

n05019

## CMS Delegation and Oversight Policy and Procedure

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### *Values*

Accountability • Integrity • Service Excellence • Innovation • Collaboration

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#### **Abstract Purpose:**

This policy defines the responsibility of each business owner for oversight of delegated entities as they relate to Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC (NHP/NHIC/NHAS)'s insurance products in providing or administering health care services for members of, including but not limited to, Medicare Part C, D or Qualified Health Plan benefits. Delegation and oversight procedures are defined in accordance with the Centers for Medicare and Medicaid Services (CMS) guidance and are reviewed annually. For additional requirements on delegation and oversight activities related to NHP/NHIC/NHAS (hereafter, Network Health) delegates and sub delegates with managed care responsibilities of Credentialing/Re-credentialing, please see Policy n00329 Delegation and Oversight Policy and Procedure.

#### **Policy Detail:**

This policy covers all aspects of Network Health's oversight, monitoring, risk assessment, auditing expectations and requirements of delegated entities. Evaluations and comprehensive assessments of the delegated entities' performance must be conducted to prevent, detect and correct issues of compliance in accordance with regulatory requirements as well as assess the ability of the entities to implement and monitor Corrective Action Plans (CAPs), as needed. (See n05016 Compliance Corrective Action Plans Policy). Attestation documents are sent to all first-tier entities within 90 days of contracting and annually thereafter. These attestations include Network Health's regulatory compliance program and code of conduct policies. 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 delegated 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. Oversight
  - A. The contract owner utilizes the contract checklist and works with the regulatory affairs and legal departments to determine if the vendor qualifies as a delegated entity.

1. The contract owner is responsible for validating and assessing the vendor's compliance with regulatory requirements before a contract is executed.
  2. 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. 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.
  - C. The business owner oversees the vendor's activities as they relate to their specific delegated operations to validate compliance with regulatory and contractual requirements. The 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 and monitor the contracted vendor to validate the entity meets applicable performance measures and regulations in accordance with regulatory requirements.
  - D. The business owner(s) work(s) with the Privacy and Compliance 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.
- II. Monitoring
- A. 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.
    1. 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.
  - B. 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 incident 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.
    1. 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.
      - 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. An annual attestation is sent to all first-tier 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;
    - v. Distribution of the code of conduct; and
    - vi. Names and functions of downstream entities.
  - d. An offshore subcontract attestation is sent to all first-tier entities biannually to evaluate the names, locations and functions of any offshore subcontractors.
    - i. All newly identified offshore vendors must be referred to the Incident Response Security Assessment team for evaluation.
- III. Risk Assessments
  - A. On an annual basis, each vendor is evaluated using internet-based database to determine the level of risk the entity poses to Network Health.
- IV. Auditing
  - A. The assigned business owner(s) work with the compliance department to audit vendor activities to validate compliance with regulatory and contractual requirements. In addition, the business owner(s) work with compliance to assist in facilitating any audits deemed necessary.
  - B. 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 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 an 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](#)

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<b>Revision Reason:</b> 02/15/2018 – Minor updates. 04/29/2020 – Separated from vendor process. Limiting policy to CMS delegation oversight only. 02/12/2021 – Annual review; Consent, Minor update to language. 6.3.22 - Annual review - submitting to committee for approval. Approved by Privacy & Compliance Committee on 06/13/2022		