Abstract Purpose:
The Delegation Oversight Policy and Procedure defines the responsibility of each business owner for oversight of vendors as they relate to Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC (NHP/NHIC/NHAS)'s insurance products. Delegation and oversight procedures are defined in accordance with the Centers for Medicare and Medicaid Services (CMS) and the Wisconsin Office of the Commissioner of Insurance (OCI) guidance and are reviewed annually. This policy applies to delegation oversight responsibilities as they relate to providing or administering health care services for members of Medicare Part C, D or Qualified Health Plan benefits. For additional requirements on delegation and oversight activities related to NHP/NHIC/NHAS delegates and sub delegates with managed care responsibilities of Credentialing/Re-credentialing, Customer Services, Quality Improvement and Utilization Management, please see Policy n00329 Delegation and Oversight Policy and Procedure.

Policy Detail:
This policy covers all aspects of NHP/NHIC/NHAS's vendors' pre and post evaluation, oversight, monitoring, risk assessment and auditing expectations and requirements. Evaluations and comprehensive assessments of the delegated entities' performance pre and post delegation must be conducted to prevent, detect and correct issues of compliance in accordance with regulatory requirements. Evaluations also serve to assess the vendor's ability to prevent, detect, and correct issues of non-compliance as well as an assessment of the vendor's ability to implement and monitor Corrective Action Plan(s) (CAP) as needed. (See policy n05016 Compliance Corrective Action Plans Policy). Evaluations must also include a review of compliance policies and the code of conduct (COC) to ensure that for First Tier, Downstream and Related Entities (FDRs), compliance policies, COC and procedures are distributed to all associates within 90 days of the time of hire or contracting, annually thereafter and whenever policies/COC revised or updated. NHP/NHIC/NHAS (hereafter, Network Health) business owners responsible for the contract, or specific delegation activities, are responsible to validate compliant monitoring and oversight of vendors. This responsibility includes ensuring staff are adequately trained and qualified to assess the delegates' activities. If the contracted vendor is unable or unwilling to fulfill delegated responsibilities according to Federal/State mandates and Network Health requirements, as indicated in the contractual provisions, Network Health shall not execute a contract, or when applicable, shall terminate the delegation agreement after making a concerted effort to bring the vendor into full compliance.

Procedure Detail:
I. Pre-Delegation Requirements
A. There must be an operational business owner assigned to oversee the prospective vendor's activities as they relate to specific operations to validate compliance with regulatory and contractual requirements. The operational business owner utilizes the contract checklist and this policy as resource to validate and assess the prospective vendor's compliance with regulatory requirements before a contract is executed and an entity becomes a vendor.

1. Oversight

   a. The business owner(s) need to validate that the prospective vendor is compliant with CMS and/or OCI laws, regulations, guidance, reporting requirements and State/Federal guidelines.

   b. Confirm that the prospective vendor can validate enrollee protection and sponsor accountability in compliance with all CMS and OCI regulations, reporting requirements and State/Federal guidelines.

      i. In addition, the business owner(s) must validate that if the vendor works with the Medicare or QHP line of business, they have disclosed any offshore subcontractor agreements and it's compliant with all CMS laws, regulations and guidance surrounding offshore subcontracting.

   c. The business owner(s) must validate that the prospective vendor is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009 and all applicable regulations regarding the ability of Covered Entities to use and disclose protected health information ("PHI").

   d. The business owner(s) must confirm that the prospective vendor will review the Network Health code of conduct upon initial contract, when updated and annually thereafter. Validate that the prospective vendor attests to reviewing Network Health's code of conduct and attests to compliance with Network Health's code of conduct.

   e. For FDR entities a member of the compliance team must ensure that applicable compliance policies and procedures will be distributed to all employees that work on Network Health accounts at the prospective vendors within 90 days of hire or contracting, whenever policies and/or the code of conduct are revised or updated and annually thereafter.

      i. A member of the compliance team must review the prospective vendor's code of conduct and training policy.

      ii. Confirm that the prospective FDR completes the CMS Fraud, Waste and Abuse (FWA) training module and provides the certificate of completion upon initial contract and annually thereafter.
iii. A member of the compliance team must review the prospective vendor’s FWA Program.

iv. The business owner(s) must validate that the prospective vendor screens and attests to reviewing all employees against the Department of Health and Human Services Office of Inspector General (DHHS-OIG) list of excluded individuals and entities (LEIE), Specially Designated Nationals (SDN) list and the General Services Administration (GSA) system for award management (SAM).

v. The Medicare business owner(s) must ensure the prospective vendor will disclose any findings from reviewing all employees against the DHHS-OIG, LEIE, SDN and GSA SAM.

f. The business owner(s) validate that the prospective vendor maintains all records according to Federal and State guidelines, including but not limited to retaining Medicare and/or QHP documents for a minimum of 10 years, or as required by CMS guidelines. Records must be kept longer if they are included as part of an audit or an open transaction.

2. Monitoring

a. Network Health business owners are responsible to validate that the proper internal controls and quality/compliance standards are in place to monitor the prospective vendor's operational and compliance activities and that staff are adequately trained and qualified. In addition, these monitoring activities are required to be sent to the compliance team for review, prior to contract execution.

b. The business owners are responsible to complete the pre-delegation assessment, using the contract check-list to validate that a prospective vendor is capable of performing the proposed delegated responsibilities and meets applicable performance standards and regulations.

II. Pre-Delegation Procedure

A. Oversight

1. The business owner(s) utilizes the contract checklist and this policy as a resource and also notify the compliance department of a potential delegation agreement via email to compliance@networkhealth.com.

a. Additionally, for FDR entities, the business owner will provide a detailed description of the proposed delegated functional and primary contact at the delegated entity to ensure the compliance team can enter the potential vendors’ information into the internet database.
2. The business owner(s) organize and coordinate the pre-delegation review and compile the final report and recommendations.

3. The business owner(s) analyze standardized monitoring tools based upon regulatory requirements and mandates. Network Health contractual requirements and established policies and procedures are used to complete the assessment and contract for the prospective vendor.

4. The pre-delegation assessment focuses on determining whether a prospective vendor is capable of performing the proposed delegated activity. The business owner will provide the documentation validating that the prospective vendor meets applicable performance measures and regulations including, but not limited to:
   
   a. Understanding standards of performance, services to be provided, and delegated tasks.
   
   b. Validate that the prospective vendor is committed to complying with all laws, rules, regulations, policies and procedures as well as standards of conduct as they apply to the delegate.
   
   c. Validate the prospective vendor can provide services to be defined in the contract agreement and maintain professional and proper working relationship.
   
   d. For FDR entities, validate that the prospective vendor has an effective compliance program in place to prevent, detect, and correct compliance issues which include ongoing monitoring that identifies root cause analysis and effective corrective action plans.
   
   e. For FDR entities, validate that the prospective vendor has a Fraud, Waste, and Abuse program and completes the CMS Fraud, Waste, and Abuse training module to assure that violations are properly reported and investigated.
   
   f. Validate that the Network Health finance team has reviewed financial records to validate financial solvency.
   
   g. Validate that the appropriate licensures are in place and, if needed, appropriate credentialing is completed as noted in policy n00198 Credentialing Process.
   
   h. Validate that compliance has completed necessary sanction screening protocols.
   
   i. For FDR entities, assure the prospective vendor monitors and audits its downstream and related entities to ensure they are in compliance with all applicable laws and regulations, as well as noting which of these downstream or related entities are offshore subcontractors.
j. Review records retention process to validate that the vendor maintains all records according to Federal and State guidelines, including by not limited to retaining Medicare and/or QHP documents for a minimum of 10 years, or as required by CMS guidelines. Records must be kept longer if they are included as part of an audit or an open transaction.

B. Evaluation of vendors

1. The business owner(s) work with the compliance team to establish the entity's performance, monitoring and auditing measures to validate compliance with CMS and other Federal and State regulations before an entity becomes a contracted vendor. The pre-delegation review may be accomplished through meetings or an exchange of documents. The business owner(s) and compliance staff determine the extent of the review, including whether a site visit is warranted, in addition to a review of the prospective vendor's documentation.

   a. Based on the functions to be delegated and the skill set and knowledge required for the review, the business owner(s) from the Network Health operational area will gather the requested materials and review them with the compliance team to determine the entity's capacity for operational compliance.

   b. The business owner(s) will review core function delegated activities with the assistance of compliance and other business owners and leadership as needed.

   c. The business owner(s) and compliance work together with subject matter experts to evaluate documents and data pertinent to their areas of expertise, participate in meetings with the entity as necessary, provide recommendations to the vendor, and prepare a written report related to evaluation outcomes.

   d. Compliance will provide assistance and guidance as necessary to the business owner(s) to plan audits and monitoring activities for the prospective vendors and the activities established will be reported in the compliance work plan. The business owner(s) schedule and facilitate all monitoring and audit activities including (but not limited to):

      i. Requesting documentation, reports, and data from the prospective vendor and receiving and tracking documentation from the entity.

   e. The business owner(s) work with the Network Health finance department to review prospective vendor's financial statements or rating/information.

C. Finalization of Contract

1. As appropriate, the business owner(s) share and discuss the pre-delegation process with operational approval committee and the Privacy and Compliance Committee. This information may be shared with other
governing bodies prior to final selection. These other committees include but are not limited to: Executive Leadership team, Quality Management Committee and Board of Directors.

2. The responsibility for approving the entity selected to perform the delegated function(s) will be the responsibility of the operational approval committee and subject to the current policy n03720 Contract Approval and Signature Authorization Policy.

III. Post Delegation Procedure

A. Oversight

1. Upon approval, the business owner(s) are considered to be the primary responsible party for the contract as noted in Network Health’s policy. The delegation agreement is updated based on regulatory requirements and mutually agreed upon changes in terms and conditions.

   a. For FDR entities the business owner notifies compliance to ensure that Medicare compliance can update the vendors information in the internet-based database.

2. The business owner oversees the vendor's activities as they relate to specific operations to validate compliance with regulatory and contractual requirements. Business owner(s) work with the compliance department to prevent, detect, and correct issues of non-compliance and to provide a root cause analysis. The business owner(s) evaluate, monitor, and audit the contracted vendor to validate the entity meets applicable performance measures and regulations in accordance with regulatory requirements.

3. Network Health's business owner(s) assess the vendor's performance on an ongoing basis, through regular monitoring reports, routine and ad hoc audits as defined in the delegation agreement and the annual compliance work plan.

4. The compliance officer works with the Privacy and Compliance Committee and operational approval committee to determine the remedial actions required including, but not limited to a request for a formal CAP, revocation of the delegated entity or administrative activities, contract termination, and/or other remedies for correcting inadequate performance in the contract or agreement.

B. Monitoring

1. To prevent, detect, and correct issues of non-compliance, evaluations and comprehensive assessments of the delegated entity's performance will be conducted throughout the calendar year as defined in the contractual agreement or as needed based on monitoring and auditing outcomes. Business owners assess each vendor's ability to perform delegated functions on an ongoing basis, through regular monitoring reports, routine and ad hoc audits as defined in the delegation agreement and work plan. The business owner(s) report issues of non-compliance by completing a compliance intake form. The compliance department
will review and follow up on all reported issues in the compliance intake form which includes findings, violations, and responses to corrective action plans.

2. Monitoring activities include but are not limited to:

   a. Business owner(s) from the operational areas are responsible for day to day interactions with the delegates, evaluating performance, and analyzing the content of the reports provided.

      i. Compliance ensures that all FDR entities have methods available for reporting compliance and FWA concerns and that the non-retaliation and non-intimidation policies are publicized throughout the vendors’ facility.

   b. Business owner(s) maintains oversight for each vendor in the compliance work plan which includes delegate's annual programs, work plans, evaluations, meeting minutes, oversight reports, reports submitted by the vendor, CAPs and follow up status reports, and vendor's applicable policies and procedures.

   c. Trends or significant risks identified are documented in the annual compliance work plan by the business owner(s) for compliance to address.

   d. A biennial offshore subcontract attestation is sent to all FDR entities to determine the following:

      i. Whether the vendors utilize an offshore subcontractor;

      ii. Whether the offshore subcontractor receives, processes, transfers, handles, stores and/or accesses Network Health members' PHI;

      iii. The offshore subcontractor's information including name, delegated function, contract effective date and country in which the subcontractor is located;

      iv. Precaution for PHI;

      v. Safeguards to protect beneficiary information; and

      vi. Audit requirements to ensure protection of PHI.

   e. An annual attestation is sent to all FDR entities which addresses the following:

      i. Monthly exclusion and sanction checks;

      ii. Compliance and fraud, waste and abuse training;
iii. Offshore subcontractors;
iv. Methods for reporting suspected fraud, waste and abuse; and/or non-compliance; and
v. Distribution of the code of conduct and
vi. Names and functions of downstream entities.

C. Risk Assessment

1. On an annual basis, each vendor is evaluated using internet-based database to determine the level of risk the entity poses to Network Health.

2. The level of risk determines the next steps:
   a. High Risk Level
      i. Depending on the results of the compliance officer’s review of the risk assessment, an onsite audit may be conducted.
      ii. If an onsite audit is not conducted, a desktop audit will be performed to review work flows, policies and procedures and any other pertinent documentation.
   b. Moderate Risk Level
      i. Depending on the results of the compliance officer's review of the risk assessment, a desktop audit may be conducted to review work flows, policies and procedures and any other pertinent documentation.
      ii. Ad-hoc audits and monitoring thereafter, either onsite or desktop will be performed as necessary.
   c. Low Risk Level
      i. Vendors assessed as low risk will be subject to the completion of attestation and training requirements.
      ii. Ad-hoc audits, either onsite or desk top, will be performed as determined necessary.
   d. Ad-Hoc audits
      i. Either desktop or onsite audits will be conducted as necessary.
D. Auditing

1. The assigned business owner(s) work with the compliance department to audit the highest risk vendor's activities to validate compliance with regulatory and contractual requirements annually. In addition, the business owner(s) work with compliance to assist in facilitating any audits deemed necessary.

2. All audits will be built into and reported out through the current year’s annual compliance work plan.

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

Business Owner: An identified person at NHP/NHIC/NHAS who is deemed as the subject matter expert for a particular area or topic.

Corrective Action Plan (CAP): Step by step plan of action that the organization develops to achieve targeted outcomes for resolution of identified problems. CAPs may also be referred to as Process Improvement Plans (PIPs).

Delegation Agreement: A legal agreement between NHP/NHIC/NHAS and the delegated entity, which expresses the terms and conditions consistent with regulatory agencies’ requirements and NHP/NHIC/NHAS's internal requirements.

Downstream Entity: Any party, including agents and brokers, that enter into a written arrangement, acceptable to CMS, with persons or entities involved with the MA, Part D or QHP benefit, below the level of the arrangement between Network Health and a first tier entity. These written arrangements continue down to the level of ultimate provider of both health and administrative services to Medicare beneficiaries, qualified individuals, qualified employers or qualified employees and their dependents.

FDR: First Tier, Downstream or Related Entity

Federally Funded Exchange: An Exchange established and operated with the State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

First Tier Entity: Any party that enters into a written arrangement, including agents and brokers, acceptable to CMS, with Network Health to provide administrative services or health care services to Medicare beneficiaries under the Medicare Advantage program or Medicare Prescription Drug program, or qualified individuals, qualified employers or qualified employees or their dependents under a Qualified Health plan on the Federally Funded Exchange.

GSA: The General Services Administration maintains the excluded parties list system that includes information on entities, debarred, suspended, proposed for debarment, excluded or disqualified throughout the United States Government from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non-financial assistance and benefits.

HITECH Act: The Health Information Technology for Economic and Clinical Health (HITECH) Act passed as part of the American Recovery and Reinvestment Act of 2009
ARRA). This guidance was developed through a joint effort by the Office of Civil Rights Bureau and the Centers for Medicare and Medicaid Services (CMS).

**Monitoring Activities:** Are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are taken and effective.

**OIG:** The office of the Inspector General within the Department of Health and Human Services (DHHS). The inspector General is responsible for audits, evaluations, investigations and law enforcement efforts relating to DHHS programs and operations, including the Medicare program.

**Protected Health Information (PHI):** Information that is created or received by a Covered Entity and relates to the past, present or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of healthcare to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

**Plan Representative:** A general term for the NHP/NHIC/NHAS staff member(s) assigned designated responsibility for oversight tasks of the vendors. The organization will determine the assignment of the staff member based on the operational, compliance or administrative expertise required.

**Qualified Health Plan:** A health plan that has in effect a certification that it meets the standards of subpart C of 45 CFR 156 or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of 45 CFR 155.

**Related Entity:** Any entity that is related to Network Health by common ownership or control and (1) performs some of Network Health'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 Network Health at a cost of more than $2,500 during a contract period.

**Risk Assessment:** an estimate of the likelihood of risk or adverse effects.

**Regulatory Citations:**

42 C.F.R. 422.503

42 C.F.R. 422.504(h-i)

42 C.F.R. 423.504

42 C.F.R. 423.505(b)(10),(h-i)

45 C.F.R. 155.20

45 C.F.R. 156.340

**Related Policies:**

n05016 - Compliance Corrective Action Plans

n00198 - Credentialing Process
n03720 - FPW0125 Contract Approval and Signature Authorization Policy

Related Documents:
None

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