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Corporate Compliance Plan

The Health Plan Corporate Compliance Plan

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INTRODUCTION

The Health Plan is dedicated to promoting compliance with all applicable federal and state laws, rules, and regulations. This includes, but is not limited to, the requirements of Medicare Part C, Medicare Part D, the Affordable Care Act and West Virginia Mountain Health Trust. All directors (i.e., board members), officers, employees, interns, volunteers, committee members, contractors, First Tier, Downstream and Related Entities (FDRs) and Mountain Health Trust Subcontractors (Subcontractors) are expected to meet various legal requirements. For these reasons, The Health Plan has developed and implemented the following Corporate Compliance Plan. The plan and its related policies, procedures and work plans are designed to ensure The Health Plan fulfills all statutory and contractual obligations in a fair, accurate and consistent manner.

The Corporate Compliance Plan not only addresses health care fraud, waste and abuse (FWA) but the requirements and obligations set forth by the Centers for Medicare and Medicaid Services (CMS) and other applicable laws and regulations. The plan covers the following areas:

- Written policies, procedures and standards of conduct
- Compliance officer, compliance committees and high level oversight
- Effective training and education
- Effective lines of communication
- Well publicized disciplinary standards
- System for routine monitoring and identification of compliance risks
- Procedures and systems for prompt response to compliance issues
- Mountain Health Trust requirements

Regulatory compliance is not optional—it is required. Failure to comply with all applicable federal and state regulations exposes The Health Plan to fines and potential loss of its Medicare and/or Mountain Health Trust program contracts. Non-compliance with the plan and all applicable regulatory statutes undermines The Health Plan's reputation and credibility with its members, providers and employees. The Corporate Compliance Plan will be reviewed at least annually, or more often as circumstances dictate.

The Health Plan's Board of Directors delegates the authority for the development and implementation of the Corporate Compliance Plan to executive management and the internal Corporate Compliance Committee.

The Vice President of Internal Audit & Quality and/or the Compliance Officer will periodically report the status of corporate compliance activities to the Corporate Compliance Committee and to the Board of Directors through the Audit and Corporate Compliance Committee (A&C).

WRITTEN POLICIES, PROCEDURES AND CODE OF CONDUCT

The Health Plan's overall expectation for compliance begins with a commitment to adhere to The Health Plan's Code of Conduct, all applicable federal and state regulations, and applicable standards and sub-regulatory guidance. Compliance training, including training on The Health Plan's Code of Conduct, occurs as part of the new hire process and is conducted annually thereafter, as determined by The Health Plan's Compliance Department. In addition, The Health Plan has policies and procedures that establish expectations that The Health Plan's employees are expected to follow. The Health Plan maintains compliance policies, procedures and written guidelines so all employees are aware of their individual responsibility for compliant and ethical business practices.

Code of Conduct

All directors, officers, employees, interns and volunteers are required to review and attest to The Health Plan's Code of Conduct upon hire or appointment and annually thereafter. FDRs and Subcontractors are expected to adopt The Health Plan's Code of Conduct or substantially similar document.

Conflict of Interest, Employee Security and Confidentiality Agreement, Acceptable Use Policy

All directors, officers, employees, interns and volunteers are required to review and sign a conflict of interest statement or questionnaire upon hire or appointment and on an annual basis thereafter. Employees, interns and volunteers are further required to review and sign the Employee Security and Confidentiality Agreement and Acceptable Use Policy upon hire and annually thereafter.

HIPAA Privacy Plan

The HIPAA Privacy Plan sets the standards for employees in safeguarding confidential and protected health information. The Health Plan is committed to complying with applicable laws, regulations and policies related to the privacy of health information. All employees, interns and volunteers are required to complete HIPAA privacy and security training at the time of hire and annually thereafter. All employees, interns and volunteers are required to perform their work duties with a conscious regard for the privacy rights of The Health Plan's members.

Under the direction of The Health Plan's Vice President of Internal Audit & Quality and/or the Compliance Officer, the privacy plan focuses on educating employees on their ongoing responsibility to protect member privacy and secure member information. The Compliance Department manages and updates the privacy policies and procedures, which are available to all The Health Plan employees via the intranet and through material distributed by the Compliance Department.

All FDRs and Subcontractors must abide by The Health Plan's Privacy Plan and corresponding policies or demonstrate that they have a dedicated privacy official who is responsible for ensuring that all individuals within the respective delegated entity are trained on HIPAA regulations and the reporting of privacy breaches. The FDR's and/or Subcontractor's privacy official is also responsible for managing any issues related to privacy breaches and reporting to The Health Plan any actual or potential privacy breach that impacts The Health Plan's members or business.

Special Investigations Unit

The Health Plan maintains a Special Investigations Unit (SIU) to uphold our commitment to prevent, detect and correct issues that could lead to FWA. The SIU is responsible for preventing, detecting, investigating and resolving health care FWA. The SIU works with the West Virginia Bureau for Medical Services (BMS), the Medicaid Fraud Control Unit (MFCU), the Office of Inspector General (OIG) and CMS to administer effective FWA detection and prevention practices. The SIU participates in coordination activities with the State of West Virginia to maximize resources for FWA issues, meets regularly and as requested with BMS and the MFCU, and attends FWA training sessions scheduled by the State.

The SIU works in collaboration with the Compliance Department. As part of this commitment, all workforce members must agree to comply with The Health Plan's Code of Conduct and complete all mandatory FWA training courses. Training is conducted at hire and on an annual basis thereafter. FWA training must include an overview of the laws and regulations related to Medicare and Medicaid FWA (e.g., False Claims Act, Anti-Kickback Statute, Deficit Reduction Act). All directors, officers, employees, interns and volunteers must receive compliance and FWA prevention training:

1. Upon hire or appointment
2. Annually
3. When there are material changes to applicable laws or regulations
4. As part of a corrective action plan (CAP) to address identified non-compliance
5. When an employee works in an area implicated in past non-compliance and/or potential FWA

FDRs and Subcontractors should complete compliance and FWA training at least annually through their own internal compliance program or using training materials supplied by The Health Plan.

The Health Plan uses a number of system edits and programmatic reviews of data to detect potential fraud. The Health Plan maintains a hotline which supports anonymous reporting. The SIU investigates all reports of potential FWA. The SIU works with designated state and federal agencies, the Investigations Medicare Drug Integrity Contractor (I-MEDIC), and law enforcement to pursue individuals or organizations who may be involved in activities indicative of potential FWA.

Fraudulent or abusive activity may involve employees, members, subscribers, health care providers or vendors/subcontractors. FWA may involve inappropriate schemes, behaviors, false documentation, inappropriate prescriptions, or falsification of conditions to trigger payment for otherwise non-covered services under Medicare, Mountain Health Trust, or other state or federal health programs.

The Health Plan’s directors, officers, employees, FDRs and Subcontractors play an important role in The Health Plan’s compliance program and fraud prevention program and are required to report suspected FWA through the channels provided. More information about FDR and Subcontractor compliance is included in the FDR/Subcontractor Standards of Conduct.

The Health Plan’s Compliance and FWA Policies

The Health Plan’s policies and procedures promote compliance and responsiveness to laws, regulations and day-to-day risks to help reduce the prospect of fraudulent, wasteful and abusive activity. Because risk areas evolve and change over time, The Health Plan’s policies and procedures are reviewed at least annually and revised when there are changes in regulatory requirements or business needs.

The Health Plan has developed compliance policies and procedures to promote compliance with the requirements of the Medicare and Mountain Health Trust programs. The Health Plan’s operational areas have

developed policies and procedures that support the compliance program by addressing the day-to-day activities in relevant business areas.

The Health Plan's policies demonstrate to employees, business partners and the community at large our strong commitment to honest and responsible business practices and regulatory compliance. The Health Plan's published policies establish procedures and provide direction to workforce members to promote compliance with applicable laws and regulations, and reduce the prospect of fraudulent, wasteful or abusive activities in our daily work.

The Health Plan requires that all FDRs and Subcontractors adopt The Health Plan's policies, procedures and Code of Conduct or maintain similar policies, procedures and standards of conduct that comply with current Medicare and Mountain Health Trust rules and regulations.

Delegated Entities, Providers, Vendors, Agents and FDRs

Various departments at The Health Plan provide services to The Health Plan's members through third party arrangements. When a third party, such as a pharmacy benefit manager, a provider group, a dental provider or another entity provides services to members, it is necessary to ensure that the third party entity adheres to all requirements of The Health Plan's compliance program. Accordingly, designated staff of The Health Plan monitor the activities and performance of FDRs, Subcontractors and providers to ensure they fulfill their contractual requirements for Medicare Part C, Medicare Part D, and Mountain Health Trust as well as established performance standards. Delegation oversight activities shall include, but are not limited to:

- Contractual language which requires adherence to compliance requirements such as those required by Medicare and Mountain Health Trust
- Audits to validate compliance with contractual, internal and regulatory requirements
- Development and implementation of CAPs in response to detected non-compliance
- Written reports of oversight activities
- Regular reporting of FDR and Subcontractor oversight activities to the Corporate Compliance Committee and the board-level A&C

COMPLIANCE OFFICER, CORPORATE COMPLIANCE COMMITTEE AND HIGH LEVEL OVERSIGHT

The Health Plan recognizes the importance of fostering a culture of compliance. To this end, The Health Plan maintains and supports a Corporate Compliance Committee, a Chief Compliance Officer and a Compliance Officer vested with clear roles, responsibilities and objectives.

Governing Body

The Corporate Compliance Program operates under the purview of the Board of Directors. In order to promote effective oversight, the Board of Directors has established The Health Plan's A&C. The purpose of the A&C is to assist the Board of Directors in fulfilling its oversight responsibilities with respect to the performance of The Health Plan's internal audit and compliance functions.

The A&C provides advice and counsel to management in its oversight of financial audits, internal controls and implementation of the Corporate Compliance Program. The A&C serves as an independent and objective party to monitor these processes and provides an open avenue of communication between the independent auditor, financial and senior management, the Internal Audit and Compliance Departments and the governing body.

The A&C, on behalf of the Board of Directors, will review and provide oversight of at least the following areas:

- Approval of the Code of Conduct (performed by the full Board of Directors)
- The scope, structure, process and effectiveness of the Corporate Compliance Program
- The findings of any significant regulatory investigations, including the results of internal and external audits
- Updates from management and the Vice President of Internal Audit & Quality (acting as the Chief Compliance Officer) and/or the Compliance Officer on legal or regulatory matters that significantly impact, or present an unmitigated risk, to the organization
- Governmental compliance enforcement activities such as notices of non-compliance, warning letters and/or formal sanctions
- Periodic updates from the Corporate Compliance Committee to the Board of Directors through communication from the Vice President of Internal Audit & Quality and/or the Compliance Officer.

The Health Plan's Board of Directors delegates the authority for the day-to-day development and implementation of the Corporate Compliance Plan to executive management, the Vice President of Internal Audit & Quality and the Compliance Officer. These items include, but are not limited to:

- Development, implementation and annual review of compliance policies and procedures
- Approval of compliance policies and procedures
- Review of general compliance, FWA and HIPAA training
- Review of the results of the organization's annual departmental risk assessment
- Review of the compliance and audit work plan (AWP) including periodic updates presented by the Vice President of Internal Audit & Quality and/or the Compliance Officer
- Review of CAPs resulting from internal or external audits
- Evaluation of the executive management's commitment to ethics and the compliance program
- Review of dashboards, scorecards, self-assessment tools, etc., that describe compliance activities and issues

Corporate Compliance Committee

The Health Plan has established a Corporate Compliance Committee to advise and assist the Vice President of Internal Audit & Quality and the Compliance Officer in the implementation of the compliance program. The committee will consist of members with relevant experience within The Health Plan and executive management.

The Corporate Compliance Committee Charter, adopted on April 15, 2019 and reviewed on an annual basis, outlines a framework for the committee including an overview of its purpose, authority and functions. The Corporate Compliance Committee's oversight includes the following disciplines:

1. General compliance including the development of a corporate compliance program structured and implemented to prevent, detect and correct issues of regulatory non-compliance.
2. SIU which investigates issues of potential FWA including responding to various regulatory entities and referring potential FWA to the appropriate authorities.
3. HIPAA privacy compliance which includes the implementation of appropriate privacy policies, procedures and processes and the investigation and remediation of potential and actual breaches of protected health information.

The voting members of the Corporate Compliance Committee shall be comprised of the following:

- Interim President and Chief Operating Officer (COO)
- Chief Financial Officer
- Senior Vice President of Administrative Services

- Senior Vice President of Provider Delivery Services
- Senior Vice President of Human Resources
- Chief Medical Officer
- Vice President of Medicaid
- Vice President of Medicare Operations
- Vice President of Internal Audit & Quality

Additional members of the Executive Management Team will be brought in on an ad hoc basis. Non-voting members will include Compliance, SIU and Internal Audit staff including the Compliance Officer. The Committee's chairperson is the Vice President of Internal Audit & Quality.

Roles and Responsibilities:

The committee's roles and responsibilities shall include:

- Meet at least four times per year, and as necessary
- Analyze the industry environment and legal requirements with which The Health Plan must comply including specific risk areas
- Assess existing policies and procedures that address risk areas
- Work with appropriate departments to promote compliance
- Recommend and monitor the development of internal systems and controls to carry out The Health Plan's standards, policies and procedures
- Determine the appropriate strategy or approach to promote compliance including the detection of any potential violations through hotlines and other reporting mechanisms
- Support the compliance department's needs for sufficient staff and resources to carry out delegated duties
- Ensure The Health Plan has appropriate, up-to-date compliance policies and procedures
- Review and address audit reports of areas in which The Health Plan is at risk of FWA and ensure CAPs are implemented as appropriate
- Review the Corporate Compliance Plan annually

Compliance Officer

The Health Plan's Vice President of Internal Audit & Quality (acting as the Chief Compliance Officer) and Compliance Officer serve important roles in the implementation of The Health Plan's Corporate Compliance Plan and act as focal points for compliance activities. The Vice President of Internal Audit & Quality has direct access and is accountable to the CEO and Board of Directors. The Compliance Officer is responsible for developing, operating and monitoring the compliance program. The Compliance Officer may delegate such responsibilities where appropriate. The Compliance Officer does not hold other responsibilities that could lead to self-policing of his or her activities.

Authority:

The Vice President of Internal Audit & Quality and the Compliance Officer have the following authority:

- Interview, or delegate the responsibility to interview, employees and other relevant individuals regarding compliance issues
- Review company contracts and other documents pertinent to the Medicare and Mountain Health Trust programs
- Review or delegate the responsibility to review the submission of data to Medicare and Mountain Health Trust to ensure that it is accurate and in compliance with reporting requirements
- Independently seek advice from legal counsel

- Report potential FWA to CMS, its designee or other required state entities or law enforcement
- Conduct and/or direct audits and investigations of The Health Plan's FDRs and Subcontractors
- Conduct and/or direct audits of any area or function of The Health Plan, including areas involved with The Health Plan's Medicare and Mountain Health Trust contracts
- Recommend policy, procedure and process changes

Roles and Responsibilities:

- Oversee and monitor the implementation of the compliance program
- Report on a regular basis to the COO, Corporate Compliance Committee and Board of Directors
- Periodically revise the compliance program in accordance with organizational needs and changes in applicable law and policy
- Develop, coordinate and participate in multifaceted educational and training programs that focus on the elements of an effective compliance program as well as specific risk areas
- Coordinate internal compliance reviews, auditing and monitoring activities
- Develop policies and programs that encourage employees to report suspected compliance issues, suspected fraud or abuse and other improprieties without fear of retaliation

The Vice President of Internal Audit & Quality and the Compliance Officer have the flexibility to design and coordinate internal investigations (e.g. responding to reports of suspected violations) and issue corrective actions (e.g. making necessary improvements to policies and practices, recommending appropriate disciplinary action) as deemed appropriate. Such activities may include, but are not limited to:

- Coordinate with Human Resources and Provider Delivery Services to ensure that the National Practitioner Data Bank, the Office of Inspector General List of Excluded Individuals and Entities (OIG) and General Services Administration System for Award Management Excluded Parties List System (SAM) databases have been checked with respect to all employees, officers, directors, committee members and providers to make sure they are not restricted from participation in federal health care programs.
- Report suspected fraud or misconduct to CMS or other appropriate agency, its designee and/or law enforcement.
- Ensure proper documentation is maintained for each report of potential non-compliance or FWA received through any reporting method (e.g. hotline, mail, email or in-person). Such documentation includes corrective and/or disciplinary action(s) taken as a result of the investigation, the respective dates when each of these events and/or actions occurred and the names of the person(s) who implemented these actions as applicable.
- Oversee the development, monitoring and implementation of CAPs.

The Vice President of Internal Audit & Quality, the Compliance Officer and/or the Director of SIU, as appropriate, collaborate with other sponsors, commercial payers, and other organizations when an issue of non-compliance or potential FWA is discovered that may involve multiple parties.

Compliance Department

The Compliance Department provides support to the Vice President of Internal Audit & Quality and the Compliance Officer in promoting ethical conduct, instilling a company-wide commitment to compliance with federal and state regulatory guidelines, and exercising diligence in ensuring the overall compliance program requirements are met. The Compliance Department is responsible for:

- Representing The Health Plan before all applicable state and federal regulatory agencies and serving as liaison for communications between the company, CMS and other regulatory entities.
- Establishing the overall framework for the compliance program to promote compliance with applicable

Medicare, Mountain Health Trust and Federal and State regulatory and legal requirements.

- Ensuring consistent and timely reporting of relevant compliance issues to the Vice President of Internal Audit & Quality and/or the Compliance Officer. The Vice President of Internal Audit & Quality and/or Compliance Officer, in turn, reports significant compliance matters to the Corporate Compliance Committee and has authority to escalate issues to executive management and the Board of Directors.
- Advising and overseeing the individual business units in the design of various monitoring activities.
- Establishing key performance measures, metrics, and reporting protocols as part of the organization's auditing and monitoring of key risk areas.
- Monitoring, auditing and reporting key compliance and performance metrics for the purpose of resolving identified patterns and trends, working with business units on corrective actions and assessing the effectiveness of the compliance program.
- Assessing new risk areas based on information gathered from a variety of sources including CMS, Mountain Health Trust, internal assessments, member complaints, governmental inquiries or other avenues and recommending new or revised metrics, policies and procedures, enhanced training, or other activities that may be tracked and measured to demonstrate compliance.
- Reporting incidents of potential or identified non-compliance, and working with the applicable business units to implement appropriate and timely corrective actions that result in measurable compliance improvements.
- Developing relevant and effective compliance training programs that support the compliance program and build compliance awareness for employees, management, FDRs and Subcontractors.
- Performing independent reviews and ongoing monitoring and auditing of identified risk areas, monitoring of compliance or performance deficiencies, and ensuring effective corrective actions are implemented in a timely manner.
- Partnering with Internal Audit to incorporate high-priority risk areas into the Internal Audit work flow and provide background and consultative guidance to Internal Audit on audit topics involving The Health Plan's Medicare and Mountain Health Trust contracts.

EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in The Health Plan's overall compliance program. The Health Plan requires all directors, officers, employees, interns and volunteers to complete mandatory compliance and FWA training courses. The following trainings must be completed within 90 days of employment or appointment and annually thereafter:

1. Code of Conduct
2. General Compliance
3. FWA

Compliance Training for FDRs and Subcontractors

All FDRs and Subcontractors that provide services to Medicare Advantage enrollees, Medicare Part D enrollees and/or Mountain Health Trust enrollees should complete compliance and FWA training through their own internal compliance program or by using training materials supplied by The Health Plan.

Tracking Required Compliance Training

Each member of The Health Plan's management is responsible for ensuring their employees complete all required compliance training. Required training courses are delivered electronically via the intranet. Training materials and test results are maintained for ten years. Failure to complete required compliance training subjects employees and their managers to disciplinary actions, up to and including termination of employment.

FDRs and Subcontractors must maintain documentation of compliance and FWA training for at least ten years.

EFFECTIVE LINES OF COMMUNICATION

The Health Plan works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of compliance with regulatory requirements and reinforcing company expectations of ethical and lawful behavior.

The Health Plan has systems in place to receive, record and respond to reports of potential or actual non-compliance from employees, members, providers, vendors, FDRs and Subcontractors.

Compliance and FWA Hotline, Website and Email

The Health Plan's hotline is a confidential, toll-free resource available to employees, members, providers, vendors, FDRs, Subcontractors and the general public twenty-four (24) hours a day, seven (7) days a week to report violations of, or raise questions or concerns relating to, non-compliance and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of The Health Plan, including members, to report suspected fraud.

Reporting mechanisms include the following:

- The Health Plan's Compliance and FWA Hotline at 877.296.7283 or internally by dialing 6111
- Online at https://fraud.healthplan.org/
- SIU@healthplan.org
- compliance@healthplan.org

Calls and online forms may be completed anonymously. These communications are never traced. Anyone can make a report without fear of intimidation or retaliation.

The Health Plan logs calls placed to The Health Plan's hotline or online form to ensure proper investigation and resolution of reported matters and to identify patterns and opportunities for additional training or corrective action. All calls to The Health Plan's hotline are investigated by The Health Plan's Compliance Department and/or SIU.

The Health Plan educates employees about The Health Plan's hotline and online form through:

1. Compliance/FWA training
2. The employee intranet
3. Posters displayed in common work areas
4. The Health Plan's policies and procedures
5. Compliance Week activities
6. Newsletters, emails and other means

Medicare Workgroup

This workgroup has the responsibility to monitor all CMS publications, revisions, new laws and regulations that may affect the delivery of Medicare Parts C and D services and communicate these changes to the affected operational areas.

Mountain Health Trust Oversight Committee

This committee has the responsibility to monitor the requirements and activities related to The Health Plan's contract with the BMS and communicate these requirements to the affected operational areas.

Reports to Executive Management, the Corporate Compliance Committee and the Board

The Vice President of Internal Audit & Quality and/or the Compliance Officer reports compliance, privacy and SIU related activities to The Health Plan's executives in monthly compliance dashboards. The Vice President of Internal Audit & Quality and/or the Compliance Officer, in collaboration with the SIU, prepares the Corporate Compliance Committee agenda for regularly scheduled committee meetings. The meeting agendas include information on routine and ad hoc activities related to general compliance, SIU and HIPAA privacy. A summary of this information is subsequently communicated to the board through the A&C by the Vice President of Internal Audit & Quality.

WELL PUBLICIZED DISCIPLINARY STANDARDS

The Health Plan publishes the Code of Conduct which establishes standards of conduct that all directors, officers, employees, interns and volunteers must follow. Everyone is responsible for abiding by the Code of Conduct and for reporting any situation believed to be illegal or unethical. FDRs and Subcontractors must also comply with standards The Health Plan has established or demonstrate that they have implemented similar standards of compliance.

The Health Plan takes its commitment to the Code of Conduct seriously and takes appropriate and immediate investigative and disciplinary action if anyone violates the Code of Conduct, The Health Plan’s policies or applicable law. The Health Plan’s strong commitment to ethical values and compliance includes:

Involvement of COO, Executive Management and Board of Directors

The COO, executive management and the Board of Directors are involved in establishing The Health Plan’s standards of conduct. This is demonstrated by the annual review and approval of the Code of Conduct by the Corporate Compliance Committee and the Board of Directors.

Enforcing Standards of Compliance

The Health Plan’s policies provide specific instructions for handling reports of potential violations of company policies, administrative rules, regulations or law. Any employee of The Health Plan who suspects a potential violation of policy or law is required to report the matter to any of the following:

1. His or her department supervisor or manager
2. The Vice President of Internal Audit & Quality, the Compliance Officer or Director of SIU
3. The Health Plan’s Compliance/FWA hotline at 877.296.7283 or internally at 6111
4. Online at https://fraud.healthplan.org/
5. Compliance@healthplan.org
6. SIU@healthplan.org

The Health Plan does not tolerate intimidation or retaliation against employees who, in good faith, report potential violations. A description of The Health Plan’s policy of non-intimidation/non-retaliation is found in the Code of Conduct, and is reinforced in a number of policies, procedures, guidelines and training materials.

Publicizing Disciplinary Guidelines

All employees of The Health Plan are informed that violations of the Code of Conduct, The Health Plan's policies, applicable regulations or laws may result in appropriate disciplinary action, up to and including termination of employment. Disciplinary policies are posted on the intranet and in the employee handbook.

EFFECTIVE SYSTEM FOR ROUTINE MONITORING AND IDENTIFICATION OF COMPLIANCE RISKS

Monitoring and auditing are critical elements of the compliance program. Compliance-related elements are used to develop metrics for evaluating performance against regulatory standards. Monitoring and auditing allows The Health Plan to identify areas that require corrective action in order to achieve compliance with specific regulatory requirements. This process of self-identification and corrective action, along with various monitoring activities, are key elements of our compliance program.

Auditing and monitoring activities are informed by the annual risk assessment process that identifies departmental risk areas. Compliance risks are separately reviewed through a variety of oversight activities, including:

- Compliance Department self-assessments
- Compliance Department and/or business unit audits and monitoring
- Third party data validation audits
- Monitoring and auditing of FDRs and Subcontractors
- Review of periodic Medicare and Mountain Health Trust readiness checklists
- SIU monitoring, audits and investigations
- External audits conducted by regulators or other external parties

Risk Assessment

The Compliance Department coordinates an annual departmental risk assessment as part of its overall program to identify and mitigate compliance risks. The Corporate Compliance Committee is provided a report of the results of the annual departmental risk assessment. Information from this risk assessment is combined with data from a variety of sources to inform the development of the AWP. These additional sources include:

1. Regulatory risks based on CMS guidance
2. Risks as identified in the OIG work plan
3. Audit findings from CMS, Mountain Health Trust and other regulatory agency or external entity
4. Notices of non-compliance from CMS and other regulatory agencies
5. Items reported through the Complaint Tracking Module (i.e., CTMs)
6. Complaints related to sales and marketing issues
7. Secret Shopper issues and findings identified by CMS
8. Findings from business unit monitoring activities
9. Identified high risk areas
10. CAP monitoring
11. Member "touch points" such as appeals and grievances, claims, member services, enrollment and disenrollment, and premium billing

12. Results of surveys and interviews with senior staff
13. Review of periodic Medicare and Mountain Health Trust readiness checklists

Audit and Compliance Work Plan

Each year the Compliance Department, in collaboration with Internal Audit and the SIU, prepares an AWP outlining the planned compliance activities for the coming year. Compliance activities include applicable Internal Audit, SIU, and HIPAA items. The plan is submitted to the Corporate Compliance Committee for review. The AWP includes:

1. Audits to be performed including estimated time frames
2. Periodic monitoring activities
3. The FDRs and Subcontractors to be audited
4. Announced or unannounced audits
5. Audit methodology
6. Necessary resources
7. Types of audit (e.g., desk or onsite)
8. Person(s) responsible
9. Final audit reports
10. Follow-up activities from findings including CAPs when applicable

Work plan activities are documented in the AWP spreadsheet and Gorman's Online Monitoring Tool (OMT). Ongoing AWP activities are documented in the AWP spreadsheet which includes a worksheet for each month's activities. Specific auditing and monitoring activities are logged in OMT. CAPs implemented as a result of identified deficiencies are also documented in OMT and reviewed on a monthly basis. Progress on AWP activities are reviewed in monthly meetings which allows for needed adjustments as well as the incorporation of ad hoc audits. The Compliance Department may modify its AWP based on issues that arise within the organization.

Medicare Compliance audits are based on regulatory guidance and, depending on the department audited, may rely on CMS guidance outlined in:

1. The Medicare Managed Care Manual
2. The Medicare Prescription Drug Benefit Manual
3. CMS Audit Protocols
4. The annual Medicare readiness checklist
5. Other applicable CMS guidance and publications

Mountain Health Trust compliance audits are based on the BMS contract and related correspondence as well as applicable regulations published by CMS.

Similar to the process CMS uses in its audits, the Compliance Department prepares a report of findings and works with appropriate staff to develop CAPs as indicated. The audit report and CAPs are distributed by the Vice President of Internal Audit & Quality to the applicable members of executive management with a summary of audit findings provided to the Corporate Compliance Committee. The Vice President of Internal Audit & Quality and/or Compliance Officer may report the audit findings and CAPs to the COO and/or the A&C

as appropriate.

Third Party Audits

The Health Plan may contract with independent third parties to audit processes and operations against CMS standards and requirements. The results of the third party audits are reported to executive management, the Vice President of Internal Audit & Quality, the Compliance Officer, the Corporate Compliance Committee, the COO and the A&C.

Monitoring and Auditing of FDRs and Subcontractors

The Health Plan contracts with various parties to administer and/or deliver Mountain Health Trust, Medicare Part C and Medicare Part D benefits. These FDRs and Subcontractors must abide by specific The Health Plan contractual and regulatory requirements. Various departments of The Health Plan are responsible for overseeing the ongoing compliance of FDRs and Subcontractors including, but not limited to:

1. Credentialing
2. Pharmacy
3. Provider Network
4. Finance
5. Medicare Operations
6. Medicare Sales
7. Medicaid Operations

The Health Plan performs auditing and monitoring to evaluate the FDRs' and Subcontractors' compliance with regulatory requirements as well as the overall effectiveness of the FDRs' and Subontractors' compliance programs. FDR and Subcontractor audit selection is based upon risk so that higher risk FDRs and Subcontractors are audited more frequently than lower risk FDRs and Subcontractors. All FDRs and Subcontractors must complete a compliance attestation on an annual basis. The Health Plan has developed a Subcontractor Oversight Committee that reviews and coordinates these oversight activities. See also FDR Monitoring Plan and Subcontractor Monitoring Plan.

SIU Monitoring, Audits and Investigations for FWA Issues

The Health Plan's SIU is responsible for investigating issues of possible FWA including investigations related to reports of potential wrong doing of The Health Plan's employees. See Internal Investigations. The SIU also develops and implements training and awareness programs to promote a commitment to compliance by all employees, contracted providers, FDRs and Subcontractors. The SIU is the focal point for FWA investigations and works with I-MEDIC, BMS' Office of Program Integrity, the WV MFCU, law enforcement and other agencies, as required. See also SIU Compliance Plan.

The SIU employs analytical data mining to identify suspicious billing patterns and other indicators of FWA. Results of SIU investigations are reported to the Vice President of Internal Audit & Quality and the Corporate Compliance Committee.

Auditing by Federal Agencies or External Parties

The Health Plan views regulatory audits as an opportunity to confirm that our ongoing compliance efforts are effective and successful. In cases where an audit outcome indicates The Health Plan has not met a regulatory requirement, The Health Plan will use the audit findings to perform a root cause analysis and develop a CAP to

address the identified deficiencies. The Health Plan may also contract with external companies to perform compliance related reviews and assist with programmatic changes to help drive compliance.

The Health Plan cooperates with federal agencies and external parties when audits are completed, and provides auditors access to information and records related to business processes, FDRs and Subcontractors as applicable. The Health Plan allows access to all applicable documentation and records for audits and maintains all records for ten years.

The Compliance Department serves as the point of contact for all audits related to the Medicare Part C and Medicare Part D programs and coordinates auditor requests with all internal departments. Staff from other The Health Plan's departments are charged with coordinating state audits or reviews, although the compliance team is notified of any audit activity and may assist in those audits as needed. See also Coordination of External Audits.

PROCEDURES AND SYSTEMS FOR PROMPT RESPONSE TO COMPLIANCE ISSUES

The Health Plan takes corrective actions whenever there is a confirmed incident of non-compliance. The Health Plan may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, regional collaborative work groups or member complaints, either directly to The Health Plan or through governmental units. Whenever The Health Plan identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

The Vice President of Internal Audit & Quality and/or the Compliance Officer, in conjunction with the Compliance Department, SIU and other key staff, are responsible for reviewing cases of non-compliance and suspect activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, particularly issues involving suspected fraud, the investigation may be delegated to the appropriate internal expert.

Any time a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area is required to implement a CAP which is overseen by the Compliance Department. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Compliance Department on a monthly basis, or at a frequency determined by the Vice President of Internal Audit & Quality and/or the Compliance Officer. The Compliance Department monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Compliance Department tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is complete, the Compliance Department may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to the Corporate Compliance Committee.

The Health Plan's oversight of FDRs and Subcontractors includes a requirement that FDRs and Subcontractors submit a CAP when material deficiencies are identified through compliance audits, ongoing monitoring and/or self-reporting. The Health Plan takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs and Subcontractors are bound contractually through written agreements with The Health

Plan that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

The Health Plan's Corporate Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in the delivery of Parts C and Part D benefits to Medicare beneficiaries, Mountain Health Trust enrollees and other members covered by The Health Plan. Policies and procedures associated with this Corporate Compliance Plan further expand the activities and oversight of the program.

MOUNTAIN HEALTH TRUST ADDENDUM

The Corporate Compliance Plan is applied consistently across all lines of business; however, there are specific requirements and regulations outlined in the contract between The Health Plan and BMS for the Mountain Health Trust line of business. This contract is updated annually by BMS. See also SIU Compliance Plan.

Additional BMS Requirements Pertaining to the Prevention and Detection of FWA

The Health Plan will collaborate with BMS, the MFCU and the OIG on all activities relating to fraud and abuse including retention of the appropriate number of staff to conduct FWA investigative activities related to its Mountain Health Trust line of business. The Health Plan is committed to effectively coordinating both state and internal resources to respond to reports of potential fraud and abuse.

The Health Plan has adopted the following activities in order to effectively respond to potential FWA:

- Underutilization and overutilization of services are monitored for potential provider and beneficiary fraud in accordance with the monitoring guidelines outlined by BMS.
- Procedures are in place to verify whether services reimbursed were actually furnished to a sample of Mountain Health Trust members.
- When The Health Plan is notified that a case has been accepted for state investigation, no further investigation will be conducted by The Health Plan unless specifically directed by the state entity conducting the investigation, or unless approval has been obtained through the established deconfliction process.

The Health Plan has adopted the following activities in order to effectively report potential FWA:

- Procedures for reporting information to BMS include submission of a report of cases involving suspected fraud and abuse within the time frame designated by BMS (by the 15th of each month). This report includes all of the information specifically outlined in the contract for each case reported. An additional report is submitted to BMS annually by June 15 of each year, providing a summary, analysis and results of FWA detection efforts.

The Health Plan has adopted the following activities to effectively address overpayments and recoveries:

- The Health Plan maintains a process for network providers to report receipt of an overpayment as designed by BMS.
- If the BMS Office of Program Integrity (OPI) or the MFCU has assumed responsibility for completion of an investigation and final disposition of any administrative, civil or criminal action taken by the State or Federal government, the BMS OPI or MFCU will direct the collection of any overpayment.
- The Health Plan diligently engages in efforts to identify and review overpayments that do not require a referral to the State of West Virginia. Overpayments identified or recovered are reported on the monthly FWA report. The Health Plan adheres to the requirements set forth in Article III, Section 8.3.3 of the

Mountain Health Trust contract pertaining to the recovery of overpayments.

The Health Plan has adopted the following measurements and milestones to promote the effectiveness of the SIU:

- Routine SIU auditing and monitoring activities are identified in the AWP and tracked in OMT.
- Routine monitoring of claims to promote accurate claims submission and payment.
- Percentage of cases closed with no further actions.
- Percentage of cases closed with action taken in relationship to total cases (e.g., education, monitoring, flagged for pre-pay review).
- Percentage of cases referred to outside entities in relationship to total cases.
- The number of new leads generated from proactive data analysis or review.

The Health Plan has adopted the following activities to promote effective FWA training and education:

- Policies and procedures have been implemented by The Health Plan for the education of employees about the Federal False Claims Act in accordance with Section 6032 of the Deficit Reduction Act of 2005, for any entity that receives or makes Title XIX (Medicaid) payments of at least $5 million annually.
- The Health Plan actively participates in BMS meetings and trainings as directed by BMS.

Oversight

The Mountain Health Trust Oversight Committee monitors all BMS contracts, CMS publications, revisions, new laws and regulations that may affect the delivery of Mountain Health Trust services, and communicates these changes to the appropriate operational areas affected.

See also the Code of Conduct

Approved by the Board of Directors on September 24, 2020.

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