investigated and resolved by the applicable Business Unit(s). This includes:
· Non-compliance issues identified by or reported to Business Units and reported to the Medicare Compliance department via an Issue Write Up form;
· Non-compliance issues identified by the Medicare Compliance department and reported to the applicable Business Unit(s) via a Corrective Action Request (CAR); and
· Non-compliance issues identified by CMS, DHCS, or another regulatory agency and reported to Health Net via a Notice of Non-Compliance, Warning Letter, or other mechanism.

Associates are required to report potential non-compliance issues related to Medicare Programs to their department Supervisor/Manager immediately upon knowledge of the issue. The Business Unit Supervisor/Manager evaluates the potential Issue to determine if an Issue Write-Up is required. If yes, a completed *Health Net Medicare Programs Issue Write-Up* including all available information is submitted to the Compliance Officer with a copy to the Medicare Write Up Reviews Lotus Notes email box and department Vice President within 24 hours of issue identification. The most current versions of the issue write up form and instructions documents can be found on the Medicare Compliance intranet site at https://hnc.healthnet.com/documents/departments/medicare_compliance/forms

The Issue Write-Up is reviewed by the Compliance Officer or designee to determine if the potential non-compliance is reportable to CMS, taking into consideration the following:
· Does the issue have a negative impact on beneficiaries?
· How many beneficiaries are affected?
· Is there significant harm or potential harm to members?

· Could the issue result in a high volume of calls or complaints to CMS or Health Net?
· Does the issue impact access to care for beneficiaries?
· Is the deficiency a result of a systemic issue that may impact the Company's ability to comply with applicable requirements?
· Does the issue require CMS intervention to resolve?
· Could there be political or media interest in the issue that could generate calls to CMS?
· Does the issue involve or was it caused by a delegate or vendor over whom Health Net has oversight responsibility?
· Did the issue involve or impact a key compliance area of focus, such as enrollment/disenrollment, sales/marketing allegations, appeals and grievances, delegated vendors and access to prescription drugs?

If the Compliance Officer or designee determines the issue is reportable to CMS, the Medicare Compliance department reports the issue to the appropriate CMS designee within 48 hours of identification of the potential non-compliance

The Medicare Compliance department tracks Issue Write-Ups in the Online Monitoring Tool (OMT). A *Medicare & Medicaid Programs Corrective Action Request* (Addendum A) may be issued if corrective action deliverables are not completed timely and the delay is not justified. Any reported issue that affects member access to care or well-being (including financial well-being) is escalated to Executive Management should the corrective action plan due date fall past due beyond 30 days.

Corrective Action Plans (CAP) may be required when deficiencies with CMS rules are identified through auditing or monitoring activities. Failure to cooperate with the CAP process may result in disciplinary action, up to and including termination of employment.

CAP tasks typically include, but may not be limited to:
· Review and revision, as applicable, of policies, procedures, desktop work instructions, workflows, member materials, and others, to ensure compliance with CMS regulation and guidelines;
· Training of applicable staff on policies, procedures, desktop work instructions, workflows, member materials, and others;
· Periodic self auditing/monitoring by the applicable Business Unit to ensure compliance is achieved and maintained; and
· Reporting of self audit/monitoring results to Medicare Compliance or other Business Unit with oversight authority

The Medicare Compliance department reviews CAPs developed by Business Units and associated tasks to determine if it is reasonable to expect compliance to be achieved and maintained once the corrective action plan is effectuated. If concerns are identified, the Medicare Compliance department works with the applicable Business Unit(s) to revise the corrective action plan as appropriate.

Health Net requires all FDRs to submit a CAP when deficiencies are identified through compliance audits, ongoing monitoring or self-reporting. Health Net will take administrative action, which may include termination of the contract, if an FDR does not comply with a CAP or does not meet its regulatory obligations as outlined in its contract with Health Net.

Identified deficiencies that involve potential fraud, waste, abuse or illegal activity are referred to

the MEDIC, the Office of the Inspector General (OIG), and/or law enforcement as appropriate.

CMS issues alerts to Part D sponsors concerning fraud schemes identified by law enforcement officials. Refer to P&P CM1115-15431 *SIU Admin Procedures* for information regarding Health Net's response to CMS-issued fraud alerts.

Health Net complies with requests by law enforcement, CMS and CMS' designees regarding monitoring of providers within Health Net's network that CMS has identified as potentially abusive or fraudulent. Refer to P&P PW323-10375 *SIU Case Investigations and Recovery* for more information.

Policy Purpose:
To ensure a process is in place to respond to detected offenses, to initiate corrective action to prevent similar offenses, and to report to government authorities when appropriate.

Scope/Limitations:
This policy and procedure 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: Performance Improvement (MP829-74055)
· Delegation Oversight - Corrective Action Plan (GS318-114855)
· HIPAA: Complaints and Investigations (MP43-7597)
· Information Security and Privacy Incident Response Plan (KL819-145819)
· Issue Identification, Tracking, Escalation & Resolution (MD321-154443)
· Issue Identification, Tracking, Escalation & Resolution – First Tier, Down Stream and Related Entities (MD45-124554)
· Medicare Programs: Compliance Element VI Monitoring and Auditing (HR810-84520)
· Medicare Programs: Medicare Compliance Plan (HR328-1543)
· Medicare Programs: Medicare-Medicaid Plan Compliance Plan (PS69-115231)
· FWA Case Investigations (PW323-10375)
· SIU Admin Procedures (CM1115-15431)
· SIU Case Investigations and Recovery (PW323-10375)
· SIU Initial Intake and Assessment of Referrals (PW323-10182)
· Special Professional Associate Policy: Performance Improvement (NK1112-94845)
· 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)
· 42 C.F.R. §422.503(b)(4)(vi)(G)
· 42 C.F.R. §423.504(b)(4)(vi)(G)

CMS Medicare Managed Care Manual
• Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements – Section 20.1
• Chapter 21 – Medicare Compliance Program Guidelines – Section 50.7

Prescription Drug Benefit Manual
• Chapter 9 – Medicare Compliance Program Guidelines – Section 50.7

Health Net Medicare Compliance Plan

Health Net 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

Addendum List:
EJ44-83292 Addendum A Medicare & Medicaid Programs Corrective Action Request

Definitions:

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

Business Solutions Quality Assurance Team
For purposes of this policy, “Business Solutions Quality Assurance Team” is defined as a team within Health Net responsible for conducting monthly sample audits of Medicare Advantage work conducted by the Appeals & Grievances, Claims and Membership Accounting departments.

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.

Corrective Action Request (CAR)
Request for corrective action to address an adverse finding.

Corrective Action Plan (CAP)
A description of the actions to be taken to correct deficiencies identified during an audit, ongoing monitoring, or self-reporting; and to ensure future compliance with the applicable requirements. A CAP usually contains accountabilities and sets timelines.

Delegation Oversight Department
A department within Health Net responsible for overseeing the ongoing compliance of delegated medical, dental, vision, chiropractic, alternative care and mental health service providers.

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.

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.

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.

Internal Audit
A department within Health Net that provides independent, objective and comprehensive reviews designed to evaluate and assess the adequacy and effectiveness of various areas of the company.

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)
An organization that is a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the requirements to offer an MA plan.

Medicare Advantage Organization (MAO)
An organization that is a public or private entity organized and licensed by a State as a risk-bearing entity that is certified by CMS as meeting the requirements to offer an MA plan.

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.

Medicare Quality Management System (MQMS)
A software tool used by the Medicare Compliance Department to track compliance-related issues and monitor corrective action plans.

Office of the Inspector General (OIG)
The OIG conducts and supervises audits and investigations relating to programs and operations of the DHHS.

Online Monitoring Tool (OMT)
A web-based, hosted oversight and compliance management tool used by the Medicare Compliance department to track Issue Write-Ups, CAPs, regulatory audits, monitoring, and other activities.

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.

Part D Sponsor
An entity that has a contract with the Federal Government to offer Medicare prescription drug coverage.

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 enrollees under an oral or written agreement.

Special Investigations Unit (SIU)
A department within Health Net responsible for detecting, investigating and deterring issues of possible Fraud, Waste and/or Abuse (FWA) in compliance with the laws, rules and regulations applicable to healthcare.

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.

Policy/Procedure:
1. Corrective Action Requests
When non-compliance is identified by the Medicare Compliance department or a regulatory agency, the Medicare Compliance department:

a. Initiates a CAR by completing the first two sections of a *Medicare & Medicaid Programs Corrective Action Request* template;
b. Submits the CAR template to the Vice President(s) of the applicable Business Unit(s) for completion with a cc: to the Compliance Officer and Medicare Compliance Director;
c. Creates a CAP in the OMT to track the corrective actions;
d. Works with the Business Unit(s), as requested, to develop the Root Cause, Corrective Action Plan, and Corrective Action Plan Tasks;
e. Reviews the completed *Medicare & Medicaid Programs Corrective Action Request* upon receipt to ensure the Root Cause, Corrective Action Plan, and Corrective Action Plan Tasks were documented appropriately and it is reasonable to expect that compliance will be achieved and maintained once the plan and associated tasks are

effectuated;
f. Works with the Business Unit(s) to revise the corrective action plan and/or associated tasks if concerns are identified;
g. Documents the Root Cause, Corrective Action Plan, and Corrective Action Plan Tasks in the OMT CAP;
h. Creates Tasks in the OMT CAP to track each of the corrective action deliverables to closure;
i. Requests and tracks updates to the corrective action deliverables;
j. Issues a CAR to the Vice President of the applicable Business Unit if a corrective action deliverable is non-timely and the delay is not justified;
k. Ensures non-compliance issues that affect member access to care or well-being (including financial well-being) are escalated to Executive Management by the Compliance Officer when the corrective action plan due date falls past due beyond 30 days;
l. Records closure of the corrective action plan in the OMT once confirmation is received that the applicable Business Unit(s) have validated compliance was achieved and, where warranted, monitoring is conducted to ensure compliance is maintained; and
m. Advises the reporting Business Unit the issue is closed and that the Medicare Compliance department may perform validation monitoring anytime in the future to confirm compliance is maintained.

2. Issue Write Ups

Upon receipt of an Issue Write-Up not related to possible fraud or other misconduct, the Medicare Compliance department:

a. Ensures the reporting Business Unit completed the *Medicare Programs Issues Write-Up* template appropriately and includes, at a minimum:
    i. The affected CMS contract(s);
    ii. An executive summary of the issue;
    iii. The regulatory and/or internal requirement(s) that apply to the issue;
    iv. A description of the incident;
    v. A description of similar incidents that occurred previously;
    vi. The number and demographics of impacted members;
    vii. A root cause analysis; and
    viii. The corrective action plan describing steps to correct and prevent recurrence of the issue.
b. Determines if it is reasonable to expect that compliance will be achieved and maintained once the plan and associated tasks are effectuated;
c. Works with the Business Unit(s) to revise the corrective action plan and/or associated tasks if concerns are identified;
d. Creates a CAP in the OMT to track the issue;
e. Determines if the issue is reportable to CMS;
i. If yes, the issue is reported to the applicable CMS designee within 48 hours of identifying the issue. The report to CMS includes all facts in sections 1a through 1h above that are known at the time the report is made.
f. Advises the reporting Business Unit whether the issue was reported to CMS;
g. Tracks and records updates to corrective action deliverables in the OMT;
h. Issues a *Medicare & Medicaid Programs Corrective Action Request* to the Vice

President(s) of the applicable Business Unit(s) if a corrective action deliverable is non-timely and the delay is not justified;
i. Ensures reported issues that affect member access to care or well-being (including financial well-being) are escalated to Executive Management by the Compliance Officer when the corrective action plan due date falls past due beyond 30 days;
j. Records closure of the issue in the OMT once confirmation is received the applicable Business Unit(s) have validated compliance was achieved and, where warranted, monitoring is conducted to ensure compliance is maintained; and
k. Advises the reporting Business Unit the issue is closed and that the Medicare Compliance department may perform validation monitoring anytime in the future to confirm compliance is maintained.

Issues Related to Possible Fraud or Illegal Activity

Upon identification of a MA or Part D compliance issue related to possible fraud or illegal activity, the Medicare Compliance department or reporting Business Unit promptly routes the issue to the SIU for investigation and possible referral to the MEDIC, OIG, and/or other law agency.

Disclaimer:

Deviations:

Addendum A

Medicare & Medicaid Programs Corrective Action Request

EJ44-83292 Addendum A Medicare & Medicaid Programs Corrective Action Request.docx

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
Mgr Compliance & ReportingCorp: Sheryl D Pessah - Approved on 02/24/2016

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