Health Partners Plans HPP

Health Partners Plans' Compliance Program

The Centers for Medicare and Medicaid Services (CMS) and the Pennsylvania Department of Human Services (DHS) take the protection of their consumers seriously. They pass that responsibility to Health Partners Plans (HPP), as we are a Managed Care Organization (MCO) held directly accountable for delegate activities and performance by CMS and DHS for government programs.

HPP's Compliance Program (referred to herein as the "Compliance Program") embodies dedication to the highest standards of ethical behavior, expressed through corporate culture and adherence to all state and federal laws, government regulations, and contractual requirements. It is vital that all HPP employees, volunteers/student interns, temporary employees, officers (referred to herein as "employees"), subcontracted agents/entities (including network providers), and consultants who perform healthcare and/or administrative services (referred to herein as "vendors"), comprehend the process of compliance and gain the knowledge and tools to uphold a "Compliance First" culture. Compliance is critical to the success of our organization.

It is HPP's intent to uphold integrity through ethical and legal conduct in the operation of our business, the provision of insurance coverage for health care and prescription drug services and the participation in government health care programs. HPP continually strives to earn and maintain a reputation for lawful and ethical behavior in the treatment of our customers, and in our relations with health insurance purchasers and health care providers.

As part of HPP's commitment to legal conduct, we have adopted standards to protect against unlawful activity. This Compliance Program specifically addresses HPP's commitment to comply with all applicable state and federal regulations, as well as set out a broader commitment to ethical and legal behavior for all employees and staff who provide services in support of the Medicare, Medicaid and CHIP programs. HPP does not condone questionable or criminal conduct by employees, other entities or individuals with whom we do business.

It is important that the Compliance Program be read thoroughly and in its entirety. Please feel free to contact the Compliance Department if you have any questions regarding information contained within this Compliance Program document.

The Compliance Program aims to advance quality in all respects by adhering to four hallmark commitments:

1. **Encourage** commitment and dedication to standards adopted under the Compliance Program by utilizing the best industry practices and methodologies to improve the health status of the community while providing high-quality health services and upholding the highest ethical and legal standards.
2. **Provide** a compliance culture that encourages employees to seek guidance and support regarding business practices. The compliance environment must be open, and employees are comfortable reporting potential violations without fear of retaliation or retribution for their actions.
3. **Conduct** operations utilizing the highest standards of ethical behavior and act with dignity and respect. To identify and mitigate potential compliance risks by employing reengineering processes; thereby, increasing our efficiency, and staying compliant.
4. **Identify** and mitigate potential compliance risks by employing reengineering processes, thereby increasing efficiency to stay compliant.

The Compliance department ensures that HPP comprehends and complies with all state and federal laws, as well as contractual requirements impacting the Medicare, Medicaid, and CHIP lines of business. The Compliance Program meets the obligations specified in regulatory and sub-regulatory guidance

from CMS which were based upon the United States Federal Sentencing Guidelines' seven elements for compliance plans. Federal regulations at 42 C.F.R. §§§422.503, 423.504, and 438.608 specify the requirements for organizations to implement an effective Compliance Program. These elements are defined explicitly within the CMS Compliance Program Guidelines found in Chapter 9 of the Prescription Drug Benefit Manual, Chapter 21 of the Medicare Managed Care Manual, as well as our State Medicaid and CHIP contracts.

To achieve these goals, HPP has adopted and implemented an effective compliance program, which includes measures to prevent, detect and correct program non-compliance, as well as Fraud, Waste, and Abuse (FWA). Our Compliance Program includes the following core requirements:

1. Written Policies, Procedures, and Standards of Conduct;
2. Compliance Officer, Compliance Committee and High-Level Oversight;
3. Effective Training and Education;
4. Effective Lines of Communication;
5. Well-Publicized Disciplinary Standards;
6. Effective System for Routine Monitoring and Identification of Compliance Risks; and
7. Procedures and System for Prompt Response to Compliance Issues.

HPP is in the business of providing and arranging for health care and prescription drug services for various government-sponsored programs. In this industry, laws and regulations exist for virtually every aspect of the transaction of business with HPP, including, but not limited to financial reporting and solvency, contract terms and conditions, call center operations, appeals and grievances, quality improvement, utilization management, marketing and sales, enrollment and disenrollment procedures, premium billing and collection, claims adjudication and general business practices. Every employee is expected to comply with all applicable laws and regulations on the federal and state levels. All employees are under a continual obligation to familiarize themselves with the laws and regulations affecting their jobs and put forth their best efforts to ensure ongoing compliance.

Our reputation can be severely damaged and HPP can face financial penalties and sanctions if even one employee violates the law. Concerns about illegal conduct or potential fraud committed by employees or those we interact with outside of HPP should always be reported. All reported incidents will always be taken seriously, fully investigated and followed through with appropriate corrective action.

Compliance Program Operation

Written Policies, Procedures, and Standards of Conduct:

HPP maintains detailed, specific, and descriptive written policies, procedures, and standards of conduct that:

1. Articulates our commitment to comply with all applicable Federal and State standards;
2. Describes compliance expectations as embodied in the Code of Business Conduct (COBC);
3. Implements the operation of our Program;
4. Provides guidance to employees and others on dealing with suspected, detected, or reported compliance issues;
5. Identifies how to communicate compliance issues to appropriate compliance personnel;
6. Describes how suspected, detected, or reported compliance issues are investigated and resolved by HPP; and
7. Includes a policy of non-intimidation and non-retaliation for good faith participation in the Program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

HPP's COBC states the overarching principles and values by which HPP operates, describes our expectations of conduct for all employees, and communicates to employees and our vendors that compliance is everyone's responsibility. The COBC is maintained by HPP's Legal Affairs Division, with contributions by the Human Resources and Privacy & Security departments. The COBC is updated

periodically to reflect changes in applicable laws, regulations, and other program requirements. In addition to the COBC, HPP has developed an extensive set of policies and procedures to assist with implementing the Compliance Program, which includes ensuring compliance and articulating HPP's commitment to comply with all applicable laws. As is the case with our COBC, policies, and procedures are updated periodically to reflect these changes in law or guidance.

HPP's written policies, procedures, and Standards of Conduct are distributed to all employees within 90 days of hire and are always available on HPP's intranet site for employees to access. For employees, initial distribution is tracked via attestation and through HPP's learning management system. For vendors, distribution occurs at the time of contracting and annually thereafter and is tracked via attestation.

HPP requires that all departments develop policies and procedures (P&P) related to the functions that fall under their purview. All corporate P&Ps are held in Legal Affairs through the P&P repository, DocMan. In addition to the use of DocMan, the Compliance department maintains a repository of departmental P&Ps, which are easily accessible to all employees via the Compliance intranet site. Compliance departmental P&Ps are also available to non-HPP employees involved in HPP's operations (e.g., vendors, consultants, etc.) upon request. Requests for departmental specific P&Ps should be sent to RegulatoryCompliance@hpplans.com. Provided below is a list of available Compliance departmental P&Ps. This list may change over time as the Compliance department reassesses the need for additional procedures or decides to retire existing procedures.

- Compliance- Departmental Structure and Operation Policy
- Compliance Audit Process
- Compliance Channels of Communication
- Compliance Corrective Action Plans
- Compliance Department Referrals of FWA to the SIU
- Compliance Monitoring Program
- Compliance Policy and Procedure Review
- Compliance Risk Management
- Compliance-Well-Publicized Disciplinary Standards
- FDR Compliance Oversight
- FDR Onboarding and Auditing
- Independent Auditor Validation Process
- Instructions for Requesting Access CMS Systems
- Medicare Audit Catalog
- Medicare Communications-Marketing Material Review
- Medicare Provider Compliance Procedure
- Regulatory Communication Management

Compliance Officer, Compliance Committee, and High-Level Oversight:

In accordance with HPP's dedication to compliant and ethical conduct, HPP ensures that its Compliance Officer is integrated into the organization at all levels and given the credibility, authority, and resources necessary to operate a robust and effective Compliance Program. To this end, HPP maintains a designated:

- Compliance Officer; and also active
- Compliance Committee

HPP's Compliance Officer is vested with the day-to-day operations and implementation of the Compliance Program, as well as chairs the Compliance Committee. The Compliance Officer directly reports to HPP's Chief Legal Officer & Head of Legal/ Risk and has unfiltered access to report as appropriate to the Chief Executive Officer (CEO). In addition, the Compliance Officer provides

routine reports on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance Program, and has ready access to HPP's CEO and senior management. The Compliance Officer regularly attends meetings of HPP's Board of Directors' (BOD) Audit Committee (referred to herein as "Audit Committee") to provide in-person reports. Consistent with regulatory guidance, HPP's Audit Committee exercises reasonable oversight with respect to the implementation and effectiveness of our Compliance Program. Furthermore, HPP's Audit Committee is responsible for approving Compliance work plans and HPP's COBC.

HPP's Compliance Committee is tasked with oversight of the Compliance Program. The Compliance Committee is comprised of a cross-section of individuals within various HPP business units, and each has decision-making authority in their respective areas of HPP business.

The Compliance department's scope is comprehensive and includes all matters relevant to HPP's compliance with contractual, regulatory, and sub-regulatory guidance. The Compliance department is responsible for identifying, reviewing, interpreting, and implementing all compliance matters consistent with CMS, Office of Inspector General (OIG), and DHS Compliance Program guidance. An additional charge of authority is as follows:

- Review, analyze, and interpret all regulatory and sub-regulatory guidance applicable to HPP's business as an MCO and serve as a communication vehicle of said guidance to all areas of HPP business;
- Distribute significant policy and guidance developments to all areas of HPP business as they relate to the Medicare, Medicaid, and CHIP programs;
- Review and identify all auditing and monitoring activity across the business related to Medicare/ Medicaid/ CHIP program requirements;
- Communicate governmental compliance enforcement activity, including Notices of Non-compliance, Warning Letters, Corrective Action Plans, and/ or more formal sanctions;
- Implement and monitor corrective actions needed to mitigate and prevent any occurrence of program non-compliance;
- Develop necessary tools and strategies to ensure proper and sustainable operational compliance;
- Ensure business units are aware of the need to have established policies and procedures to maintain compliance with all relevant contractual, regulatory, and sub-regulatory guidance;
- Serve as an authoritative source to develop and implement additional mechanisms to support the sustainability of HPP's Compliance Program, as needed

To support the Compliance department, duties of the Compliance Committee include, but are not limited to:

- Meeting at least quarterly, or more frequently as necessary to enable reasonable oversight of the compliance program;
- Developing strategies to promote compliance and the detection of any potential violations;
- Discussing potential or actual risks to assist with the creation and implementation of the compliance risk assessment and the compliance monitoring and auditing work plan;
- Assisting in the creation, implementation, and monitoring of effective corrective actions if needed;
- Reviewing and approving the annual Compliance Work Plan;
- Reviewing the effectiveness of the system of internal controls designed to ensure compliance with regulations in daily operations;
- Supporting the Compliance department's needs for sufficient staff and resources to carry out duties;
- Reviewing and addressing reports of monitoring and auditing of areas in which HPP is at risk for program non-compliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness.

Effective Training and Education:

HPP provides effective training and education for all employees, staff, and vendors. Compliance and Fraud, Waste and Abuse (FWA) training and education occur during New Employee Orientation (typically first day of hire) and on an annual basis thereafter. HPP employees are trained in person and via online training modules.

When necessary, HPP will provide Compliance and FWA education within 90 days of a contract to vendors via the provision of materials and an associated attestation process. Compliance and FWA education materials are updated whenever material changes in regulations, policy, or guidance require it and are also reviewed annually.

HPP's Compliance training and education communicate information regarding HPP's Compliance Program, including a review of policies and procedures, the COBC, and HPP's commitment to compliance with all regulatory requirements. Both the Compliance training content and educational materials provide information regarding reporting compliance issues/ concerns or asking compliance-related questions. HPP's training clearly emphasizes confidentiality, anonymity, and non-retaliation for compliance-related questions or reports of suspected or detected non-compliance or potential FWA. Furthermore, it communicates the requirement of all employees and vendors to report actual or suspected non-compliance or potential FWA.

HPP's FWA training and education communicate information regarding laws and regulations related to FWA including, for example, False Claims Act, Anti-Kickback Statute, and HIPAA/HITECH. Processes for HPP's and our vendors' employees to report suspected FWA to HPP are inherent within HPP's training and education, including protections for anyone who reports suspected FWA in good faith.

In addition to HPP's Compliance and FWA training, HPP employees working in the functional areas must understand and keep up with a wide range of regulations, contractual requirements, data reporting requirements, policy guidance, and CMS manuals that pertain to their specialized work. To facilitate the process of keeping abreast of constantly evolving requirements, each department is expected to conduct ongoing training sessions on an as-needed basis, covering topics of specific concern for that department. For example, when a revised Medicare Managed Care Manual (MMCM) chapter is released by CMS, the department(s) affected by the revisions may develop and conduct a special training session to educate the employees in that department on the revised policies. The department manager is responsible for determining specialized training needs and scheduling training sessions in a timely manner. Each department is advised to collect documentation of attendance and training content and is expected to forward the documentation to HPP's Learning and Development unit to maintain employee files.

In addition to training applicable department staff on newly issued or updated policy guidance, regulations, contractual requirements, CMS manual chapter updates, etc., each department is expected to revise and update its policies and procedures, desktop procedures, manuals, etc., to reflect the new or revised policies if necessary.

Consistent with regulatory guidance, HPP's Audit Committee exercises reasonable oversight with respect to the implementation and effectiveness of our Compliance Program. The Audit Committee and the BOD receive general Compliance and Fraud, Waste and Abuse training and education on an ongoing basis (upon appointment and annually thereafter) for the purpose of understanding HPP's compliance program structure and remaining informed about Compliance Program activities, notably regarding the operation of the Program.

Effective Lines of Communication:

HPP maintains various lines of communication intended to allow for accessibility to and from employees, staff, vendors, and HPP's Compliance Program. When warranted, HPP ensures the utmost confidentiality and also allows compliance issues to be reported anonymously, if so desired by the reporter. This is embodied in the COBC, in addition to numerous policies and procedures throughout the organization. The methods available for reporting compliance or FWA concerns and the non-retaliation policy are publicized throughout HPP's facilities, are provided to vendors with encouragement to do the same, and are included in multiple compliance training initiatives. Nearly all reporting mechanisms are available 24/7, and none are encouraged any more or less than another.

HPP must have an effective way to communicate information from the Compliance Officer to

others. Such information includes but is not limited to laws, regulations, and guidance impacting our Medicare, Medicaid, and CHIP lines of business. The Compliance department will ensure updated laws, regulations, and guidance that impacts HPP is disseminated to the impacted business area(s) on an ongoing basis (whenever necessary).

For example, the most common communication of information from the Compliance department consistent with this element is that of CMS-issued sub-regulatory requirements, typically in the form of HPMS memorandums. Information is communicated via email distribution and may be discussed further via email communications, individual and/or group meetings as needed. In all instances, the Compliance department strives to disseminate information as soon as possible, if not always within a reasonable time, and to all appropriate parties. The Compliance department maintains a repository of regulatory communications received and tracks any necessary actions taken in response to the communication. This repository is easily accessible to all employees via the Regulatory Communications module located on the Compliance intranet site.

HPP maintains a system to receive, record, respond to and track compliance questions or reports of suspected or detected non-compliance or potential FWA from employees, staff, and vendors (including their employees). In nearly all instances, reports are kept confidential to the greatest extent possible and, in some cases, allow for total anonymity should the reporter so desire. Anonymity is made available through an externally sourced hotline that provides the Compliance Officer and other members of senior management with immediate access to reports. Retaliation or retribution against employees or vendors who, in good faith, report suspected non-compliance or FWA is unacceptable and expressly prohibited. HPP's non-retaliation policy conveys a zero-tolerance approach towards non-retaliation policy violations and is widely publicized by HPP.

Reporting Concerns

- To report actual or suspected non-compliance or FWA, email Compliance@hpplans.com
- For general inquiries or requests for information from the Compliance department, email RegulatoryCompliance@hpplans.com
- Complete and submit anonymously online: EthicsPoint online reporting tool
- Call the anonymous HPP Hotline: **1-866-477-4848**
- Reports of suspected FWA can also be sent directly to HPP's Special Investigations Unit (SIU) by emailing SIUtips@hpplans.com
- Reports of suspected FWA can also be submitted to the Office of Inspector General/Health and Human Services (OIG/HHS), Centers for Medicare and Medicaid Services (CMS), or Pennsylvania Department of Human Services (DHS) Fraud & Abuse Hotlines (**Anonymous**).
  - OIG Hotline: 1-800-HHS-TIPS (1-800-447-8477)
  - CMS Hotline: 1-800-MEDICARE (1-800-633-4227)
  - DHS Hotline: 1-866-DPW-TIPS (1-866-379-8477)

HPP has established reporting mechanisms to ensure that members/ beneficiaries/ enrollees or their caregivers can easily report compliance issues and FWA concerns anonymously. Reporting can be initiated via the HPP internet site or by calling the same hotline as identified above.

In addition to the above communication channels, employees and vendors can report issues directly to Compliance, Privacy & Security, SIU, Legal, or their supervisor. All reports will remain confidential to the greatest extent possible.

Title/Area of Responsibility	Employee & Email Address	Number
HPP's Compliance Officer -**OR**- Compliance team	Shawn Adams SAdams@hpplans.com RegulatoryCompliance@hpplans.com	267-385-3854
Chief Legal Officer & Division Head for Legal, Compliance, and Risk Management	Johnna Baker, Esq. jbaker@hpplans.com	215-991-4051
Chief Information Security Officer (Thomas Jefferson University & Jefferson Health)	Mark Odom Mark.Odom@jefferson.edu	215-503-2439
HIPAA Privacy Manager (HIPAA Privacy & Security Officer) -**OR**- HPP Privacy Office	Prerna Dahiya pdahiya@hpplans.com PrivacyOfficial@hpplans.com	215-991-4154
Director of SIU (FWA)	Christian Sondergaard csondergaard@hpplans.com	215-991-4046

For reports to the Compliance department, Compliance will acknowledge, assess, investigate to the extent warranted, and respond to all compliance questions and reports of suspected or detected noncompliance. Appropriate actions will be taken in accordance with HPP's Compliance policies and procedures regarding monitoring, auditing, and risk assessment and management.

Note: In the event of an instance of significant non-compliance, the Compliance Officer or their designee will report such incident to CMS (Medicare) or DHS (Medicaid and CHIP) as soon as possible after discovery, in accordance with relevant regulatory requirements and guidance. For issues related to FWA, when appropriate, the SIU will report such incidents to the appropriate agencies (e.g. DHS Bureau of Program Integrity, Investigations Medicare Drug Integrity Contractor (I-MEDIC), OIG, etc.)

Non-compliance is conduct that does not conform to the law, Federal or State health care program requirements, or an organization's ethical and business policies. If HPP employees or those with whom we do business with observe non-compliance in the workplace, they are required to report it to the Compliance department. When necessary, depending on the details of the issue reported, the Compliance department may need to coordinate or refer issues to the Legal Affairs department, Privacy Office, or the SIU to address such issues. Examples of non-compliance include but is not limited to:

1. Insufficient administration of health plan operations
2. Failure to follow operational procedures
3. Failure to properly administer benefits (e.g., Misconduct related to payment or delivery of items or services under the contract);
4. Marketing or advertising our products to members in a way that violates rules
5. Violations of our Code of Business Conduct or Compliance Program
6. Failing to follow regulatory and/ or contractual requirements such as:
    - Medicare Advantage and Prescription Drug Benefit Program requirements
    - HealthChoices contract requirements
    - CHIP contract requirements
    - sub-regulatory guidance issued by a regulatory agency

Although not an all-inclusive list, provided below is a list of areas that CMS has identified to be high-risk for Managed Care Organizations:

- Agent / broker misrepresentation;
- Appeals and grievance review (for example, coverage an organization determinations);
- Beneficiary notices;
- Claims processing;
- Credentialing and provider networks;
- Documentation and Timeliness requirements;
- Ethics;
- Delegated Vendor oversight and monitoring;
- Marketing and enrollment;
- Pharmacy, formulary, and benefit administration; and
- Quality of care.

Examples of fraudulent activity that should be reported to the SIU may include, but is not limited to:

Fraud by Members (may include but is not limited to):

- Submitting false information or omitting material information on a group or individual;
- Submitting false information on application or enrollment forms;
- Forging or altering applications, enrollment forms, prescriptions, etc.;
- Filing false claims;
- Misuse of a member identification card (whether for Medical or Prescription Drug Utilization).

Fraud by Providers (may include but is not limited to):

- Filing claims for services not performed;
- Filing claims for unnecessary or inappropriate services that were performed; Filing claims for more extensive or complicated services than were performed;
- Submitting incorrect information or omitting material information on a provider credentialing application;
- Misrepresentation of the provider who administered a service.

Fraud by Employees (may include but is not limited to):

- Paying claims that are known to be false;
- Distorting, altering or destroying applications, enrollment forms, member materials, medical records, physician referrals, etc.;
- Submitting false information to a government agency.

Well-Publicized Disciplinary Standards:

HPP maintains well-publicized disciplinary standards through the implementation of procedures that encourage good faith participation in the compliance program by all affected individuals. Disciplinary standards include policies that articulate HPP's expectations for identifying non-compliance or unethical behavior, reporting compliance issues, assisting in their resolution, and providing timely, consistent, and effective enforcement of the standards when such behavior is determined. HPP's disciplinary policies and procedures reflect clear and specific disciplinary standards and describe our expectations for the reporting of compliance issues, including non-compliant, unethical, or illegal behavior.

Disciplinary action must be administered consistently and in a non-discriminatory manner. It must be fair and equitable, appropriate to the seriousness of the violation. Depending on the severity of the violation, progressive steps in the disciplinary action process may be omitted if appropriate so that immediate corrective measures, including termination, can be taken.

Disciplinary Standards for Employees for COBC Violations

For details related to disciplinary actions that may be taken against employees for violations pertaining to the COBC, please refer to the section of HPP's COBC titled "Disciplinary Standards for Employees for COBC Violations."

Consistent with HPP's COBC, any time an employee observes or suspects a violation of the COBC, Compliance Program, the law, or our policies, they are obligated to report it. HPP maintains various lines of communication intended to allow for accessibility to and from employees, staff, vendors, and the Compliance department. When warranted, HPP ensures the utmost confidentiality and also allows compliance issues to be reported anonymously, if so desired by the reporter. This is embodied in HPP's COBC, in addition to numerous policies and procedures throughout the organization. For details related to reporting methods, please refer to the section of HPP's COBC titled "Reporting Your Concerns."

The intent of the disciplinary process is to improve performance and eliminate non-compliance, misconduct, or corporate violations. For the most effective use of disciplinary action, employees must be familiar with the scope of their job responsibilities, applicable laws, regulations, and contractual requirements. Furthermore, they must be well-informed of HPP's policies and departmental requirements so that infractions are quickly and accurately identified.

Examples of the types of infractions or violations for which disciplinary or corrective action may be taken include, but are not limited to:

- Non-compliance with laws, regulations, contractual requirements, policies, or procedures;
- Encouraging or assisting another to engage in non-compliance;
- Failure to report non-compliance;
- Failure to detect non-compliance by an individual who should have detected such non-compliance;
- Knowingly submitting a false, malicious, or frivolous report of non-compliance against other employees.
- 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 non-compliance.

The above 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. As stated, the list is not exhaustive of all types of conduct that may constitute grounds for disciplinary action.

No employee shall be disciplined solely because s/he reported what was reasonably believed to be an act of wrongdoing. Procedurally, a thorough investigation must be conducted before disciplinary action is administered. Depending on the situation, the investigation may be conducted by the supervisor, manager, Human Resources, Compliance Officer, HPP's Chief Legal 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 in accordance with their departmental policies and procedures or, in the absence thereof, with HPP's Human Resources policy.

Depending on the situation, the supervisor or manager may need to discuss the action with the next level of management, the Compliance Officer, internal Legal Counsel, external counsel or consultants, or Human Resources to ensure appropriate applicability, documentation, and procedural steps. The nature and seriousness of the infraction, all relevant facts and information, and any mitigating or aggravating circumstances should be considered when formulating disciplinary action.

The level of discipline assessed for all violations should be determined on a case by case basis, and HPP must be able to demonstrate that disciplinary standards are enforced in a timely, consistent and effective manner. All violations impacting regulatory Compliance must be brought to the attention of the Compliance Officer irrespective of any prior Compliance involvement.

As a general rule, disciplinary standards are contingent upon the severity of the offense and the intent of the offender. For infractions of the Compliance Program, the level of intent is paramount when recommending disciplinary action for violations. Intent may fall into one of three categories:

a) Negligent: Failing to take proper care of something

b) Reckless: Failing to appreciate the consequences of one's actions; acting hastily

c) Intentional: Done with purpose and deliberation

Circumstances that may be considered to be mitigating factors include:

- The employee reported the violation promptly
- The employee cooperated with HPP 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 HPP 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 before 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 misconduct found or acknowledged by the employee evidence 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 HPP policies and procedures;
- The employee's misconduct significantly harmed HPP;
- The employee demonstrated indifference toward rectification of or atonement for the consequences of their misconduct; and
- The employee displayed a lack of candor or cooperation with HPP during the investigation or disciplinary process.

Disciplinary Standards for Delegated Vendors

All of HPP's vendors must comply with all applicable Federal and State laws, regulations, and communications, adhere to their contractual obligations and comply with the terms of the COBC and Compliance Program.

To meet these requirements, vendors have the following responsibilities:

- Participate in Compliance and FWA training (when necessary) and education
  - Compliance and FWA education are completed via the provision of materials.
- Comply with the terms of their contract with HPP, including all associated exhibits and/ or addendums, as well as the Business Associate Agreement (BAA), which includes, but is not limited to:
  - Perform Excluded Entity Checks against the Office of the Inspector General List of Excluded Entities and Individuals (OIG LEIE), the System for Awards Management (SAM) database and Medicheck (when applicable);
  - Record Retention;
  - Oversight of Downstream Entities;
  - MCO's Right to Audit, Evaluate, and Inspect Records;
  - Protection of Personal Health Information (PHI);
  - Adherence to Health Insurance Portability and Accountability Act (HIPAA) regulations;
  - Comply with all applicable Federal and State laws, regulations, and instructions;
  - Maintain an effective compliance program —
    - All vendors are required to have an effective compliance program to ensure that the vendor is complying with the provisions within the contract, including all associated exhibits and/ or addendums, as well as the BAA, and operating under the appropriate Federal and State laws, rules, and regulations.
  - Report all potential non-compliance violations relating to HPP's business, including unethical or illegal behavior as noted in the COBC;
  - Adhere to the terms of the COBC.

HPP will thoroughly research any allegation of potential non-compliance or fraud, waste, and abuse in accordance with HPP's policies and procedures. The vendor shall assist in the resolution of reported issues as needed.

Once the Compliance Officer (or designee) has been made aware of an incident, s/he will assign a staff member the responsibility for the investigation. The Compliance department will initiate the investigation as quickly as possible, but no later than two (2) weeks after the date the potential non-compliance or incident was identified.

If it is determined that a vendor is not meeting compliance expectations or performing effectively as outlined in their contract or is in violation of the COBC, appropriate action will be taken. Such action may include, but is not limited to, training and education, corrective action, contract termination, and/ or reporting of non-compliant, unethical, or illegal behavior to the appropriate government agency (e.g., CMS, Department of Insurance, etc.). The seriousness of the violation of the COBC will determine the disciplinary action to be administered.

If the vendor's performance falls below the expectations of the contract, or if the organization engages in inappropriate conduct, disciplinary action will be taken.

Corrective counseling or discipline will be applied on a progressive basis except in certain situations involving misconduct (e.g., actions that affect HPP's reputation, such as falsifying company records, fraudulently submitting claims, etc.). HPP reserves the right to skip or repeat steps at its discretion. HPP reserves the right to terminate its contract with the vendor if it is determined that the organization has failed to comply with the provisions of its contract with HPP, including all associated exhibits and addendums, including but not limited to the Medicare Specific Provisions and Requirements Exhibit (if applicable) and the Medicaid & CHIP Specific Provisions & Requirements Addendum (if applicable), as well as the BAA, or HPP's COBC.

Provided below are examples of corrective counseling or discipline that may occur:

- **Verbal Counseling:** The nature of the performance standard or conduct is discussed with the vendor, and requirements for performance/conduct improvement are identified.

- **Written Warning:** If unacceptable performance or behavior continues, the vendor will be notified in writing of their failure to adhere to certain requirements. The written warning will define the desired outcome, establish deadlines, and document that no significant improvement has occurred since the verbal counseling. It also will identify any consequences that are a result of the entity's failure to comply.
- **Corrective Action Plan:** If the issue has not been resolved through verbal counseling or written warning, the vendor will be placed on a corrective action plan. The corrective action plan should detail the infraction, outline the action required to improve performance, identify consequences for failing to improve performance, and establish specific dates for performance discussion between HPP and the vendor entity and a time frame by which improvement must be made.
- **Suspension:** A suspension may be warranted when circumstances reasonably require an investigation of a serious incident in which an organization, or employee thereof, was allegedly involved; when repeated warnings have been unsuccessful in changing outcomes; or when there is a serious violation of either the contract, any associated exhibits and/ or addendums, the BAA, or COBC. Suspension is not a required step in the corrective action process.
- **Termination:** If it is determined that a violation is egregious enough, HPP retains the right to terminate its contract with the vendor

Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks:

HPP maintains effective systems for routine monitoring, auditing, and identification of compliance risks. Each component of internal monitoring, auditing, and risk assessment is intended to evaluate HPP's compliance with regulatory requirements and the overall effectiveness of our Compliance Program. HPP's monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance. HPP audits consist of more formal compliance reviews with a particular set of standards (e.g., policies and procedures, laws, regulations, and contractual requirements) used as base measures. For both monitoring and auditing efforts, HPP strives to ensure that corrective actions are undertaken and effective. On an annual basis, the Compliance department develops a monitoring and auditing work plan that address the risks associated with the Medicare, Medicaid, and CHIP lines of business. The Compliance Officer, Compliance Committee, senior leadership, and the Audit Committee are key participants in this process, and ultimately, the work plan requires Audit Committee approval.

HPP maintains policies and procedures that address each of these functions of monitoring, auditing, and risk assessment. Our risk assessment process is an ongoing process that considers all operational business areas, each of which is assessed for the types and levels of risk the area presents to HPP's lines of business. Risks identified by the assessment process are ranked by likelihood and severity to determine which risk items will have the most significant impact on HPP from a compliance perspective. These risks, in turn, feed the ongoing monitoring and auditing work plan with placeholders for notably high-risk items that are unforeseeable at the time the work plan is developed and approved. Risk areas identified through regulatory agency audits and oversight activities, as well as through HPP's monitoring, audits, and investigations, are considered priority risks.

The Compliance department relies heavily on its ongoing assessment of risk when developing its monitoring and auditing work plan. The work plan includes a schedule that lists the monitoring and auditing activities for the calendar year and is primarily arranged by the Compliance Program element, followed by the schedule. HPP includes internal audits of our operational areas as well as audits of our directly contracted vendors. Within HPP's policies and procedures, processes for responding to all monitoring and auditing results and for conducting follow-up reviews of areas found to be non-compliant can be found.

HPP's "Compliance Audit" function is performed within the Compliance department and includes Compliance department staff. Participants of HPP's audit function are knowledgeable about operational requirements for their respective areas under review, and when appropriate, are educated on new areas. On occasion, the Compliance department may request that operational business unit staff assist in audit activities provided the assistance is compatible with the independence of the audit function and the business unit's other responsibilities.

In addition to the development of the Compliance department's Work Plan, the Compliance team also

maintains a strategy to monitor and audit our vendors to ensure they are compliant with applicable laws, regulations, and our State Contractual requirements (when applicable- Medicaid and CHIP) and to ensure that they are monitoring the compliance of the entities with which they contract (the sponsors' "downstream" entities).

Aligned with the Compliance department's monitoring efforts of internal operational areas, the Compliance department also conducts specific monitoring of our vendors and their delegated responsibilities to ensure they fulfill program requirements. Due to resource constraints and in the interest of maximizing our Compliance Program effectiveness, this effort is largely based upon a vendor risk assessment that aims to identify our highest risk vendors and then target a reasonable number of these entities to audit or monitor more closely.

The Compliance department tracks and documents all compliance efforts using various mechanisms, including dashboards, reports, issue logs, and other mechanisms that show the extent to which operational areas and delegated responsibilities are meeting compliance thresholds and/ or goals. Compliance of operational areas is tracked by the Compliance department as well as various operational units, and issues of non-compliance identified in dashboards are shared with senior management.

Concerning exclusion screenings, HPP's Compliance department does not directly handle conducting exclusion screenings. HPP, through various business units, reviews the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and System for Award Management (SAM) - formerly the GSA Excluded Parties Lists System (EPLS), prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or vendor, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs. After entities are initially screened against the entire LEIE and SAM at the time of hire or contracting, HPP reviews these exclusions monthly. In addition to the OIG and SAM exclusion screenings, for the Medicare line of business, HPP reviews the CMS Preclusion List, which contains the names of prescribers, individuals, and or entities that are unable to receive payment for Medicare Advantage (MA) items and service and or Part D drugs prescribed or provided to Medicare beneficiaries. For the Pennsylvania Medicaid and CHIP lines of business, HPP also reviews the Medicheck Precluded Providers List.

HPP openly allows access to any auditor acting on behalf of the federal government, DHS, or CMS to conduct an on-site audit, as well as providing records to CMS/DHS or its designee upon request. To this end, HPP maintains an absolute cooperative policy with regard to cooperation with initiatives such as these and allows access as requested.

Procedures and System for Prompt Response to Compliance Issues

As described in HPP's COBC, and within this Compliance Program document, employees, members of the Board of Directors, and vendor (FDR/subcontractor) employees are required to report suspected or detected non-compliance, and potential FWA. To accommodate the various topics and to establish preferred communication methods, HPP has developed various user-friendly and easy-to-access methods of reporting. The Compliance department conducts timely inquiries into any compliance incidents or issues involving potential program non-compliance. The Compliance department will respond to, assess, and investigate to the extent warranted, all compliance questions and reports of suspected or detected non-compliance.

Once the Compliance department is made aware of suspected or detected non-compliance, they will:

- Triage the reported incident or inquiry
- Assign the incident or inquiry to a compliance representative for investigation
- Send an acknowledgement of receipt to the initiator within 3 business days
- Begin investigation as soon as possible but no later than 2 weeks after receipt
- Interview applicable individuals (internally at HPP as well as delegated vendor/ provider employees, if necessary);
- Request and review documentation pertaining to the incident;
- Identify potential risks related to or as a result of the incident;

- Provide a response/ resolution upon completion of the investigation
- Based on the nature of the issue, the Compliance department may issue an Improvement Action Plan (IAP)
- Incidents or inquiries involving FWA will be referred to HPP's SIU for review/ investigation
- Incidents or inquiries involving privacy/ security violations will be referred to the Privacy Office for review and investigation
- At times, depending on the nature of the incident or inquiry, the Compliance department, SIU, or Privacy Office may coordinate with the Legal Affairs division for investigation and resolution
- HPP will comply with the directives of government agencies

The Compliance department's investigative activities include a preliminary review of the matter by Compliance personnel, including the Compliance Officer and, as warranted, HPP's SIU, notably if the issue appears to involve potential fraud or abuse. See HPP's SIU Fraud, Waste, and Abuse Plan for additional information on responses to potential FWA reported.

Note: In the event of an instance of significant non-compliance, the Compliance Officer or their designee will report such incident to CMS (Medicare) or DHS (Medicaid and CHIP) as soon as possible after discovery, in accordance with relevant regulatory requirements and guidance. For issues related to FWA, when appropriate, the SIU will report such incidents to the appropriate agencies (e.g. DHS Bureau of Program Integrity, Investigations Medicare Drug Integrity Contractor (I-MEDIC), OIG, etc.)

HPP's ongoing monitoring of program non-compliance is shared with the appropriate regulatory agency during ongoing communications, and if necessary, is referred to either CMS or DHS for purposes of self-reporting and ensuring proper compliance remediation. In instances of identified non-compliance, the Compliance department bears responsibility for undertaking appropriate corrective actions in response to the degree of non-compliance. Corrective actions and mitigation thereof are designed to correct the underlying problem that results in the non-compliance at issue and to prevent future re-occurrence. Additionally, a root cause analysis determines what caused the non-compliance to occur.

HPP business units are tasked with overseeing their vendors; this includes ensuring that vendors both report program non-compliance that has been delegated to them, as well as ensuring the vendor(s) have corrected their deficiencies. HPP business leaders are held accountable for these vendors' activities and ensure their vendor counterparts have implemented the appropriate corrective actions. HPP also reserves the right to audit vendors, including ensuring that corrective actions were appropriately implemented.

To effectively identify issues pertaining to potential FWA, the Compliance department engages in activities including, but not limited to:

- **Auditing:** An audit is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. The Compliance department conducts audits to test and confirm compliance with regulatory/ sub-regulatory guidance, contractual requirements, as well as internal policies and procedures to protect against program non-compliance and potential FWA. If it is determined that there is suspected FWA identified during an audit, the Compliance department will notify the SIU.
- **Monitoring:** Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. Monitoring efforts conducted by the Compliance department are intended to protect against program non-compliance and potential FWA. If it is determined that there is actual or suspected FWA identified through ongoing monitoring, Compliance will notify the SIU.
- **Risk Assessment:** As an MCO, we are required to establish and implement a process to conduct a formal baseline assessment of the major compliance and FWA risk areas. The Compliance department performs an ongoing compliance risk assessment to identify potential risk areas that may have a significant impact on the organization. Many of these risks require in-depth analysis. If it is determined that there is actual or suspected FWA identified during the risk assessment process, the Compliance department will notify the SIU.

- **Compliance Investigations:** As an MCO, we must conduct a timely and well-documented reasonable inquiry into any compliance incident or issue involving potential program non-compliance or potential FWA. Program non-compliance and FWA may occur at the level of the sponsor or its vendors. The Compliance department is responsible for handling the investigations related to actual or suspected non-compliance. The SIU is responsible for handling investigations related to FWA. If the Compliance department identifies an instance of potential or actual FWA during a compliance investigation, the issue will be referred to the SIU for investigation.

Any irregular, unusual, or suspicious patterns or activity detected by the methods listed above will be referred immediately to the SIU by the Compliance department.

Important Laws and Regulations to Consider

Anti-Trust Laws: These are statutes and Acts (such as the Sherman Act and the Clayton Act) that apply to questionable business operations and activities that the government monitors to protect consumers from predatory business practices and to ensure fair competition by businesses. They address issues such as market allocation, bid submissions, price-fixing, and monopolies.

Antitrust laws protect consumers and commerce from unfair business practices such as unfair restraints, monopolies, and price-fixing. HPP is prohibited from:

- Entering into an agreement with another healthcare organization with a similar line of business that would significantly reduce competition in the marketplace;
- Using exclusionary practices to blockade entry or expansion by alternative insurers;
- Entering into an agreement with competitors to raise, lower, or otherwise stabilize the price range, or any other competitive term that will be offered for their products or services (this includes fixing premiums and provider payments);
- Implement supposedly quality-improving or cost-reducing measures simply to raise prices
- Partner with other organizations to boycott or jointly refuse to deal with a supplier, customer, or provider (HPP reserves the right on its own to refuse to do business with another supplier, customer, or provider);
- Disclose confidential information to competitors that would otherwise have a negative impact on the marketplace

Anti-Trust laws are designed to protect competition by prohibiting monopolization, price-fixing, predatory pricing, and other practices that unreasonably restrain trade. As an organization, we do not discuss pricing, suppliers, territories, or any additional proprietary information with competitors nor make arrangements with them on these competitive issues. Under certain circumstances, even informal discussions with competitors regarding the business plan, marketing, pricing, cost, or other similar matters may be illegal.

When necessary, we acquire information on our competitors only in legal and ethical ways. Just as we expect our competitors to respect our confidential information, we respect theirs. Improperly obtained competitor proprietary information cannot be used to the advantage of HPP.

Questions regarding potential violations of Anti-Trust laws should be directed to HPP's Legal department. Please refer to the section titled "Reporting your concerns."

Confidentiality Acts and Laws: There are also state and federal laws that go above and beyond HIPAA regarding consent, substance treatment, mental health, treatment of minors, peer-protected information, medical records, and many other categories.

Confidentiality is the responsibility of all HPP employees and vendors to maintain in strict confidence any proprietary or confidential information regarding HPP business operations or providers. This information may include but is not limited to information on members, employees, vendors, providers, research, and financial and business operations. Such information is made confidential by law or by HPP Confidentiality policy. Further, anyone who has any role at all in the production, gathering, storing, processing, or transmittal of confidential and/or protected health information (PHI) must be careful in how they deal with privacy issues in the workplace. This information should not be discussed with anybody, except as necessary to do your job, including other members, co-workers, other families, your

family, and friends. You must be alert to others overhearing your professional discussions regarding a member or an employee's behavior or performance. HPP employees and vendors are trained to protect the confidentiality and privacy of all constituents. Disclosure of confidential information is grounds for disciplinary action up to and including termination.

Questions or concerns regarding confidentiality related laws, acts, and processes are to be directed to the Legal department. Please refer to the section titled "Reporting your concerns."

Deficit Reduction Act (DRA) of 2005: Fraud and abuse in the Medicaid Program divert dollars that could otherwise be spent to safeguard the health and welfare of beneficiaries. Section 6032 of the Deficit Reduction Act of 2005 establishes section 1902(a)(68) of the Social Security Act (the Act), and relates to "Employee Education About False Claims Recovery."

Section 6032 of the DRA requires any entity that receives or makes payments to the State Medicaid Program of at least $5,000,000 annually, to provide Federal False Claims Act education to their employees. All entities that receive $5 million or more annually in Medicaid payments must establish specific written policies and procedures that address prevention of false claims submissions, set forth the civil and criminal penalties for making false claims and statements, give whistleblower protections, and cover other applicable policies.

As a "Covered Entity", HPP must have written policies and procedures that contain detailed information about the Federal laws identified in section 1902(a)(68) of the Social Security Act, such as the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, as well as Pennsylvania laws imposing civil or criminal penalties for false claims and statements, and about whistleblower protections under such laws, including 62 P.S. §§ 1407 (relating to provider prohibited acts, criminal penalties and civil remedies) and 1408 (relating to other prohibited acts, criminal penalties and civil remedies), and the Pennsylvania Whistleblower Law, 43 P.S. §§ 1421-1428.

In accordance with the DRA, HPP creates and disseminates written materials for the purpose of educating employees, managers, providers, subcontractors, and subcontractors' employees about health care Fraud laws, HPP's policies and procedures for preventing and detecting Fraud and Abuse, and the rights of employees to act as whistleblowers. HPP's written policies and procedures contain detailed information regarding our policies and procedures to detect and prevent fraud, waste, and abuse.

HPP's CEO submits an annual DRA Attestation to the Pennsylvania Department of Human Services (DHS) verifying that we have the required written policies and procedures and that we provide the appropriate education to our employees, contractors, agents, or other persons who furnish, or otherwise authorize the furnishing of, health care items or services; perform billing or coding functions; or are involved in the monitoring of health care services provided by HPP.

Additional information about the education requirement (Section 6032) of the Deficit Reduction Act of 2005 is available online at the Centers for Medicare and Medicaid Services (CMS) website. We provided a few links below.

- CMS - Final Guidance Regarding Employee Education for False Claims Recovery (03/22/2007):
  - http://www.cms.gov/smdl/downloads/SMD032207.pdf
  - http://www.cms.gov/smdl/downloads/SMD032207Att1.pdf
  - http://www.cms.gov/smdl/downloads/SMD032207Att2.pdf
- CMS - Employee Education About False Claims Recovery (12/13/2006):
  - http://www.cms.gov/smdl/downloads/SMD121306.pdf

False Claims Act (FCA): It is illegal to submit claims to the federal government for payment when the individual or entity knows or should know that the claims are false or fraudulent.

It is the policy of HPP to provide detailed information to its employees – and those of its vendors – about the role of the federal False Claims Act, the federal Program Fraud Civil Remedies Act, and applicable state false claims laws in preventing fraud, waste, and abuse in federal health care programs, including the Medicaid and CHIP program.

False claims laws seek to prevent fraud, waste, and abuse in government health care programs in two

significant ways. First, they permit the government to bring civil lawsuits to recover damages and penalties against health care providers that submit false claims. Second, these laws often permit private persons, including current or former employees of such providers, to bring so-called "whistleblower" actions against the providers on the government's behalf.

Under the Whistleblower Provision ("Qui Tam") provision of the FCA, a private person with knowledge of a false claim may bring a civil action on behalf of the United States government to recover funds it has paid as a result of that false claim. The government will investigate the whistleblower's allegations and may or may not choose to join in the lawsuit. If the government chooses to participate, it assumes responsibility for all of the expenses associated with the lawsuit. If the lawsuit is ultimately successful, the court may award the whistleblower who initially brought the suit a percentage of the funds recovered. That percentage is lower when the government joins in the action.

Regardless of whether the government participates, the court may reduce the whistleblower's share of the proceeds if it finds that the whistleblower planned and initiated the false claim violation. If the whistleblower is convicted of criminal conduct related to his or her role in the preparation or submission of the false claim, finally, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

The federal FCA also contains a provision that protects a whistleblower from retaliation by his or her employer. That provision applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against because of the employee's lawful conduct in furtherance of a false claim action. In such a case, the employee may bring an action in the appropriate federal district court and, if he or she prevails, is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the retaliation, such as litigation costs and reasonable attorney's fees.

Good faith reporting of suspected non-compliance or fraud, waste, and abuse is expected and accepted behavior. Anyone who in good faith reports a violation is referred to as a "whistleblower" and is protected from any retaliation by the Company. If you suspect any violations of the FCA, you are required to report this to either the SIU or the Legal department. For information on how to file an incident, please refer to the section titled "Reporting your concerns."

Federal Anti-Kickback Statute (AKS): This is a criminal law that prohibits the exchange of anything for value to reward referrals or generation of business/services payable by federal health care programs.

HPP complies with applicable federal and state Anti-Kickback laws and regulations. These laws prohibit payment or receipt of value intended to encourage purchasing, leasing, or ordering of an item or service that may be reimbursed under a government health care program, such as Medicare, Medicaid, or CHIP. Something of value can take many forms, such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt, or the sale or purchase of items at a price that is not consistent with fair market value. It also may include the waiver of copayments and/ or coinsurance.

The Federal Anti-Kickback Statute's main purpose is to protect patients and the federal health care programs from fraud and abuse by curtailing the corrupting influence of money on health care decisions. The Federal Anti-Kickback Statute prohibits the knowing and willful solicitation, offer, payment, or acceptance of any remuneration (anything of value), directly or indirectly, overtly or covertly, in cash or in kind in return for:

- referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program; or
- purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program.

The law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony. Violations of the law are punishable by up to five years in prison, criminal fines, administrative civil money penalties, and exclusion from participation in federal health care programs.

In 1987, Congress authorized the issuance of regulations designating specific "safe harbors" for various

payment and business practices that, while potentially prohibited by the law, would not be prosecuted. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor. Failure to comply with a safe harbor provision does not necessarily mean that an arrangement is illegal. Compliance with safe harbors is voluntary, and arrangements that do not comply with a safe harbor must be analyzed on a case-by-case basis for compliance with the Anti-Kickback statute.

Anti-Kickback laws are complex. If you suspect any violations of the Anti-Kickback Statute, you are required to report this to the SIU. The SIU will determine whether or not there is an actual violation or if it is an arrangement that is covered by an existing Safe Harbor. You may also report any concerns to our Legal Department. For information on how to file an incident, please refer to the section titled "Reporting your concerns." Vendors should also consult with their Legal department about whether it is appropriate to provide something of value to those we serve.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): The Health Insurance Portability and Accountability Act of 1996, as supplemented by The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 (collectively, HIPAA Rules) are federal laws that apply to health plans. HIPAA and all applicable regulations were enacted to simplify the administration of health insurance and ensure the safeguarding of protected health information (PHI). Protected health information may be information in any form e.g. written, electronic, oral, overheard, or observed. All employees and vendors need to understand HPP's HIPAA policy, privacy and security procedures as it directly relates to the management of PHI. Access to all information is granted on a "need to know basis". A "need to know" is defined as information that is required in order to do your job.

HPP has implemented all transaction and code requirements, adopted privacy and security procedures, designated a Privacy & Security official, and provided ongoing training to all workforce members. It is important for all employees to understand HIPAA privacy and security procedures as it directly relates to the requirements for member healthcare information. For business functions not conducted at HPP that involve the sharing of PHI, we require all vendors, subcontractors, consultants, etc., to sign written Business Associate Agreements that ensure these entities adhere to all HIPAA requirements. Additionally, the HPP Notice of Privacy Practices is sent to new members upon enrollment and existing members every three years and as requested. Our members have rights, under federal law, to access, restrict and amend their medical records, obtain an accounting of any use of their PHI, and to request alternative methods of communicating information. We also have a process for members to use in filing and dealing with complaints. Finally, we take measures necessary to see that PHI is not used for marketing or fundraising.

If you feel that a member's privacy or confidentiality has been violated or become aware of a privacy or security incident, report the incident or complaint to your supervisor/manager or contact:

- HPP Privacy Office email box at PrivacyOfficial@hpplans.com
- Compliance Hotline (anonymous reporting option) at 1-866-477-4848; or

For additional reporting channels, please refer to the section titled "Reporting your concerns."

Program Fraud Civil Remedies Act (PFCRA): In 1986, sections 6103 and 6104 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-501) set forth the Program Fraud Civil Remedies Act of 1986 (PFCRA). Specifically, this statute provides an additional legal remedy for the FCA, as well as imposes a Civil Monetary Penalty (CMP) and an assessment against any person who, with knowledge or reason to know, makes, submits, or presents a false, fictitious, or fraudulent claim or statement to the Government.

The PFCRA provides an administrative remedy promulgated to complement the FCA. PFCRA cases typically involve smaller claims and false statements the Department of Justice (DOJ) might not otherwise select for criminal or civil enforcement. Under the FCA, damages are treble rather than the double damages available under the PFCRA. The PFCRA's liability provisions are similar to the liability provisions of the FCA, except PFCRA extends to false statements even in the absence of any claim. Under PFCRA, the false statements must be certified.

Stark Laws: The Physician Self-Referral Law, commonly referred to as the Stark Law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment

interests and compensation arrangements.

Stark Law prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third-party payer) for those referred services. This law has established a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

The following items or services are considered "Designated Health Services":

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services

The Stark Law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark Law prohibits the submission or causing the submission of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

If you suspect any violations of Stark Laws, you are required to report this to either the SIU or the Legal department. For information on how to file an incident, please refer to the section titled "Reporting your concerns."

For more information, see CMS's Stark Law Web site: http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html

The Beneficiary Inducement Statute (42 U.S. Code § 1320a–7a - Civil monetary penalties): The federal Beneficiary Inducement Statute (BIS) prohibits an individual or entity from providing remuneration to patients who are eligible for Medicare or Medicaid benefits if that individual or entity knows (or should know) that doing so is likely to influence the patient's decision to order or receive items or services from a particular provider. Similarly, the AKS prohibits remuneration to induce a person, including a patient, to refer others or themselves to someone for the furnishing of items or services paid by federal healthcare programs.

Remuneration includes providing items or services for free or below fair market value, such as gifts, waivers of coinsurance, and deductibles. However, the definition of "remuneration" for purposes of the BIS is important because it excludes certain types of benefits and, as a result, allows those types of benefits to be provided to Medicare and Medicaid beneficiaries without implicating the BIS.

If an arrangement implicates the BIS, it must be structured to comply with the law. Because the BIS is an intent-based law, in interpreting compliance with the BIS, the government will look at the facts and circumstances of the arrangement to determine if the involved individuals knew or should have known that the remuneration would have affected the Medicare or Medicaid beneficiary's decision to order or receive items or services from a particular provider. Violations of the BIS may result in the imposition of civil money penalties (CMP), and the Office of Inspector General (OIG) may exclude violators from the Medicare and Medicaid programs. In the event that BIS compliance is unclear, the parties to the arrangement can avail themselves of the (OIG) advisory opinion process.

If you suspect any potential violations of the BIS, you should contact HPP's Legal department so they may review to determine if there is a perceived violation or if an exception applies. Refer to the section titled "Reporting your concerns."

Compliance Related Resources

Provided below is a reference library of valuable compliance-related resources (not all-inclusive):

Federal Register- Centers for Medicare and Medicaid Services	
Federal Register- CMS	• Federal agency regulations • Proposed Rules and Notices of interest to the public • Executive orders • Proclamations • Other Presidential documents
Electronic Code of Federal Regulations	
Title 42, Part 422, Medicare Advantage Program Title 42, Part 423, Medicare Prescription Drug Program Title 42, Part 438, Medical Assistance Programs- Managed Care Title 42, Part 455, Medical Assistance Programs- Program Integrity: Medicaid	The Electronic Code of Federal Regulations (e-CFR) is a currently updated version of the Code of Federal Regulations (CFR). The e-CFR contains the codification of the general and permanent rules published in the Federal Register. The referenced "Parts" impact HPP's product lines.
Pennsylvania Code	
Title 28 Pa. Code: Health & Safety Title 31 Pa. Code: Insurance Title 55 Pa. Code: Human Services	The Pennsylvania Code is the Commonwealth's official publication of rules and regulations.
HealthChoices Agreement	
Pennsylvania Medicaid Managed Care Information	• This section of the DHS website contains information for partners and providers on managed health care, including the location of the HealthChoices agreement and associated Exhibits for the Medicaid product. Note: The DHS website may not contain the most up-to-date version of the HealthChoices Agreement and corresponding exhibits due to potential mid-year updates. Additionally, it may take time for DHS to post current contract year versions of the agreement on their website. Questions related to the HealthChoices agreement, including whether the version posted is current, should be directed to the Compliance department by emailing: RegulatoryCompliance@hpplans.com
CHIP Procedures Handbook	
Pennsylvania CHIP Resource Page	• Location of the CHIP Procedures Handbook (2018 version) agreement for the CHIP product
HPMS Memorandums issued by CMS	
Centers for Medicare and Medicaid Services Health Plan Management System Memos Archive	• Provides access to sub-regulatory guidance produced by CMS, issued through HPMS memos

Medicare Managed Care Manual (Click Here)	
Chapter 1 - General Provisions (PDF)	• Legislative history of the Medicare Advantage (MA) program • Types of MA Plans
Chapter 2 - Medicare Advantage Enrollment and Disenrollment (PDF)	• Eligibility requirements for enrollment in MA plans • Election periods and effective dates • Enrollment and disenrollment procedures • Cancellations, Reinstatements, and Retroactive Transactions • Model Enrollment forms and notices
Chapter 4 - Benefits and Beneficiary Protections (PDF)	• Types of benefits • Hospice coverage rules • Uniform Benefit and Nondiscrimination • Clinical Trials • Part B Drug Coverage • Transplants • DME, Prosthetics, Orthotics, and Supplies • Skilled Nursing Facility (SNF) Coverage • Ambulance, Emergency, Urgent care rules, including Post-stabilization care • Supplemental benefits and OTC • Cost-sharing and OOP liability guidance • Meaningful Difference • Nonrenewal for Low Enrollment • Value Added Items/ Services • NCD/ LCD information • Rewards and Incentives guidance • Access- Provider Network standards, Payment to Noncontracted Providers • Provider Directory requirements • Medicare Secondary Payer (MSP) Procedures • Service area rules • Plan Directed Care and balance billing • Advance Directives • Part C EOB
Chapter 5 - Quality Assessment (PDF)	• Chronic Care Improvement and Quality Improvement Projects (CCIP/ QIP) • MAO Reporting Requirements • MA Deeming Program Requirements

Medicare Managed Care Manual (Continued)	
Chapter 6 - Relationships With Providers (PDF)	• Provider involvement in Policymaking • Provider participation information • Noninterference and Antidiscrimination provisions • Credentialing, suspension, terminations, and nonrenewal of provider status • Physician Incentive Plans • Prohibition on provider indemnification of MA organization • Special rules for services provided by Noncontracted providers
Chapter 7 - Risk Adjustment (PDF)	• CMS Risk Adjustment Models- CMS- HCC, ESRD, RxHCC • Operations and Data collection to support Risk Adjustment • Risk Score verification- RAPS, MARx, Model Software
Chapter 8 – Payments to Medicare Advantage Organizations (PDF)	• General rules for calculating payment to MA plans • Capitation rates/ methodology • Special rates- Out of Service Area, ESRD, Hospice
Chapter 10 – MA Organization Compliance with State Law and Preemption by Federal Law (PDF)	• State licensure requirements • Federal Preemption rules • MSP rules
Chapter 11 – Medicare Advantage Application Procedures and Contract Requirements (PDF)	• General application procedures • Minimum enrollment requirements • Contract Prohibitions • Contract Renewal/ Nonrenewal • Contract Termination process • MA contract provisions • Relationships with FDRs, Contractors, and Subcontractors
Chapter 12 - Effect of Change of Ownership (PDF)	• Notification requirements for change of ownership • Novation agreements
Chapter 14 - Contract Determinations and Appeals (PDF)	• Procedures for MA plan to request review/ appeal of CMS contract determinations
Chapter 15 - Intermediate Sanctions (PDF)	• Types of Sanctions • Basis for imposing sanctions
Chapter 16b – Subchapter B – Special Needs Plans (PDF)	• Types of Special Needs Plans (SNPs) – Chronic Conditions – Dual Eligible – Fully Integrated Dual Eligible – Institutional • Service area, enrollment, marketing, quality improvement requirements • Covered benefits

Medicare Managed Care Manual (Continued)	
Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual Chapter 9 – Compliance Program Guidelines (PDF)	• Seven elements of a Compliance Program • Sponsor's accountability for First Tier, Downstream, and Related Entities (FDRs)
Medicare Communications and Marketing Guidelines	• Description of communications vs. marketing materials • Required documents • Required disclaimers • Agent/ broker requirements • Marketing review process • Website requirements
Medicare Managed Care and Prescription Drug Appeals & Grievances • Parts C & D Enrollee Grievances, Organization/ Coverage Determinations, and Appeals Guidance (PDF)	• Plan responsibilities and Enrollee rights • Authorized representative requirements • Complaints- distinguishing between Appeals and Grievances • Timeframes for processing standard and expedited organization determinations • Denial language requirements • Timeframes and processing requirements for preservice and post-service reconsiderations • Waiver of Liability (WOL) requirements • Timeframes and processing requirements for standard and expedited grievances • IRE Reconsiderations • ALJ, MAC, and Judicial Review • Reopening • Effectuations of decisions reversed by Plan and by IRE/ALJ/MAC • Effectuations requirements for former enrollees • Review process for Inpatients- NOMC/DENC/ QIO requirements • Denial notices • Part D Coverage Determinations, Grievances, Redeterminations, and DMR explanations • IRE, ALJ, and MAC clarifications and explanations • Denials, Approvals, and Effectuation explanations
Prescription Drug Benefit Manual (Click Here)	
Medicare Prescription Drug Eligibility and Enrollment • Chapter 3 - CY2021 PDP Enrollment and Disenrollment Guidance (PDF) • HPMS Memo CY 2021 Enrollment Guidance Changes Final (PDF)	• Eligibility requirements for enrollment into Part D plans • Election periods and effective dates • Disenrollment procedures • Model Enrollment forms and notices

Prescription Drug Benefit Manual (Continued)	
Creditable Coverage and Late Enrollment Penalty • Chapter 4 - FINAL Creditable Coverage and LEP Guidance	• Guidance on Creditable Coverage Period Determinations and the Late Enrollment Penalty • Reporting Creditable Coverage information for former plan members • Updated Attestation Forms for reporting Creditable Coverage
Chapter 5 - Benefits and Beneficiary Protection (v09.20.11) (PDF)	• Description of Standard Prescription Drug Coverage and Alternative Prescription Drug Coverage • Long Term Care (LTC) Dispensing requirements • Plan Benefit Package guidance • Mail Order pharmacy requirements
Chapter 6 - Part D Drugs and Formulary Requirements (v.01.19.16) (PDF)	• Definition of Part D covered drugs • Definition of Part D excluded drugs • Transition benefits
Chapter 7 – Medication Therapy Management and Quality Improvement Program (v02.19.10) (PDF)	• Definition of MTM and QIP programs • Definition of Drug Utilization Review (DUR) programs • Definition of Quality Assurance programs • Definition of e-prescribing
Chapter 13 - Premium and Cost-Sharing Subsidies for Low-Income Individuals (v09 14 2018) (PDF)	• Eligibility requirements for Low Income Cost Sharing (LICs) beneficiaries • Various subsidy explanations • Requirements and limitations for payments made by and on behalf of low-income Medicare beneficiaries who enroll in a Part D plan
Chapter 14 - Coordination of Benefits (v.09 17 2018) (PDF)	• CMS requirements for Coordination of Benefits (COB) • Beneficiary requirements for COB • Provider requirements for COB