PROVIDENCE
Medicare Advantage Plans

A division of Providence Health Assurance

Providence Medicare Advantage Plans (PMAP)

2023 Medicare Delegation Oversight Program Manual

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Introduction

Providence Medicare Advantage Plans (PMAP) has a robust delegation oversight program in accordance with the Medicare Managed Care Manual Chapter 21 and the Prescription Drug Benefit Manual Chapter 9. The delegation program is overseen by the Manager of the Medicare Compliance Program and facilitated by the Medicare Delegation Program Consultant. The Medicare Compliance Officer is ultimately responsible for PMAP's delegation program and is committed to clear communication and compliant results.

PMAP has a policy and procedure outlining our process for determining if a contracted entity qualifies as a First Tier, Downstream or Related Entity (FDR) for delegated functions. FDRs are reviewed on an annual basis to identify any changes in the contractual relationship. While the delegate is responsible for the daily operational activities, PMAP recognizes that we are fully responsible for ensuring all delegates are in compliance with Medicare regulatory requirements.

Definitions

Abuse: Includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit: Is 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: Is the key stakeholder in PMAP's operational areas. Business owners are the subject matter experts on operational processes.

Delegated Entity: Is a First Tier, Downstream or Related Entity (FDR) that is contracted with PMAP and performs a function on behalf of PMAP.

Medicare Delegation Program Consultant: Is the person that reports directly to the Manager of the Medicare Compliance Program and is responsible for the day-to-day compliance activities of the delegation oversight program.

Downstream Is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between a MA or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements between first tier entities and sub-contracted entities continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §, 423.501).

Employee(s) / Caregiver(s): Refers to those persons employed by the sponsor or FDR who provide health or administrative services for an enrollee.

Excluded Parties: A person or entity that is federally excluded to receive payment by federal funds. Excluded parties will show up on the Office of Inspector General (OIG), General Services Administration (GSA), System for Award Management (SAM) exclusion list(s) or, for providers, on the Preclusion List published monthly by CMS.

FDR: Is the First Tier, Downstream or Related Entity.

First Tier Entity: Is any party that enters into a written arrangement, acceptable to CMS, with an MA 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.

Fraud: Is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

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

Offshore/Offshore Subcontractor: The term "offshore" refers to any country that is not one of the fifty United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Examples of countries that meet the definition of "offshore" include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside of the United States or foreign-owned companies with their operations performed outside of the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Related Entity: Any entity that is related to a Medicare Advantage Organization (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 morethan $2,500 during a contract period.

Waste: Is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Delegated Entities' Functions

Per the Medicare Managed Care Manual Chapter 21 and the Prescription Drug Benefit Manual Chapter 9, Providence Medicare Advantage Plans considers the below functions to be delegated when performed by an entity other than the Medicare Advantage plan sponsor. All CMS Program Requirements under our contract with CMS apply to our delegates.

- Sales and marketing;

- Utilization management;
- Quality improvement;
- Applications processing;
- Enrollment, disenrollment, membership functions;
- Claims administration, processing and coverage adjudication;
- Appeals and grievances;
- Licensing and credentialing;
- Benefit management;
- Customer service;
- Bid preparation;
- Outbound enrollment verification;
- Provider Network Management;
- Processing of pharmacy claims at the point of sale;
- Negotiation with prescription drug manufacturers and others for rebates, discounts or other price concessions on prescription drugs;
- Administration and tracking our members drug benefits, including TrOOP balance processing;
- Coordination with other benefit programs such as Medicaid, state pharmaceutical assistance or other insurance programs;
- Entities that generate claims data; and
- Health care services.

Roles & Responsibilities

Delegate: The delegate is responsible for knowing all rules and regulations as applicable to their delegated function and the Medicare line of business. The delegate works with the business owner and the Medicare Delegation Program Consultant to meet operational, regulatory and compliance requirements. The delegate is required to respond to and complete all auditing and monitoring activities, communications, inquiries and attestations, and to provide appropriate documentation upon request.

Business Owner: The business owner is responsible for assisting in the oversight of the delegate from an operational standpoint. The business owner works in the department performing the function internally for Providence Medicare Advantage Plans. This role is critical to the delegate's success as the business owner is the subject matter expert in the operational area. The business owner will concurrently review the data sent from the delegate for operational challenges and/or effective processes while the Medicare Delegation Program Consultant reviews for Medicare compliance. The business owner alerts the Medicare Delegation Program Consultant if they see anything operationally that could potentially be a non-compliance issue.

Medicare Delegation Program Consultant: The Medicare Delegation Program Consultant is responsible for the compliance activities and oversight of delegates. This role reports directly to the Manager of the Medicare Compliance Program and is responsible for the annual delegate self-assessment and attestation process. In addition, auditing and monitoring of and by the delegate is reviewed by the Medicare Delegation Program Consultant and may be performed by a Medicare compliance program analyst or auditor. Communication and education as it relates to Medicare compliance requirements is the responsibility of this position as well. HPMS memos that contain information related to the delegate's function are relayed by the Medicare Delegation Program Consultant to the delegate. The CMS Preclusion List of providers excluded from receiving payment from Medicare is forwarded to

applicable delegates monthly. This role ensures that all compliance related activities and obligations are completed in a timely manner. Member communications or marketing must be reviewed for approval.

Annual Process

Delegate Self-Assessment

At the beginning of the fourth quarter of each year, all delegates will be sent the Delegate Self-Assessment and are required to respond as to the compliance status of their organization. The delegate's self-assessment asks specific questions regarding the delegate's functions, responsibilities, processes and compliance. Specific documentation will be requested as proof of compliance.

PMAP Risk Assessment

Upon receipt of the Delegate Self-Assessment, the Medicare Delegation Program Consultant will perform an independent risk assessment. Risks identified by the Medicare Delegation Program Consultant will be considered and factored into the ranking by the Manager of the Medicare Compliance Program in order to determine which risk areas will have the greatest impact on our members, the delegate and PMAP. Each delegate is assigned a red, yellow or green risk level. The Medicare Delegation Program Consultant will prioritize and tailor the monitoring and auditing strategy according to the risk level. Continuous assessment/reviews of the delegates' performance will also happen throughout the year. Potential risks of non-compliance, FWA and a periodic re-evaluation of the delegated entities' compliance status is also performed. Additionally, areas of concern identified during the Risk Assessment may require a monitoring and auditing work plan to encompass additional monitoring/auditing.

Setting the Auditing/Monitoring Schedule

By the end of each calendar year the Medicare Delegation Program Consultant with input from the business owner at the direction of the Medicare Compliance Officer creates an auditing and monitoring schedule for the following calendar year for each delegate. Frequency of the delegate routine auditing and monitoring is based on the delegate risk level and is adjusted when audit and/or monitoring results indicate such a change is appropriate. Additional audits/monitoring efforts will be added as needed at the direction of the Medicare Compliance Officer.

Delegate Monitoring & Auditing done by PMAP

The Medicare Compliance Officer or designee oversees the completion of self-monitoring performed by the delegate. Delegates submit monitoring according to the delegate monitoring schedule. The Medicare Delegation Program Consultant will perform an independent review to validate findings while the business owner will perform an operational review. Any potential or confirmed non-compliance issues will require training and/or a work plan or corrective action plan.

Tracking and validating monitoring

The Medicare Delegation Program Consultant is responsible for tracking, reviewing and validating the monitoring results sent in by the delegate each month. The results of this review are tracked by utilizing the current CMS protocol templates for monitoring.

Delegate Self-monitoring

Delegates are required to submit self-monitoring when requested according to the monitoring schedule. If monitoring is due and not received in a timely manner, a notice of non-compliance may be issued. If self-monitoring is not received by the date on the notice of non-compliance, further corrective action will be pursued. FWA self-monitoring by delegates should be performed monthly. Any findings are to be reported to PHAMedicareCompliance@providence.org.

Business Owner Role in Monitoring

The business owner will concurrently review the self-monitoring sent in by the delegate for operational challenges and/or ineffective processes while the Medicare Delegation Program Consultant reviews for compliance adherence. The business owner alerts the Medicare Delegation Program Consultant if they see anything operationally that could potentially be a non-compliance issue.

Medicare Delegation Program Consultant Role in Monitoring

Monitoring of and by the delegate is reviewed and validated by the Medicare Delegation Program Consultant for compliance standards and metrics. In the event that an issue of potential non-compliance is identified, the Medicare Delegation Program Consultant will facilitate all compliance action needed from the delegate in communication with the business owner. A corrective action and/or work plan with timeframes for implementation will be developed. Self-monitoring results are provided to the Medicare Compliance Officer on a monthly basis, which are then shared with the Chief Compliance Officer and the Compliance Committee.

Monitoring Communications

The Medicare Delegation Program Consultant is responsible for all compliance communication to the delegate while the business owner will work with the delegate on operational issues found as appropriate. Business owners will be copied on communications regarding issues or requests from the delegate as needed. The Medicare Delegation Program Consultant will be copied on all communications sent by the business owner and the business owner will be copied on all communications sent by the Medicare Delegation Program Consultant.

Ad Hoc Monitoring

If self-monitoring submitted by the delegate reveals any compliance issues, or reviews by PMAP show any potential non-compliance, additional monitoring will be added to the monitoring schedule and will be required of the delegate.

Auditing & Performance (Scorecards)

Delegation Auditing Program & Audit Types

PMAP has a formal auditing program that follows the current CMS Audit Protocol and the outlined Delegate Audit Schedule. This ensures compliance from delegates according to their delegated functions. Each FDR must cooperate in auditing activities. PMAP audits delegates on a regular basis according to the auditing schedule or on an ad-hoc basis when deemed appropriate. PMAP will be conducting audits, to ensure transparency and full compliance. The auditing program and schedule reflects the following:

Live Audits:

1. Medicare Delegation Program Consultant and the Business Owner will review submitted

universes
   a. Medicare Delegation Program Consultant or Analyst/Auditor will conduct timeliness tests to identify possible issues of noncompliance.

   b. The Business Owner will review the file to ensure appropriate data has been submitted based on what is delegated.
2. Medicare Delegation Program Consultant or Analyst/Auditor will select case files based on overall universe timeliness tests
3. Case files will be sent to Delegate who will have 24 hours to pull case files and gather applicable documentation.
4. On the day of the live audit, Delegate will share screen (via WebEx) walk through each selected case, explaining the life of the claim or authorization. Both the Medicare Delegation Program Consultant and Business Owner will attend the live presentation to review applicable material.
5. Medicare Delegation Program Consultant will apply CMS Compliance Standards, recording findings and issues on noncompliance in real-time on Live Audit Template.
6. Medicare Delegation Program Consultant or Analyst/Auditor will provide results to Delegate within 48 hours as well as any next steps.
7. Remediation, if applicable, by the delegate, will be complete by the deadline set forth by the Medicare Delegation Program Consultant.

Desk Audits:

1. Medicare Delegation Program Consultant and the Business Owner will review submitted universes
   a. Medicare Delegation Program Consultant or Analyst/Auditor will conduct timeliness tests to identify possible issues of noncompliance.
   b. The Business Owner will review the file to ensure appropriate data has been submitted based on what is delegated.
2. Medicare Delegation Program Consultant or Analyst/Auditor will filter the universe and select five (5) cases based off a targeted review and timeliness tests.
   a. The case file selection will be sent to the delegate and Business Owner will be copied.
   b. The delegate will have seven (7) business days to gather case files and send to the Business Owner and Medicare Delegation Program Consultant.
3. Medicare Delegation Program Consultant and the Business Owner will perform concurrent review on the selected case files. Business owner will conduct an operational review; Medicare Delegation Program Consultant will conduct CMS Audit protocol review.
4. Medicare Delegation Program Consultant or Analyst/Auditor will compile the results and scores, which will be shared via email with delegate and the Business Owner within three (3) business days.
5. Future meetings will be scheduled to discuss remediation progress, if applicable.

Tracer Audit

A Tracer audit will be conducted by the Medicare Compliance team as needed. This audit utilizes Tracer methodology outlined in the Compliance Program Effectiveness (CPE) protocol published by CMS. For audit purposes we will use a similar tracer method to evaluate implementation of applicable compliance elements and determine whether the delegate functions in a way that is effective to address compliance and FWA issues in a timely and well-documented manner.

1. Tracer case samples will be selected from the current universe or from previous audit

results. This will be done within three (3) business days of the release of the universes.

2. The delegate will have ten (7 business) days to compile requested documents. A reminder notice, late notice (if the deadline is missed), and a notice of non-compliance may be issued if a response is not received in a timely manner.
3. Selected tracer documents will be audited by the Medicare Compliance team. At a minimum, the cases will be evaluated against the Compliance Standards. The Medicare Delegation Program Consultant may review factors not specifically addressed in these questions if it is determined that there are other related ODAG or CDAG requirements not being met.
4. Medicare Delegation Program Consultant or Analyst/Auditor will provide results to the business area within 10 business days.
5. Remediation by the delegate, when applicable, will be complete by the deadline set forth between the Medicare Delegation Program Consultant and the delegate's compliance department representative.
6. Medicare Delegation Program Consultant will compile the results of the audit for the Compliance Scorecard.

Tracking auditing on COA Universe

The Medicare Delegation Program Consultant and Analyst/Auditors are responsible for tracking, reviewing and auditing the universes sent in by the delegate each month. The results of this review and audit are tracked by utilizing the current CMS protocol templates according to the auditable area, specifically the COA universe.

Medicare Compliance Role in Auditing

The Medicare Delegation Program Consultant will perform independent audits to validate compliance standards are met. Targeted training, a work plan and/or a corrective action plan will result if an area of potential non- compliance is identified and confirmed.

Monthly Compliance Scorecards

Delegate scores will be documented on monthly compliance scorecards. Scores will be calculated using multiple factors including but not limited to:

- Policies and Procedures
- Training and Education
- Effective Lines of Communication
- Auditing and Monitoring
- Prompt and Effective Response to Detected Offenses
- Other Operational Issues Affecting Overall Compliance

Additional Audits

Additional audits may be performed as compliance concerns arise or as PMAP deems appropriate.

Audit Review Meetings

Audit meetings may be held between the Medicare Delegation Program Consultant, Business Owner and FDR to review audit results and any applicable corrective action steps. This process is overseen by the Manager of the Compliance Program and the Medicare Compliance Officer. Status reports and related risk assessments regarding operational routine monitoring, FDR monitoring, auditing, work plans and corrective action plans (CAPs) will be reported regularly by the Medicare Compliance Officer to the Chief Compliance Officer and the Compliance Committee.

Reporting Potential Non-Compliance

Program non-compliance and FWA may be discovered in a variety of ways, a hotline, a website, an enrollee complaint, during routine monitoring or self-evaluation, during an audit, or by regulatory authorities.

Delegate Expectations for Reporting Potential Non-Compliance

Regardless of how non-compliance or FWA is identified, the delegate is expected to respond and participate in full remediation as appropriate.
The delegate can self-report a potential non-compliance concern in the following ways:

- Delegates may report potential non-compliance through routine auditing and monitoring by reporting with their monthly audit submission.
- Delegates may contact the Medicare Delegation Program Consultant via e-mail or phone.
- Delegates may e-mail PHAMedicareCompliance@providence.org

Business Owner Process for Reporting Potential Non-Compliance

If the business owner discovers or is notified of potential non-compliance, they will notify the Medicare Delegation Program Consultant or the Manager of the Medicare Compliance Program or Medicare Compliance Officer immediately.

Medicare Compliance Investigation Process for Potential Non-Compliance

The Medicare Delegation Program Consultant will investigate potential non-compliance issues and will communicate the outcome of the investigation to the Manager of the Medicare Compliance Program and/or the Medicare Compliance Officer as needed.

Communicating Investigation Results

The Medicare Delegation Program Consultant will communicate the outcome of the investigation as well as any needed remediation to the business owner and will monitor the delegate until all corrective action is complete.

Communication

Day-to-day operational communications

The business owner is responsible for day-to-day operational communications to and from the delegate as appropriate. Communications to the delegate will include a copy to the Medicare Delegation Program Consultant when related to compliance matters.

Day-to-day compliance communications

The Medicare Delegation Program Consultant is responsible for all compliance related communications to the delegate. Communications to the delegate will include a copy to the Business Owner as appropriate.

Formal compliance communications

The Medicare Delegation Program Consultant is responsible for communicating all formal compliance communications to the delegate. These communications will include education to the delegate about requirement and impact as it relates to them. Communications to the delegate will include a copy to the Business Owner.

Data Validation

Delegates contracted for Part C and/or Part D reporting functions are required to report data to PMAP on a variety of measures. CMS has developed reporting standards and data validation specifications with respect to the Part C and Part D reporting that are utilized by PMAP. These standards and specifications provide a review process for delegates to conduct data validation checks on their reported Part C and Part D data. The data validation is "retrospective," referring to the fact that it normally occurs in the year subsequent to the measurement year. Periodic audits for data validation may be conducted to ensure data integrity is being maintained.

Delegate responsibilities for Data Validation

Delegates are required to submit their data by the specified due date(s). PMAP expects that data is accurate on the date they are submitted. Data submitted after the given reporting period deadline shall be considered late and a notice of non-compliance will be issued to the delegate. Additionally, incorrect data is also subject to a notice of non-compliance. The accuracy and integrity of this data is the delegate's responsibility, but is the ultimate responsibility of PMAP. By sending the data to PMAP, the delegate is attesting that this file has been reviewed. Each delegate will be required to attest that this information has been reviewed and is without deficiencies.

Medicare Compliance Contact Data Validation Role

PMAP will review the submitted data to ensure that lines total correctly and will submit this data to CMS by the CMS Reporting Deadline. If there are any issues identified, the delegate non-compliance process will be followed.

CMS Communications

PMAP Process for CMS Communication/Guidance to Delegates

As CMS updates and/or releases new guidance, PMAP will interpret and disseminate that guidance to the delegate, as applicable. The Medicare Delegation Program Consultant will monitor a delegate's compliance with implementing the guidance request. The Business Owner will participate and support this process.

Business Owner Role in CMS Communications

If there is guidance sent out that would impact operational processes, the business owner will assist the delegate with implementation as appropriate.

Delegate Responsibilities for implementation

Delegates are required to implement required changes as quickly as possible. PMAP will work with delegates to provide guidance and support while these changes are employed. The delegate is responsible for communicating to PMAP if there is an issue with implementation and the estimated timeframe for resolution.

Delegate's Responsibilities Regarding Downstream Entities

Delegates are required to gain PMAP approval of any entities or individuals with whom they intend to sub-contract duties for PMAP. These sub-contractors become PMAP's downstream entities.

Off-Shore Subcontracting

CMS has strict requirements for MA sponsors regarding offshore subcontracting. Therefore, delegates must have offshore sub-contracting fully approved by PMAP before a delegate allows any work related to PMAP to take place. The term "off-shore" refers to any country that is not one of the fifty United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Training & Education

Annual Training & Education

Training and education is required of all delegates on an annual basis. Delegates can be supplied with appropriate training modules by the Medicare Delegation Program Consultant if needed. Delegates also have the option of taking the CMS Online Training or of creating their own CMS based training. Training must include general Medicare compliance, fraud, waste and abuse training, and HIPAA/HITECH security training.

Additional Training & Education

Additional, specialized or refresher training may be provided on issues posing non-compliance or FWA risks based on the delegated function.
Training may be provided:

- upon appointment of a new delegate;
- when requirements change;
- when delegates are found to be non-compliant.

The Medicare Delegation Program Consultant may choose to tailor the training in response to circumstances surrounding potential non-compliance and/or FWA, issues identified via monitoring/auditing, and/or specific functions performed by FDRs.

OIG/SAM/Exclusion Checks

Monthly OIG Exclusion Checks by PMAP

PMAP reviews the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS) prior to contracting with an entity that has the potential to become a delegated entity and on a monthly basis thereafter to ensure that none of the delegates are barred from participation in a government program.

Delegate responsibilities for OIG/SAM/Exclusion Checks

Delegates are responsible for screening all employees and any contracted entities on a monthly basis for any exclusions. If an exclusion is found, the delegated entity is required to notify the Medicare Delegation Program Consultant immediately.

Preclusion List Screening

PMAP responsibility

The Preclusion list, implemented by CMS in 2019, is published monthly and consists of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or

Part D drugs furnished or prescribed to Medicare beneficiaries. Each month, when the list becomes available to Part D sponsors, the Medicare Delegation Program Consultant will send the list via secure e-mail to the appropriate claims processing and credentialing delegates.

Delegate responsibilities

Applicable delegates will be required to screen providers against the Preclusion List to ensure that no payment has been or will be made to providers who appear on the list. Providers whose names have been published on the Preclusion list are not eligible to receive Medicare reimbursement unless eventually cleared and removed from the Preclusion List. MA Plans are required to deny payment for a health care item or service furnished by an individual or entity on the Preclusion List after notifying impacted members. A member is considered affected if their provider or prescriber is on the Preclusion list and has submitted any claims or prescribed or furnished any medications for the member within the prior 12 months.

FDR Website

https://healthplans.providence.org/providers/provider-support/fdr-training

Purpose of FDR Website

Providence Medicare Advantage Plans has a website to assist our delegates in understanding how we do business and to outline their responsibilities in providing services to Providence Medicare Advantage Plans and our Medicare members.

Content of FDR Website

On the FDR Website, you will find the Providence Medicare Advantage Plan Standards of Conduct, Delegate Policies and Procedures, applicable Providence Medicare Advantage Plans Policies and Procedures, information on CMS-required compliance and Fraud, Waste and Abuse (FWA) training; and how to report compliance concerns.

CMS Program Audit

Medicare Compliance Role in a CMS Program Audit

In the event of a CMS Program Audit, the Medicare Delegation Program Consultant will lead communication with impacted delegates. In addition, a schedule of timeframes will be sent to all affected delegates.

Business Owner Role in a CMS Program Audit

The Business Owner will assist the Medicare Delegation Program Consultant with universe review, mock webinars and communication as needed. The Business Owner will be in the room during the CMS webinar as a resource for the delegate.

Delegate expectations and role in a CMS Program Audit

Expectations are that delegates provide timely and accurate data files, be available for practice webinars, validation, and the CMS Program Audit webinars. The timeline of the audit will be communicated ahead of time so the proper staffing and resources will be made available.

Delegate Remediation

Operational Remediation

If operational issues are identified, the Business Owner will direct the delegate on the needed remediation steps with assistance from the Medicare Delegation Program Consultant when needed.

Compliance Remediation

If compliance issues are identified and remediation is needed from the delegate, the Medicare Delegation Program Consultant is responsible for communicating any remediation, work plans, and/or corrective actions plans, as appropriate.

Audit Protocol Remediation

All communication associated with audit findings resulting in remediation will be communicated by the Medicare Delegation Program Consultant with a copy to the business owner.

CMS Program Remediation

If remediation is needed from a CMS Program Audit by the delegate, the timeline and remediation request will be communicated by the Medicare Delegation Program Consultant with a copy to the Business owner.

Providence Medicare Advantage Plans - Policies & Procedures

Policies and Procedures that affect delegated entities are provided to delegated entities on the Providence Medicare Advantage Plans FDR Website and the annual self-assessment. Policies and procedures are updated annually in accordance with CMS rules and regulations and are distributed to the delegate.

Medicare Compliance e-mail

Questions or concerns from FDR's can be addressed to the Medicare Delegation Program Consultant directly or to the Medicare Compliance team by using the following e-mail address: PHAMedicareCompliance@providence.org

FDR Grid

The table below is a guide to FDR compliance obligations and timelines. Not all activities listed will apply to every delegate. Activities deemed appropriate to ensure oversight will be communicated by the Medicare Delegation Program Consultant. Items that apply to all delegates are indicated with an *asterisk.

Annually	Description
*Training	* General compliance, HIPAA/HITECH Privacy, Fraud, Waste & Abuse training including compliance policies and standards of conduct is required by all delegates. Training must be conducted within 90 days of hire and annually thereafter. Delegates may adopt Providence

	Standards of Conduct or use their own parallel standard of conduct or code of ethics. Proof of training will be required annually.
*Compliance Policies	*Compliance policies apply to all delegates and must be distributed to your employees and contractors within 90 days of hire (and annually thereafter). Policies will be submitted to Providence for annual audit along with the delegates' self-assessment.
*Self-Assessment and Attestation	*The Annual Self-Assessment and Attestation, sent in the 4th quarter of each year, contains compliance related questions and statements. Delegates will have a deadline for submitting the completed and signed form along with specific documentation such as policies and procedures, training materials, and proof of screening.
*Downstream (FDR) Attestations	*All delegates must report sub-contracted entities performing functions for PHA. Downstream entities are subject to audit. PHA's first tier delegate will facilitate this exchange of information, obtaining the required self-assessment and documentation from entities with whom they sub-contract PMAP related functions. Delegates will forward upon request. (Note: sub-delegation must be pre-approved by PHA.)
Data Validation	Data validation is a yearly reporting process required by CMS. For delegates subject to CMS reporting requirements such as claims and utilization management, data validation must be submitted by the annual due date or upon request. Delegate files will be reviewed retrospectively for CMS specified data requirements
Bi-Annually	**Description**
Prompt Pay Interest Rate	Clean, approved claims must be paid to providers within 30 days of approval. When the Federal Prompt Pay Interest Rate changes, applicable delegates will be notified and must configure their systems accordingly within a reasonable period of time or specified period of time. Confirmation of implementation is required.
Monthly	**Description**
*Self-Monitoring	*All delegates are expected to perform self-monitoring of their processes, outcomes and data.

	Delegates are also required to audit and monitor PHA related sub-delegates when other entities or individuals are involved. Monitoring for Fraud, Waste or Abuse should be performed at least monthly.
Universe Auditing	Universe submissions (if applicable) must be sent each month by the 15th via secure file transfer protocol (SFTP). Timeliness and accuracy will be audited. All letters issued to members or providers must conform to the required elements and set timeframes. Auditing cadence can vary based on findings and ad-hoc submissions may be requested.
Desk Audits	Desk audits for applicable core delegates alternating with live audits may be conducted monthly or quarterly. Cadence is subject to change. Any necessary remediation will be communicated by PHA's Medicare Delegation Program Consultant. Known issues should be submitted with a pre-audit issue summary.
Live Audits	Live audits may be conducted monthly or quarterly. Cases for live audits will be sent to the delegate 24 hours in advance of the live audit. Delegates will be showing documentation from their internal claims processing and/or utilization management systems. Known issues should include a pre-audit issue summary.
*OIG/SAM and CMS Preclusion Lists	*Delegated entities must screen employees and contractors monthly using the Office of Inspector General's (OIG) List of Excluded Entities and Individuals (LEIE) and System for Award Management (SAM) exclusion lists.
Preclusion List Screening	The CMS published Preclusion List will be sent via secure e-mail to applicable delegates upon CMS publication. Providers/prescribers must be screened against this list monthly. Upon discovery, any positive match must be reported to the Providence Medicare Program Delegation Consultant, who will then communicate any further PHA or CMS required actions to the delegate.
Ad Hoc	Description
*HPMS/CMS Memos	*CMS frequently issues Health Plan Management System (HPMS) memos or CMS announcements via e-

	mail. All memos are evaluated and will be disseminated via e-mail to any applicable delegate by the Medicare Delegation Program Consultant.
*Communications	*As needed, correspondence with delegates will be conducted via e-mail, web-ex meetings or over the phone. On occasion, formal letters may also be mailed to delegates. Business owners will be included on communications when applicable to operations.
*Potential Non-Compliance	*All delegates are responsible for compliance. Potential non-Compliance can be found by the delegate self reporting concerns, by the business owner in the course of operations, or during an audit. Non-compliance concerns will be investigated. Findings will be shared with the delegate and business owner. When appropriate, plans for remediation will be communicated to the both the delegate and the business owner as well as the Manager of the Medicare Compliance Program and/or the Medicare Compliance Officer.
*Notices	* Reminder Notices call out a deadline as a courtesy. Late Notices may be sent if a deadline is missed. Notices of Non-Compliance may be issued for findings. Work Plans will be developed when appropriate. Timely response by delegates is required. Corrective Action Plans may be issued for remediation and proof of correction.