Federal Sanction Screening Policy

Policy Statement
Intermountain does not conduct business with excluded individuals or organizations that are debarred, suspended, or excluded from State and Federal programs.

Scope
Intermountain Health Care, Inc.

Definitions
List of Excluded Individuals and Entities (LEIE) - A list of individuals and entities to which no Federal healthcare program payment may be made or any item or services furnished by an excluded individual or entity, or directed or prescribed by an excluded physician. This payment ban applies to all methods of Federal program reimbursement. Any items or services furnished by an excluded individual or entity are not reimbursable under Federal health care programs. Any items or services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment is made to another provider, practitioner, or supplier that is not excluded.

System for Award Management (SAM) Exclusion List - A list of individuals and firms excluded by Federal government agencies from receiving federal contracts or federally approved subcontracts and from certain types of federal financial and nonfinancial assistance and benefits.

Provisions
1. Intermountain does not employ or engage in a business relationship with anyone who is currently excluded by the OIG or any other duly authorized enforcement agency, or licensing or disciplining authority.

2. Intermountain does not employ any individuals who have been recently convicted of a criminal offense related to health care or who are listed as excluded or otherwise ineligible for participation in Federal health care programs.

3. Intermountain may remove individuals with direct responsibility for, or involvement in, any Federal health care program as well as those pending the resolution of any criminal charges or proposed exclusion. Contractors under pending criminal charges can be suspended from continued work until charges are cleared.

4. Intermountain regularly reviews the Health and Human Services Office of Inspector General LEIE and SAM Exclusion List.

Exceptions
None

Primary Sources
42 CFR 1001

Secondary Materials
Federal Sanction Screening Procedure
Confidential and proprietary to Intermountain Health Care, Inc. If Intermountain Healthcare authorizes a person to access policies, procedures, and guidelines (PPGs), it also authorizes that person to disclose information from PPGs – not copies – but only as reasonably necessary for healthcare matters related to Intermountain Healthcare.

Reasonable efforts will be made to keep employees informed of policy changes; however, Intermountain Healthcare reserves the right in its sole discretion to amend, replace, and/or terminate this policy at any time. Intermountain Healthcare is an At-Will Employer. The terms of this policy do not, either directly or indirectly, constitute any form of employment contract or other binding agreement between any employee and Intermountain.

Contact Intermountain Healthcare’s Legal Department for questions.
Medicare Advantage Compliance Investigation Procedure

Purpose
This procedure describes SelectHealth's method for investigating reports made by employees, enrollees, or First Tier, Downstream, and Related Entities (FDR) and their employees when one of those parties reports possible noncompliant activity contrary to Medicare applicable laws, regulations, or requirements.

Scope
SelectHealth, Inc.

Definitions
First Tier, Downstream, or Related Entity (FDR) - 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 MA program or Part D program. Downstream Entity - any party to a written agreement below the level of an agreement between a Medicare Advantage/Part D organization and a first tier entity. Related Entity - any entity that is related to an MAO or Part D Sponsor by common ownership or control and (1) Performs some of the MAO or Part D plan Sponsor's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an oral or written agreement; or (3) 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.
Fraud, Waste, and Abuse (FWA) - Fraud - An intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person. Waste - The inappropriate utilization and/or inefficient use of resources. Abuse - Occurs when an individual or entity unintentionally provides information to Medicare which results in higher payments than the individual or entity is entitled to receive.
Special Investigations Unit (SIU) - An internal investigative unit responsible for identifying and conducting investigations of potential FWA.
National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) - Health Integrity is the Medicare Part C and Part D program integrity contractor for the Centers for Medicare & Medicaid Services. The purpose of the NBI MEDIC is to detect and prevent fraud, waste, and abuse in the Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level.

Procedure
1. Employees and FDRs are provided guidance regarding how to prevent, detect, and respond to potential compliance issues.

2. SelectHealth employees and all FDRs and their employees have an obligation to report suspected, detected, or reported compliance violations, misconduct, violations of law, and FWA that have occurred or they believe will occur. SelectHealth does not participate in or tolerate intimidation or retaliation against employees, beneficiaries, or members of the governing board that report these issues and FDRs must have a similar policy in place (see Compliance Violation Reporting Policy).

3. Suspected, detected, or reported violations can be reported anonymously and confidentially in several ways as described in the Medicare Advantage Compliance Violation Reporting Procedure. Potential violations may also be detected through the Medicare Compliance Audit Plan and ongoing monitoring activities.

4. Issue Tracking
4.1 SelectHealth maintains a Medicare compliance database to receive, record, and track reported compliance and FWA issues related to Medicare Advantage. The tool is designed to facilitate the response to compliance questions or reports of potential or actual non-compliance or FWA from employees, members of the governing board, beneficiaries, and FDRs and their employees.

4.1.1 When individuals report a suspected or detected Medicare compliance violation in good faith, an investigation occurs and any relevant information gathered in advance of, during, and at the conclusion of the investigation is entered into the Medicare Advantage database.

4.1.2 Information in the database is regularly analyzed to generate reports of suspected Medicare Advantage compliance violations and FWA reporting activity. This information is utilized to identify patterns of possible misconduct within SelectHealth or by one of SelectHealth's FDRs.

4.2 SelectHealth also receives reports of suspected or actual compliance violations and FWA from Intermountain Healthcare when these violations are reported.

4.3 SelectHealth maintains information on providers who have been the subject of complaints, investigations, violations, and prosecutions. Specific examples include:

4.3.1 Enrollee complaints
4.3.2 NBI MEDIC investigations
4.3.3 OIG and/or Department of Justice investigations
4.3.4 US Attorney prosecutions
4.3.5 Other civil, criminal, or administrative action for violations of federal health care program requirements

5 FWA Investigations

5.1 The Medicare Compliance Team coordinates closely with the SIU to ensure that the Medicare Parts C and D benefits are protected from fraudulent, abusive, and wasteful schemes throughout the administration and delivery of benefits at SelectHealth and with its FDRs.

5.2 An effective FWA program is vital to an effective Medicare Compliance Program. Effective detection, prevention, and reduction of FWA will assist SelectHealth to:

5.2.1 Preserve and protect assets and reduce or eliminate Medicare Advantage and Part D benefit costs due to FWA
5.2.2 Ensure proper value of Medicare Advantage and Part D benefits, including correct pricing, quantity, and quality
5.2.3 Reduce or eliminate fraudulent or abusive claims paid for with federal dollars
5.2.4 Identify members with drug addiction problems and other overutilization issues
5.2.5 Identify and recommend providers for exclusion including those who have defrauded or abused the system
5.2.6 Refer potential cases of illegal drug activity, including drug diversion, to the NBI MEDIC and/or law enforcement and conduct case development and support activities for NBI MEDIC and law enforcement investigations
5.2.7 Assist law enforcement by providing information needed to develop successful prosecutions
5.2.8 Provide fraud awareness training to SelectHealth employees

6 Investigative Process

6.1 The Medicare Compliance Officer, in collaboration with the Medicare Compliance Team, SIU, and in some cases the Medicare Compliance Committee follows a consistent method in processing suspected, detected, or reported compliance violations and FWA. In general, this method includes:

6.1.1 Documenting the suspected or detected violation in the SelectHealth compliance database
6.1.2 Assessing the risk involved and considering the risk as part of the risk assessment process
6.1.3 Gaining an understanding of the scope and severity of the potential problem
6.1.4 Assigning accountability(s) for the resulting investigation
6.1.5 Tracking the issue until it is resolved and/or the corrective action is complete.
6.1.6 Auditing as necessary

6.2 Those handling the investigation may also solicit the support and guidance of other specialists with knowledge of applicable laws, regulations, and related rules, policies, and procedures. These specialists may include:

6.2.1 Intermountain Healthcare’s Internal Audit and Corporate Compliance teams
6.2.2 FDRs and its equivalent compliance functional teams
6.2.3 External auditors
6.2.4 NBI MEDIC resources and tools

6.3 The Medicare Compliance Team and/or SIU will commence FWA investigations within two weeks of receiving a report of possible non-compliance or FWA. The decision to refer the potential issue to the assigned NBI MEDIC or CMS is based on the seriousness of the potential issue and the time or resources required to investigate the potential misconduct in a timely manner. The potential issue must be referred to the NBI MEDIC within 30 days of discovery.

6.4 Reports of potential fraud at the FDR level or by the FDR may be referred by the Medicare Compliance Officer to the NBI MEDIC within 30 days as required when the Medicare Compliance Officer, the Medicare Compliance Committee, and/or the SIU deem that a sufficient investigation requires more resources than are available internally to investigate the issue.

6.5 FDR(s) providing health care services under the Medicare program that want to disclose their own non-compliance or violations of law are encouraged to utilize the Intermountain Healthcare Compliance Hotline or Compliance email box (corporate.compliance@imail.org), or contact the Medicare Compliance Officer. FDRs are educated about which sources they may utilize to report potential non-compliance or FWA.

6.6 Investigations of potential FWA are concluded in a timely manner after discovery. If it is determined by the Medicare Compliance Officer in cooperation with the Medicare Compliance Committee, contracted provider organizations, and the SIU that an FWA activity has occurred, CMS expects SelectHealth to refer the issue to the NBI MEDIC as promptly as is possible given the information needed for the report.

6.6.1 In the event of a referral, the NBI MEDIC will request specific information about the case in order to investigate and resolve the matter. The information is provided within 30 days unless otherwise specified. SelectHealth will also provide additional information to the NBI MEDIC as that information is identified.

6.6.2 The NBI MEDIC investigates referrals, develops investigations, and makes referrals to law enforcement as appropriate. The NBI MEDIC apprises SelectHealth of the status of the investigation.

6.6.3 In cases where the NBI MEDIC believes the matter referred is related to non-compliance or error rather than FWA, the matter is returned to SelectHealth or CMS for follow up.

6.7 The Medicare Compliance Officer could also consider reporting potential fraudulent conduct to the Health and Human Services Office of Inspector General or other government entity after consulting with the Medicare Compliance Committee and considering CMS guidance.

6.8 SelectHealth complies with requests from law enforcement, CMS, and CMS' designees to monitor providers with SelectHealth’s Medicare Advantage network identified as having potential involvement in FWA activities.

6.9 At the conclusion of an investigation, a report is provided to the SelectHealth CEO, the SelectHealth Board of Trustees, the Medicare Compliance Committee, and the SelectHealth Executive Team.

7 Corrective Action

7.1 Following a full investigation of suspected, detected, or reported compliance or violations or FWA activities by employees, consultants, or FDRs, corrective action is taken according to the Compliance Corrective Action Policy.
7.2 SelectHealth maintains files in matters involving corrective action containing:
   7.2.1 Documented warnings and educational contacts
   7.2.2 Results of prior investigations
   7.2.3 Copies of complaints resulting in investigations

7.3 Significant Compliance violations committed by an FDR may result in sanctions, as determined by SelectHealth management, up to and including termination of the relationship.

Exceptions
No exceptions are allowed except as authorized by the SelectHealth Medicare Compliance Committee.

Primary Sources
None

Secondary Materials
Compliance Violation Reporting Policy
Medicare Advantage Compliance Violation Reporting Procedure
Compliance Corrective Action Policy

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Contact Intermountain Healthcare’s Legal Department for questions.
Medicare Advantage Compliance Violation Reporting Procedure

Purpose
The purpose of this procedure is to establish SelectHealth’s method for employees, beneficiaries, governing board members, or First Tier, Downstream, and Related Entities and their employees to report possible noncompliant activity that is contrary to Medicare applicable laws, regulations, or requirements.

Scope
SelectHealth, Inc.

Definitions
First Tier, Downstream, or Related Entity (FDR) - 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 MA program or Part D program. Downstream Entity - any party to a written agreement below the level of an agreement between a Medicare Advantage/Part D organization and a first tier entity. Related Entity - any entity that is related to an MAO or Part D Sponsor by common ownership or control and (1) Performs some of the MAO or Part D plan Sponsor's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an oral or written agreement; or (3) 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.

Fraud, Waste, and Abuse (FWA) - Fraud - An intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person. Waste - The inappropriate utilization and/or inefficient use of resources. Abuse - Occurs when an individual or entity unintentionally provides information to Medicare which results in higher payments than the individual or entity is entitled to receive.

Special Investigations Unit (SIU) - An internal investigative unit responsible for identifying and conducting investigations of potential FWA.

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) - Health Integrity is the Medicare Part C and Part D program integrity contractor for the Centers for Medicare & Medicaid Services. The purpose of the NBI MEDIC is to detect and prevent fraud, waste, and abuse in the Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level.

Procedure
1 SelectHealth's general compliance training and Fraud, Waste, and Abuse (FWA) training assists employees and FDRs in recognizing compliance violations, misconduct, violations of law, and FWA. Training includes a review of compliance policies and procedures, the Code of Conduct and Business Ethics Policy, and the requirement to report suspected, detected, or reported compliance violations, misconduct, violations of law, and FWA that have occurred, or believed will occur (see Compliance Violation Reporting Policy).

2 The Medicare Compliance Team has a system in place to receive, record, respond to, and track compliance questions or reports of potential or actual non-compliance from employees, members of the governing body, beneficiaries, and FDRs and their employees (see Medicare Advantage Compliance Issue Procedure).

3 Compliance violation reporting obligations are presented during compliance and FWA training for new employees and governing body members, and annual compliance and FWA training is conducted thereafter.
3.1 SelectHealth does not participate in or tolerate intimidation or retaliation against employees, beneficiaries, or members of the governing body who in good faith report issues and FDRs must have a similar policy in place.

3.2 Employees, governing body members, and FDRs and their employees who fulfill their responsibility to report suspected or detected compliance violations, misconduct, violations of law, and FWA can do so anonymously (through certain reporting methods) and confidentially (to the extent possible).

3.3 Employees, the governing body, beneficiaries, and FDRs receive an explanation of how compliance reports are processed and investigated from the Medicare Compliance Team.

3.4 Individuals that report a suspected issue receive a timely response with the expectation that they can receive progress reports as appropriate. The response also includes a commitment to confidentiality and non-retaliation or intimidation.

4 SelectHealth provides several different methods, as described below, for reporting suspected, detected, or reported compliance violations, misconduct, violations of law, or FWA that have occurred or believed will occur. The methods of reporting are publicized at various locations in SelectHealth’s office space, as well as on the SelectHealth website.

5 An individual who has a good faith belief that a potential compliance violation has occurred, or may occur, may report their concern as follows:

5.1 Direct Report - An individual may directly contact their supervisor, manager, the Medicare Compliance Officer or any Medicare Compliance Team member, the Intermountain Healthcare Compliance Officer or any Compliance staff member, or a Human Resources representative.

5.2 Telecommunication Report - A reporting hotline is available 24 hours a day, 7 days a week 1-800-442-4845. Callers speak to, or receive a return call from compliance staff. There is also a secure fax line for reporting concerns at 1-801-442-0505.

5.3 Mail Report - Compliance concerns may be mailed directly to the Intermountain Healthcare Vice President of Business Ethics and Compliance: c/o Intermountain Healthcare, Inc., 36 South State St., Salt Lake City, UT 84111 or the Medicare Compliance Officer: c/o SelectHealth, Inc., 5381 S Green St, Murray, UT 84123.

5.4 Online Report - An online reporting tool is available on the Compliance website to submit compliance concerns.

5.5 Email Reporting - A dedicated compliance email address is available (corporate.compliance@imail.org).

5.6 NBI MEDIC - An online self-reporting mechanism used by SelectHealth and its FDRs in combating FWA and noncompliance in the Medicare programs (see Medicare Advantage Compliance Issue Procedure).

5.6.1 Self-reporting of suspected, detected, and reported FWA and Medicare program non-compliance is voluntary but encouraged by Centers for Medicare and Medicaid Services (CMS).

5.6.2 SelectHealth self-reports potential fraud discovered at the plan level and potential fraud by FDRs in cases where the SIU does not have the time, resources, or experience to investigate specific reports of non-compliance.

5.6.3 In the event the Medicare Compliance Officer, in coordination with other stakeholders, determines that fraud or misconduct has occurred, the activity is referred to the NBI MEDIC as promptly as the proper documentation and information can be assembled. Cases meeting any of the following criteria are referred to the NBI MEDIC by the Medicare Compliance Officer (see Medicare Managed Care Manual, Ch. 21, § 50.7.5)

- Potential criminal, civil, or administrative law violations
- Allegations extending beyond SelectHealth, Inc. involving multiple health plans, multiple states, or widespread schemes
- Allegations involving known patterns of fraud
- Pattern of fraud or abuse threatening the life or well-being of beneficiaries
- Scheme with large financial risk to the Medicare program or beneficiaries

6 If SelectHealth discovers an incident of significant or serious Medicare program noncompliance, SelectHealth reports the incident to CMS as promptly as the proper documentation and information can be assembled. The Medicare Compliance Committee is informed of the issue and has an opportunity to provide direction before a report is made to CMS. Reports made to CMS enable them to provide guidance on the matter and to mitigate harm.

Exceptions
No exceptions are allowed except as authorized by the SelectHealth Medicare Compliance Committee.

Primary Sources
Medicare Managed Care Manual, Ch.21, 50.1.4-50.1.5, 50.1.7, 50.4.2, 50.7.3-50.7.6

Secondary Materials
Code of Conduct Business Ethics Policy
Compliance Violation Reporting Policy

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Reasonable efforts will be made to keep employees informed of policy changes; however, Intermountain Healthcare reserves the right in its sole discretion to amend, replace, and/or terminate this policy at any time. Intermountain Healthcare is an At-Will Employer. The terms of this policy do not, either directly or indirectly, constitute any form of employment contract or other binding agreement between any employee and Intermountain.
Contact Intermountain Healthcare’s Legal Department for questions.
Medicare Advantage Corrective Action Procedure

Purpose
This procedure outlines how SelectHealth develops corrective actions to remedy compliance violations and fraud, waste, and abuse activities to prevent future non-compliance.

Scope
SelectHealth, Inc.

Definitions
**Corrective Action Plan (CAP)** - A description of actions to be taken to correct identified deficiencies and to ensure future compliance with the applicable requirements. A CAP usually contains accountabilities and set timelines.

**Fraud, Waste, and Abuse (FWA)** - **Fraud** - An intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person. **Waste** - The inappropriate utilization and/or inefficient use of resources. **Abuse** - Occurs when an individual or entity unintentionally provides information to Medicare which results in higher payments than the individual or entity is entitled to receive.

**First Tier, Downstream, or Related Entity (FDR)** - **First Tier Entity** - is 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 MA program or Part D program. **Downstream Entity** - any party to a written agreement below the level of an agreement between a Medicare Advantage/Part D organization and a first tier entity. **Related Entity** - means any entity that is related to an MAO or Part D Sponsor by common ownership or control and (1) Performs some of the MAO or Part D plan Sponsor's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an oral or written agreement; or (3) 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.

**National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)** - Health Integrity is the Medicare Part C and Part D program integrity contractor for the Centers for Medicare & Medicaid Services. The purpose of the NBI MEDIC is to detect and prevent fraud, waste, and abuse in the Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level.

**Special Investigations Unit (SIU)** - An internal investigative unit responsible for identifying and conducting investigations of potential FWA.

Procedure
1 Developing Corrective Actions
   1.1 The SIU in collaboration with the Medicare Compliance Team, will complete a full investigation of suspected, detected, or reported compliance violations or FWA activities.
   1.2 When a compliance issue or potential FWA is identified, corrective action is taken (see Medicare Advantage Compliance Issue Procedure).
      1.2.1 A root cause analysis may be conducted to determine what caused or allowed the non-compliance, misconduct, problem, or deficiency to occur. The root cause analysis is performed by the Medicare Compliance Team in collaboration with the operational area(s) that caused or allowed the issue to occur or who are affected by the issue.
      1.2.2 Each item identified in the root cause analysis is included in the CAP as further outlined below.
1.3 When significant compliance violations or FWA issues are found, those issues are reviewed by the Medicare Compliance Committee and when indicated, reported to the SelectHealth Audit and Compliance Committee of the Board of Trustees. The significance of a violation is determined through consideration of the annual risk assessment, CMS guidance and emphases, financial or enrollee impact, and previous trends of non-compliance or FWA.

2 Corrective Action Plan for Internal Issues

2.1 After root cause analysis and collaboration has taken place with the identified stakeholders involved or affected by a particular incidence or issue, the Medicare Compliance Team will tailor a CAP to specifically address each issue noted in the root cause analysis.

2.2 Each issue is considered to determine if it was an isolated issue or if there was a pattern or trend. Each instance of misconduct, non-compliance, or other deficiency is evaluated separately. A risk assessment determines the level of risk the issue poses to regulatory compliance in the Medicare Advantage program.

2.3 The CAP includes follow-up with particular operational areas that are included in the Medicare Advantage audit plan and risk assessment. The various corrective action activities for the plan may include:

- 2.3.1 Employee counseling
- 2.3.2 Updating policies and procedures
- 2.3.3 Training on updated policies and procedures
- 2.3.4 Testing on the training received
- 2.3.5 Monitoring to ensure the corrective action is effectively implemented
- 2.3.6 Providing metrics to ensure sustained compliance after the CAP is fully implemented

2.4 Timeframes for each item in the CAP are assigned to operational areas and monitored for completion within the timeframes specified.

- 2.4.1 CMS may require SelectHealth to establish an immediate corrective action with a specified timeframe in certain cases. These notifications are communicated to the Medicare Compliance Officer or other specified contact.
- 2.4.2 Operational areas have an opportunity to provide feedback on the expectations assigned to them.
- 2.4.3 System issues, such as IT changes or barriers to completion of a timely and effective corrective action, should be noted early in the process.

2.5 Operational areas report progress to the Medicare Compliance Team before each assigned deadline to document the issue.

2.6 If operational areas fail to meet CAP deadlines, the Medicare Compliance Team will discuss the reasons for not meeting the deadline and will report the failure to meet CAP timeframes or goals to the applicable Executive Team member either immediately or as part of regular reports.

- 2.6.1 Problems meeting deadlines are included in reports to the Medicare Compliance Committee and/or the Audit and Compliance Committee of the SelectHealth Board of Trustees. Failure to formulate a timely CAP to correct deficiencies could result in disciplinary action.
- 2.6.2 Compliance obligations apply to SelectHealth employees and leaders.

2.7 Upon effective completion of all the CAP items, the Medicare Compliance Team will report the CAP results to the Medicare Compliance Committee and the Audit and Compliance Committee of the SelectHealth Board of Trustees.

2.8 If the Medicare Compliance Committee, or the Audit and Compliance Committee of the Board feels further actions must occur to confirm sustained compliance, ongoing monitoring will occur upon closure of the CAP.

2.9 Oversight monitoring or auditing, or further follow up may occur depending on the issue in question and based on the risk the issue poses to SelectHealth’s Medicare Advantage contracts with CMS.

3 Corrective Action Plans for FDRs
3.1 In addition to performing root cause analysis with the FDR once a compliance or FWA issue is identified, the Medicare Compliance Team partners with the FDR to develop and implement a CAP as outlined above. The Medicare Compliance Officer and Medicare Compliance Committee oversee the FDR to verify that the CAP is implemented and that sufficient follow up is conducted to ensure the issue has been corrected.

3.2 SelectHealth requires the respective FDR to sign a written agreement that details each element of the CAP and the timeframes and expectations for correcting deficiencies. The agreement also includes ramifications (up to and including termination of the relationship with SelectHealth) if the FDR fails to implement the corrective action satisfactorily.

3.3 The Medicare Compliance Team, in collaboration with operational areas who may provide expertise, conduct independent audits of the FDR and/or review the FDR's monitoring or audit reports.

3.4 Reports on progress in meeting expectations are provided to SelectHealth by the FDR. Those reports are shared with the Medicare Compliance Committee and the Audit and Compliance Committee of the SelectHealth Board of Trustees.

3.5 Further follow up and/or audits may occur depending on the issue in question and based on the risk the issue poses to SelectHealth’s Medicare Advantage contracts with CMS. The issues are reported in the annual Medicare audit plan and risk assessment.

4 Self Reporting

4.1 Although self-reporting of potential FWA and Medicare program non-compliance is voluntary, SelectHealth believes self-reporting is an important component in demonstrating that it has an effective compliance program (see Self Disclosure Guideline). After completing an investigation and preliminary review of the root cause through discussion of the issues with the appropriate stakeholders, significant compliance issues are reported as outlined below:

4.1.1 Specifically for FWA issues, stakeholders may include the SIU, the Vice President of Intermountain Healthcare Business Ethics and Compliance, members of the Medicare Compliance Committee, and SelectHealth leaders.

4.1.2 The Medicare Compliance Officer will report serious or significant non-compliance to the Medicare Compliance Committee and the SelectHealth Executive Team as soon as possible. An immediate report to the Audit and Compliance Committee of the SelectHealth Board of Trustees is not required, but non-compliance is reported regularly to the Audit and Compliance Committee who may offer feedback and guidance for current and potential future issues.

4.1.3 If the Medicare Compliance Officer, after collaborating on the issue with other stakeholders, believes that SelectHealth lacks the time, resources, or experience to adequately investigate potentially fraudulent misconduct (and therefore not able to reach a decision on whether the issue should be reported), the Medicare Compliance Officer refers the issue to NBI MEDIC within 30 calendar days of discovery.

4.1.4 After the SIU and the Medicare Compliance Team conduct a reasonable investigation into potential non-compliance or FWA, and the Medicare Compliance Officer and others involved in the investigation are confident that fraudulent misconduct has occurred, the case is referred to the NBI MEDIC the next business day after a decision to report is made (see Medicare Managed Care Manual, Ch. 21, § 50.7.5 for criteria in reporting to the NBI MEDIC).

4.1.5 The Medicare Compliance Officer is ultimately accountable for making decisions about self-reporting issues in the Medicare Advantage program. Self-reporting is an important practice in maintaining an effective Compliance program.

4.1.6 When serious incidences of potential non-compliance are discovered, the Medicare Compliance Team may report the incidences to CMS immediately if incidences are serious or
significant. CMS encourages plan sponsors to over-report rather than under-report these incidences. CMS will provide SelectHealth with directions on mitigating immediate harm.

4.1.7 SelectHealth may also report fraudulent conduct to government authorities either directly or through Intermountain Healthcare's Vice President of Compliance and Business Ethics. Such reporting is made using the applicable reporting tool or method, as designated by the governmental agency overseeing the activity.

4.2 Individual issues that are self-reported are not included among samples pulled during a CMS audit.

4.3 Self-reporting can offer the opportunity to minimize potential cost and disruption of a full scale CMS audit and investigation as well as potential compliance actions or sanctions against SelectHealth.

5 Documentation

5.1 SelectHealth maintains files in matters involving corrective actions in its Medicare compliance tool. These files include but are not limited to:

5.1.1 Deficiencies, non-compliance, FWA, misconduct, or problems identified
5.1.2 Copies of complaints resulting in investigations
5.1.3 Results of current investigations
5.1.4 Results of prior investigations on the same or related issues
5.1.5 Root Cause Analyses
5.1.6 CAPs with timeframes and expectations
5.1.7 Signed agreements from FDRs for CAPs
5.1.8 CAP progress reports
5.1.9 Records of independent audits performed by SelectHealth and monitoring and audit reports from FDRs
5.1.10 Reports provided to the Medicare Compliance Committee and/or Audit and Compliance Committee of the Board of Trustees
5.1.11 Issues referred to SelectHealth Human Resources for disciplinary actions taken against SelectHealth employees (up to and including termination of employment)
5.1.12 Sanctions or actions taken against FDRs (including termination of relationship with SelectHealth)
5.1.13 Self-reports made to CMS.

Exceptions

No exceptions are allowed except as authorized by the SelectHealth Medicare Compliance Committee.

Primary Sources

42 CFR §§ 422.503(b)(4)(vi)(G), 423.504(b)(4)(vi)(G)
PPACA § 6402(d)(2)
Medicare Managed Care Manual, Ch.21, §§ 50.7.2-50.7.3
Prescription Drug Benefit Manual, Ch. 9, §§ 50.7.2-50.7.3

Secondary Materials

Medicare Advantage Compliance Issue Procedure
Corrective Action Policy
Self-Disclosure Guideline

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Medicare Advantage Training Procedure

Purpose
This procedure describes how SelectHealth provides Medicare Advantage and Medicare Advantage Prescription Drug plan compliance and fraud, waste, and abuse training and education for employees, Board of Trustees, and first tier, downstream, and related entities and their employees.

Scope
SelectHealth, Inc.

Definitions

Fraud, Waste, and Abuse (FWA) - Fraud - An intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person. Waste - The inappropriate utilization and/or inefficient use of resources. Abuse - Occurs when an individual or entity unintentionally provides information to Medicare which results in higher payments than the individual or entity is entitled to receive.

First Tier, Downstream, or Related Entity (FDR) - First Tier Entity - is 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 MA program or Part D program. Downstream Entity - any party to a written agreement below the level of an agreement between a Medicare Advantage/Part D organization and a first tier entity. Related Entity - means any entity that is related to an MAO or Part D Sponsor by common ownership or control and (1) Performs some of the MAO or Part D plan Sponsor's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an oral or written agreement; or (3) 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.

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

Medicare Advantage Prescription Drug Plan (MA-PD) - A Medicare Advantage plan that provides qualified prescription drug coverage. Also referred to as Medicare Part D.

Procedure

1 Training and education on FWA and compliance is done to ensure that SelectHealth employees and FDRs are aware of the Medicare requirements in general as well as the specific requirements related to their job function. The effectiveness of training and education is evaluated based on overall compliance program reviews, audits, and monitoring for areas of non-compliance.

2 Training Types
   2.1 SelectHealth staff, SelectHealth Board of Trustees, and FDRs and their employees who have involvement in the administration or delivery of MA or MA-PD benefits must receive general compliance training within 90 days of hire (or contracting date for FDRs) and annually thereafter.
   2.2 Specialized compliance training may also be required for internal operational areas or for FDRs where there are specific compliance risk areas based on employee job functions in those areas. Specialized training is conducted at the time of hire, annually, when regulations change, or upon evaluation of the effectiveness of the compliance program.
   2.3 SelectHealth is accountable to ensure that all employees, managers, the CEO, Executive Team, and Board members as well as its FDRs and its employees receive FWA training. This includes all
employees who assist in the administration of MA and MA-PD functions and in the delivery of MA or MA-PD benefits.

2.3.1 Physicians, hospitals, outpatient surgery centers and other entities or persons who are enrolled in the Medicare program or are accredited as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are considered to have met the FWA training requirements due to their Medicare participation and thus are deemed to have been trained and therefore are not required to separately complete the SelectHealth FWA training.

2.4 Agents and brokers contracted to sell MA and MA-PD products for SelectHealth must participate and be tested annually and after initial contracting on details specific to the Medicare Marketing Guidelines and the plan products that they sell. This training is done in person by a Medicare Broker Account Manager or Medicare Compliance Team member in collaboration with the Medicare Sales Manager. Training is always available in SelectHealth’s Broker Exchange.

3 Training Content

3.1 A number of topics that are communicated in general compliance training. Topics include but are not limited to:

3.1.1 A description of the Intermountain Healthcare’s Compliance Program, including a review of compliance policies and procedures, the Code of Conduct and Business Ethics Policy, and SelectHealth’s commitment to business ethics and compliance with all Medicare program requirements

3.1.2 An overview of how to ask compliance questions, request compliance clarification or report suspected or detected non-compliance. Training will emphasize confidentiality, anonymity, and non-retaliation for compliance related questions or reports of suspected or detected non-compliance or FWA

3.1.3 The requirement to report to SelectHealth actual or suspected Medicare program non-compliance or potential FWA

3.1.4 Examples of reportable non-compliance that an employee might observe

3.1.5 A review of the disciplinary guidelines for non-compliant or fraudulent behavior. The guidelines communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported

3.1.6 Attendance and participation in compliance and FWA training programs as a condition of continued employment and a criterion included in employee evaluations

3.1.7 A review of policies related to contracting with the federal government

3.1.8 A review of potential conflicts of interest and SelectHealth’s system for regular disclosure of conflicts of interest

3.1.9 A reminder of the importance of maintaining the confidentiality of personal health information

3.1.10 An overview of the monitoring and auditing process

3.1.11 A review of the laws that govern employee conduct in the Medicare program. (see Medicare Advantage Compliance Violation Reporting Procedure)

3.2 Specialized compliance training may be offered to staff of functional areas such as Pharmacy, Appeals, Sales, and Enrollment; or to employees of FDRs among others when there are changes in regulations or policies and when specialized training is warranted based on risk assessment, corrective action plans, or a history of non-compliance or FWA. Examples of specialized compliance training include:

3.2.1 Marketing the Medicare Advantage Prescription Drug plans to beneficiaries

3.2.2 Managing the grievance and appeals process

3.2.3 Calculating TrOOP (true out of pocket)

3.2.4 Submitting a bid to CMS

3.2.5 Administering the Medicare Compliance Program

3.2.6 Submitting MA and MA-PD data to CMS
3.2.7 Payment reconciliation
3.2.8 CMS reporting requirements
3.2.9 Security and authentication requirements in health information technology.

3.3 FWA training will contain at least the following content:
3.3.1 Laws and regulations related to MA and MA-PD FWA (e.g., False Claims Act, Anti-kickback statute, HIPAA)
3.3.2 Obligations of FDRs to have appropriate policies and procedures to address FWA
3.3.3 Processes for SelectHealth employees and FDR employees to report suspected FWA to SelectHealth or their employer, who is obligated to report it to SelectHealth's Medicare Compliance Team
3.3.4 Protections from retaliation or intimidation for employees and FDR employees who report suspected FWA
3.3.5 Types of FWA that can occur in the settings in which SelectHealth and FDR employees work
3.3.6 Trends in FWA that have been identified by CMS or are contained in the OIG Work Plan

4 Training Methods
4.1 SelectHealth creates and utilizes its own compliance and FWA training to satisfy training requirements for the MA and MA-PD Compliance Program. Training is available to all of SelectHealth’s contracted FDRs who are involved in the administration or delivery of MA or MA-PD benefits and services.
4.2 FDRs must utilize SelectHealth’s compliance and FWA training or a training distributed by SelectHealth’s Medicare Compliance Officer with possible input from the Medicare Compliance Committee. CMS’ FWA training is an example of acceptable training to meet the requirement.
4.3 Training is distributed to FDRs through provider guides and through a provider and FDR web portal.

5 Training Updates and Review
5.1 Compliance and FWA training is reviewed annually to ensure that the training addresses areas of focus as outlined by CMS and based on SelectHealth’s Medicare program risks.
5.2 Training updates are made in response to:
   5.2.1 Regulatory changes
   5.2.2 Policy changes
   5.2.3 Issues of non-compliance and/or FWA
   5.2.4 Compliance action or sanction against SelectHealth by CMS
   5.2.5 Training ineffectiveness

6 Tracking
6.1 SelectHealth demonstrates that its employees have fulfilled these training requirements through its internal learning management system which tracks successfully completed training.
6.2 SelectHealth demonstrates that its contracted FDRs and their employees, including its contracted agents and brokers (see Medicare Advantage Sales Certification Procedure) have completed required compliance and FWA training through sign-in sheets, attestations from FDRs, and electronic certifications from the employees taking and completing the training.
6.3 Records of completed training are stored in SelectHealth’s Medicare compliance tool. Records are stored for ten years. Training may be completed through an external portal which records competed education and/or testing.

Exceptions
No exceptions are allowed except as authorized by the SelectHealth Medicare Compliance Committee.
Primary Sources
42 CFR §§ 422.503(b)(4)(vi)(C), 423.504(b)(4)(vi)(C)
Medicare Managed Care Manual, Ch.21, § 50.3
Prescription Drug Manual, Ch.9 § 50.3

Secondary Materials
Medicare Advantage Compliance Violation Reporting Procedure

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