Government Program Vendor Overview and Obligations

The term **"Government Programs Vendor"** (GPV) is used throughout this document and is intended to include the Senior Care Options (SCO) "Subcontractors", MassHealth "Material Subcontractors", and Medicare Advantage (MA) "First Tier, Downstream, or Related Entities" (FDRs) as defined below.

General Definitions

Plan, Sponsor, and/or Contractor – These terms are used interchangeably throughout this document and refer to Fallon Health.

The Centers for Medicare and Medicaid Services (CMS) – The federal agency which administers the Medicare Advantage (MA) Program and Prescription Drug Plan (Part D) Program. The Medicare Advantage program is, also, known as Medicare Part C (Part C). The Medicare Prescription Drug Plan is, also, referred to as Medicare Part D (Part D).

Executive Office of Health and Human Services (EOHHS) – The State Agency responsible for administering the Medicaid program in Massachusetts known as MassHealth, as well as the Senior Care Options (SCO) program.

Government Programs Addendum (GPA) – An addendum to the Plan's contract with the GPV that the GPV is required to agree to prior to contracting, and which outlines the applicable regulatory requirements associated with being a GPV.

MA Programs Definitions

First Tier Entity is any party that enters into a written arrangement with a Medicare Advantage Organization (MAO) 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. (See, 42 C.F.R. § 423.501).

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

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. (See, 42 C.F.R. § 423.501).

Sponsors may enter into contracts with FDRs to provide administrative and/or health care services for enrollees on behalf of the sponsor.

MassHealth Program Definitions

Material Subcontractor is any entity which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of its Administrative Services for any program area or function that relates to the delivery of a Managed Care Organization's (MCO) Covered Services, including, but not limited to, behavioral health, claims processing, care management, utilization management or pharmacy benefits, including specialty pharmacy providers.

Administrative Services is the performance of services or functions necessary for the management of, the delivery of, and payment for, MCO Covered Services, and the coordination of Non-MCO Covered Services, including but not limited to network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems (MIS) operation and reporting, and state agency service coordination, including behavioral health.

SCO Program Definitions

Subcontractor is an individual or entity that enters into an agreement with the Contractor to fulfill an obligation of the Contractor under the contract.

What types of GPVs must comply with Government Program requirements?

Government Program requirements apply to GPVs to whom the Plan has delegated administrative or health care service functions relating to the Plan's contracts for government programs and meet the definitions for the applicable program, as noted in the aforementioned definitions. These requirements do not apply to persons and entities whose contracts with the sponsor do not relate to the Plan's government programs core functions. For example, a contract between a sponsor and a real estate broker in connection with the rental of office space would not be required to comply with the requirements. In general, a GPV performs a service that the MAO or MassHealth Plan needs in order to function as a Plan.

Below are examples of core functions that relate to the sponsor's Medicare Advantage (Part C) and Part D contracts, including SCO, and may apply to the sponsor's MassHealth contracts (see definition of Administrative Services above).

Note: This list should not be considered exhaustive. The Plan has the discretion to determine which GPVs meet the requirements to be a GPV based on the below criteria and additional analysis of the GPVs functions.

- 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;
- Pharmacy benefit management;
- Hotline operations;
- 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 of enrollees' 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.

How does Fallon determine when an entity is a GPV?

Below are some factors Fallon considers in determining whether an entity is a GPV:

- The function to be performed by the delegated entity;
- Whether the function is something the sponsor is required to do or to provide under its contract with CMS, the applicable federal regulations or CMS guidance, or under its contract with the State;
- To what extent the function directly impacts enrollees;
- To what extent the delegated entity has interaction with enrollees, either orally or in writing;
- Whether the delegated entity has access to beneficiary information or personal health information;
- Whether the delegated entity has decision-making authority (e.g., enrollment vendor deciding time frames) or whether the entity strictly takes direction from the sponsor;
- The extent to which the function places the delegated entity in a position to commit health care fraud, waste or abuse; and

- The risk that the entity could harm enrollees or otherwise violate Medicare or Medicaid program requirements or commit fraud, waste, and abuse (FWA)

Fallon's Government Programs Vendor Oversight Committee utilizes the above factors as well as applicable federal and state regulations and guidance to determine which vendors qualify as GPVs.

What are some of the Requirements for a Government Programs Vendor?

As a GPV, there are certain regulatory requirements that must be met in order for the Plan to remain compliant with Federal and/or State contracts. These include, but are not limited to the following:

1. **Fraud, Waste, and Abuse and Compliance Training** – Plans must ensure that all GPVs provide Fraud, Waste, and Abuse and Compliance training to their employees and Board Members. This Compliance Training includes, but is not limited to, review of the Vendor/Supplier Code of Conduct and review of Plan compliance policies and procedures, when applicable. The Plan will distribute Compliance Training, in addition to the Vendor/Supplier Code of Conduct, to its GPVs upon contracting and annually thereafter. Each GPV is required to maintain evidence of both FWA and Compliance Training, which may include training logs, attestations and training programs. Evidence of compliance may be requested at any time by the Plan.

2. **Excluded Entity Checks** – Per CMS and EOHHS, Plans are required to ensure that all GPVs perform excluded entity checks on a monthly basis for all Board Members, employees, consultants, and volunteers. These checks must be conducted upon or before hire/contracting and monthly thereafter against the Office of the Inspector General List of Excluded Entities and Individuals (OIG LEIE) and the System for Awards Management (SAM). Evidence of the monthly checks must be provided to Plan. Evidence can be in the form of a screen shot, if manual searches are completed, or if your organization performs a more automated system, the documentation may be based on the information within that system. The documentation should clearly identify the name of the entity/individual checked, the date the check was performed, and the results of the check. Positive matches to the exclusion databases must be immediately reported to the Plan.

   If the organization delegates any functions to a Downstream entity, the organization must ensure that the Downstream entity is, also, completing the exclusion checks for the same individuals as noted above. The Plan may request documentation of these checks to ensure that the organization is in compliance.

3. **Record Retention** – Per CMS regulations, all information associated with the Medicare Advantage Program must be maintained for at least 10 years. This includes, but is not limited to, documentation, data, and report code.

4. **Plan Right to Audit, Evaluate, and Inspect Records** – It is expected that GPVs provide access to information pertinent to the Plan's contract with the GPV. This information includes, but is not limited to, any books, contracts, computer or other electronic systems (including medical records, report code, claims processing, etc…)

5. **Compliance with all applicable Medicare laws, regulations, and CMS instructions** – For those GPVs contracted with the Plan to provide services under the Medicare Advantage, NaviCare or PACE, lines of business, the GPV must comply with all applicable Medicare laws, regulations, and CMS instructions unless otherwise noted by the plan in a separate, program-specific addendum.

6. **Plan Right to Monitor** – CMS expects that all Plans will provide oversight and monitoring of their GPVs providing services on behalf of the Plan. This monitoring may include, but is not limited to, report requests, performance evaluations, attestations, or even auditing of the GPV at varying intervals.

7. **Oversight of Downstream Entities and Related Parties** – It is expected that any GPV which contracts with a Downstream or related Entity to perform services for the Plan on behalf of the GPV will be monitored and audited, periodically, to ensure that the terms of the GPA are met. In addition, it is expected that the GPV impose corrective actions when deficiencies are identified, which may, in some cases, mean termination of a contract. The Plan has the right to request evidence of this monitoring and auditing.

8. **Compliance Program** – All GPVs are required to have an effective compliance program to ensure that the GPV is complying with the provisions within the contract and GPA and operating under the applicable Federal and/or State laws, rules, and regulations.

9. **Notification of Offshore Subcontractors** – CMS is concerned about beneficiary personal health information (PHI) being handled outside of the United States and therefore encourages the use of measures to ensure that offshore arrangements protect beneficiary privacy. CMS asks that all organizations using offshore subcontractors submit specific subcontract information and an attestation that they have taken appropriate steps to address the specific risks associated with the use of subcontractors outside the United States.

   Organizations must, therefore submit one attestation for each offshore subcontractor they have engaged to perform Medicare-related work. This attestation includes, in part:

1. Offshore subcontractor's name and functions
2. Description of PHI provided to the offshore subcontractor
3. Offshore subcontracting arrangement safeguards adopted to protect beneficiary information
4. Offshore subcontractor audit requirements

The form to be used for reporting of offshore subcontractors will be provided by the Plan. Offshore subcontractor attestations must be submitted to CMS thirty (30) calendar days after the offshore subcontract is signed. Therefore, it is expected that the GPV will provide notification to the Plan in a timely fashion.

Please note that the above only outlines some of the responsibilities a GPV has under their contract with the Plan. The Plan's GPA, which all GPVs are required to agree to prior to contracting, outlines the applicable regulatory requirements associated with being a GPV.