



care@care
Insurance Company, Inc.

MEDICARE
COMPLIANCE PLAN
& PROGRAM POLICIES

FOR CARE N' CARE INSURANCE COMPANY, INC.

BOARD OF DIRECTORS APPROVAL

FEBRUARY 21, 2017

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I. COMPLIANCE PLAN GOVERNANCE

The Medicare Compliance Plan is updated annually and is approved by the Board of Directors for Care N' Care Insurance Company, Inc. ("Care N' Care") and subsidiaries that hold contracts with the Centers for Medicare & Medicaid Services ("CMS").

The Medicare Compliance Plan is a component of Care N' Care's overall compliance program and reinforces the Company's commitment to comply with all applicable Federal and state regulations as well as ethical standards of conduct. The overall compliance program at Care N' Care includes the Code of Conduct which is also endorsed and approved by the Care N' Care Board of Directors. This Compliance Plan incorporates the requirements and related provisions, as provided by the Centers for Medicare & Medicaid Services (CMS), for a Medicare Advantage Organization (MAO) to establish and maintain an effective Compliance Program for both a Medicare Advantage (Part C Plan sponsor) and a Medicare Advantage Prescription Drug (MA-PD Plan sponsor), hereinafter collectively referred to as Parts C & D.

The Compliance Program and all components of the plan are designed to promote a culture of integrity, ethical behavior and compliance with applicable laws and regulations. One of the key elements in the Medicare compliance program is the creation of a Medicare Compliance Committee, which is charged with supporting the Medicare Compliance Officer ("Compliance Officer") in review and oversight of the Medicare compliance program. The Committee is responsible to Senior Management, the Chief Executive Officer, and the Board of Directors for reviewing the effectiveness of the Medicare compliance program through self-audits and monitoring of metrics and key indicators and to ensure prompt and effective corrective actions are taken where deficiencies are noted. The Compliance Officer and the Committee are responsible for escalating compliance deficiencies and ongoing issues of noncompliance to senior management, the Chief Executive Officer, and the Board of Directors.

Care N' Care makes this Medicare Compliance Plan available to all employees and Board of Directors (the "Board"), as well as contractors, subcontractors, vendors, agents, and first-tier, downstream and related entities ("FDRs"). The Compliance Officer reserves the right to amend and update components of the Medicare compliance program, including the material in this Medicare Compliance Plan, at any time to make changes based on regulatory guidance, enhancements to the program to improve effectiveness, or for any other reason.

All Care N' Care employees, Directors and affiliates must read and understand the content of this Medicare Compliance Plan and associated policies and procedures.

FDRs and other business partners have the option to:

- 1) Adopt the Care N' Care's Code of Conduct, Medicare Compliance Plan, and associated compliance policies and procedures;
- 2) Develop and follow their own code of conduct, compliance plan, and/or equivalent policies and procedures that describe their commitment to comply with applicable laws and regulations; or
- 3) Adopt the code of conduct, compliance plan, and/or equivalent compliance policies and procedures of another entity contracted with CMS.

If an FDR or other business partner follows a code of conduct, compliance plan, and/or equivalent policies and procedures not developed by Care N' Care, the Company reserves the right to review and approve these documents.

Please contact the Compliance Officer if you have questions regarding information contained in this Medicare Compliance Plan.

II. MEDICARE COMPLIANCE PLAN

Care N' Care understands that participation in federal programs is a tremendous responsibility and has a Compliance Program that is structured around the elements of an effective compliance program as recommended in the Department of Health and Human Services Office of Inspector General's (OIG) Compliance Program Guidance publications and the Federal Sentencing Commission's Guidelines to ensure that Medicare Part C and Part D practices are conducted properly and to ensure compliance with applicable federal, state and local statutory and regulatory obligations. These compliance obligations include, but are not limited to, the following:

- Federal and state False Claims Acts
- Anti-Kickback Statute
- Prohibition on inducements to beneficiaries
- Health Insurance Portability and Accountability Act
- Code of Federal Regulations – specifically 42 C.F.R. § 400, 403, 411, 417, 422, 423, 1001 and 1003
- All sub-regulatory guidance produced by the Centers for Medicare & Medicaid Services (CMS) such as manuals, training materials and guides
- Applicable Civil Monetary Penalties and Exclusions
- Applicable Provisions of the Federal Food, Drug and Cosmetic Act
- Applicable State laws and Contractual commitments

Care N' Care is committed to maintaining a working environment that promotes ethical values, exemplary behavior and compliance with the letter and spirit of all applicable laws. Such an environment can exist only if Care N' Care employees, physicians and agents demonstrate the highest ethical standards in performing their daily tasks.

Care N' Care recognizes that federal agencies responsible for enforcement of Medicare and Medicaid laws and regulations applicable to healthcare providers require Medicare Advantage organizations to develop and implement corporate compliance programs. Care N' Care's Compliance Program is designed to comply with that requirement.

A successful Compliance Program contributes to this purpose in the following ways:

- Stating and re-stating Care N' Care's commitment to regulatory compliance and legal conduct
- Identifying, reporting and preventing non-compliance and illegal activities
- Providing training about internal compliance-oriented controls to promote compliance with State and Federal laws, rules and regulations as well as internal policies and procedures that are used to ensure compliance,

- Providing an operational environment that allows employees to identify problems within the organization, that directly addresses problems and that fairly disciplines non-compliant behavior.

The Compliance Program follows the seven core elements of an effective compliance program to ensure that the program meets Medicare regulations as well as guidelines recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG):

1. Care N' Care maintains written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
2. Care N' Care designates a Compliance Officer and Compliance Committee (CC) that are accountable to senior management.
3. Care N' Care provides effective training and education to Care N' Care employees.
4. Care N' Care maintains effective lines of communication to Care N' Care employees.
5. Care N' Care enforces standards through well-publicized disciplinary guidelines, including policies and procedures for dealing with sanctioned individuals/entities.
6. Care N' Care monitors and audits its operations.
7. Care N' Care maintains procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to the Medicare Advantage contract.

III. MEDICARE COMPLIANCE PROGRAM ELEMENTS

Each component of the Medicare Compliance Program and Care N' Care's approach to complying with each component is discussed below.

1. Code of Conduct and Written Policies and Procedures

Code of Conduct

Care N' Care has adopted a Code of Conduct, which is intended to serve as a guide to provide standards by which employees, Board members, contractors and agents shall conduct themselves to protect and promote organization-wide integrity and to enhance Care N' Care's ability to achieve its mission. The Code of Conduct is designed to assist in carrying out their daily responsibilities within the appropriate legal and ethical standards. However, the Code of Conduct cannot possibly encompass all legal and ethical standards, and is not a substitute for each employee, Board member, contractor or agent's good judgment and sense of honesty, integrity and fairness.

The Code of Conduct shall be supplemented by this Compliance Plan and applicable policies and procedures. The Code of Conduct is made available to:

- The Board of Directors and Executive Leadership team at the time of appointment and annually thereafter;
- Each employee, including officers and temporary employees, at the time of employment and annually thereafter; and
- First tier, downstream and related entities, including all providers at the onset of their contract and annually thereafter.

Providers and first tier, downstream and related entities are required to adopt and follow a code of conduct particular to their own organization and that reflects their own commitment to

ethical behavior, compliance and detecting, preventing and correcting fraud, waste and abuse. The organization ensures this requirement is met through on-going monitoring and audits, as appropriate, of first tier, downstream, and related entities. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) days of the appointment, hire, or commencement of the contract, and annually thereafter. FDRs may also attest to following their own Code of Conduct.

Policies and Procedures

All departments are required to maintain current Policies and Procedures (P&Ps) that are updated annually or when guidance or internal changes occur. All P&Ps are reviewed during internal audits to ensure the policies reflect the processes being followed on a day-to-day basis. These policies address all statutes, rules, contractual requirements, and program instructions applicable to their area of responsibility and are made available to employees upon hire, when there are updates to the policies, and annually thereafter.

The Compliance Department, with support from other applicable functional areas, develops and implements written policies and procedures to support the compliance functions of the organization.

A policy and procedure is maintained to define the process for the development, revision, review, approval, maintenance, storage and communication of policies and procedures. Policies and procedures are reviewed at least annually, and are revised during the contract year in response to changes in Medicare or other Federal requirements that relate to the Medicare Advantage program. In addition, new policies may be developed or current ones revised in response to identified risks or areas for improvement which occur in the general course of plan operations or through monitoring.

2. Compliance Officer, Compliance Committee and High Level Oversight

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout Care N' Care's operations, including, but not limited to, key roles and responsibilities by the Board, the Compliance Officer, the Compliance Committee, the Delegation Oversight Committee, and Senior Management.

a. Governing Body

The CNC Board of Directors, as the Governing Body, is responsible for approving, implementing, and monitoring a Compliance Program governing Care N' Care's operations. The Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an employee of CNC, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CNC Board remains accountable for ensuring the effectiveness of the Compliance Program within CNC and monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

b. Director of Compliance (Compliance Officer)

The Director of Compliance serves as the Compliance Officer and coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day to day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the Care N' Care Board at any time. Furthermore, the Compliance Officer ensures that CNC meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the Care N' Care Board, CEO, Care N' Care's executive and departmental management, FDRs, legal, State and Federal representatives and others as required. In addition, the Compliance Officer supervises the Compliance Department, which includes compliance professionals with expertise and responsibilities for the following areas: Medicare Compliance, Privacy, FDR oversight, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee is authorized to fulfill its mission by, and is accountable directly to the Care N' Care Board of Directors. The Compliance Officer and Compliance Committee report directly and are accountable to the organization's chief executive. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program. The Compliance Committee is authorized to and is responsible for investigating all reports of suspected noncompliance and Fraud, Waste and Abuse (FWA) violations or questionable conduct under the Compliance Program. Compliance Committee membership shall consist of the Compliance Officer, Compliance Committee Chairperson, clinical personnel, and management staff including representatives from Operations, Quality, Clinical Pharmacy Services, and Member Services as outlined in the Committee Charter.

The primary responsibilities of the Compliance Committee include, but are not limited to, the following:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to approval by the Care N' Care Board;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised;
- Review and monitor the effectiveness of the Compliance Program, including monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing corrective actions to ensure they are promptly and effectively implemented;
- Develop standards of business conduct and Policies and Procedures to promote compliance;
- Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal and contractual requirements;

- Recommend and monitor the development of internal systems and controls to implement Care N' Care's standards and Policies and Procedures as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports designating areas in which Care N' Care is at risk for program noncompliance and potential FWA, and ensure that corrective action plans are implemented and monitored for effectiveness;
- Suggest and implement appropriate actions necessary to ensure that Care N' Care and its FDRs conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and
- Provides regular and ad hoc reports on the status of compliance with recommendations to the Board.

d. Delegation Oversight Committee (DOC)

The Delegation Oversight Committee (DOC) is a subcommittee of the Compliance Committee and is chaired by the (Compliance Program Manager). The DOC is responsible for overseeing the delegated activities. The DOC has final approval authority for any delegation activity as permitted by the Care N' Care Board. Committee members include representatives from CNC's departments as provided for in the DOC charter. In addition to the monthly scheduled meetings, the DOC may conduct ad hoc online meetings, as needed. All materials presented are approved by a quorum. A quorum is defined as one over fifty percent. DOC may approve and/or implement Corrective Action Plans (CAPs); however, recommendations for FDR sanctioning and/or de-delegation are submitted to the Compliance Committee for final approval.

Responsibilities of the Delegation Oversight Committee include:

- Annual review, revision, and approval of the Delegation Oversight Program Description, Policies and Procedures, and audit tools;
- Review findings of the pre-delegation audit and readiness assessment to evaluate a potential FDR's ability to perform the delegated function(s);
- Review and approve potential FDR entities for delegation of functions;
- Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all Parties consistent with applicable laws, regulations and contractual obligations;
- Conduct formal, ongoing evaluation and monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual on-sight audit;
- Ensure all Downstream and Related Entities are monitored in accordance with CNC oversight procedures;
- Propose sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of delegation, to the Compliance Committee for unresolved issues of compliance.

3. Effective Training and Education

Education and training are critical elements of the Compliance Program. Care N' Care requires that all Board Members, Employees and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover the Code of Conduct, compliance obligations and relevant laws, and FWA, as applicable.

Care N' Care utilizes web-based training courses which are updated regularly to ensure that employees are kept fully informed about any changes in procedures, regulations and requirements. The Compliance Officer is responsible for coordinating compliance education and training programs with Human Resources and ensuring that records of completion are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law.

Code of Conduct

Care N' Care's training program includes the distribution of the Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.

Mandatory Training Courses (Compliance Oversight and FWA)

Care N' Care requires Board Members and Employees regardless of role or position to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; HIPAA privacy and security requirements; ethics; and a high level overview of the Medicare Program. Care N' Care's training courses covers Care N' Care's commitment to compliance with Federal and State laws and regulations, contractual obligations, internal policies and ethics. Elements of the Compliance Program are highlighted, including, but not limited to, an emphasis on the requirement to and different means to report suspected or actual noncompliance, violations, and/or FWA issues, along with Care N' Care's policy on confidentiality, anonymity, and non-retaliation for such reporting. Employees must complete the required compliance training courses with 90 days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment. Board Members are required to complete the required compliance training courses within ninety (90) days of appointment, and annually thereafter.

Employees have access via internal shared drives to Care N' Care's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Training and Education for FDRs

All Care N' Care FDRs and their employees who have involvement in the administration or delivery of Parts C and D benefits are required to perform their contracted responsibilities in compliance with Care N' Care policy, CMS regulatory requirements, and all applicable laws and regulations.

Care N' Care requires all FDRs to provide FWA training compliant with CMS requirements and requires its employees to take training developed by CMS and available through CMS Medicare Learning Network (MLN). FDRs and their employees must receive general compliance training within 90 days of contracting/hire and annually thereafter as a condition of employment. FDRs will have three (3) options for ensuring FDRs have satisfied the general compliance training requirement:

(1) FDRs can complete the general compliance and/or FWA training modules located on the CMS MLN. Once an individual completes the training, the system will generate a certificate of completion. The MLN certificate of completion must be accepted by Sponsors.

(2) Sponsors and FDRs can incorporate the content of the CMS standardized training modules from the CMS website into their organizations' existing compliance training materials/systems.

(3) Sponsors and FDRs can incorporate the content of the CMS training modules into written documents for providers (e.g. Provider Guides, Participation Manuals, Business Associate Agreements, etc.).

FDRs that have met FWA certifications through enrollment into the Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier are deemed to have met the FWA training and education requirement. However, deemed providers are not exempt from the general compliance training requirement.

Care N' Care must establish effective mechanisms to ensure that FDRs fulfill the compliance training requirements (e.g. incorporate the requirement into contracts with FDRs, collect attestations from FDRs, training material coupled with monitoring and auditing of a sample of FDRs to validate training requirements were fulfilled, etc.). The Code of Conduct and Policies and Procedures providing an overview of the Care N' Care Compliance Program, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their employees, agents, and/or Downstream Entities or use their own equivalent Code of Conduct. All FDRs will be required to complete the FDR Compliance Attestation upon contracting and annually thereafter confirming the organization has completed the appropriate general compliance and FWA training. This attestation is distributed to all FDRs and also posted on the CNC website under resources for FDRs.

4. Effective Lines of Communication

Care N' Care employs multiple mechanisms to ensure effective lines of communication between the Compliance Officer and all levels of employees, contractors, temporary employees, providers, FDRs, as well as with individuals serving on the board. These established mechanisms allow for providing guidance on CMS requirements and Care N' Care's compliance program to all employees, temporary staff, vendors, contractors and providers, the reporting of improper conduct, suspected non-compliance as well as allegations of fraud, waste and abuse or any other impropriety. The organization expects reporting of issues to be able to occur without the involvement of supervisors or other personnel and the fear of potential retaliation or retribution.

These lines of communication will be accessible to all and allow for anonymous and confidential good faith reporting of potential compliance issues as they are identified. Information on how to report issues or contact the Compliance Officer is posted on the ADP Portal, included in the Code of Conduct, included on the CNC website, posted on signs in break rooms and common areas.

Note: Appropriate training and education, and an effective internal incident reporting process are key components of communication within the organization. These areas are each addressed fully in separate Policies and Procedures.

The Compliance Officer will maintain open lines of communication with the CEO and Board of Directors regarding activities of the Compliance Committee and Compliance Department. This includes, but is not necessarily limited to, the following:

- Compliance Committee Minutes
- Compliance Program and Compliance Department Work Plan
- Audit Results
- Compliance or Ethics Issues

The Compliance Officer will keep the Committee informed and seek its guidance on compliance or ethics issues that represent potential risk to the organization.

The Compliance Officer and Compliance Committee will maintain open lines of communication with Care N' Care management staff. This includes, but is not necessarily limited to, the following:

- The Compliance Committee is comprised of management staff responsible for the main departments and functions within the organization. The structure of the Committee therefore facilitates communication with management.
- All management staff shall receive a copy of the Compliance Program, including all significant revisions. Managers are responsible for understanding the Compliance Program and distributing a copy to all employees.
- The Compliance Officer serves as the organization's main point of contact with regulatory authorities. The Compliance Officer shall route incoming program information and regulatory guidance to the appropriate individual(s).
- The Compliance Department tracks all communications from CMS and communicates all sub-regulatory guidance produced by CMS and HHS such as manuals, training materials, HPMS memos, and guides throughout the organization as appropriate.

The Compliance Officer and Compliance Committee will maintain open lines of communication with employees at all levels of the organization. This includes, but is not necessarily limited to, the following:

- All employees shall receive a copy of the Compliance Program, including the Code of Conduct, at the time of employment and upon revision thereafter. The Code of Conduct will be made available to delegated (first-tier, downstream, and related) entities. Employees shall be required to certify their receipt and understanding and return a signed Acknowledgment to Human Resources at the time of hire.

- As noted above, the Compliance Committee is comprised of management staff with responsibility for key departments or functions within the organization. Routine or informal communication, particularly in situations where documentation is not required, may therefore be achieved through normal organizational channels.
- The annual Compliance Work Plan shall include a basic plan for ongoing employee communication. Examples of possible methods include newsletters, bulletins, emails, meetings, interviews, etc. (Note: This requirement may be satisfied in conjunction with requirements for employee training and education).
- As noted above, employee training and incident reporting are key aspects of organizational communication. These components are addressed in separate Policies and Procedures.

The Compliance Officer and Compliance committee will develop and utilize mechanisms for communicating with contracted entities, including health care providers, management service organizations, and brokers. Such communication will typically occur in collaboration with Care N' Care departments or committees having established methods of contractor communication. Examples include Contracting, Marketing, UM/QM Delegations Oversight, and Claims Oversight.

Care N' Care will maintain open communication with regulatory authorities.

- The Compliance Officer is Care N' Care's primary point of contact with regulatory authorities. Normal, ongoing communication with regulators will be routed through the Compliance Officer.
- Individual Departments may have such direct communication with regulatory authorities as is appropriate to fulfillment of their responsibilities. For example, Enrollment may be required to contact CMS regarding retro-active transactions; IT may be required to contact the CMS Help Desk regarding transmission of data; etc.
- For elevated issues such as investigation, litigation, interaction with enforcement authorities, or any situation that poses similar risk to the organization, communication will be governed by, as appropriate:
 - ✓ Company policy, if applicable policy exists
 - ✓ Direction from senior management
 - ✓ Advice of outside counsel

Care N' Care will maintain open communication with our members and educate our members on identifying and reporting noncompliance and FWA. Methods of communication with our members include newsletters, bulletins, emails, meetings, information published on Care N' Care's website, etc.

Compliance Hotline

All employees, supervisors, managers, and administrators are required under the compliance program to report, anonymously if desired, known or suspected violations of an applicable law or regulation, or the Code of Conduct, without fear of retaliation.

Care N' Care maintains an easily accessible Compliance Hotline, available 24 hours a day, 7 days a week, in which CNC may receive anonymous issues on a confidential basis. The toll free

Compliance Hotline is 1-844-760-5838. The Compliance Hotline allows for anonymous reporting online via the ComplianceLine website at www.mycompliance.com.

Report Directly to the Compliance Officer

The Compliance Officer is available to receive reports of suspected or actual compliance violations or FWA issues on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and Members. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected fraud and abuse to CNC pursuant to regulatory and contractual requirements.

Report Directly to a Supervisor or Manager

Care N' Care employees are encouraged to contact their immediate supervisor or manager when non-compliant activity is suspected or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance or violation. The supervisor or manager will promptly escalate the report to the Compliance Officer for further investigation and reporting to the Compliance Committee (as applicable). If an Employee is concerned that his or her supervisor or manager did not adequately address his or her report or complaint, the employee may go directly to the Compliance Officer or the CEO.

Report Directly to the Compliance Department

Reports may be made directly to Care N' Care's Compliance Department via mail or email for confidential reporting. Emails can be sent to CNCCompliance@cnc.com. Written correspondence can be set to: CNC Compliance Department at 1701 River Run, Suite 402, Fort Worth, TX 76107.

Confidentiality and Non-Retaliation

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, Care N' Care has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance or FWA issues in good faith. This non-retaliation policy extends to reports received from FDRs and members.

Care N' Care takes violations of its non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other corrective action plans for violations, as appropriate, with the approval of the Compliance Committee.

5. Well Publicized Disciplinary Standards

Care N' Care employees are expected to comply with governing laws and regulations, as well as provisions of the Care N' Care Compliance Program, Code of Conduct, and any other applicable company policies. These policies are made available to each employee at the new employee orientation and annually thereafter through various forms, including the ADP portal and the company internal shared drive. Failure to do so may result in the use of disciplinary action to correct such situations and, as appropriate, motivate employees to participate directly in the resolution.

Disciplinary action shall be administered on a fair and equitable basis, appropriate to the seriousness of the violation and consistent with Care N' Care's personnel policies and procedures. Depending on the severity of the violation, progressive steps in the disciplinary action process may be omitted if appropriate in order that immediate corrective measures, including termination, can be taken.

The actions listed below are guidelines only. Nothing in this Policy or any other Compliance policies and procedures should be construed as preventing, limiting or delaying Care N' Care from taking other appropriate disciplinary action, including immediate termination, in any circumstances where Care N' Care, in its sole discretion, deems such action appropriate.

Nothing in this policy or any other Compliance Policies and Procedures is intended to alter the "at-will" nature of the employment relationship between Care N' Care and its employees as set forth in Care N' Care's employment policies, procedures and manuals.

The intent for the disciplinary process is to improve performance and eliminate misconduct or rule violations. For the most effective use of the disciplinary action, it is necessary that all employees, supervisors and managers in particular, be familiar with applicable laws and regulations, Care N' Care policies and department requirements so that infractions are quickly and accurately identified. A supervisor must be willing to discuss with employees situations or events which may, if not corrected, eventually lead to on-the-job problems.

Examples of the types of infraction or violation for which disciplinary or corrective action will be taken include:

- Noncompliance with laws, regulations, policies or procedures;
- Encouraging or assisting another to engage in noncompliance;
- Failure to report noncompliance;
- Failure to detect noncompliance by an individual who should have detected such noncompliance;
- Knowingly submitting a false, malicious or frivolous report of noncompliance against another employee.
- Failure to satisfy the education and training requirements of the Compliance Program;
- Failure of a supervisor or manager to assure that their subordinates understand the requirements of the Program; and
- Retaliation against an employee, agent, or contractor who reports in good faith a concern relating to possible noncompliance.

This list is designed to illustrate common categories or areas of compliance violations. It is intended to aid employees in identifying specific conduct that may violate applicable laws or company policy. The list is not exhaustive of all types of conduct that may constitute grounds for disciplinary action, including termination of employment.

No employee shall be disciplined solely because s/he reported what was reasonably believed to be an act of wrongdoing or a violation of the Compliance Program.

A thorough investigation must be conducted before disciplinary action is administered. Depending on the situation, the investigation may be conducted by the supervisor, manager, Compliance Officer, or outside entity.

If management determines after a thorough investigation that action beyond counseling is warranted, it is the duty of the appropriate supervisor or manager to initiate disciplinary action. Depending on the situation, the supervisor or manager may need to discuss the action with the next level of management, the Compliance Officer, Legal Counsel, or Human Resources to ensure appropriate applicability, documentation, and procedure.

Management must consider the nature and seriousness of the infraction, all relevant facts and information, and any mitigating or aggravating circumstances when formulating disciplinary action. All guidelines must be applied consistently and in a non-discriminatory manner, and thorough documentation is essential. Senior management, the Compliance Officer, Human Resources, or legal counsel should be consulted as appropriate when evaluating the circumstances affecting disciplinary action.

As a general rule, disciplinary action shall be more severe for conduct that is a knowing, intentional, willful, or reckless violation of the law or of Care N' Care standards or policies. Intentional or reckless noncompliance is to be punishable with "significant sanctions," which can range from oral warnings to suspension or termination as appropriate. Where the guidelines below recommend termination, a lesser disciplinary action may be imposed, at Care N' Care's sole discretion, after consideration of all relevant facts, including, without limitation, mitigating and aggravating circumstances.

Circumstances that shall be considered to be mitigating can include:

- The employee reported the violation promptly
- The employee cooperated with Care N' Care in the investigation
- The employee accepted responsibility for the violation

Admission of wrongdoing does not guarantee protection from disciplinary or corrective action. The weight to be given to the admission shall depend on all the facts known to Care N' Care at the time the decision concerning disciplinary or corrective action is made. Such facts include whether the individual's conduct was known or its discovery was imminent prior to the admission, and whether the admission was complete and truthful.

Circumstances that shall be considered to be aggravating include, but are not necessarily limited to:

- The existence of a prior record of discipline and the nature and extent of that record;
- The current misconduct found or acknowledged by the employee evidences multiple acts of wrongdoing or demonstrates a pattern of misconduct;
- The employee's misconduct was surrounded by or followed by bad faith, dishonesty, concealment, overreaching or other violations of Care N' Care's policies and procedures;
- The employee's misconduct harmed significantly Care N' Care;

- The employee demonstrated indifference toward rectification of or atonement for the consequences of his or her misconduct; and
- The employee displayed a lack of candor or cooperation with Care N' Care during the investigation or disciplinary process.

Employment of and Contracting with Ineligible Persons

Care N' Care prohibits hiring or entering into contracts with individuals and/or entities who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in Federal health programs. Care N' Care shall utilize the DHHS Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE list) and the System for Award Management Exclusion List (formerly the GSA Excluded Parties Lists System) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, board member, or FDR, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

6. Effective System for Routine Monitoring and Identification of Compliance Risks

Care N' Care will develop and implement appropriate monitoring and auditing processes to evaluate compliance with applicable laws, regulations and policies, and rapidly detect potential issues, problems or violations. Care N' Care will provide proactive, targeted efforts to prevent, detect, and respond to fraud, waste, and abuse issues. Monitoring and auditing of first tier, downstream, and related entities will be conducted and may result in programmatic actions.

The Compliance Committee is responsible for oversight of Care N' Care's monitoring and auditing efforts and will receive regular reports regarding performance, updates to systems, staffing, etc.

Risk Assessment and Monitoring

An effective monitoring and auditing program begins with an internal risk assessment. The Compliance Officer will conduct a formal baseline assessment of the organization's major compliance and fraud, waste, and abuse areas. Each operational area must be assessed for the types and levels of risks the area presents to the Medicare program, Care N' Care and its members. Factors considered in determining the risks associated with each area include but are not limited to:

- Direct Beneficiary Contact
- Potential for fraudulent or abusive activities (i.e., claims, Part D)
- Size of department
- Complexity of work
- Amount of training that has taken place
- Past compliance issues
- Budget

An audit work plan is developed annually based upon results of the internal risk assessment and sets forth the audits to be performed, audit schedules, and methodology. The work plan contains a process for addressing all monitoring and auditing results and for conducting follow-up reviews of areas found to be non-compliant to determine if the implemented corrective

actions have fully addressed the underlying problems. Corrective action and follow-up activities are conducted by the Compliance Officer and may include the reporting of such findings to CMS.

FDR Annual Risk Assessment

The Compliance Officer, or his or her designee, will conduct an annual comprehensive risk assessment to determine FDR's vulnerabilities and high risk areas. High risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and Care N' Care requirements. Any previously identified issues, which includes any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk or vulnerable is presented to the Delegation Oversight Committee for suggested follow-up audit. FDRs determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her designee, and presented to the Compliance Committee for review and discussion.

Auditing

The Compliance Department will conduct or facilitate operational and first-tier audits sufficient to evaluate the organizations compliance with applicable laws, regulations and company policies. All operational and first-tier audits will be appropriately planned and structured according to established methodology, using an accepted tools and standards (CMS Program Audit Protocols). The Compliance Officer will arrange focused audits of specific departments, first tier entities, or areas as necessary. Focused audits may result from risk assessment data, departmental monitoring, regulatory concerns (e.g., OIG Work Plan), members, complaints filed with CMS, employee incident reporting, or any other credible indicators.

The Compliance Officer will periodically schedule routine audits to do spot checks of Care N' Care departments or first tier entities, as necessary and at a frequency to be determined by the Compliance Officer and Compliance Committee.

Care N' Care's contractual agreements with first tier entities provide for routine and random auditing. Where FDRs perform their own audits, Care N' Care will request a copy of the FDR's audit work plan and request the audit results. When corrective action is needed, Care N' Care will ensure that corrective actions are taken by the entity.

Reports that will be reviewed as part of FDR monitoring and auditing include, but are not limited to:

- Accuracy of claims processing;
- Appeal/Grievance reports;
- Payment reports;
- Drug utilization reports;
- Provider utilization reports;
- Prescribing and referral patterns by physician reports; and
- Geographic zip reports

Any audit result indicative of a potential issue, problem or noncompliance must be adequately addressed. Based on the scope and severity of the issue, the Compliance Officer and Department Manager will determine appropriate next steps.

Confirmed problems or cases of noncompliance must be remediated with appropriate corrective action.

The Compliance Officer, with input and approval of the Compliance Committee, will develop and publish an Annual Audit Plan. The Audit Plan is subject to review and revision throughout the year as new indicators for focused audit may emerge. The Audit Plan includes:

- Audits to be performed;
- Audit schedules, including start and end dates;
- Announced and/or unannounced audits;
- Audit methodology;
- Necessary resources;
- Types of audit (desk or onsite);
- Number of FDRs that will be audited and how the entities will be identified for auditing;
- Person(s) responsible;
- Final audit report due date; and
- Follow up activities from findings

Audit findings that represent significant risk to the organization will be reported immediately to the CEO and the Board of Directors.

The Compliance Officer will prepare a quarterly report of the status of the Audit Plan. The report should summarize:

- Audit objectives
- Scope and methodology
- Results of current audits, including any detected issues or non-compliance and resulting corrective action
- Recommendations

Corrective Actions

Corrective action initiatives as identified through routine monitoring and internal audit activities are monitored and managed by the Compliance Officer. Corrective actions are designed to correct the underlying problem that results in Medicare Advantage program violations and to prevent future violations.

Corrective action plans are implemented for both internal initiatives, as well as when necessary, for actions of a first tier, downstream, or related entities. Corrective action plans are documented in a format determined by the Compliance Officer and include specific implementation tasks, the names of individuals accountable for implementation and required time frames for remediation activities.

Corrective action initiatives may include actions such as the repayment of identified overpayments and making reports to government authorities, including CMS or its designees

(e.g., MEDIC), and law enforcement, as necessary or required. The Compliance Officer will report corrective actions to the Compliance Committee, the senior leadership team and the board, on a monthly basis.

Corrective Actions and Additional Monitoring and Auditing

The Compliance Officer shall submit regular reports of all monitoring, audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a corrective action plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or his or her designee. Supplemental and focused audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, Care N' Care may implement sanctions or require remediation by an FDR for failure to fulfill contractual obligations including development and implementation of a corrective action plan. Failure to cooperate with Care N' Care in any manner may result in termination of the delegation agreement, in a manner authorized under the terms of the agreement.

7. Procedures and Systems for Prompt Response to Compliance Issues

Care N' Care recognizes that violations of its Compliance Program, violations of applicable federal or state law, or other types of misconduct threaten its status as a reliable, honest, and trustworthy organization capable of participating in federal and private programs. Consequently, upon report or reasonable indication of suspected noncompliance, the Compliance Officer along with management will initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the compliance program has occurred, and if so, take steps to correct the problem.

Care N' Care will establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence and ensure ongoing compliance with CMS requirements.

- If Care N' Care discovers evidence of misconduct related to the payment or delivery of prescription drug items or services under the contract, Care N' Care will conduct a timely reasonable inquiry into that conduct.
- Care N' Care will conduct appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) in response to the potential violation referenced above.
- Care N' Care has procedures to voluntarily self-report potential fraud and misconduct related to the program to CMS, or its designee.

As appropriate, such steps to investigate misconduct will include the following:

All reports of any alleged misconduct that may rise to the level of fraud and abuse will immediately be communicated to the Compliance Officer. Reporting may be anonymous. Reports may be made without fear of retaliation.

Such reports will be investigated as soon as reasonably possible, as but no later than two weeks following the receipt of the report, information, or complaint regarding the potential

noncompliance. The Compliance Officer will begin the investigation and obtain the support and direction of Compliance Committee/management as necessary and appropriate.

Depending upon the nature of the alleged violations, an internal investigation will include interviews and a review of relevant documents.

For violations that are severe upon initial review, the Compliance Officer will engage outside counsel, auditors, or other experts to assist in the investigation.

All employees, vendors and FDRs are required to cooperate fully in all compliance investigations. Failure to cooperate in an investigation may lead to disciplinary action. Intimidation or retaliation against any employee who cooperates in a compliance investigation is strictly prohibited and will lead to disciplinary action up to and including termination.

Records of the investigation will contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed the results of the investigation, e.g., any disciplinary action taken, and the corrective action implemented.

The Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation for a period of ten (10) years.

If an investigation of an alleged violation is undertaken and the Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those subjects will be removed from their current work activity until the investigation is completed.

A corrective action plan will be created if any fraud and abuse or material violation of this program is found to have occurred.

Any violations, which are found to have occurred, will be reported to the suspected individuals.

Any discipline that the Compliance Officer, and when appropriate the compliance committee and/or the board, determines is necessary will be implemented.

If any overpayment or underpayment was involved, a report will be sent to the appropriate personnel/agency pursuant to government and other applicable guidelines.

When appropriate and in consultation with legal counsel, an immediate referral should be made to criminal and/or civil law enforcement authorities.

Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning fraud schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. Care N' Care may take action (including denying or reversing claims) in instances where Care N' Care's own analysis of its claims activity indicates that fraud may be occurring. Care N' Care's decision to deny or reverse claims shall be made on a claim-specific basis.

When a Fraud Alert is received, Care N' Care is also obligated to review its past paid claims from entities identified in a fraud alert. With the issuance of a fraud alert, CMS places Care N' Care on notice (see 42 CFR 423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, Care N' Care will work with delegates and shall make its best efforts to identify claims that may be or may have been part of an alleged fraud scheme and remove them from the sets of prescription drug event data submissions.

8. Fraud, Waste and Abuse

Care N' Care is strongly committed to the detection and prevention of FWA at the plan level, as well as within its first-tier, downstream or related entities. Care N' Care maintains ultimate responsibility for adhering to and otherwise fully complying with all applicable federal and state statutory, regulatory, and other requirements related to the delivery of the Medicare benefits, including the compliance plan requirements found at 42 CFR §422.503(b)(4)(vi); 42 C.F.R. § 423.504(b)(4)(vi)(H). Care N' Care will work in an ongoing manner with the appropriate entities to detect and prevent FWA as is required by the Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual, Ch. 9 – Compliance Program Guidelines.

Furthermore, self-reporting plays a critical role in reducing FWA and maintaining program integrity. Therefore, Care N' Care should self-report potential fraud discovered at the plan, first-tier entity, downstream entity, or related entity levels to the appropriate entities. In doing so, Care N' Care may receive the benefits of voluntary self-reporting found in the False Claims Act and federal sentencing guidelines. Self-reporting offers plans the opportunity to minimize the potential cost and disruption of a full scale audit and investigation, to negotiate a fair monetary settlement, and to potentially avoid an OIG permissive exclusion preventing Care N' Care from doing business with the Federal health care programs. CMS strongly encourages plans to immediately self-disclose marketing violations to CMS and proactively report any corrective action measures that they have taken to respond to any violations. Both the DOJ and the OIG also have longstanding policies favoring self-disclosure. The Provider Self-Disclosure Protocol for the DHHS OIG can be found at 63 Fed. Reg. 58,399-403 (1998).

LAW & REGULATIONS RELATED TO FWA:

- a. 42 CFR § 423.504(b)(4)(vi)(H)
- b. 42 CFR §422.503(b)(4)(vi)
- c. Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual, Ch. 9 – Compliance Program Guidelines
- d. Anti-Kickback Regulations – 42 U.S.C. § 1320a-7b (b)
- e. Stark Law Amendments – 42 U.S.C. § 1395nn
- f. Mail and Wire Fraud – 18 U.S.C. § 1341
- g. False Claims Act – 31 U.S.C. § 3729-33
- h. HIPAA/HITECH – 45 CFR, Part 164
- i. Provider Self-Disclosure Protocol – 63 Fed. Reg. 58,399-403 (1998)

Notable changes (with page number)

No changes since last revision 2/2016

This overview has been provided to list the key points of notable changes and the sections in which they are detailed.

1. Compliance Officer and High Level Oversight section updated to revise functions of the Compliance Committee and include new Delegation Oversight Committee – Page 8
2. Training & Education this section further clarifies the required training requirements for Board Members, Employees, and FDRs. Language is included that outlines the new web based training application portal implemented last year. This section also includes the new requirement that mandates FDRs to complete training developed by CMS and available through CMS Medicare Learning Network (MLN). – Page 10
3. Code of Conduct clarifies the distribution process for the Code of Conduct and the Code is now included on the CNC website – Page 11
4. Effective Lines of Communications section clarifies that the new Compliance Hotline is managed by a third party vendor and outlines the various mechanisms in place to allow for anonymous and confidential reporting – Page 13
5. Risk Assessment and Monitoring updated to include Annual FDR Risk Assessment – Page 17
6. Corrective Actions and Additional Monitoring section added – Page 19
7. Response to CMS Fraud Alerts section added – Page 21

Appendix A

Compliance Program

Policies & Procedures

The following is a subset of the Care N' Care Compliance Policies and Procedures a complete listing of policies are located on the Compliance shared drive.



Insurance Company, Inc.

Policy and Procedure Name: Compliance Program Policy	Policy Number: COM-001.1	
Functional Business Owner's Name: Nakia Smith, Director of Compliance	Effective Date: 10/1/2015	Review Date:
Approver's Name: Wendy Karsten, Chief Executive Officer	Approval Date: 10/22/2015	

PURPOSE:

Care N' Care Insurance Company, Inc. ("Care N' Care") hereafter known as the "Company", understands that participation in federal programs is a tremendous responsibility. As such, the Company is committed to conducting business ethically, with integrity, and in compliance with applicable state and federal laws and regulations. The Company has designed and implemented a formal compliance program (Program). The Program's purpose is to integrate business conduct, compliance and ethics, standards into the daily business activities of the Company through communication, education and training, monitoring, investigation, detection, and reporting of perceived, potential, or actual violations including, fraud, waste, and abuse (FWA).

This policy serves to formally establish the guiding principles for the Program's overall effectiveness and accountability and serves as the link to all other Company policies and procedures related to matters of ethics, business conduct, and compliance with legal, regulatory and sub-regulatory requirements.

SCOPE

This policy applies to all members of the board of directors, employees, first tier, downstream and related entities (FDRs), contractors, and agents of Care N' Care Insurance Company, Inc.

DEFINITIONS:

Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. 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.

First-Tier Entity: Any party that enters into a written agreement, acceptable to CMS, with a Medicare Advantage organization, Part D plan sponsor, or contract applicant (hereinafter referred to as a "Sponsor") to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage or Part D programs.

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a Sponsor and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include, but are not limited to, mail order pharmacies, firms providing agent/broker services, agents, brokers, marketing firms, and call center firms.

Related Entity: Any entity that is related to a Sponsor by common ownership or control and (1) performs some of the 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 Sponsor at a cost of more than \$2,500 during a contract period. (See 42 C.F.R. §423.501).

Fraud: 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.

Waste: 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 the misuse of resources.

RESPONSIBILITIES

The Board of Directors is knowledgeable and responsible for oversight of the Company's Program and conducts a review of the Company's compliance program annually to:

- Evaluate the efficiency and effectiveness of the program;
- Evaluate employee, officer, and director compliance with the program and the company's systems to monitor compliance with the program;
- Recommend to the Compliance Officer (CO) improvements to the program as necessary;
- Monitor the findings of any audits by regulatory agencies and the corrective actions taken by the Company to address the findings;
- Monitor procedures for handling complaints regarding any violations of the program and for confidential, anonymous submission of concerns by employees, including those regarding accounting and auditing matters;
- Receive suggestions from directors and officers for improvement of the compliance program;
- Meet at least four times annually with the CO to discuss the status of the compliance program, including employee training and education, reports of suspected violations of the program, reports of FWA, and investigations of such reports, and discipline or other actions resulting from such investigations, and confirm that remediation has occurred;
- Meet, at least four times annually, with the CO to review the status of the Company's compliance with Medicare requirements and periodically to review compliance with other federal and status regulatory requirements;
- Approve the appointment and the replacement of the CO;
- Provide input to the annual evaluation of the performance of the CO; and

In addition to the Board of Directors, the Company has an internal Compliance Committee the responsibilities of which are to:

- Oversee the Program's implementation and operation, including the development of strategies to promote compliance and detect any potential violation, the implementation of corrective and preventive action, when required, and the use of internal controls designed to ensure compliance in daily operations;
- Foster and promote a culture that encourages ethical conduct and a commitment to compliance with the Code of Conduct and laws, regulations, policies and procedures;
- Review reports from the CO, and other compliance personnel, including dashboards, self-assessments, scorecards and similar tools that would reveal compliance issues;
- Ensure that the Program has up-to-date compliance policies and procedures;
- Ensure that the Company has a system for workforce to ask compliance questions and report potential instances of non-compliance and potential FWA confidentially or anonymously without fear of retaliation;
- Ensure that the Company has a method for employees, beneficiaries and others to report potential FWA;
- Review and address reports of monitoring and auditing of areas in which the Company is at risk for noncompliance or potential FWA and ensure that corrective action plans are implemented and monitored for effectiveness;

- Serve as a conduit for elevating operational compliance issues, risks, barriers, and opportunities that may impact the business;
- Monitor the status of issues, critical incident reports, audit findings, and potential process issues;
- Identify resource and funding needs for elevation to appropriate senior leadership for resolution; and
- Coordinate and share information from meetings with functional areas and key governance committees to facilitate the timely and accurate reporting to senior leadership and to the Board of Directors.

The CO, as the facilitator and the focal point for the day-to-day operation of the Company's compliance program, is responsible for:

- Implementing the Compliance Program, including defining the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all personnel and FDRs.
- Submitting to the CEO and senior management and/or ensuring that senior management receives reports of risk areas facing the Company, strategies being implemented to address them and the results of those strategies, and reports on Medicare program noncompliance and FWA for issues identified, investigated and resolved.
- Advising the CEO of all governmental compliance enforcement activity from Notices of Non-compliance to formal enforcement actions.
- Create and coordinate (or delegate) educational training programs to ensure that officers, directors, managers, employees, FDRs, and other individuals working in the government programs are knowledgeable about the Compliance Program, written Code of Conduct, compliance policies and procedures, and all applicable statutory and regulatory requirements.
- Coordinate personnel issues with Human Resources to ensure that covered persons are checked against the OIG exclusion lists and GSA debarment lists monthly. CNC will require FDRs to provide signed attestation/certification of their compliance with this requirement.
- Oversee the development and monitoring of corrective action plans.

The Compliance Department is responsible for:

- Facilitating with the Compliance Program Policy and applicable Company procedures.
- Providing effective training and education, including FWA to the workforce within 90 days of hiring, appointment and/or contracting and annually thereafter.
- Maintaining a system to receive, record and respond to and track compliance questions or concerns and reports of potential FWA from the workforce, including anonymous good-faith reports of potential or actual misconduct and maintaining confidentiality to the extent possible; and, enforcing a no-tolerance policy for retaliation or retribution against the workforce for good-faith reporting of noncompliance and FWA.
- Ongoing oversight of all first tier, downstream and related entities activities;
- Conducting reasonable, well-documented inquiries into all compliance incidents and potential FWA.
- Assisting in removing barriers within the organization to meeting compliance with the Program;
- Assisting in ensuring required changes to processes and/or internal controls are implemented to maintain effective and appropriate compliance with the Program.
- Establishing and maintaining an effective continuous improvement process for identification, correction and reporting of systemic problems related to compliance of the Program.
- Communicating changes to laws, regulations, and/or compliance requirements to impacted areas and through the Compliance Committee.
- Determining the appropriate area responsible for communication with regulatory agencies on issues relating to the Company's compliance.

Management is responsible for:

- Ensuring their respective areas are performing their compliance responsibilities according to the applicable requirements.
- Operational oversight of the compliance process and program components.
- Developing and maintaining appropriate written policies and procedures for their areas of accountability which incorporate compliance requirements; having internal controls in place for all affected business processes and effective monitoring, evaluation and improvement of all business processes,
- Periodic training on internal processes related to functional responsibilities and FWA risks which include review of applicable state and federal laws, regulatory and sub-regulatory requirements, their relationship to the functional areas' responsibilities including SOPs, desk procedures, internal controls and individual avoidance of unlawful or unethical occurrences.
- Training of the workforce when there are changes to laws, regulations and accreditation or compliance requirements which impact the area's responsibilities.
- Promoting methods to report good-faith allegation of suspected or actual wrongdoing, including FWA, and the policy of non-intimidation and non-retaliation.
- Developing and implementing a corrective action plan for a business area at the direction of the Compliance department.
- Reinforcing to the workforce its responsible for reporting to the CO any activity that it is believed, in good faith, may violate this policy.

CROSS-REFERENCED DOCUMENTATION:

N/A

REVISION HISTORY		
Description of Change	Author	Effective Date

RELEVANT REGULATORY CITATIONS	
Document	Title
Code of Federal Regulations	42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)
Medicare Managed Care Manual	Chapter 21 – Compliance Program Guidelines
Prescription Drug Benefit Manual	Chapter 9 – Compliance Program Guidelines

Review/Approval Date:

Signature on File

Signature

10/22/2015

Approval Date



Insurance Company, Inc.

Policy and Procedure Name: Compliance Officer, Compliance Committee and High Level Oversight	Policy Number: COM-001	
Functional Business Owner's Name: Nakia Smith, Director of Compliance	Effective Date: 6/30/2012	Review Date: 9/1/2015
Approver's Name: Wendy Karsten, Chief Executive Officer	Approval Date: 10/22/2015	

PURPOSE:

The purpose of this policy and procedure is to ensure the effective implementation of the Care N' Care compliance program by establishing a Compliance Committee.

DEFINITIONS:

N/A

POLICY:

CNC will maintain a Compliance Officer, Compliance Committee and High Level Oversight. The Compliance Officer is tasked with the daily operations of the compliance program, is an employee of the organization, and reports to the Chief Executive Officer. In no event shall the Compliance Officer be an employee of CNC's first tier, downstream and related entity (FDR), or serve dual roles in operational areas. The Compliance Committee advises the Compliance Officer and is primarily responsible for oversight and implementation of the Compliance Program. The Committee shall also provide leadership in establishing a culture of ethical conduct and compliance within the organization. High Level Oversight shall be conducted by the contracting entity's Governing Body which shall exercise reasonable oversight of the implementation and effectiveness of the compliance program.

PROCEDURE:

- I. Mission – CNC is committed to conducting its business operations with honesty, integrity, and in full compliance with all applicable federal and state standards. The mission of the Compliance Officer and the Compliance Committee is to ensure CNC honors this commitment. Both the Compliance Officer and Compliance Committee fulfills its mission by:
 - A. Overseeing implementation and execution of the Corporate Compliance Program.
 - B. Providing leadership to the organization in the areas of regulatory compliance and ethical conduct.
 - C. Providing guidance to employees and others for dealing with potential compliance issues.

- II. Authority – The Compliance Officer and Compliance Committee is authorized to fulfill its mission by, and is accountable directly to, the CNC Board of Directors. The Compliance Officer shall report on a recurring basis directly to the governing body of the organization on activities/status of the Compliance Program, including issues identified, investigated, and resolved.

- III. Membership – The Compliance Committee membership shall consist of the Compliance Officer, Chief Executive Officer and/or Chief Operating Officer, Director of Operations, Director of Clinical Pharmacy Services, Director of Quality and other management staff with the responsibility for key departments or functions within the organization.

- The Compliance Committee is a senior oversight body. Members must be capable of evaluating and addressing issues affecting all levels and areas across the organization, as well as their specific areas of direct authority.
- Membership considerations, including the addition and removal of committee members, can be made by any committee member at any time. An assessment of the current membership representation shall be conducted on an annual basis.

IV. Committee Responsibilities – The primary responsibilities of the Compliance Committee include, but are not limited to, the following:

- Assist and advise the Compliance Officer with development and implementation of the Corporate Compliance Program.
- Analyze the organization's industry environment, the legal requirements with which it must comply, and implementing the risk assessment, monitoring and auditing work plan.
- Assess existing policies and procedures that address the identified risk areas for possible incorporation into the Compliance Program. Policies and procedures will be updated, Medicare-specific, and reflect Medicare current laws (ACA False Claims Act requirement to report overpayments) and regulatory requirements. They will also reflect CNC's operational practices.
- Work with CNC departments to develop standards of conduct and policies and procedures to promote compliance, describe compliance expectations, and detect potential violations.
- Recommend and monitor, in conjunction with the relevant departments, the development of internal systems and controls to carry out Medicare regulations and CNC's standards, policies and procedures.
- Determine the appropriate strategy or approach to promote adherence to the Compliance Program and to allow employees and FDRs to ask compliance questions and report potential violations confidentially or anonymously (if desired), such as through hotlines and other fraud reporting mechanisms, without fear of retaliation.
- Develop a system to solicit, evaluate, and respond to complaints and problems.
- Monitor internal and external audits and investigations for the purpose of identifying troublesome trends and issues and implementing effective corrective and preventive actions.
- Develop innovative ways to implement appropriate corrective and preventive action.
- Confer with the Compliance Officer on findings of internal compliance reviews, recommendations, and follow-up actions to be taken on potential violations of standards, rules, regulations, and laws.
- Provide regular and ad hoc reports on the status of compliance with recommendations to CNC's governing body.
- Support the Compliance Officer's needs for sufficient staff and ensure that sufficient resources are committed to operation of the Compliance Program and all related policies, plans and activities.
- Ensure compliance training and education is effective and appropriately completed.

The Committee may also perform other functions as the concept of corporate compliance becomes part of CNC's overall operating structure and daily routine.

V. Individual Member Responsibilities - The primary responsibilities of the individual members include, but are not limited to, the following:

- Compliance Officer – The Compliance Officer will serve as co-chair of the Compliance Committee. As the focal point for day-to-day operations of the compliance program, the CO will ensure the committee is aware of the overall effectiveness of the Compliance Program, potential areas of risk, and

mitigation/corrective action taken to address identified risks.

- Chief Executive Officer – As the senior executive member of the Committee, the CEO is primarily responsible for ensuring that the Committee is equipped and empowered to fulfill its mission.
- All Committee Members – Each Committee member is accountable and accepts responsibility for the overall success and effectiveness of the Compliance Program. Each Committee member agrees to:
 - Actively contribute to the effectiveness of Committee meetings, as described below.
 - Diligently execute assigned duties and action items.
 - Lead by example, and promote an organizational culture that emphasizes regulatory compliance and values ethical conduct.

VI. Meetings

- A. Frequency - The Compliance Committee will meet bimonthly; more frequent meetings will be scheduled if need arises.
- B. The Compliance Officer and/or delegate shall distribute the meeting agenda, draft minutes from the previous meeting, and any other materials that require Committee review prior to the meeting.
- C. Effectiveness - Committee members shall strive to make meetings as productive and time-effective as possible. Every effort shall be made to start and end meetings on time. Committee member agree to:
 - Regularly attends all Committee meetings. If a Committee member is unable to attend a scheduled meeting, he/she should notify the Compliance Officer in advance and, if appropriate, designate a representative to attend in his/her place.
 - Prepare for each meeting. This includes review of materials that have been distributed ahead of time (agenda, minutes from the previous meeting, etc.) and completion of assigned action items.
 - Actively participates in each meeting.

CROSS-REFERENCED DOCUMENTATION:

N/A

REVISION HISTORY		
Description of Change	Author	Effective Date
Updated in compliance with Chapter 9 & 21	Lydia Cervantez	January 8, 2014
Revised Policy Owner and Approver, updated Compliance Committee oversight and membership.	Nakia Smith	September 1, 2015

RELEVANT REGULATORY CITATIONS	
Document	Title
Code of Federal Regulations	42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)
Medicare Managed Care Manual	Chapter 21 – Compliance Program Guidelines
Prescription Drug Benefit Manual	Chapter 9 – Compliance Program Guidelines

Review/Approval Date:

Signature on File

Signature

10/22/2015

Approval Date



Insurance Company, Inc.

Policy and Procedure Name: Effective Lines of Communication	Policy Number: COM-009	
Functional Business Owner's Name: Nakia Smith, Director of Compliance	Effective Date: 6/30/2012	Review Date: 9/1/2015
Approver's Name: Wendy Karsten, Chief Executive Officer	Approval Date: 10/22/2015	

PURPOSE

The purpose of this policy is to implement the relevant provisions of 42 C.F.R. § 422.503(b)(4)(vi) and 423.504(b)(4)(vi) and Chapter 9 of the Medicare Prescription Drug Manual, and Chapter 21 of the Medicare Managed Care Manual, which requires sponsors to implement an effective compliance program, including procedures for effective lines of communication ensuring confidentiality between the Compliance Officer and the organization's employees, managers, governing body, members of the Compliance Committee, and first-tier, downstream and related entities (FDRs).

SCOPE

This policy applies to all members of the board of directors, employees, first tier, downstream and related entities (FDRs), contractors, and agents of Care N' Care Insurance Company, Inc.

DEFINITIONS

Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. 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.

First-Tier Entity: Any party that enters into a written agreement, acceptable to CMS, with a Medicare Advantage organization, Part D plan sponsor, or contract applicant (hereinafter referred to as a "Sponsor") to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage or Part D programs.

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a Sponsor and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include, but are not limited to, mail order pharmacies, firms providing agent/broker services, agents, brokers, marketing firms, and call center firms.

Related Entity: Any entity that is related to a Sponsor by common ownership or control and (1) performs some of the 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 Sponsor at a cost of more than \$2,500 during a contract period.

Fraud: 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.

Waste: 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 the misuse of resources.

POLICY

Care N' Care will comply with all applicable federal and state regulations regarding the establishment of a compliance program. Specifically, the Compliance department will adhere to standards for effective lines of communication, ensuring confidentiality between the Compliance Officer, members of the Compliance Committee, employees, managers and governing body, and CNC's FDRs. Such lines of communication will be accessible to all, be user-friendly, and allow for anonymous and confidential good faith reporting of potential or actual compliance issues as well as suspected or actual violations relating to the Medicare program. In addition, CNC has adopted a policy of non-intimidation and non-retaliation and enforces a no tolerance policy for retaliation or retribution for good faith reporting of suspected non-compliance or fraud, waste and abuse concerns.

PROCEDURE

- I. **Communication with the CEO and Board of Directors** - The Compliance Officer will maintain open lines of communication with the CEO and Board of Directors regarding activities of the Compliance Committee and Compliance Department. This includes, but is not necessarily limited to, the following:
 - Regulatory Updates
 - Ongoing reports involving Non-Compliance/Risks
 - Compliance Program
 - Compliance Work Plan
 - Auditing & Monitoring efforts
- II. **Communication with the Compliance Committee** – The Compliance Committee will meet bi-monthly for the purpose of overseeing the Compliance Program. The Compliance Officer will keep the Committee informed and seek its guidance on compliance or ethics issues that represent potential risk to the organization.
- III. **Communication with Management** – The Compliance Officer will maintain open lines of communication with CNC management staff. This includes, but is not necessarily limited to, the following:
 - A. **Compliance Program** – All management staff shall receive a copy of the Compliance Program, including all significant revisions. Managers are responsible for understanding the Compliance Program and distributing a copy to all employees.
 - B. **Program Guidance** – Compliance will distribute statutory, regulatory and sub-regulatory guidance, including HPMS Memos and operational guidance through the compliance distribution list and direct communication (See COM-025 Communications Regarding Regulatory Changes).
 - **Part C/D User Group Calls:** The Compliance Department also tracks and documents regulatory guidance through the CMS user group calls, and communicates this to business owners when applicable. Compliance sends out notices to business owners impacted by the content of the call.
 - **CMS Educational Notices:** The Compliance Department routinely disseminates new compliance information to business owners and applicable FDRs. The notices summarize changes in CMS regulations, fraud alerts, CMS sanctions and

enforcement actions against other health plans, CMS conferences, and industry/association training and conferences.

- C. Issues Tracking Log – The Compliance Department tracks all compliance violations and communications from CMS via the Issues Tracking Log. Compliance will track any action item associated with regulatory guidance and send out reminders to managers until all required actions are implemented.
- IV. **Communication with Employees** - The Compliance Officer will maintain open lines of communication with employees at all levels of the organization. This includes, but is not necessarily limited to, the following:
- A. Compliance Policies and Code of Conduct – All employees shall receive copies of the Compliance P&Ps including the Code of Conduct, at the time of employment and annually thereafter. The Code of Conduct will be made available to delegated (first-tier, downstream, and related) entities. Employees shall be required to certify their receipt and understanding and acknowledgement.
- B. Training and Education, Incident Reporting – Employee training and incident reporting are key aspects of organizational communication. These components are addressed in separate Policies and Procedures.
- V. **Communication with First-tier, downstream, and related entities** – The Compliance Officer and Compliance Committee will develop and utilize mechanisms for communicating with first tier, downstream and related entities (FDRs), including health care providers, management service organizations, and brokers. Such communication will typically occur in collaboration with CNC departments or committees having established methods of contractor communication. Examples include Pharmacy Benefit Management, Marketing, Care Management (Utilization Management) and Claims Oversight. CNC will also communicate changes in relevant laws, regulations, and policies and procedures to FDRs.
- A. FDRs are required to report any suspected and/or actual misconduct without fear of intimidation or retaliation for good faith reporting in the Compliance Program. The FDR management shall communicate any suspected and/or actual misconduct to the Compliance Officer within a reasonable time after discovery or knowledge.
- VI. **Communication with Regulatory Authorities** – CNC will maintain open communication with regulatory authorities.
- A. The Compliance Officer is CNC's primary point of contact with regulatory authorities. Normal, ongoing communication with regulators will be routed through the Compliance Officer.
- B. Individual departments may have such direct communication with regulatory authorities as is appropriate to fulfillment of their responsibilities. For example, Enrollment may be required to contact CMS regarding retro-active transactions; IT may be required to contact the CMS Help Desk regarding transmission of data; etc.
- C. For elevated issues such as investigation, litigation, interaction with enforcement authorities, or any situation that poses similar risk to the organization, communication will be governed by, as appropriate:
- Company policy, if applicable policy exists
 - Direction from senior management
 - Legal department
- VII. **Communication with Members** - CNC will maintain open communication with our members and educate our members on identifying and reporting noncompliance and FWA. Methods of communication with our members include newsletters, emails, meetings and information published on CNC's website.

VIII. **Reporting to Compliance** - As described in CNC's Code of Conduct, employees, members of the Board of Directors, and FDR are required to report suspected or detected noncompliance, and potential FWA. To accommodate the various topics and to establish preferred communication methods, CNC has developed several mechanisms for reporting potential or actual non-compliance and FWA issues.

- A. Directly to the Compliance Officer or any member of the Compliance team at 1701 River Run, Suite 402, Fort Worth, TX 76107.
- B. By sending an email to the compliance Officer or the designated compliance email box at CNCCompliance@cnchealthplan.com
- C. Through the Compliance Hotline at **1-844-760-5838**. Reports made through the compliance hotline can be made confidentially or anonymously, 24 hours a day, 7 days a week.
- D. The Compliance Hotline allows for anonymous reporting via the ComplianceLine website at www.mycompliancereport.com.

IX. **Recording, Responding To, and Tracking Issues**

- A. Compliance will respond to, assess and investigate to the extent warranted, all compliance questions and reports of suspected or detected noncompliance or potential FWA and take appropriate action.
- B. Compliance ensures the recording and tracking of reports of suspected or detected noncompliance or potential FWA which may be used to identify trends and potential systemic issues.
- C. FWA case details are maintained in accordance with CNC's Record Retention Policy.
- D. For issues that have an impact on personnel matters, Human Resources will be engaged appropriately to handle compliance or FWA issues that impact such personnel matters.

X. **Non-Retaliation** – No employees will be discriminated or retaliated against in any way for bringing forward a question or good faith complaint. All employees are required to support both the letter and spirit of this commitment. Those who retaliate against an individual who makes a good faith effort to report a compliance or FWA issue will be subject to CNC's corrective action policy.

XI. **Disclosure to CMS** – In the spirit of transparency, and pursuant to CMS requirement, the Compliance Department will disclose to the CMS Regional Office applicable incidents of noncompliance and FWA that impact beneficiary safety and access to care. Regular updates will be provided to the CMS Account Manager on the status and outcome of corrective action plans and any follow-up monitoring activities that may be done to ensure that the issue is not likely to reoccur.

CNC will follow policy guidance for making self-disclosures regarding violations of federal criminal law or the civil False Claims Act to the U.S. Department of Health and Human Services (HHS)

CROSS-REFERENCED DOCUMENTATION:

COM-025 Communications Regarding Regulatory Changes

REVISION HISTORY		
Description of Change	Author	Effective Date
Revised language related to First Tier, Downstream and Related Entities per CMS guidance. Policy revisions made to compliance committee oversight, Annual Compliance Workplan and Communication	Nakia Smith	8/5/2014

REVISION HISTORY		
Description of Change	Author	Effective Date
methods.		
Annual Review and Update, revised hotline language	Nakia Smith	9/1/2015

RELEVANT REGULATORY CITATIONS	
Document	Title
Code of Federal Regulations	42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)
Medicare Managed Care Manual	Chapter 21 – Compliance Program Guidelines
Prescription Drug Benefit Manual	Chapter 9 – Compliance Program Guidelines (§50.1.5, 50.1.7)
U.S. Department of Health and Human Services (HHS), Office of Inspector General	Guidance for Submitting a Contractor Self Disclosure, April 2014

Review/Approval Date:

Signature on File

Signature

10/22/2015

Approval Date



Insurance Company, Inc.

Policy and Procedure Name: Corrective Action Plans	Policy Number: COM-005	
Functional Business Owner's Name: Nakia Smith, Director of Compliance	Effective Date: 6/30/2012	Review Date: 10/1/2015
Approver's Name: Wendy Karsten, Chief Executive Officer	Approval Date: 10/22/2015	

PURPOSE:

To correct actual or potential performance issues related to regulatory compliance or ethical conduct, reduce risk of recurrence, and promote a culture of continuous improvement.

DEFINITIONS:

Beneficiary Impact Analysis: (BIA) is an analysis completed when noncompliant conditions are found, to identify how many beneficiaries were adversely impacted by the noncompliance.

Corrective Action Plan Request: Notices from the Compliance Department to an individual, department or FDR that a Corrective Action Plan is required.

Corrective Action Plans (CAP): Document provided to the Compliance Department by an individual, department or FDR which identifies deficiencies requiring resolution and provides a detailed plan to resolve those deficiencies, a timeline to correct the deficiencies, and a person responsible for leading the effort to correct the deficiency.

First-Tier Entity: Any party that enters into a written agreement, acceptable to CMS, with a Medicare Advantage organization, Part D plan sponsor, or contract applicant (hereinafter referred to as a "Sponsor") to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage or Part D programs.

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a Sponsor and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include, but are not limited to, mail order pharmacies, firms providing agent/broker services, agents, brokers, marketing firms, and call center firms.

Related Entity: Any entity that is related to a Sponsor by common ownership or control and (1) performs some of the 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 Sponsor at a cost of more than \$2,500 during a contract period. (See 42 C.F.R. §423.501).

Root Cause Analysis: A description of what caused or allowed the FWA, problem or deficiency to occur.

POLICY:

The Compliance Officer (CO), as the executive accountable for day to-day operations of the Compliance Program, is responsible for the oversight, development and implementation of Corrective Action Plans as a means to maintaining compliance with regulatory standards both with internal operational areas and all First Tier, Downstream and Related Entities (FDR). Detection of potential or actual issues related to

compliance, ethical conduct, or other measurable areas of performance shall result in the initiation of appropriate corrective action.

PROCEDURE:

I. Basis for Corrective Action Plan (CAP)

- A. CNC monitors and audits internal operational areas and FDR performance through a variety of mechanisms. The data and documentation reviewed is established based on operational area or the contractual functions performed.
- B. Non-compliance with statutory, regulatory, contractual, policy or other requirements related to the Compliance program may be identified from information obtained through audits, operational reports, reports of HIPAA, reports of Fraud, Waste and Abuse violations, operational monitoring, member and provider surveys, compliance or other investigations, appeals, grievances, trend analysis or any other reviews or audits.
- C. In the event that CNC determines that an operational area or FDR has failed to comply with any statutory, regulatory, contractual, policy or other requirements relating to the Compliance program, CNC may issue a request for CAP.
- D. All CAPs are reviewed and approved by the CO prior to issuance to the deficient internal operational area or FDR. The CO and/or a member of the Compliance Team will meet with the department or FDR to review findings and provide expectations for timeframes of completion and content required for CAP submission.
- E. Once a CAP is issued, the responsible individual, department, or FDR has ten (10) business days to respond and provide a plan to remediate the deficiency.

II. Corrective Action Plan General Requirements

- A. Non-compliance with specific requirements that have the potential to cause significant Member harm or place CNC's contractual status with regulatory agencies in jeopardy will require an Immediate Corrective Action Plan (ICAP) on the part of the FDR or operational area. Significant Member harm exists if the non-compliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to the Member's health and safety due to non-existent or inadequate policies and procedures, systems operations or staffing. All ICAPs will require completion of a Beneficiary Impact Analysis (BIA).
- B. If the finding is an ICAP, a resolution or steps taken to immediately stop beneficiary harm is required within three (3) calendar days from the issuance of the finding.
- C. A standard CAP not resulting in a material finding should be resolved within 60 calendar days.
- D. Departmental or FDR CAPs must effectively address the particular instance or issue of noncompliance and are tailored to reflect the severity of non-compliance identified through self reporting, monitoring or auditing.
- E. A CAP must include, at a minimum, a root cause analysis and a detailed corrective plan.
- F. A root cause analysis identifies the source of the noncompliance, such as system defects, human error, lack of staff knowledge or training, resource issues, etc. For internal compliance deficiencies, if the root cause is found to be related to human error, negligence, reckless disregard of company policies or procedures, and applicable laws and regulations, or willful misconduct, Compliance consults with leadership and/or Human Resources (HR).
- G. A plan to correct the deficiency must include the following:

- Development of or revision to company and/or department policies or FDR policies as applicable,
- Due date to accomplish each corrective action,
- Identification of responsible person for each element of the Corrective Action Plan,
- Education/training curriculum and dates, and,
- Short-term and long-term monitoring and reporting plans.

III. Compliance Officer (CO) Oversight and Reporting of Corrective Action Plans Oversight

- A. CAPs are reviewed by the CO to ensure that all actions, deliverables and timeframes are acceptable. The department or FDR is notified in writing of all required changes. Throughout the CAP process, the CO and Compliance Committee are provided status updates on a regular basis. The CO is provided biweekly status reports. Reports identify the status of all deliverables (in process, due, and overdue).
- B. The CO issues a request for immediate response for all overdue responses to the responsible internal operational area or FDR via email. The responsible parties are given twenty-four (24) hours to provide a response as to the reason for the delay and the revised timeframe required to provide the deliverable.
- C. If the response is provided within twenty-four (24) hours, the CO will review and respond with either an approval of the extension or provide the modified deliverable due date. If the response is either not provided, or provided and subsequently not completed within the agreed upon modified timeframe, the CO will escalate the delinquency to the responsible VP for remediation.
- D. With respect to FDRs, should an FDR fail to correct deficiencies or identified issues of noncompliance, according to the criteria of the Corrective Action Plan(s) issued, CNC may seek to invoke provisions outlined in the contract.

Reporting

- A. The CO evaluates each CAP for self-reporting to CMS. If a CAP is found to have reached the level requiring self-reporting, the CO will notify the CEO and CMS. The CO provides CAP ongoing status updates to the Compliance Committee and to the Board of Directors as applicable. Recommendations provided by either body are incorporated into the CAP and updates are provided to the responsible parties.

IV. Closing Corrective Action Plans

- A. Upon successful completion of a CAP, validation audits and/or increased monitoring of the operational area or FDR are added to one or more of the following:
 - Compliance Auditing work plan; and/or
 - Compliance Monitoring work plan.
- A. Documentation regarding Corrective Action Plans is filed and maintained by the Compliance Department and in accordance with the requirements of the Document/Record Retention Policy.

CROSS-REFERENCED DOCUMENTATION:

N/A

REVISION HISTORY		
Description of Change	Author	Effective Date
Revised to align with CMS audit	Nakia Smith	10/1/2015

Care N' Care, COM-005, Corrective Action Plans

REVISION HISTORY		
Description of Change	Author	Effective Date
methodology and CAP process.		

RELEVANT REGULATORY CITATIONS	
Document	Title
Code of Federal Regulations	42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)
Medicare Managed Care Manual	Chapter 21 – Compliance Program Guidelines
Prescription Drug Benefit Manual	Chapter 9 – Compliance Program Guidelines

Review/Approval Date:

Signature on File

Signature

10/22/2015

Approval Date



Insurance Company, Inc.

Policy and Procedure Name: Investigating & Responding to Potential Compliance Issues	Policy Number: COM-012	
Functional Business Owner's Name: Nakia Smith, Director of Compliance	Effective Date: 06/30/12	Review Date: 09/1/2015
Approver's Name: Wendy Karsten, Chief Executive Officer	Approval Date: 10/22/2015	

PURPOSE

The purpose of this policy is to outline the steps for receiving, investigating and reporting potential compliance issues.

SCOPE

This policy applies to all members of the board of directors, employees, first tier, downstream and related entities (FDRs), contractors, and agents of Care N' Care Insurance Company, Inc.

DEFINITIONS

ComplianceLine – contracted vendor that administers a reporting and case management system for potential compliance issues. ComplianceLine takes reports via phone or internet made either anonymously or confidentially and is available 24 hours a day, 7 days a week.

Inconclusive – an investigation outcome in which a determination of whether a violation of the Code of Conduct, laws, regulations, and/or company policies occurred cannot be made.

Potential Compliance Issues - issues that may be reported to the Compliance Officer, officers, directors, and first tier, downstream, and related entities regarding suspected violations of the Code of Conduct, laws, regulations, and/or company policies.

Substantiated – an investigation outcome in which a violation of the Code of Conduct, laws, regulations, and/or company policies occurred.

Unsubstantiated – an investigation outcome in which a violation of the Code of Conduct, laws, regulations, and/or company policies did not occur.

POLICY

Care N' Care (CNC) recognizes that violations of its Compliance Program, violations of applicable federal or state law or regulations, or other types of misconduct threaten its status as a reliable, honest, and trustworthy organization capable of participating in federal and private programs. Any report or evidence of suspected violations of law, regulations, or applicable standards of conduct can be reported to the Compliance officer, including anonymous reports using the ComplianceLine. CNC reviews and investigates all reports of potential compliance issues. CNC will treat all reports seriously and in a confidential manner, to the extent possible, and will take appropriate corrective action, including necessary reporting to appropriate governmental agencies, as a result of the investigation.

All employees are required to cooperate fully in all compliance investigations. Failure to cooperate in an investigation may lead to disciplinary action. Intimidation or retaliation against any employee who cooperates in a compliance investigation is strictly prohibited and will lead to disciplinary action up to and including termination.

PROCEDURE

- I. All employees, consultants, temporary staff, first tier, downstream and related entities (FDRs) are given direction on how to report potential compliance issues during new hire orientation, at contracting and through compliance policy and procedures. The Code of Conduct provides instruction on the various mechanisms for reporting potential compliance issues, including how to report issues through the ComplianceLine system. Employees, consultants, temporary staff and FDRs can also report compliance issues directly to the Compliance Officer or any of the Compliance staff.
- II. For reports that are made through the ComplianceLine system, the Compliance Officer receives an email from the ComplianceLine Reporting system when a report is made. The Compliance Officer maintains an Excel database for reports received outside the ComplianceLine system.
- III. For all reports, regardless of the route taken to report to Compliance Department, the Compliance Officer reviews the report to determine if it is a Potential Compliance Issue.
 - a. If it is not, a referral is made to the more appropriate person (i.e., Human Resources) for follow up.
 - b. If the report includes a Potential Compliance Issue, the Compliance Officer will investigate the case. The Compliance Officer may consult with legal counsel on some cases if the report indicates that it is more appropriate for another party, including outside counsel, to investigate the case.
 - c. Depending upon the nature of the alleged violations, an internal investigation will include interviews and a review of relevant documents. See Attachment A: Internal Investigation of Alleged Violations Checklist
 - d. The ComplianceLine reporting system has a feature where implicated persons included in a report would not receive notices of such. Therefore, if the Compliance Officer is implicated and/or the subject of a case, the report would be forwarded to the Director of Human Resources, the back up for the Compliance Officer.

IV. Investigations Conducted by the Compliance Department:

The Compliance Officer may investigate the case or may assign a case to the Compliance Program Manager as Investigator. In either case, the documentation of all interviews, documents, and findings will be maintained in the case file.

Once the investigation is concluded, the Compliance Officer makes a determination. Please proceed to the section below titled "Compliance Officer Determination."

V. Investigations Conducted by Legal Counsel:

For cases that are referred to Legal Counsel, the notes and records of counsel, as well as legal counsel's report, shall be considered confidential and privileged communications from attorney to client. No board members, officer, employee or agent shall be authorized to release them to any outside agency without the written approval of the Chief Executive Officer and Legal Counsel.

Upon receipt of counsel's investigative findings, proceed to the section below titled "Compliance Officer Determination".

VI. Compliance Officer Determination

The Compliance Officer will determine if the investigation outcome is Substantiated, Unsubstantiated, or Inconclusive and note the determination in the case file.

- a. If Unsubstantiated or Inconclusive, the case will be closed.

- b. If Substantiated, the Compliance Officer will make recommendations, including but not limited to the following actions:
 - Disciplinary Action of a person or persons, up to and including termination, to the CEO and Director of Human Resources.
 - Operational process improvements and/or other necessary corrective actions to the leadership of the operational area.
 - A corrective action plan will be created if any fraud and abuse or material violation of this program is found to have occurred. Where applicable, a root cause analysis of the issue shall be conducted to identify gaps in CNC policies and procedures.
 - Review by Legal Counsel for a legal determination of potential violation of regulation, statute, or law.
 - If Legal Counsel concludes that a violation of the law has occurred, a potential compliance issues report may be made to the appropriate governmental agency. This potential compliance issues report may take the form of a voluntary disclosure to the Office of Inspector General of the Department of Health and Human Services or other compliance issues report, as counsel deems appropriate.
 - The potential compliance issues report will be completed by the Compliance Officer with the assistance of legal counsel and may contain documentation of the suspected violation, copies of key document, a log of witnesses interviewed and documents reviewed, and a summary of any disciplinary or corrective actions taken as a result of the investigation. The potential compliance issues report will be forwarded to the appropriate agency with a designation of the legal counsel who shall be the primary point of contact with agency until the matter is concluded.
- c. Records of the investigation will contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, the results of the investigation, *e.g.*, any disciplinary action taken, and the corrective action implemented

VII. The Compliance Officer will report summary data of the types and outcomes of Compliance Issues at least annually to the Compliance Committee and to the Board of Directors as applicable.

CROSS-REFERENCED DOCUMENTATION:

COM-025 Communications Regarding Regulatory Changes
 ComplianceLine Procedures – Original Report

REVISION HISTORY		
Description of Change	Author	Effective Date
Revised title from “Internal Investigations of Alleged Violations”.	Nakia Smith	9/1/2015
Updated processes to include ComplianceLine reporting system.	Nakia Smith	9/1/2015

RELEVANT REGULATORY CITATIONS	
Document	Title

Code of Federal Regulations	42 CFR Part 422.503(b)(4)(vi)(A) through (G)
Code of Federal Regulations	42 CFR Part 423.504(b)(4)(vi)(A) through (G)
U.S. Department of Health and Human Services (HHS), Office of Inspector General	Guidance for Submitting a Contractor Self Disclosure, April 2014

Review/Approval Date:

Signature on File

Signature

10/22/2015

Approval Date



Insurance Company, Inc.

Policy and Procedure Name: Reporting Fraud, Waste and Abuse	Policy Number: COM-015	
Functional Business Owner's Name: Nakia Smith, Director of Compliance	Effective Date: 06/30/2012	Review Date: 09/1/2015
Approver's Name: Wendy Karsten, Chief Executive Officer	Approval Date: 10/22/2015	

PURPOSE:

To ensure timely and proper reporting to the appropriate entities in detecting and preventing suspected fraud, waste, and abuse (FWA), including but not limited to the:

- U.S. Department of Justice (DOJ) and U.S. Department of Health & Human Services, Office of Inspector General (OIG)'s Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Centers for Medicare & Medicaid Services (CMS)
- Medicare Drug Integrity Contractor (MEDIC)
- Texas Department of Insurance

DEFINITIONS:

Fraud - means an intentional deception or misrepresentation that the individual 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 himself/herself or to some other person.

Waste - is the inappropriate utilization and/or inefficient use of resources.

Abuse - occurs when an individual or entity unintentionally provides information to Medicare which results in higher payments than the individual or entity is entitled to receive.

FWA - within a plan or its first-tier, downstream, or related entities may be discovered through a hotline, a website, a beneficiary complaint, during routine monitoring or self-evaluation, an audit, or by regulatory authorities. The reporting of potential fraud is an important mechanism for protecting Medicare beneficiaries from harm and the Medicare Trust Fund from FWA. Potential FWA may be reported to government authorities, such as the HEAT, CMS, MEDIC, DMHC, and/or DOI.

BACKGROUND:

In May 2009, the DOJ and OIG announced the creation of their joint Health Care Fraud Prevention and Enforcement Action Team (HEAT). HEAT's mission is to do the following: (1) to marshal significant resources across government to prevent waste, fraud and, abuse in the Medicare and Medicaid programs and crack down on the fraud perpetrators who are abusing the system and costing us all billions of dollars; (2) to reduce skyrocketing health care costs and improve the quality of care by ridding the system of perpetrators who are preying on Medicare and Medicaid beneficiaries; (3) to highlight best practices by providers and public sector employees who are dedicated to ending waste, fraud, and abuse in Medicare; and (4) to build upon existing partnerships that already exist between the DOJ and the DHHS to reduce fraud and recover taxpayer dollars.

The Centers for Medicare & Medicaid Services (CMS) is another entity dedicated to preventing FWA and has created a Surveillance Marketing Allegation Response Team (SMART) to assist in the investigation of marketing violations. CMS strongly encourages Care N' Care (CNC) to immediately self-disclose such violations to CMS and to be proactive in reporting any corrective action measures taken to respond to any violations.

CMS has also contracted with private organizations, called MEDICs, to assist in the management of CMS' anti-fraud and abuse efforts. The MEDIC's responsibilities include: investigating potential fraud in Part C and Part D; receiving and resolving fraud complaints (from beneficiaries, plan sponsors, other interested parties); referring fraud cases to law enforcement; responding to law enforcement requests for information; providing support to law enforcement through investigations and case development; performing data analyses (proactive and reactive); identifying program vulnerabilities; and sharing information with stakeholders (beneficiaries, plan sponsors, state and local agencies). CMS requires CNC to report potential instances of FWA to its designated MEDIC, Health Integrity, LLC. When MEDICs discover plan violations of criminal, civil or administrative law, they will refer them to the appropriate law enforcement entity.

Finally, the TDI have authority over how the insurance industry conducts business within Texas and is responsible for enforcing many of the insurance-related laws of the state. The TDI is responsible for handling the litigation needs of the State, representing it in actions to enforce the managed care laws. The DOI is foremost a consumer protection agency that aims to protect insurance consumers by regulating the industry's practices. More specifically, the DOI actively investigates suspected fraud and violations of the Texas Insurance Code by licensees.

POLICY:

Care N' Care (CNC) is strongly committed to the detection and prevention of FWA at the plan level, as well as within its first-tier entities, downstream entities, or related entities. CNC maintains ultimate responsibility for adhering to and otherwise fully complying with all applicable federal and state statutory, regulatory, and other requirements related to the delivery of the Medicare benefits, including the compliance plan requirements found at 42 C.F.R. § 423.504(b)(4)(vi)(H). CNC will work in an ongoing manner with the appropriate entities to detect and prevent FWA as is required by the CMS Prescription Drug Benefit Manual, Ch. 9 and 21– Part D and C Program to Control FWA.

Furthermore, self-reporting plays a critical role in reducing FWA and maintaining program integrity. Therefore, CNC will self-report potential fraud discovered at the plan, first-tier entity, downstream entity, or related entity levels to the appropriate entities. In doing so, CNC may receive the benefits of voluntary self-reporting found in the False Claims Act and federal sentencing guidelines. Self-reporting offers plans the opportunity to minimize the potential cost and disruption of a full scale audit and investigation, to negotiate a fair monetary settlement, and to potentially avoid an OIG permissive exclusion preventing CNC from doing business with the Federal health care programs. CMS strongly encourages plans to immediately self-disclose marketing violations to CMS and proactively report any corrective action measures that they have taken to respond to any violations. Both the DOJ and the OIG also have longstanding policies favoring self-disclosure. The Provider Self-Disclosure Protocol for the DHHS OIG can be found at 63 Fed. Reg. 58,399-403 (1998).

LAW & REGULATIONS RELATED TO FWA:

- a. 42 CFR § 423.504(b)(4)(vi)(H)
- b. CMS Prescription Drug Benefit Manual, Ch. 9 and 21– Part D and C Program to Control FWA
- c. Anti-Kickback Regulations – 42 U.S.C.A. § 1320a-7b(b)
- d. Stark Law Amendments – 42 U.S.C. § 1395nn
- e. Mail and Wire Fraud – 18 U.S.C. § 1341
- f. False Claims Act – 31 U.S.C. § 3729-33
- g. HIPAA – 45 CFR, Part 164

h. Provider Self-Disclosure Protocol – 63 Fed. Reg. 58,399-403 (1998)

PROCEDURE:

A. Initiate Reasonable Inquiry

1. When the Compliance Officer becomes aware of the potential instance of FWA, s/he should initiate a reasonable inquiry immediately, but no later than two weeks from the date that the potential misconduct is identified.
2. If the Compliance Officer determines that CNC has adequate time, resources, and experience to investigate the potentially fraudulent activity, he/she should initiate such an investigation to determine whether potential fraud or misconduct has occurred.
3. CNC must conclude investigations of potential misconduct within a reasonable time period after the potentially fraudulent activity is discovered and complete a FWA Investigation Report form (see Attachment). If after conducting a reasonable inquiry it is determined that potential fraud or misconduct has occurred, the conduct must be reported to the appropriate entity or entities promptly, but no later than 30 days after the misconduct has been detected, unless an alternate timeframe is specified.

Additional instructions for reporting potential FWA to the MEDIC:

- To the extent that potential fraud is discovered at the first-tier entity, downstream entity, or related entity levels, the Compliance Officer should report the conduct to the MEDIC sooner so that the MEDIC can help identify and address any scams or schemes.
- If the Compliance Officer determines that CNC does not have adequate time, resources, or experience to adequately investigate the potentially fraudulent misconduct, s/he should report the matter to the MEDIC within two weeks from when the potentially fraudulent or abusive activity is discovered.

B. Determine Which Entity (or Entities) to Report to: To be clear, a single incident may be reported to multiple entities. A report should be made to each entity that has jurisdiction over the incident.

1. Health Care Fraud Prevention and Enforcement Action Team (HEAT):

Reports of FWA to the DOJ and OIG's HEAT are made to the OIG. Such reports may include the following: false/fraudulent claims submitted to Medicare/Medicaid, kickbacks/inducements for referrals by Medicare/Medicaid providers, medical identity theft involving Medicare and/or Medicaid beneficiaries, door-to-door solicitation of Medicare/Medicaid beneficiaries, misrepresentation of Medicare private plans, abuse/neglect in nursing homes and other long term care facilities, and fraud/waste in American Recovery and Reinvestment Act grants.

Reports of failure to safeguard medical information (i.e., HIPAA violations) should not be forwarded to the OIG, but rather the DHHS Office for Civil Rights.

For additional examples of instances that should and should not be reported to the DHHS OIG, visit <http://oig.hhs.gov/fraud/report-fraud/index.asp>.

2. Centers for Medicare and Medicaid Services (CMS):

Potential internal and external marketing violations made known to CNC should be

reported to CMS. CNC will complete the CMS Surveillance Marketing Allegation Response Team (SMART) Referral Form upon request, or upon suspected marketing misrepresentation warranting an investigation from CMS.

If CMS contacts CNC in response to an allegation through the CMS Surveillance Module on HPMS, CNC will provide a thorough response to CMS within five business days, unless otherwise specified. The timeframe starts on the next business day following the receipt of the notification.

3. Medicare Drug Integrity Contractor (MEDIC):

Any suspected FWA in Medicare Part C or D should be reported to Health Integrity, LLC, CNC's designated MEDIC. Fraud cases may involve beneficiaries, pharmacies, physicians or other providers, health plans, or other organizations. For specific examples, see the CMS Prescription Drug Benefit Manual, Ch. 9 § 70 or Pharmacy Policy and Procedure: Part D Program to Control FWA.

In addition, cases meeting any of the following criteria should be reported to the MEDIC:

- Potential criminal, civil, or administrative law violations;
- Allegations extending beyond the PDP/MAPD, involving multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of fraud;
- Pattern of fraud or abuse threatening the life or well-being of beneficiaries; or
- Schemes with large financial risk to the Medicare Program or beneficiaries.

4. Reporting to Texas Department of Insurance

The Compliance Officer should fill out a Request for Assistance Form **within 60 days** of determining that a contracted agent, broker, or field marketing organization (FMO) engaged in marketing misconduct.

C. Create Report - Unless otherwise specified, the Compliance Officer should develop a report that includes, to the extent available, the following:

- Plan name, organization, and contact information for follow up
- Summary of the Issue
 - Include the basic who, what, when, where, how, and why
 - Any potential legal violations
- Specific Statutes and Allegations
 - List civil, criminal, and administrative code or rule violations, state and federal
 - Provide detailed description of the allegations or pattern of fraud, waste, or abuse
- Incidents and Issues
 - List incidents and issues related to the allegations
- Background information
 - Contact information for the complainant, the perpetrator or subject of the investigation, and beneficiaries, pharmacies, providers, or other entities involved
 - Additional background information that may assist investigators, such as names and contact information of informants, relators, witnesses, websites, geographic locations, corporate relationships, networks.
- Perspectives of Interested Parties
 - Perspective of Plan, CMS, beneficiary

- Data
 - Existing and potential data sources
 - Graphs and trending
 - Maps
 - Financial impact estimates
- Recommendations in Pursuing the Case
 - Next steps, special considerations, cautions

D. Send Report – Once the above information is collected, it should be detailed in the appropriate form, if applicable, and sent to the appropriate entity or entities:

1. Health Care Fraud Prevention and Enforcement Action Team (HEAT):

i. Telephone (Hotline): 1-800-HHS-TIPS (1-800-447-8477)

ii. Online: <http://oig.hhs.gov/fraud/report-fraud/report-fraud-form.asp>

iii. Fax: 1-800-223-8164; in order to accept submissions for review via facsimile, the OIG Hotline requires a complaint to include a formal cover letter or the use of the downloadable complaint submission form available at http://oig.hhs.gov/fraud/report-fraud/hotline_complaint_submission_form.pdf.

iv. Email: hhstips@oig.hhs.gov

v. Mail:

Office of Inspector General
Department of Health & Human Services
ATTN: HOTLINE
PO Box 23489
Washington, DC 20026

2. Centers for Medicare and Medicaid Services (CMS)

- Email: Surveillance@cms.hhs.gov

3. Medicare Drug Integrity Contractor (MEDIC):

- Reporting Forms:

MEDIC Compromised ID Report Form - Use this form only if reporting potential theft of a beneficiary's HICN or a prescriber's identifier, often called compromised identifiers. Transmit this form via fax.

4. Texas Department of Insurance (DOI):

- Telephone: 1-800-252-3439
- Email: FraudUnit@tdi.state.tx.us

E. Follow-Up

1. Health Care Fraud Prevention and Enforcement Action Team (HEAT):

An OIG analyst will review the report for relevance and completeness. Not all reports result in an investigation. A reviewing official may contact CNC for further information.

The OIG Hotline is not authorized to disclose any information on records in its possession: the Hotline will not be able to confirm receipt of the report, respond to any inquiries about action taken on the report, or provide the status of reports.

However, a request for pertinent Federal agency records may be made through the OIG Freedom of Information Act (FOIA) officer. A request may be submitted through the following means:

Online: <http://oig.hhs.gov/foia/submit.asp>

Mail:

OIG Freedom of Information Officer
Cohen Building, Suite 1062
Department of Health and Human Services
330 Independence Ave, S.W.
Washington, D.C. 20201
Fax: (202) 205-4030

When submitting a request, phrase the request in terms of a search for records pertinent to the report, not status. Wait at least six months before filing such a request. Fees may apply.

2. Medicare Drug Integrity Contractor (MEDIC):

The MEDIC will further investigate reports from CNC, develop the investigations, and make referrals to appropriate law enforcement agencies or other outside entities when necessary. To the extent it is feasible; the MEDIC will keep CNC informed of the development and status of the investigation. If the MEDIC determines a referral to be a matter related to non-compliance or mere error rather than fraud or abuse, it will be returned to CMS and/or CNC for appropriate follow-up.

MEDIC investigators may contact CNC to discuss details or obtain written documents or other information.

- If the MEDIC requests additional information, the Compliance Officer shall furnish the requested information **within 30 days**, unless the MEDIC otherwise specifies.
- Additionally, the Compliance Officer should provide updates to the MEDIC when new information regarding the matter is identified.

All cases referred to the MEDIC are to receive:

- An acknowledgement letter within **five days** and
- A resolution letter once the case has reached a conclusion.

F. Record Keeping

Any information related to a potential fraud case should be retained for **ten years**. Specifically regarding providers, CNC must maintain files on providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes enrollee complaints, NBI MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal health care program requirements. CNC must also maintain files that contain documented warnings (i.e., fraud alerts) and

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educational contacts, the results of previous investigations, and copies of complaints resulting in investigations.

CROSS-REFERENCED DOCUMENTATION:

N/A

REVISION HISTORY		
Description of Change	Author	Effective Date

RELEVANT REGULATORY CITATIONS	
Document	Title
Code of Federal Regulations	42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)
Medicare Managed Care Manual	Chapter 21 – Compliance Program Guidelines
Prescription Drug Benefit Manual	Chapter 9 – Compliance Program Guidelines

Review/Approval Date:

Signature on File

Signature

10/22/2015

Approval Date

care@care

Insurance Company, Inc.