Perennial Advantage, Inc.

This Compliance Program applies to Perennial Advantage of Ohio, Inc. and Perennial Advantage of Colorado, Inc. Medicare Part C and Part D lines of business and will be referred to as "the Plan". The Program supports the Plan's commitment and strategy to comply with all applicable Federal and State laws and regulations with an emphasis on Medicare Advantage health plan compliance. The activities that comprise the Compliance Program helps to ensure that the Plan meets its mission, vision, and values while complying with the applicable regulatory requirements.

2022 Compliance Program

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Definitions

These terms have the following meaning throughout the Compliance Program:

1. **Abuse** – Occurs when provider, contractor, employee or member practices are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to state and federally funded programs, including, but not limited to practices that result in reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care. It also includes enrollee practices that result in unnecessary cost to state and federally funded programs.
2. **Board Compliance Committee -** means the Corporate Compliance Committee comprised of the Plan Health CEO, President, Board members, Compliance Officer, and other members of management selected by the Board which meets quarterly to discuss corporate compliance initiatives, reports of noncompliance, compliance actions, auditing and monitoring reports, and any other compliance topics applicable to Medicare Advantage (Part C), Medicare Prescription Drug (Part D), Medicaid, Federally Facilitated Marketplace, and commercial lines of business.
3. **Claim –** includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.
4. **Contractor** – means any entity that provides services to the Plan pursuant to the terms of a written agreement. Additionally, for the purposes of this Plan, the term contractor includes subcontractors with whom the contractor subcontracts work relating to the Medicare Advantage (Part C) and/or Prescription Drug (Part D) plans. This term shall expressly include, but not be limited to first tier, downstream, and related entities.
5. **Delegated Entity** – means any entity that the Plan determines meets the definition of a first tier, downstream, or related entity. See First Tier Entity, Downstream Entity, and Related Entity definitions for additional detail.
6. **Downstream Entity –** as defined by 42 C.F.R. §423.501, means any party that enters in an acceptable written arrangement below the level of the arrangement between the Plan and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
7. **Employee** – means any full time, part time, or temporary employee of the

Plan who works directly or indirectly on the Medicare Advantage and/or Prescription Drug (Part D) plans. Additionally, for the purposes of this Program, the term employee includes the Plan volunteers who work directly or indirectly on the Medicare Advantage and/or Prescription Drug (Part D) plans.

8. **Federal Health Care Offense** – means a violation of, or a criminal conspiracy to violate any of the provisions set forth under Section II.A. if the violation or conspiracy relates to a health care benefit program.
9. **Federal Health Care Program** – as defined at 18 U.S.C. §241320a-7b(f), includes any plan or program that provides health benefits to any individual, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or state health care program, including but not limited to, Medicare, Medicaid, CHAMPUS, Veterans Administration, Federal Bureau of Prisons, and Indian Health Service, but not excluding the Federal Employees Health Benefit Program.
10. **First Tier Entity** – as defined by 42 C.F.R. §423.501, means any party that enters into a written arrangement with the Plan to provide administrative services or health care services for a Medicare eligible individual.
11. **Fraud** – means an intentional deception or misrepresentation that the person knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to herself, himself, or some other person.
12. **Health Care Benefit Program** – as defined at 18 U.S.C §24(a), includes any public or private plan or contract for the provision of any medical benefit, item, or service to any individual.
13. **Knowingly** – as defined in 31 U.S.C §3729(b), means that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.
14. **Operational Committee** – means the Corporate Compliance Committee comprised of operational business area management which meets monthly to discuss corporate compliance initiatives, reports of noncompliance, compliance actions, auditing and monitoring report, and any other compliance topics applicable to Medicare Advantage (Part C), Medicare Prescription Drug (Part D), Medicaid, Federally Facilitated Marketplace, and commercial lines of business.
15. **Related Entity** – as defined by 42 C.F.R. §423.501, means any entity that is related to the Plan by common ownership or control and:

a. Performs some of the Plan's management functions under contract or delegation;
b. Furnishes services to Medicare enrollees under an oral or written agreement; or
c. Leases real property or sells materials to the Plan at a cost of more than $2,500 during a contract period.

16. **Waste** – means the inappropriate or inefficient utilization of services or resources. Means also an over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to federal and state funded programs. Waste is generally not considered to be caused by criminally negligent actions but rather misuse of resources.

Overview and Scope of The Plan Compliance Program

Perennial Advantage of Ohio, Inc., ("hereafter referred to as "the Plan"), which includes a Medicare Advantage Plan (Part C) and Medicare Prescription Drug Plan (Part D) with Perennial Advantage of Ohio, Inc. and Perennial Advantage of Colorado, Inc. Medicare Part C and Part D lines of business, has adopted its Compliance Program to support the Plan's commitment and strategy to comply with all applicable state and federal laws and regulations with an emphasis on Medicare Advantage and Medicare Part D compliance. The activities that comprise the Compliance Program help the Plan meet its mission, vision, and values. The Compliance Program has been developed to assist in establishing a culture within the Plan that promotes the prevention, detection, and resolution of instances of conduct that do not conform to federal and state law and federal and state health care program requirements.

The Plan Compliance Program describes the Plan's commitment to ethical business practices and behavior. Additionally, the Compliance Program provides the framework to assure that the Plan's employees, including officers, managers, volunteers, interns, Board of Directors, vendors (i.e., contracts, subcontractors), and first-tier, downstream, and related entities (FDRs) comply with the applicable legal and ethical standards of conduct, including Plan standards of conduct and requirements to prevent, detect, and mitigate fraud, waste, and abuse (FWA).

The Compliance Program is specifically tailored to the Plan's unique operations and circumstances. Certain FDRs provide administrative or health care services for enrollees on behalf of the Plan, apart from compliance program administrative functions (e.g., Compliance Officer, compliance committee, compliance reporting to senior management, etc.). The Plan utilizes certain FDRs for compliance activities such as monitoring, auditing, and training, while maintaining the ultimate responsibility for fulfilling the terms and conditions of its contract with CMS. FDRs with delegated administrative or health care service functions relating to the Plan's Medicare Parts C and D contracts are required to meet all Medicare program requirements.

The Plan is committed to maintaining, documenting, and reporting compliance with all legal and contractual requirements of the Plan. The Compliance Program includes, but is not limited to, the seven elements of effective compliance programs specified in 42 C.F.R. §§ 422.503(b)(vi) and 423.504(b)(4)(vi) and associated sub regulations:

1. Written policies, procedures and Standards of Conduct;
2. Designated compliance officer and compliance committee;
3. Effective training and education;
4. Effective lines of communication;
5. Enforcement of standards through well-publicized disciplinary guidelines;
6. Effective system for internal monitoring and auditing; and
7. Prompt response to detected problems through corrective actions.

In collaboration with CMS's seven elements, The Plan's Compliance Program closely follows the five goals listed below:

- Ensure adequate processes are in place to facilitate ethical conduct through policy development and education;
- Serve as an internal control to potential fraud, waste, and abuse focused business areas;
- Minimize loss through early detection and reporting (both financially through the FWA program, as well as criminal sanctions through OIG/GSA screening);
- Provide a central contact for employees to receive information and guidance on applicable federal and state statues, regulations, and other requirements; and
- Ensure prompt, thorough investigation of alleged misconduct, and initiate immediate and appropriate corrective action.

This Program Description and the Plan's Compliance policies and procedures include processes for assessing the effectiveness of the Compliance Program, through the use of effective, two-way communications and reporting metrics. While not limited to the following, the effectiveness of the Plan Compliance Program may be evaluated by review of:

- Structure indicators such as Medicare related hotline calls investigated within two working days and resolved within 60 days; reports to the Board; Standards of Conduct provided yearly to 100% of Plan employees.
- Process indicators such as 100% of Plan employees trained annually on Compliance/HIPAA/FWA; 100% of Plan employees checked monthly against LEIE/System for Award Management (SAM) database
- Outcome indicators such as reporting requirement timelines met; 100% of member materials filed and approved prior to distribution; 100% of enrollment materials distributed according to open enrollment deadlines; 100% of member communications sent timely according to applicable deadlines (i.e., appeals, organization or coverage determinations).

The Compliance Program applies to all the Plan employees including officers, managers, volunteers, interns, Board of Directors, vendors (i.e., contractors, subcontractors), and FDRs who have a role in the Plan's Medicare Advantage and Medicare Part D program, even indirectly. Compliance is not assigned to one person or department, but rather it is the responsibility of every employee of the organization.

The Compliance Program, Standards of Conduct, and all other applicable compliance policies and procedures are made available to all Plan employees on the Policy and Procedure Library.

Note: Within this document, the term "employee" refers to all permanent, temporary, full-time, part-time and volunteer employees who: 1) have primary job duties related to The Plan's Part C and Part D operations and/or sales; and/or 2) are members of the Plan Board of Directors.

I. WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT

As an element of the Plan Compliance Program, the Plan maintains all compliance-specific

and operational policies and procedures online on the Plan's Intranet site. All employees are provided access to these policies and procedures no later than 90 days of hire and are notified of significant policy and procedure updates. The Plan's expectations for compliance are detailed in compliance-specific policies, including but not limited to policies regarding non-intimidation, non-retaliation, security and applicable laws and regulations regarding FWA, including:

- *Standards of Conduct* (which describes the policies and procedures for Conflict of Interest);
- Applicable privacy and security regulations of the Health Insurance Portability and Accountability Act of 1996, which is included within the *HIPAA Privacy and Security Plan;* and the
- *Fraud, Waste, and Abuse* policy.

These policies set a minimum standard of conduct for employees, associated, and Board members. Policies and procedures have also been implemented that describe how compliance issues will be investigated and resolved by the Compliance Officer.

The Compliance Officer works directly with each department to implement the compliance policies and procedures within their respective departments. Additionally, each department is also required to implement department-specific operational policies and procedures in support of the Plan's regulatory and contractual obligations.

Policies and procedures set forth in the Compliance Program shall be fully enforced and adhered to by all Plan employees, associate, contractors, FDRs, and Board members.

The Compliance Program and its policies and procedures are reviewed and revised at least annually, and more frequently, if needed. The Plan's Compliance Committee reviews and approves the Compliance Program, while the Board of Directors is informed and receives an overview report.

Standards of Conduct

The Plan's *Standards of Conduct* ("Standards") are the Plan's statement of the ethical and compliance principles that guide its daily operations. The Standards articulate the Plan's commitment to the lawful and ethical conduct of its business, and to promote lawful and ethical behavior by its employees, associates, contractors, FDRs, Board members, and business partners.

The Standards, approved by the Board of Directors, establish that the Plan expects employees to conduct themselves in an ethical manner and to act in accordance with law and applicable Plan policies.

The Standards are updated annually or as needed to incorporate changes in applicable laws, regulations, and other program requirements as appropriate.

Included in the Standards is how to report compliance issues and potential FWA using the appropriate mechanisms set forth by the Plan for such purpose and that reported issues

will be addresses and corrected in a timely manner. The Plan's Standards also provides details concerning non-intimidation and non-retaliation for good faith reporting of compliance concerns and alleged violations.

During new hire orientation, all Plan employees are required to review the Standards of Conduct and agree to follow the Standards of Conduct. The Standards of Conduct is provided upon hire to all employees and included in the annual employee training.

Conflict of Interest

The Conflict-of-Interest Policy (found within the *Standards of Conduct)* is designed to protect the Plan's interest when it is contemplating entering in a transaction or arrangement that might benefit the private interests of an employee or might result in a possible excess benefit transaction. A conflict of interest occurs when a Plan employee allows personal gain to interfere or influence the performance of his or her work duties.

Plan employees are encouraged to avoid situations that may be called into question and to disclose any potential conflict of interest by submitting an email to the Plan compliance mailbox (compliance@perennialadvantage.com) or anonymously through the Compliance Hotline at 1-844-317-9059. They should also contact the Compliance Officer whenever there is doubt about any activity or relationship that has the potential to create a conflict of interest.

To facilitate the assessment of any perceived or actual conflicts of interest, the Standards of Conduct encourages Plan employees to disclose any potential or perceived conflict of interest when they occur.

HIPAA Privacy and Security

The Plan's *HIPAA Privacy and Security Plan* documents the Plan's privacy and security policies and procedures in accordance with the Health Insurance Portability and Accountability Act of 1996. Upon hire and annually thereafter, all employees are required to complete and pass the Plan's training program for HIPAA and HITECH privacy and security.

Fraud, Waste, and Abuse (FWA) Plan

The Plan's *Fraud, Waste, and Abuse* policy demonstrates the Plan's commitment to the responsible stewardship of Plan resources and to maintaining a comprehensive plan for detecting, preventing, and correcting FWA. The *Fraud, Waste, and Abuse* policy includes, but is not limited to, initial background checks to review associates' backgrounds for, at a minimum, the Office of Inspector General's List of Excluded Individuals and the Office of Foreign Assets Control exclusions.

The Plan reviews vendors and first-tier entities prior to entering business relationships to ensure that downstream entities are also checked for exclusion. The Plan's policies prohibit the use of federal or state funds for the payment of excluded parties.

Upon hire or initiation of a contract, individuals and entities must agree to comply with the

Plan's Standards of Conduct and complete all mandatory FWA training. All Plan employees play an important role in the Plan FWA program and are required to report suspected fraud, waste or abuse, whether through their immediate supervisor, Compliance mailbox (compliance@perennialadvantage.com), or anonymously through the Compliance Hotline (1-844-317-9059).

Vendors and First Tier, Downstream, and Related Entities (FDRs)

The Plan's vendors and FDRs must comply with the Plan Compliance Program and the *Fraud, Waste, and Abuse* policy. All FDRs who provide administration or health care services under contract with the Plan are also responsible for following the Plan's compliance policies and procedures. FDRs may either adopt the Plan's Standards of Conduct or implement their own policies, procedures, and standards of conduct that adhere to the Plan's. The Plan has the right to review and approve FDR policies, procedures, and Standards of Conduct.

The Plan's policies and procedures are provided to vendors and FDRs in the form of manuals, policy and procedure documents and training materials. These documents may be distributed to Plan FDRs by, but not limited to, the following methods: e-mail, fax, website, portal, or by other means, as appropriate. Periodic monitoring of the FDRs, including review of their compliance policies and programs Standards of Conduct and performance, also occurs.

Although some FDRs may be deemed to have met the requirements for the Medicare training requirements due to their enrollment into the Medicare Program, these deemed individuals must still receive general Medicare compliance training and specialized compliance training in connection with their job responsibilities.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE AND HIGH-LEVEL OVERSIGHT

The Plan's Board of Directors is responsible for the oversight of the Plan's Compliance Program. The Board of Directors reviews the reports provided by the Compliance Officer, Human Resources, and the Compliance Committee on planned and implemented compliance activities; the status of the compliance program, including issues identified, investigated and resolved through the Compliance Program; and makes recommendations for the implementation and effectiveness of the program.

Compliance Officer

The Compliance Officer is a Perennial corporate, senior-level employee who is dedicated to and responsible for the Plan's daily Medicare Advantage Compliance operations, including implementation and oversight of the Institutional Special Needs Plan (I-SNP) and Chronic Special Needs Plan (C-SNP) compliance with Medicare Part C and Medicare Part D program requirements. The Compliance Officer does not hold any other operational responsibilities. The Compliance Officer reports directly to the Chief Executive Officer (CEO). and is accountable to the Plan's Board of Directors and Compliance Committee. The Compliance Officer has express authority to provide unfiltered, in-person reports directly to the CEO of the Plan and the Board of Directors. The Compliance Officer does not need prior Board of

Directors or CEO approval to implement needed compliance actions and activities if those activities are reported to the Board of Directors at its next scheduled meeting.

The Compliance Officer is accountable for effective implementation of the Plan Compliance Program, including developing, monitoring, and ensuring compliance with the specific requirements of the SNP. Responsibilities include, but are not limited to:

- Interview or delegate the responsibility to interview the sponsor's employees and other relevant individuals regarding compliance issues;
- Review or delegate the responsibility to review Plan contracts and other documents pertinent to the Medicare program;
- Review or delegate the responsibility to review the submission of data to CMS to ensure that it is accurate and in compliance with CMS reporting requirements;
- Independently seek advice from legal counsel;
- Implement processes for reporting potential compliance issues and/or FWA and correction of same, as appropriate;
- Report potential FWA to CMS, its designee, or law enforcement;
- Conduct, direct, and/or delegate authority to conduct/direct audits and investigations of any FDRs;
- Conduct, direct, and/or delegate authority to conduct/direct audits of any area or function involved with Medicare Parts C or D plans; and
- Recommend policy, procedure, and process changes.

The role also performs the following:

- Oversees and monitors the implementation of the compliance program;
- Reports on a regular basis to the Chief Executive Officer, Compliance Committee, and Board of Directors;
- Periodically revises the Compliance Program to respond to the needs of the Plan, and to changes in law or policies and procedures of governmental agencies;
- Develops, coordinates, and participates in educational and training programs that focus on the elements of the Compliance Program;
- Coordinates internal compliance review and monitoring activities; and
- Develops policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

The Compliance Officer has the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and issue any resulting corrective action (e.g., making necessary improvements to policies and practices and recommending appropriate disciplinary action) working through the Compliance Program. The Compliance Officer is empowered to do the following:

- Coordinate with the applicable Plan departments to ensure that no employees are listed on the Office of Inspector General (OIG), General Services Administration (GSA), and Office of the Medicaid Inspector General (OMIG). This is done prior to hire/contracting and monthly thereafter.
- Report any applicable fraud or misconduct to CMS, its designee, and/or law enforcement.
- Ensure that proper documentation is maintained for each allegation of potential non-compliance or FWA received through any of the reporting methods (e.g., hotline, mail, and in-person). Such documentation includes all corrective and/or disciplinary action(s) taken as a result of the investigation, the respective dates when each of these events and/or actions occurred, and the names and contact information for the person(s) who took and documented these actions.
- Oversee the development and monitoring the implementation of corrective action plans.
- Independently investigate and coordinate potential fraud investigations/referrals and, where applicable, coordinating and cooperating with the appropriate Medicare Drug Integrity Contractor (MEDIC). The Compliance Officer, as appropriate, collaborates with other sponsors, state Medicaid Programs, Medicaid Fraud Control Units, commercial payers, and other organizations when an FWA issue is discovered involving multiple parties.

Compliance Committee

The Plan has established a Compliance Committee to advise and assist the Compliance Officer in the implementation and oversight of the compliance program.

The Compliance Committee's responsibilities include:

- Meeting at least quarterly, and more often if necessary;
- Analyzing the industry environment, legal requirements with which the Plan must comply, and specific risk areas;
- Assessing existing policies and procedures that address these risk areas;
- Working with appropriate departments to promote compliance;
- Recommending and monitoring the development of internal systems and controls to carry out the Plan's standards, policies and procedures;
- Determining the appropriate strategy/approach to promote compliance with the program and the detection of any potential violations through hotlines and other fraud reporting mechanisms;
- Supporting the Compliance Officer's needs for sufficient staff and resources to carry out his or her duties;
- Ensuring The Plan has appropriate, up-to-date compliance policies and procedures;

- Reviewing and addressing reports of monitoring and auditing of areas in which the Plan is at risk of FWA and ensuring corrective action plans are implemented and monitored.
- Providing reports on the status of compliance with recommendations to the Board of Directors and The Plan's senior-most leader (i.e., CEO).

The Compliance Committee is comprised of senior management-level individuals from a variety of backgrounds. They have decision-making authority in their respective areas of expertise.

The Compliance Officer together with the Compliance Committee periodically reports to the Board of Directors on the activities and status of the Compliance Program, including issues identified, investigated and resolved by the Compliance Committee. Meeting minutes are maintained by the Compliance Officer.

Board of Directors

The Plan's governing body of the Compliance Program is the Board of Directors. As such, the Board is accountable for the status of the Plan Compliance Program and exercises reasonable oversight of its implementation and effectiveness. When presented with compliance issues, the Board makes further inquiry and takes appropriate action to ensure the issues are resolved.

The Board of Directors receives training and education on the structure and operation of the Plan Compliance Program. As the governing body, the Board of Directors is knowledgeable about compliance risks and strategies, understands outcomes, and is able to assess the effectiveness of the Compliance Program.

Reasonable oversight of the Board of Directors includes, but is not limited to:

- Approving the Standards of Conduct;
- Understanding the Compliance Program structure;
- Remaining informed about Compliance Program outcomes, including results of internal and external audits;
- Remaining informed about governmental compliance enforcement activity such as Notices of Non-Compliance, Warning Letters, and/or formal sanctions;
- Receiving regulatory scheduled, periodic updates from the Compliance Officer and Compliance Committee; and
- Reviewing the results of performance and effectiveness assessments of the Compliance Program.

The following are examples of activities in which the Board of Directors may be involved as it relates to the Compliance Program:

- Review and approval of compliance risk assessment;
- Review of internal and external audit work plans and audits results;

- Review and approval of corrective action plans (CAPs) resulting from audits;
- Review and approval of appointment of the Compliance Officer;
- Review and approval of performance goals for the Compliance Officer; and
- Review of dashboards, scorecards, self-assessment tools, etc., that reveal compliance issues.

The Board of Directors reviews measurable evidences (including risk reduction and other Medicare noncompliance) that the Compliance Program has detected and corrected on a timely basis. It is a best practice for the governing body to be provided with data showing that the program has reduced the risks of program noncompliance and FWA.

Board of Directors meeting minutes are available to ensure validation of the active engagement of the governing body on the oversight of the Plan Compliance Program.

Senior Management Involvement

The Plan senior leadership, including the CEO, COO, and the Board of Directors, recognizes the importance of an effective Compliance Program to ensure the Plan's success and the best healthcare and services for its Medicare beneficiaries. Each leadership member is highly engaged in the Compliance Program.

The CEO and senior management ensure that the Plan Compliance Officer is integrated into the organization and given the credibility, authority, and resources necessary to operate a robust and effective compliance program. The CEO receives periodic reports from the Compliance Officer regarding risk areas that the Plan may face, the strategies being implemented to address them, and the results of those strategies. The Compliance Officer also advises the CEO of all governmental compliance enforcement activity, from Notices of Non-Compliance to formal enforcement activities.

III. EFFECTIVE TRAINING AND EDUCATION

General Compliance and Fraud, Waste, and Abuse Training for Plan Employees

The Plan provides general compliance and FWA training and education to employees using various training mechanisms appropriate to the audience. Training and education mechanisms include, but are not limited to, computer-based training (CBT) modules, facilitated presentations, policy and procedure manuals, provider manuals, posters, memoranda, mail and e-mail reminder notices, and websites. It is the responsibility of the Compliance Officer to ensure that general compliance training and education, including FWA-specific content, is provided to the above audiences.

The content of compliance training and education materials is commensurate with the training needs of the intended audience. In general, formal compliance trainings convey the Plan's commitment to legal and ethical behavior, including preventing, detecting, mitigating, and reporting potential instances of non-compliance. Specifically, these trainings discuss the obligation of the Plan and its employees to adhere to Plan compliance

policies and procedures, including a "zero-tolerance" policy for FWA and misconduct, along with the requirement for good-faith reporting of suspected or actual FWA, non-compliance, and misconduct to the appropriate individuals or parties. Further, the trainings emphasize The Plan's policy of non-retribution, non-retaliation, and non-intimidation for good-faith reporting, as well as the availability of confidential and anonymous lines of communication, including, but not limited to, the confidential and anonymous compliance hotline.

Compliance training is part of new orientation training for new employees and Directors. New hires receive general compliance and FWA training which includes Standards of Conduct. If needed, additional training sessions are presented as the result of regulatory changes, policy and procedure revisions, and/or to mitigate compliance-related issues that may arise. Compliance training is provided and must be completed within 90 days of initial hire, or in the case of Directors, appointment, and annually thereafter.

Each Plan employee also receives a departmental-specific orientation at the time of hire to ensure their understanding of the Medicare requirements related to their job function. If an employee requires additional training as a result of not comprehending compliance training, it will be provided. In some cases, employees may not be permitted to commence work until department management staff deems that the employee meets the expected performance levels.

General Compliance Training includes the following topics:

- Compliance Program description, including a review of compliance policies and procedures, the Standards of Conduct, and The Plan's commitment to business ethics and compliance with all Medicare program requirements.
- Instruction on how to ask compliance questions, request compliance clarification or report suspected or detected non-compliance. Confidentiality, anonymity, and non-retaliation for compliance-related questions or reports of suspected or actual non-compliance or potential FWA is highlighted.
- Examples of reportable non-compliance that an employee might observe.
- Review of disciplinary guidelines for non-compliant or fraudulent behavior and potential resulting disciplinary actions.
- Participation in compliance and FWA training programs as a condition of continued employment and criterion to be included in employee evaluations.
- A review of policies related to contracting with the government, including laws that govern employee conduct in the Medicare program (i.e., gifts and gratuities for Government employees).
- Review of potential conflicts of interest and The Plan's system for disclosure of conflicts of interest.
- An oversight of HIPAA/HITECH and the importance of maintaining the confidentiality of personal health information (PHI).

The Plan's FWA training program includes examples of common types of FWA, including, but are not limited to:

- Inappropriate marketing schemes;
- Improper provision of benefits/services to our members;
- Fraudulent billing by providers/entities;
- Members attempting to improperly obtain services by loaning their Plan member card to a non-member; and
- Failure to provide medically necessary services.

General Compliance and Fraud, Waste, and Abuse Training for FDRs

FDR agents (e.g., office staff and other personnel associated with or employed by an FDR) who have met the FWA certification requirements through enrollment into the Medicare Advantage program or through accreditation as a supplier of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the FWA training and education requirements. All FDR agents who are not deemed to have met the FWA training and education requirement are required to complete the FWA training within 90 days of contracting and annually thereafter.

FDRs have the option of using the standardized FWA training and education module available through the CMS Medicare Learning Network (MLN) at http://www.cms.gov/MLNProducts or their own substantively equivalent training program to meet the Plan's FWA training requirements. Regardless of the training program used, the Plan requires FDR agents to complete and pass the FWA training within 90 days of contracting with the Plan and annually thereafter. The Plan requires that FDRs maintain thorough and accurate records of all completed training in accordance with their written agreement and present such records to the Plan upon request.

All FDR agents who assist in the administration of delivery of the Plan's Medicare Advantage Prescription Drug Plan (MA-PD) and/or I-SNP, whether full-time, part-time, temporary, volunteer or otherwise, are required to complete and pass general compliance training within 90 days of their contracting with the Plan and annually thereafter.

The Plan communicates general compliance training and education materials, including content about its Standards of Conduct, to vendors and FDRs through provider manuals and the Plan website.

Tracking Mandatory Compliance Training

Every level of the Plan management is responsible for ensuring their employees complete all required compliance training by the required due date. Employees and managers receive regular reminders of their training obligations and are alerted to any overdue training requirements.

Completion of mandatory compliance training courses may be tied to each employee's annual performance goals. Failure to complete required compliance training may subject employees and their managers to performance actions, up to and including termination of employment.

The Plan tracks the fulfillment of all required parties to complete their annual general compliance and FWA training by several means, including but not limited to, sign-in sheets, attestations, and electronic certifications.

The Plan reviews and updates, as appropriate, the general compliance and FWA training content annually and whenever there are material changes in regulations, policies, or guidance.

IV. EFFECTIVE LINES OF COMMUNICATION

The Plan fosters a culture of compliance throughout the entire organization by regularly communicating its expectation of ethical and lawful behavior and the availability of communication channels for reporting.

The Plan has implemented lines of communication that encourages effective and confidential, two-way communication between the Compliance Officer, the Compliance Committee, and the Plan's employees, Directors, vendors, and FDRs.

The Plan has established channels of communication for employees in order to promote prompt disclosure and investigation of potential violations of law and of the compliance program. Employees are encouraged to discuss their concerns with their supervisor or manager but can also communicate directly with the Plan Compliance Officer, and such communications will be kept as confidential as possible.

Mechanisms for raising compliance concerns and reporting suspected and/or actual non-compliance, misconduct, and/or FWA issues are well-publicized to Plan employees through the *Standards of Conduct*. The Plan's published policies for reporting emphasize the following:

- Any employee aware of any violation of the Standards of Conduct has a duty to report the violation either to his/her supervisor, the Compliance Officer, or anonymously through the Compliance Hotline. Further, employees are made aware of the requirement that they assist in the resolution of suspected and/or actual violations.
- The Plan does not tolerate retaliation or retribution against Plan employees who make good-faith reports of unethical behavior, suspected, and/or actual non-compliance or FWA violations. The Plan's stance on non-retaliation is described in the *Standards of Conduct* and is required in the general compliance/FWA training materials so all employees are aware of the requirements.
- Vendors and FDRs are notified of their obligation to report unethical behavior, suspected, and/or actual non-compliance and FWA violations to The Plan and to assist in the resolution of these possible violations. Further, vendors and FDRs are notified of the Plan's "zero-tolerance" policy for retaliation or retribution against any employee or agent who in good-faith reports suspected and/or actual non-compliance or FWA violations.

Plan communication channels include, but are not limited to, one-to-one confidential conversations with the Compliance Officer, group compliance trainings or departmental

meetings, posters, pamphlets, anonymous hotlines and website forms, the Intranet and Internet, interoffice mail, external mail, e-mail, employee exit interviews, and other forums that promote information exchange. The areas below are key areas of the Plan Compliance communications strategy. Means to report compliance and FWA concerns, and the non-retaliation policy (provided within the *Standards of Conduct*), is publicized through the The Plan facilities and those of their FDRs.

The Plan has implemented a process to receive, record, respond to, and track compliance questions and reports of suspected or detected noncompliance and/or potential FWA from employees, the Board of Directors, enrollees, and FDRs. To the greatest extent possible, confidentiality of the report is maintained. All Plan employees can report compliance questions and/or suspected or detected non-compliance and/or potential FWA 24 hours a day.

Plan Policy and Procedures Module

For initial training and retraining purposes, the Plan maintains a Policy and Procedure Library containing Plan policies and procedures for ready access by employees on compliance-specific and operational policies and procedures.

Lines of Communications with Members

The Plan also has effective lines of communication with its enrollees. The Plan website contains information on reporting FWA, including a compliance hotline for FWA reporting. Further, member explanation of benefits (EOB) documents contain messages encouraging members to report suspected and/or actual fraud to 1-800-Medicare (or 1-877-486-2048 for TTY users). As defined in the *Grievance Resolution* policy, the Plan has defined processes for timely hearing and resolution of grievances between members and the Plan or any other entity or individual through whom the Plan provides covered benefits.

V. WELL-PUBLICIZED DISCIPLINARY STANDARDS AND ENFORCEMENT

An integral part of the Plan's Compliance Program is the Plan's published *Standards of Conduct*, which articulates and establishes standards of conduct that all employees and FDRs must follow. Every employee is responsible for abiding by the *Standards of Conduct* and for reporting any situation where an employee believes non-compliant, illegal, or unethical conduct may have occurred. Any employee aware of any violation of the *Standards of Conduct* has a duty to report the violation either to his or her supervisor, the Compliance Officer, the Compliance Hotline, or using other available reporting mechanisms outlined above. Further, employees are notified through the *Standards of Conduct* of their duty to participate in the resolution of reported compliance issues.

The Plan is committed to Standards of Conduct adherence and takes appropriate and immediate investigative and disciplinary action if anyone violates the *Standards of Conduct*. The Plan maintains disciplinary standards which provide for consistent and effective enforcement of The Plan's Standards of Conduct when non-compliant or unethical behavior is substantiated.

Disciplinary action is appropriate to the seriousness of the violation. The policies and procedures that support disciplinary actions are clear and specific. Serious or severe performance or conduct problems may result in immediate written notice and/or termination of employment or contract. For employee conduct problems that do not rise to the level of serious or severe, the Plan utilizes a progressive performance improvement process (as defined in the Human Resource *Performance Management* policy), which offers a fair, equitable, and consistent method of guiding employees toward acceptable job performance and conduct.

In training and communication materials, employees are made aware of the Plan's disciplinary and enforcement standards, including that failing to maintain compliance or engaging in FWA could result in disciplinary action up to and including employment termination or contract termination. The *Standards of Conduct* and supporting training and communication materials include examples of non-compliant conduct that employees might encounter on the job.

FDRs are contractually required to institute The Plan's *Standards of Conduct* or substantively equivalent policies specifying the ethical and legal standards of conduct expected of FDR employees/agents. FDRs are made aware that failure to implement and enforce such standards of conduct may result in corrective actions, up to and including contract termination. Further, FDR standards of conduct must notify employees/agents of their duty to report unethical behaviors or suspected and/or actual non-compliance and to participate in the resolution of reported compliance issues as indicated. Lastly, FDR standards of conduct must make employees/agents aware that failure to adhere to ethical and legal behaviors could result in disciplinary action up to and including employment termination or contract termination.

The Plan publicizes disciplinary standards for employees and FDRs—including the duty to report issues and concerns—through a variety of mechanisms which may include, but not be limited to:

- Presentations and meetings
- Intranet sites

The Plan enforces disciplinary standards in a timely, consistent and effective manner. Records are maintained for a period of ten years for all compliance violation disciplinary actions and include the date the violation was reported, description of the violation, date of the investigation, summary of the findings, and any resulting disciplinary action that was taken.

VI. EFFECTIVE SYSTEM FOR ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

Risk identification, monitoring, and auditing are important aspects of The Plan's Compliance Program. Risk, monitoring, and auditing areas are identified through multiple channels including, but not limited to: a formal annual risk identification; regulatory department assessments; operational area self-assessments; internal, external, and regulatory agency reviews and audit findings; reviews of newly promulgated laws and

regulations; regulatory audit work plans (e.g., Office of Inspector General [OIG]); and member feedback. Plan self-assessments allow the Plan to identify high risk areas and add those areas to the work plan for further investigation, including auditing and monitoring. This process of self-assessment and corrective action, as needed, is a key element of the Plan's Compliance Program. Compliance risks are reviewed through a variety of oversight activities, including, but not limited to:

- Risk reviews;
- Business unit self-assessment, monitoring and corrective action;
- Third party data validation audits;
- Monitoring and auditing operational areas and FDRs;
- Auditing by external parties;
- Reviews and audits by regulatory agencies; and
- Fraud, waste and abuse department monitoring, audits and investigations.

The various components that make up the Plan monitoring and auditing activities are:

Risk Assessment

The Plan conducts a formal risk assessment on a bi-annual basis to identify primary compliance and FWA risk areas. This assessment is a review of each Medicare operational area for levels of risks that the area may be challenged with as it relates to the Medicare Advantage program and the Plan. The identified risks are ranked to determine those with greatest potential impact on the Plan, and the Plan prioritizes the monitoring and auditing strategy accordingly. The Plan recognizes risk areas identified through CMS audits and oversight, as well as through the Plan's monitoring, auditing, and investigating priority risks which may include, but are not limited to:

- Regulatory risks based on CMS guidance;
- Risks as identified in the OIG work plan;
- Audit findings from CMS;
- Notices of non-compliance from CMS;
- Complaints filed with CMS (CTMs);
- Complaints related to sales and marketing issues;
- Monitoring outcomes from CMS;
- Operational unit self-monitoring findings;
- Corrective Action Plan monitoring; and
- Member impacted areas, such as Appeals and Grievances, Claims, Customer Service,

Enrollment/Disenrollment, and Utilization Management.

Risk assessment findings are used to determine annual oversight monitoring and risk review topics. The Compliance team and Compliance Committee may modify the annual audit work plan based on issues that arise within the organization.

Audits are performed by independent reviewers with subject matter expertise in the area being audited. The Plan's Compliance Program effectiveness is also audited on an annual basis and the results of that review are reported to the Compliance Committee and Board of Directors.

Monitoring and Audit Work Plan

Compliance and FWA monitoring and auditing initiatives are based on regulatory guidance as outlined below, and leverage standard audit protocols when available:

- CMS Medicare Advantage and Part D Prescription Drug Plan regulations (i.e., 42 C.F.R., Part 422 and 42 C.F.R., Part 423);
- The Medicare Managed Care Manual;
- Medicare Advantage Prescription Drug Manual;
- CMS readiness checklists;
- CMS HPMS memorandum; and
- CMS audit guides.

The Plan develops a monitoring and auditing work plan that addresses the identified risks associated with the Medicare Parts C and D operations. The Compliance Officer is a key resource in the development, coordination, and oversight of the work plan. The work plan also includes a schedule that identifies the monitoring and auditing activities for the calendar year. Internal operational areas, as well as those of first tier entities are included in the schedule.

The Plan considers the types of audits (to include but not limited to high-risk and for cause risks, as well as validation of corrective actions implemented) to include in the work plan by assessing various factors, including but not limited to:

- Risk areas most likely to affect the Plan;
- Appropriate audit and review methodologies to employee for specific audit types;
- Compliance with internal processes and procedures; and
- Performance of the Compliance Program.

The results of monitoring and audits are reviewed by the Compliance Officer, or his or her designee, business unit leaders, and Compliance Committee members. Subsequently, final audit reports are prepared. Corrective action plans are developed to address any findings, as appropriate. The findings and corrective action plan are reported to senior management and the Compliance Committee, and in turn, the Compliance Officer reports to the Plan's

Boards of Directors, as appropriate.

Regulatory Dashboards and Metrics

The Plan produces and reviews compliance-related dashboards. These dashboards are designed to provide a means to readily monitor organizational compliance by senior management and the Compliance Committee. Examples of dashboards include, but are not limited to, those used to monitor regulatory report submissions; claims prompt payment data; enrollment submission timeliness; grievance and appeals statuses; regulatory complaints; sales complaints; drug utilization; fraud, waste, and abuse (e.g., provider utilization reports); claims accuracy; Part D drug transition compliance, etc.

RegulatoryTracking Database

The Plan maintains a database to specifically track compliance-related issues, complaints, and reports of suspected and/or confirmed non-compliance. This database helps ensure that:

- Compliance issues are recorded consistently and transparently;
- Compliance-related fact-finding, evidence documents, communications, and outcomes are maintained for future review; and
- Corrective action plans are recorded, instituted, and reviewed for sustained implementation; and Compliance issue dashboards can be consistently generated and reviewed.

Operational Unit Self-Monitoring

The Plan's operational areas perform monitoring to test and confirm compliance with Medicare regulations, sub-regulatory guidance, contractual agreements and all applicable Federal and State laws, as well as integral policies and procedures against Medicare program non-compliance and potential FWA. The Plan's operational departments conduct day-to-day self-monitoring to measure their performance against CMS and other regulatory requirements. Compliance metrics are reported to senior management and/or the Compliance Committee for review and oversight.

Third Party Validation Review Audits

The Plan contracts with independent third parties to audit the Plan's processes and operations against CMS and other regulatory standards, in instances where the Plan lacks sufficient resources. The results of the third-party audits are reported to the business unit leader, the Compliance Officer, senior management, and/or the Compliance Committee.

OIG/GSA Exclusion

Since Plans must not use federal funds to pay for service, equipment, or drugs prescribed or provided by a provider, supplier, employee who is excluded on the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) or General Services Administration (GSA), The Plan reviews the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS) prior to hiring or contracting new employees, temporary employees, volunteers, consultants, governing body members, and/or FDRs, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

Monitoring and Auditing of First Tier, Downstream, and Related Entities (FDRs)

The Plan contracts with various entities to administer and/or provide MA-PD benefits and services on the Plan's behalf. These first-tier entities and their downstream contractors must abide by the Plan's contractual agreements and regulatory requirements. Various Plan departments and business areas are responsible for overseeing the ongoing compliance of FDRs.

The Plan has various methods to monitor and audit FDRs and their entities, including desk reviews, on-site audits, and monitoring of self-audit reports to ensure they fulfill Medicare Part C and/or Part D requirements. Oversight activities and results are reported regularly to senior management. Departments responsible for overseeing FDRs must ensure that appropriate corrective actions are implemented on a timely basis.

VII. COMPLIANCE TEAM FRAUD, WASTE, AND ABUSE MONITORING, AUDITING, AND INVESTIGATIONS

The Plan's Compliance team is responsible for investigating issues of suspected and/or actual FWA. The Plan performs effective monitoring and conducts analytical data mining to identify referral patterns, possible payment errors, utilization trends, and other indicators of potential FWA. The Compliance team performs proactive and reactive data analysis of medical and prescription drug claims to detect outliers that may indicate potential fraud, waste, and abuse. This process enables The Plan to combat fraud, waste, and abuse.

The Compliance team reports FWA metrics to senior management and the Compliance Committee. In addition, the Compliance team also report FWA investigative findings to and cooperate with the OIG, law enforcement, or other regulatory agencies, as required.

Auditing by External Auditors and Regulatory Agencies

The regulatory review and audit process and outcomes provide the Plan with valuable information about its compliance readiness. The Plan views regulatory reviews and audits as an opportunity to identify its compliance status, including confirmed compliance or non-compliance. In cases where a review or audit outcome indicates the Plan has not met a regulatory requirement, The Plan uses the audit findings to perform root cause analysis and develop corrective action plans to address identified areas of non-compliance. The Plan may also contract with external companies to perform compliance-related reviews and

assist with programmatic changes to help ensure Plan compliance.

VIII. PROCEDURES AND SYSTEM FOR PROMPT RESPONSE TO COMPLIANCE ISSUES

Disciplinary Action

The Plan enforces disciplinary standards in a timely, consistent, and effective manner. Records are maintained for a period of ten years for all compliance violation disciplinary actions and include the date the violation was reported, description of the violation, date of the investigation, summary of the findings, and any resulting disciplinary action that was taken.

Corrective Action

The Plan Compliance Program maintains a process for tracking, fact finding, investigating, and responding to reports of suspected and/or actual non-compliance, misconduct, and FWA issues related to the Plan. The Compliance Officer will conduct a timely, reasonable inquiry upon evidence of misconduct related to payment or delivery of services or items under the contract. The Compliance Officer and Compliance Committee oversee corrective actions and follow-up activities. Reports of suspected and actual non-compliance, misconduct, FWA allegations are reviewed with the Compliance Committee and senior management, including all credible allegations whether such information concerns actions or omissions by the Plan, its employees, Directors, vendors, or FDRs. With respect to identified overpayments, the Plan will promptly repay identified overpayments, and when appropriate, timely report the overpayments to the applicable regulatory authority.

The Plan develops corrective action plans whenever there is a confirmed incident of non-compliance. Incidents of non-compliance may be identified through a variety of sources, such as, but not limited to, employee or FDR self-reporting; internal monitoring and audits; regulatory agency audits including but not limited to CMS and the OIG; hotline calls; external audits; or member complaints. Whenever the Plan identifies an incident of non-compliance, misconduct, or FWA, the Plan takes prompt action to investigate the matter, determine root cause, and outline effective corrective action.

Any time an incident of misconduct or non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the department is required to submit a corrective action plan to the Compliance team. Corrective action plans represent a commitment from the department to correct the identified issue in a timely manner and specify the tasks to be completed, completion dates, and responsible parties. The Compliance Officer is responsible for approving the corrective action plan of its implementation.

Reporting

The status of open corrective action plans is reported to the Compliance Officer and the Compliance Committee. The Compliance Officer, or his or her designee, systematically tracks and monitors corrective action plan implementations and requires that the business department provide interim status updates for corrective action plans. Once a corrective

action plan is complete and supporting documentation has been secured, the Compliance team validates the corrective action plan by monitoring individual action items over a period to demonstrate sustained compliance was achieved and the corrective action plan was effective.

The Compliance Committee is charged with reviewing ongoing activity to ensure that corrective action plans being undertaken are timely and effective and to report ongoing non-compliance risks to senior management.

The Plan requires that FDRs submit a corrective action plan when deficiencies are identified through oversight compliance audits, ongoing monitoring, or self-reporting. The Plan takes appropriate action against any contracted organization that does not comply with a corrective action plan or does not meet its regulatory obligations, up to and including termination of their agreement. FDRs delegated to perform specific administrative or plan functions are bound contractually through written agreements with the Plan that stipulate compliance with CMS and other regulatory requirements and contain provisions for the removal of delegation or termination for failure to cure performance deficiencies.

When appropriate, the Plan will notify the regulatory authorities of aberrant findings, including reports to CMS and the OIG. Such reporting includes voluntary disclosure/self-reports of misconduct and fraud and abuse identified within the Plan related to the I-SNP. Self-reports will be submitted to the respective regulatory agencies in the format prescribed by the applicable agency. The decision to disclose may be made in conjunction with the guidance and advice of legal counsel.

The Compliance Officer is primarily responsible for ensuring cases of non-compliance and misconduct are disclosed to regulatory authorities. The Compliance Officer may delegate all or a portion of the responsibility for corrective action to the appropriate internal expert.