JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Compliance and Regulatory Affairs** **Corporate**	*Policy Number*	COR.018
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	Subject **Ongoing Monitoring for State and Federal Exclusion, Debarment and Sanctions**	*Revision Date*	10/08/2018
		Page	1 of 6

This document applies to the following Participating Organizations:

EHP | Elder Plus | Johns Hopkins Advantage MD | Priority Partners

US Family Health Plan

Keywords: debarment, exclusions, federal, monitoring, sanctions, state

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I. ACTION

	New Policy	
	Repealed Policy Date	
	Superseded Policy Number	

II. POLICY

The U.S. Department of Health and Human Services, Office of Inspector General, has the authority to exclude individuals and entities who have engaged in fraud and abuse from participation in Medicare, Medicaid, and other Federal Health Care Programs and to impose civil monetary penalties (“CMPs”) for certain misconduct related to Federal and State Health Care Programs. Exclusions are either mandatory or permissive: mandatory exclusions are required by law and permissive exclusions are imposed by the Office of Inspector General’s discretion. The effect of any exclusion is that no government-issued payment may be made for any items or services (1) furnished by an excluded individual or entity, or (2) directed or prescribed by an excluded physician. Anyone who hires or contracts with an individual or entity excluded by the Office of Inspector General

may also be subject to CMPs. To avoid CMP liability, the Office of Inspector General recommends that health care entities screen new hires or contractors and current employees and contractors for such exclusion on a monthly basis.

The Centers for Medicare and Medicaid Services issued guidance to State Medicaid Agencies on January 16, 2009 that advises States of their obligation to direct providers to screen their employees and contractors for such exclusion to prevent Medicaid payments for items or services furnished or ordered by excluded individuals or entities. It further advises States to require providers to search the Office of Inspector General's List of Excluded Individuals and Entities monthly to capture new exclusions or reinstatements that occurred since the last search.

Johns Hopkins Health Plans and its Participating Organizations are committed to ensuring that all employees, medical staff, contractors, vendors and others providing administrative or health care services relating to Federal and State Health Care Programs with whom Johns Hopkins Health Plans and its Participating Organizations do business with are properly screened for exclusions, debarment, and state sanctions and are authorized to participate in Federal and State Health Care Programs. Such screening involves diligent research on the U.S. Department of Health and Human Services-Office of the Inspector General's List of Excluded Individuals and Entities, the General Services Administration's System for Award Management, and the Maryland Department of Health's Sanctioned Provider's List.

Johns Hopkins Health Plans and its Participating Organizations will not employ or engage in a business relationship with anyone who is currently under exclusion, debarment, or sanction by the U. S. Department of Health and Human Services-Office of Inspector General, the Maryland Department of Health, and any other duly authorized enforcement agency or licensing and disciplining authority.

Johns Hopkins Health Plans and its Participating Organizations will not employ any individuals who have been recently convicted of a criminal offense related to healthcare and will remove individuals with direct responsibility for or involvement with any Federal or State Health Care Program, as well as those pending the resolution of any criminal charges or proposed exclusion, debarment, or sanction.

III. SCOPE

This policy applies to personnel at Johns Hopkins Health Plans and Johns Hopkins Health System ("JHHS"), an affiliate of Johns Hopkins Health Plans, tasked with conducting screenings for the Participating Organization's new and current workforce members, Board of Directors, contractors, medical staff, vendors, and First Tier, Downstream, or Related Entities as defined in Appendix A.

The following are brief descriptions of the Participating Organizations impacted by this policy:

- **EHP**: a Third Party Administrator for Self-Insured Plans.
- **ElderPlus**: a Medicare PACE program designed to provide and coordinate all needed preventative, primary, acute, and long-term care services so that older individuals can continue living in the community.
- **Johns Hopkins Advantage MD**: a Medicare Advantage Organization ("MAO").
- **Priority Partners**: a Medicaid Managed Care Organization.
- **US Family Health Plan**: a managed care program developed by the Defense Health Agency that offers health care benefits to eligible beneficiaries of the uniformed services, including active-duty family members, retirees and their family members, and survivors.

IV. ABBREVIATIONS

- Centers for Medicare and Medicaid Services (CMS)
- Code of Federal Regulations (CFR)
- Code of Maryland Annotated Regulations (COMAR)

- Department of Health and Human Services (DHHS)
- General Services Administration (GSA)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Maryland Department of Health (MDH)
- Office of Inspector General (OIG)
- Social Security Act (SSA)
- System Award Management (SAM)
- United States Code (USC)

V. KEY TERMS & DEFINITIONS

See Appendix A for a Glossary of Terms used in the content of this policy. All definitions used shall be deemed automatically updated as revisions to laws or regulations occur from time to time.

VI. REQUIREMENTS, RESPONSIBILITIES & PROCEDURES

As part of an effective compliance program, HHS-OIG and CMS require Federal and State Health Care Programs to:

1. Not engage, employ, contract with, or pay claims to any individuals, including workforce members (including permanent, temporary , interns, and volunteers), Board members and/or attendees, providers, or contractors who are currently debarred, sanctioned, or mandatorily or permissively excluded from participation in Federal or State Health Care Programs or who have opted out of the Medicare program; and
2. Require all FDRs that provide administrative or health care services for Federal or State Health Care Programs to comply with all applicable laws and regulations.

In addition to the screening and monitoring requirements, all new and existing workforce members, Board members and attendees, and contractors must immediately disclose to the Participating Organization any debarment, exclusion, or any other event that makes them ineligible to perform work directly or indirectly related to Federal or State Health Care Programs.

A. **Responsible Parties for Initial and Ongoing Monitoring**
Appendix B outlines by type, all exclusionary/debarment/sanction checks performed by Johns Hopkins Health Plans, on behalf of the Participating Organizations, in accordance with regulatory requirements.

B. **Participating vs. Non-Participating - Federal and/or State Exclusions, Debarments, Sanctions, and Contract Violations**

1. Exclusions:
If a Participating (PAR) Provider or Non-Participating (NON-PAR) Provider is excluded from any Federal Health Care Program, the Participating Organization may not pay the excluded provider using federal monies dating back to the date of the exclusion and continuing until reinstatement, unless the exception for Emergency Services applies. This prohibition applies to Johns Hopkins Advantage MD, Priority Partners, ElderPlus, and US Family Health Plan, respectively.
2. Debarments:
If a PAR or NON-PAR Provider is federally debarred, the Participating Organization may not pay the debarred provider through or with funds from any Federal Health Care Program dating back to the date of debarment and continuing until the debarred provider is no longer debarred. This prohibition applies to Johns Hopkins Advantage MD, Priority Partners, ElderPlus, and US Family Health Plan, respectively.
3. State Sanctions:

If a PAR or NON-PAR Provider is sanctioned on the Maryland Department of Health's Sanctioned Provider's List, the Participating Organization may not pay the sanctioned provider through or with funds from any Federal or State Health Care Program dating back to the date of the sanction and continuing until the sanctioned provider is no longer sanctioned. This prohibition applies to Johns Hopkins Advantage MD, Priority Partners, ElderPlus, and US Family Health Plan, respectively.

4. License Board Sanction:
   a. A PAR or NON-PAR Provider whose state license is suspended, expired, or revoked will not be reimbursed for any items or services dating back to the date of the suspension and continuing until such suspension is lifted.
   b. A PAR or NON-PAR Provider with US Family Health Plan whose license is active but not at full clinical practice level will not be reimbursed for any items of services dating back to the date of the restriction and continuing until such restriction is lifted. Full clinical practice level is defined as an unrestricted license that is not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. Any other PAR or NON-PAR Provider whose state license is active but restricted may be reimbursed.
5. Contract violations:
   Exclusion, debarment, state sanctions, and license board sanctions each result in the Par Provider's breach of the provider contract with the Participating Organization. As such, the providers in breach of their contract may not be paid through or with funds from any Federal or State Health Care Program dating back to the date of exclusion, debarment, state sanction, or license board sanction and continuing until the action is resolved.

C. **Termination of Providers/Entities and/or FDRs Found to be Excluded, Debarred, Sanctioned, or Without Valid Licensure**

1. Providers/entities
   a. The Credentialing Department will immediately terminate excluded, debarred, sanctioned, or unlicensed providers or entities from all of the networks of the Participating Organizations.
   b. The Provider Maintenance Department will annotate the claim system concerning the Participating Organization's inability to pay said provider.
   c. The Participating Organization's delegated party responsible for credentialing must terminate its Johns Hopkins Health Plans contract with any excluded, debarred, sanctioned, or unlicensed providers/entities.
2. FDRs
   a. For MAOs, generally, the Vice President of Medicare Advantage will terminate the MAO's relationship with such FDRs found to be excluded, debarred, or without valid licensure; and
   b. For all other Participating Organizations, the appropriate senior level management will be notified and appropriate action will be taken.

CI. **Recoupment of Any and All Errant Participating Organization Payments**

1. If payment is made to an excluded, debarred, sanctioned, or unlicensed individual or entity, the Compliance Department will:
   a. Review the Participating Organization's contract with the provider to determine whether the contract is with an individual provider or with a group provider.
   b. Send a notification letter to the provider and/or group notifying the recipient of the determination.
   c. If the Department does not receive a timely response from the affected provider and/or group (i.e., within five calendar days of the notice), the Department will forward the case to the Manager of COB for placement in collections and/or futures as detailed in D.2.b below
   d. All written communication is to occur by a trackable method.
2. Use of Futures

a. No provider/entity who is excluded, debarred, sanctioned, or unlicensed should be placed in futures as there cannot be future billings or future claims to offset for return to the appropriate Participating Organization.

b. Exceptions:

i. If the Participating Organization's contract is with a provider group that the excluded provider is a member of, the Compliance Department will send its correspondence to the group and not the individual provider since it is the group that is being reimbursed and not the individual provider. If the group fails to make payment, the group will be placed into futures until the repayment obligation is satisfied. Use of futures is not a condition of collections such that the group may be placed immediately into collections, at the Participating Organization's sole discretion.

ii. If the Participating Organization's contract is with a single provider and the provider has IBNR (incurred but not reported) claims for a period prior to exclusion, debarment, or sanction, the provider will be placed in futures, until the repayment obligation is satisfied. Use of futures is not a condition of collections such that the provider may be placed immediately into collections, at the Participating Organization's sole discretion.

E. **Attestation**

Annually, Participating Organizations may require FDRs and contractors to sign an attestation signifying their compliance with exclusion/debarment monitoring and its willingness/ability to provide proof of said monitoring upon request by either the Participating Organization, CMS, or the State of Maryland (or their designees) as applicable. Monitoring includes the First Tier Entity's employees, and its Downstream and Related Entities.

1. Annually, as part of its ongoing monitoring efforts, the MAO will pull a random sample across all FDR types to assess the provider/entity(ies) compliance with this standard.
2. Any FDR not in compliance with this standard will be immediately re-educated, required to demonstrate proof (within three (3) business days) of entire workforce member screening, imposition of a corrective action plan (which includes monthly ongoing monitoring by the Compliance Department), and referral to the FDR Oversight Committee for potential further disciplinary action.

F. **Reporting**

Results of the Compliance Departments' ongoing monitoring of the MAOs and its FDRs exclusionary/debarment activities will be reported monthly to the Medicare FDR Oversight Committee, quarterly to the appropriate Compliance Committee, and semi-annually to the appropriate Board.

G. **Storage and Retrieval of Data**

All ongoing monitoring results will be stored electronically for ten (10) years. All documents will be retrievable and be made available for audit upon request for audit by CMS or its designee.

VII. REFERENCES

- Social Security Act §1128: Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs
- 42 CFR 1001: Program Integrity – Medicare and State Health Care Programs
- 42 USC 1320a-7: Criminal Penalties for Acts Involving Federal Health Care Programs
- HHS-OIG Special Advisory Bulletin on the Effect of Exclusion from Participation in federal Health Care Programs (2013).
- 42 CFR Part 422: Medicare Advantage Program
- 42 CFR Part 423: Voluntary Medicare Drug Benefit
- 42 CFR 438.610: Managed Care: Additional Program Integrity Safeguards: Prohibited Affiliations

- COMAR 10.67.03.03: Maryland Medicaid Managed Care Program: MCO Application: Organization, Operations, and Financing
- Title XVIII of the Social Security Act: Health Insurance for the Aged and Disables
- Title XIX of the Social Security Act: Grants to States for Medical Assistance Programs
- Executive Order 12549 Debarment and Suspension; 13 CFR 400.109 – Government-wide Debarment and Suspension (non-procurement).
- 32 CFR 199.9 (f): Administrative Remedies for Fraud, Abuse and Conflict of Interest
- 31 USC 3729: Federal False Claims Act
- MD Code, General Provisions, Title 8: Maryland State False Claims Act
- Medicare Managed Care Manual, Chapter 6: Relationships with Providers
- Medicare Prescription Drug Benefit Manual
- MAPD Policies and their associated Compliance Department workflows and procedures related to:
  - Risk Assessment
  - Special Investigation Unit Investigation, Corrective Action Assignment and Monitoring
  - Annual Audit Work Plan
  - FDR Oversight Committee
  - Hopkins Health Advantage Compliance Oversight Committee
- JI-11-1C Credentialing Policy PCR 002
- TRICARE Operations Manual Chapter 13 Sections 6 and 7
- TRICARE Policy Manual Chapter 11 Section 3.2

VIII. APPROVALS

Electronic Signature(s)	Date
Mary Donnelly Medicare Compliance Officer	11/30/2021
Amanda Walter Manager, SI, Audits and Ongoing Monitoring	11/26/2021

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