



Medicare Compliance Program 2022

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Definitions

AHCCCS	Arizona Health Care Cost Containment System
CMS	Centers for Medicare and Medicaid Services
CTM	CMS Complaints Tracking Module
EPLS	Excluded Parties List System
FDR	First Tier, Downstream and Related Entity
FWA	Fraud, Waste, and Abuse
GSA	General Services Administration
LEIE	List of Excluded Individuals and Entities
MAPD	Medicare Advantage Prescription Drug
MCA	Mercy Care Advantage
MEDIC	Medicare Drug Integrity Contractor
MIPPA	Medicare Improvements for Patients and Providers Act
MOC	Model of Care (required by CMS for SNP plans)
OIG	Office of Inspector General
SIU	Special Investigations Unit
SNP	Special Needs Plan

Introduction

Mercy Care d/b/a Mercy Care Advantage, holds a contract with the Centers for Medicare and Medicaid Services (CMS) and has a Medicare Compliance Program implemented that meets the requirements and obligations specified in regulations and guidance issued by the CMS and the U.S. Department of Health and Human Services Office of the Inspector General (OIG) which were based upon the United States Federal Sentencing Guidelines' 7 elements for compliance plans. These elements are specifically defined within the CMS Compliance Program Guidelines found in Chapter 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual. Mercy Care has established various policies, processes, and procedural guides which collectively comprise the Program and are used to meet the Part C Medicare Advantage and Part D Medicare Prescription Drug (MAPD) contract requirements. The Program is designed to prevent, detect, and correct Part C and D Medicare program noncompliance and fraud, waste, and abuse (FWA). This document does not necessarily address all compliance activities or details that are conducted on behalf of the Program.

This Medicare Compliance Program is an evergreen document that is updated at least annually or more often as needed to incorporate regulatory and/or Program changes with any material revisions approved by the Mercy Care Audit and Compliance Committee (ACC) which includes members of the Board of Directors (the Board).

For purposes of this document, the Mercy Care organization is referred to as "Health Plan".

Mercy Care is a not-for-profit provider sponsored organization jointly sponsored by Dignity Health d/b/a St. Joseph's Hospital and Medical Center, a California nonprofit public benefit corporation ("Dignity") and Ascension Care Management Insurance Holdings, a Missouri nonprofit corporation ("Ascension Care Management"). Mercy Care holds a contract with the Arizona Health Care Cost Containment System (AHCCCS), which is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. Mercy Care offers integrated care to children, adults and seniors eligible for AHCCCS Medicaid benefits. Mercy Care has been serving Medicaid members across Arizona since 1985. Mercy Care has extensive experience working with the Medicaid funded programs and actively participates the following AHCCCS programs:

- Physical and general mental health and substance use concerns (Mercy Care Complete Care)
- Long Term Care/ elderly, physically disabled (EPD/ALTCS)
- Developmental/cognitive disabilities/ long term care (DDD/ALTCS)
- Medicare and Medicaid (Mercy Care Advantage)
- Serious mental illness (RBHA)

Mercy Care Advantage is a Dual Eligible Special Needs Plan (D-SNP) that provides Medicare Part C covered services and items and Part D prescription drug coverage. Mercy Care Advantage enrolls individuals who are entitled to both Medicare (Title XVIII) and Medical Assistance from the Arizona Health Care Cost Containment System (AHCCCS) under Title XIX (Medicaid). MCA began serving the Medicare dual eligible population as of January 1, 2006.

A first tier delegated Plan Management Service Agreement exists between Mercy Care and CVS/Aetna. Under the Plan Management Services Agreement, both CVS/Aetna and Aetna Medicaid Administrators, LLC, are responsible to provide daily operational plan management services for the Mercy Care and Mercy Care Advantage Plans. This Medicare Compliance Program along with the Medicare Compliance policies and the CVS/Aetna standards of conduct, Code of Conduct, policies and procedural guides and tools maintained by CVS/Aetna and Mercy Care collectively comprise the Medicare Compliance Program. CVS/Aetna follow the CVS Health Code of Conduct (Code). As set forth in the Code and/or Compliance Policies and Procedures, the Company is committed to conducting business in an ethical and professional manner and in full compliance with all applicable federal and state laws, regulatory and sub-regulatory guidance applicable to the Mercy Care Medicare Advantage Prescription Drug contracts held with CMS.

Mercy Care leadership and CVS/Aetna are committed to make Compliance a Core Competency throughout the company. Compliance as a Core Competency means creating and maintaining a company culture where employees at all levels are committed to:

- Complying with our legal and regulatory obligations
- Honoring commitments and keeping our promises
- Doing the right things for the right reasons, and asking for help when the choices aren't clear
- Behaving ethically
- Raising problems and concerns as soon as they come to light so they can be addressed in a timely manner

Because of this commitment, compliance is also an important measure used in employee performance evaluations.

Section 1. Medicare Compliance Officer, Compliance Committee, and Oversight Structure

The Medicare Compliance Officer (MCO) supporting Mercy Care Advantage is a full time, experienced employee of Dignity Health, one of the co-sponsoring organizations accountable for Mercy Care. The MCO is primarily responsible to act as the principal leader in the oversight, development, and implementation of the Program. The MCO serves as the Chair of the Medicare Compliance Committee (MCC) to oversee implementation and monitor the execution of the Program with support from the MCC and compliance personnel. The MCO has “dotted line” reporting responsibility to the Chief Executive Officer, Chief Operating Officer and the Head of Medicare Product. The MCO provides unfiltered reports to the Mercy Care Audit and Compliance Committee of the Board of Directors. The MCO has access to company personnel, documents, legal counsel, operational units, first tier, downstream, and related entities (FDRs), as needed to support the Program activities.

The MCO and compliance staff are responsible for managing and implementing the Program and work collaboratively with the Mercy Care Leadership, Mercy Care Audit and Compliance Committee and Corporate Compliance to monitor and maintain compliance with our Medicare contract requirements.

I. Medicare Compliance Officer

The MCO’s primary responsibility is to facilitate the day-to-day operations of the Program. The MCO supports the Health Plan and contracted FDR staff in performing their respective operational functions and oversight and monitoring activities in compliance with all federal and State laws to comply with applicable regulatory requirements and conduct themselves in conformity with the required standards of conduct described in the CVS Code of Conduct.

The MCO duties include, but are not limited to:

- a. Regularly creating and delivering reports, as applicable, such as:
 - Medicare Compliance Reports for CEO, COO and Medicaid Quarterly Business Review
 - Medicare Compliance Reports for the Medicare Compliance Committee and Mercy Care Audit and Compliance Committee
- b. Ensuring Mercy Care Leadership, the Medicare Compliance Committee, Mercy Care Audit and Compliance Committee, and Board have an awareness of Program activities, including risk issues identified, investigated, and resolved as well as any regulatory enforcement actions, audit results, and corrective actions implemented.
- c. Acting as the Medicare Compliance central point of contact for internal and external constituents.
- d. Providing timely and accurate responses to regulatory and internal inquiries.
- e. Hosting/Participating in ongoing and periodic meetings with operational business units to provide compliance, support and input. Collaborating with management on the development and implementation of effective training for employees who have responsibility for MCA operations and the Model of Care requirements.
- f. Oversee and monitor that applicable Corporate trainings (Code of Conduct, Compliance and FWA, etc.) are completed at time of hire and annually by the Mercy Care governing body, managers, employees (including temporary employees & volunteers), FDRs, and other individuals supporting MCA.
- g. Maintaining awareness of Medicare Program guidance and any revisions published by CMS and the OIG in order to amend the Program, as appropriate. Ensuring new federal regulations or guidance applicable to the Medicare Advantage Prescription Drug (MAPD) program are reviewed and disseminated to the appropriate operational staff/FDRs and monitored for timely implementation.
- h. Coordinating and conducting regular compliance audits to validate contract performance and compliance with applicable federal and state standards. Coordinate with operational business management to facilitate the activities required for CMS Program Audits and other types of regulatory audits and monitoring projects. Oversee the development, implementation and monitoring of corrective action plans based on the outcome of internal and external audits.

- i. Requiring management and employees of impacted departments and/or sub-contractors to implement corrective action(s), as appropriate, upon completion of internal investigation of identified compliance or FWA risk issues.
- j. Monitoring Health Plan compliance with the development and timely submission of all Part C and D reporting and other contract deliverables in accordance the guidelines and timelines established by CMS.
- k. Promote through education and other activities, the no-tolerance policy for retribution or retaliation against any good faith reporting conducted by employees and FDRs.
- l. Oversee and monitor the completion of monthly verification of the Health Plan's governing body, employees, contractors and temporary employees and volunteers supporting MCA are checked against the Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS) exclusion lists prior to hire and monthly thereafter.
- m. Support the Health Plan efforts to monitor and oversee first tier, downstream and related entities (FDRS) contracted to perform delegated functions on behalf of MCA.
- n. Coordinate with CVS/Aetna Special Investigations Units ("SIU") to support the investigation of suspected Health Plan fraud or misconduct cases identified through internal or external monitoring and data analysis. Assist in the development of appropriate corrective or disciplinary actions, as required and ensure timely reporting to the NBI MEDIC, AHCCCS, law enforcement and/or other applicable government authorities as required. Keep the Mercy Care Leadership, the Medicare Compliance Committee and Mercy Care Audit and Compliance Committee apprised of identified and reported incidents.

II. Medicare Compliance Committee (MCC)

The Medicare Compliance Committee (MCC) oversees the Program and is comprised of management staff from the Health Plan's operational business areas. The MCC is chaired by the MCO and meets at least quarterly. An MCC Charter is maintained and describes the committee's obligations. The MCO regularly reports the outcome of MCC activities and other types of contractual information to the CEO, COO, and Mercy Care Audit and Compliance Committee, and governing body.

III. Governing Body and Mercy Care Audit and Compliance Committee

Mercy Care has an established Board of Directors and several sub-committees to oversee Health Plan compliance with legal and regulatory requirements. Mercy Care's Executive Leadership meets on a regular basis, but no less than quarterly with the Mercy Care Audit and Compliance sub-committee and Board of Directors. Several members of the Board of Directors are members of the Mercy Care Audit and Compliance Committee.

The Mercy Care Audit and Compliance sub-committee identifies standing agenda topics and reports prior to the beginning of each calendar year. The Medicare Compliance report is a required standing report. The MCO develops and presents a Medicare Compliance report for each Mercy Care Audit and Compliance Committee. Reports include details on the status of Program activities, including but not limited to compliance or operational risk issues identified, investigated, and resolved, enforcement actions imposed by CMS, results of internal and/or CMS audits and corrective action activities implemented, and new regulatory requirements that affect the Mercy Care Advantage contract. If the MCO is unable to attend a meeting, the Medicare Compliance Manager will attend to present the report. Additional actions requested by the committee are captured in the meeting minutes and status updates from the MCO are shared at the next scheduled meeting or via email depending on the urgency. Issues raised by the MCO requiring action or support from members of the Audit and Compliance Committee are documented in the meeting minutes. The Chair of the Mercy Care Audit and Compliance Committee keeps the Board apprised of risk issues and other important Medicare contract requirements reported by the MCO. The Health Plan and Board maintain copies of the Mercy Care Audit and Compliance Committee agendas, reports, and minutes.

IV. Mercy Care Leadership and Sub-Committee Engagement

Mercy Care Leadership and Medicare Compliance work collaboratively to implement processes that provide effective oversight, monitoring, reporting, and corrective action for identified risks issues. Listed below are the key standing

committees that support the monitoring and oversight efforts of the Program. Reports and information obtained from these committees are reported to the Medicare Compliance Committee and the Audit and Compliance Committees.

Arizona Collaboration and Information Team (ACI)

The ACI consists of executive and senior leadership staff that meet regularly to discuss new and existing business initiatives, operational and compliance issues. At this meeting, the MCO reports identified compliance risks, compliance initiatives, audit activities and new regulatory guidance.

MCA Joint Operating Meeting:

The MCA Joint Operations Meeting is a monthly sub-committee of the Medicare Compliance Committee and is chaired by the Director of Medicare Product. This committee includes Medicare Compliance and management staff from the Health Plan's operational business units. The objective of this committee is to:

- Discuss operational issues and identified compliance risks/concerns affecting Mercy Care Advantage
- Discuss open audits (internal/external), finalized results and status of corrective action plans
- Discuss enforcement actions imposed by CMS
- Discuss new regulatory requirements and guidance and monitor timely business implementation and policy development
- Discuss existing and new business initiatives
- Discuss and review MCA performance metrics, including the status of Medicare Part C & D reporting data, Model of Care evaluations and other Medicare contract deliverables.

Delegation Oversight Committee

The Delegation Oversight Committee meets monthly to track, monitor, and oversee the operational functions delegated to First Tier, Downstream and Related Entities (FDRs). The Delegation Oversight Committee objectives include the review of new delegation proposals to assess the level of risk involved to determine if an FDR selected is appropriate to manage the functions proposed for delegation and to oversee, monitor, and validate existing FDR performance, which includes the outcomes of routine monitoring and auditing, corrective action plan implementation and compliance with applicable laws, rules, and regulations with respect to the Medicare Part C and D programs and State Medicaid Program. Medicare Compliance supports the committee objectives, provides reporting, education, and helps ensure there are effective lines of communication with contracted FDRs to comply with their contractual requirements and to remediate reported compliance concerns in a timely manner. Mercy Care maintains ultimate responsibility for adhering to and fully complying with all terms and conditions of its CMS contract, including the responsibilities and contractual obligations performed by FDRs.

FDR Joint Operating Committees

Mercy Care holds routine Joint Operating Committees (JOC) with contracted FDRs to use as a forum to review their performance metrics, audits results and corrective actions plans and to provide oversight, monitoring and education for new regulations affecting the Mercy Care lines of business supported by the FDR.

Section 2. Policies and Procedures, and Code of Conduct

I. Standards of Conduct and/or Compliance Policies and Procedures

CVS/Aetna and Mercy Care are committed to following the standards of conduct outlined in the CVS Health Code of Conduct (Code). This includes the implementation of standards of conduct and/or Compliance Policies and Procedures that reflect a commitment to conduct business based on the highest ethical standards and in strict compliance with applicable federal and state laws and regulations. These documents describe compliance expectations and operations and support implementation of the Program. These documents are reviewed annually and updated, as necessary, to incorporate regulatory and/or Program changes. The Code and/or Compliance Policies and Procedures include, at a minimum, the following:

- a) Our commitment to the highest standards of ethical business conduct and compliance with all applicable laws and regulations, sub-regulatory requirements, and standards.
- b) The expectation that employees perform job responsibilities in compliance with the Code, applicable laws and regulations, and company policies, as well as their obligation to immediately report any suspected violations of the Code, the law or company policies and the methods available for reporting.
- c) Expectations and resources for reporting, investigating, and resolving potential, detected, or reported compliance and/or Fraud, Waste and Abuse ("FWA") concerns with the assurance of non-retaliation.
- d) The assurance that every reported compliance or FWA concern will be thoroughly investigated, as warranted, and the situation resolved/corrected.
- e) Disciplinary Policy, including a policy of non-intimidation and/or non-retaliation for good faith participation in the Program for reporting concerns internally, collaborating on investigations, conducting self-evaluations, audits and remedial actions, reporting concerns to law enforcement or a government agency, or other activities in support of the Program.

CVS Code of Conduct: <https://www.cvshealth.com/sites/default/files/cvs-health-code-of-conduct.pdf>

II. Policies and Procedures

The Medicare Compliance Policies and Procedures define and implement the Program. They are reviewed at least annually and updated as necessary. These policies and procedures address specific Program requirements such as the following: effective lines of communication; training; monitoring and auditing; issue identification, investigation, and corrective action plan implementation.

In addition, the Health Plan's business units are responsible to develop and maintain departmental policies and desktop procedures to support the organization's operations, business standards, and regulatory requirements. The CVS/Aetna Special Investigation Units maintain Anti-Fraud Plans and policies to facilitate prompt and appropriate actions for instances of potential FWA. The management staff of each operational business unit is accountable to distribute approved policies and desktops to their employees and conduct training when policy and desktop changes occur. Employees are expected to be well versed in the current operational policies and desktop procedures applicable to his or her job responsibilities.

All new and existing departmental operational policies must go through the Health Plan's Policy Committee for review and approval annually or when new regulatory guidance is introduced and must be incorporated. Medicare Compliance reviews policies applicable to the MCA line of business and participates in the Policy Committee. The policy committee tracks the status of all operational policies reviewed and approved, including maintaining policies for record retention..

Distribution of Standards of Conduct, the Medicare Compliance Program and Policies and Procedures

The CVS Health Code of Conduct is distributed to all employees along with mandated compliance and fraud, waste, and abuse training which is conducted initially within 90 days of hire/appointment and at least annually thereafter and/or when material changes occur and expresses general compliance expectations to all employees involved in the administration of Medicare business. The Code is available via the Company's external Internet sites, as well as via the Company's internal website, which is accessible to all employees. The Code is updated as needed and distributed at least annually and/or when material changes to its content are made.

Medicare Compliance publishes the Medicare Compliance Program and Medicare Compliance Policies on the Medicare Compliance SharePoint site which is accessible to Mercy Care employees. On an annual basis, Medicare Compliance distributes an overview of the Medicare Compliance Program requirements via an employee newsletter that explains how to contact Medicare Compliance with any questions about the Program and how to report compliance issues or concerns.

First Tier, Downstream and Related Entities (FDRs)

Contracted FDRs must have a Compliance Program that includes applicable compliance and business policies including monitoring, investigating, and reporting suspected FWA. Mercy Care issues an annual FDR Compliance Packet and Attestation which outlines contracted FDRs obligations. FDRs are required to complete and return a signed attestation confirming organizational compliance with their contract, federal and state requirements, and obligations. A copy of the Mercy Care Advantage Compliance Program and CVS Code of Conduct are made available to FDRs via the Health Plan's website and compliance policies are made available to a contracted FDRs upon request.

Section 3. Training and Education

A key component to building and maintaining a culture of compliance is effective communication, education, and training programs. Medicare Compliance helps to oversee that training and education is provided to all employees supporting MCA, which includes General Compliance, FWA, new regulatory guidance, and specialized training at the time hire and annually thereafter.

I. General Compliance and Fraud, Waste and Abuse Training

CVS/Aetna has instituted a robust compliance training program that includes the CVS Health Code of Conduct and Medicare General Compliance and FWA content as well as expectations for ethical conduct as set forth in the Code. Completion of this training program is required of all employees that support the Medicare product lines, including executives and senior managers. These trainings are made available to employees via the Learning Hub and includes testing. Employees must complete the CVS Health Code of Conduct and the general compliance and FWA training at the time of hire and annually thereafter. Completion is tracked to demonstrate fulfillment of the training requirement. The training includes the reporting requirements and the various methods available for reporting.

As an employee of Dignity Health, the MCO completes the Dignity Health Code of Conduct and specialized trainings, the CVS Health Code of Conduct and the general compliance and FWA training as well as other specialized CVS and Mercy Care trainings required annually.

Members of the Mercy Care Board of Directors complete the Code of Conduct applicable to their sponsoring organization when appointed and annually thereafter. In addition, general compliance and FWA training is provided to the members of the governing body via a power-point training presentation prepared by the Center of Medicare and Medicaid Services (CMS). Medicare Compliance distributes the CMS training presentation to the existing governing body members electronically at the time of appointment and annually thereafter. When changes to the Board of Directors occur, Medicare Compliance is notified and provides the newly appointed member with the required training electronically for completion within 90-days of appointment. Both existing and new governing body members are required provide a completed training attestation to Medicare Compliance within 30-days of receiving the required training.

Mercy Care Leadership, managers, employees, temporary employees, contractor, and contracted FDRs must comply with all Federal laws and regulations designed to prevent fraud, waste, and abuse including, but not limited to, applicable provisions of the Federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq.), the anti-kickback statute (section 1128B (b)) of the Act and HIPAA privacy and administrative simplification rules at 45 CFR parts 160, 162 and 164.

First Tier, Downstream and Related Entities (FDRs)

Medicare Compliance communicates training expectations to contracted FDRs in the annual FDR Compliance Packet, newsletters and other important compliance/FWA information. FDRs are expected to have a Compliance Program and compliance and business policies implemented and must conduct applicable training for employees at time of hire and annually thereafter. The annual FDR Compliance Packet is provided to contracted FDRs via electronic delivery at the time of contracting and annually thereafter. FDRs are required to complete and return a signed attestation confirming their organizations compliance within the timeframe specified. Copies of the annual FDR Compliance Packet attestations are tracked and retained as part of the Delegation Oversight Committee processes. Audits of FDRs are conducted to validate compliance with their contractual obligation to provide and maintain documentation to support required employee training.

Contracts executed with FDRs who will administer Medicare Part C and D benefits include a Medicare Advantage Addendum that contains the CMS contracting language requirements. The addendum includes the following contract requirements: HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with the MA organization) through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later (422.504(i)(2)(i) and (ii)).

In addition to the requirements set forth by CMS and the OIG, Mercy Care and contracted FDRs must abide by the applicable provisions under Title 42 of the Code of Federal Regulations, Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973 Genetic Information Nondiscrimination Act of 2008, and Americans with Disabilities Act.

Providers

Contracted providers are responsible to provide Medicare Parts C and D Fraud, Waste and Abuse and General Compliance training to their staff at time of hire and annually and may utilize CMS training to meet this requirement. Providers who have met the FWA certification requirements through enrollment into the Medicare program or have accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and supplies (DMEPOS) are deemed to have met the FWA training and educational requirements but are still required to complete the general compliance training component.

Members

FWA education is communicated to members through various mechanisms, such as member website information and newsletters.

III. Specialized Training

Specialized training may be developed, delivered, and required based on an employee's job function and training needs as identified by Medicare Compliance and/or Management to address operational and procedure requirements or education on regulatory and sub-regulatory requirements or a combination of both.

Dual Eligible Special Needs Plan Model of Care (MOC) Training

As required under our Medicare Advantage Dual Eligible Special Needs Plan contract, MCA is required to implement a Model of Care training that describes the following:

- Define Model of Care, Special Needs Plan, Interdisciplinary Team, and other terminology used
- Describe the targeted populations that meet the criteria for the Model of Care
- Review the SNP quality requirements based upon Medicare Improvements for Patients and Providers Act "MIPPA" regulations
- Recognize the key components that comprise the Model of Care
- Describe the integrated complex case management program
- Identify departments responsible for the management of the program
- Outline the benefits of this program for enrollees

The MOC training is maintained by Medicare Product and reviewed annually for required updates. All employees, providers and FDRs supporting MCA are required to complete Model of Care Training within 90 days of hire or contracting and annually thereafter. This training is included as part of the MCA employee new hire training curriculum and is available via the Aetna Learning Center.

Network providers are educated on the MOC requirements and receive training via the online training module on the Mercy Care Provider website. The training includes an attestation that must be completed by providers. Network Management Representatives monitors provider completion and include reminders during the monthly Joint Operating

Committee when meeting with providers. Additionally, the MCA Provider Manual contains information about the MOC training requirement.

Delegated entities (FDRs) responsible to perform functions associated to the MOC requirements are provided with an electronic copy of the MOC training for completion at time of contracting and annually upon updating. Training must be completed by FDR employees within 90 days of receipt.

Regulatory Guidance Distribution

Medicare Compliance is responsible for tracking, analyzing, summarizing, and distributing new laws, regulations, and guidance policies specific to the Medicare Program. Medicare Compliance facilitates timely distribution of all guidance memos and new regulations issued by CMS to appropriate Health Plan staff and FDRs. Medicare Compliance discusses new regulatory guidance at applicable standing operational committees. In addition, the Medicare Compliance Officer communicates key regulatory guidance and actions required to the CEO/COO and the Mercy Care Board via standing compliance reports.

New regulatory guidance issued that has significant MCA operational impact and requires system enhancements and Information Technology (IT) funding or new operational policies and procedures is reviewed and facilitated via applicable standing operational committees and/or a workgroup to monitor timely implementation. A guidance summary containing a brief description of all CMS memos issued is distributed twice a month to all business areas supporting MCA to promote general awareness. All regulatory guidance distributed is retained on the Medicare Compliance SharePoint site.

Section 4. Effective Lines of Communication

Compliance risk issues can be identified and reported by internal and external sources. Medicare Compliance and Corporate Compliance foster open lines of communication among all Program constituents (e.g., Health Plan employees, FDRs, business partners and Board members). Various methods of communication are used to ensure critical information is communicated timely across the organization and to external entities to ensure employees and business partners understand compliance, who to contact to ask compliance questions and how to report compliance concerns.

The following are examples of the methods of communication used:

- Email Communications
- Compliance Newsletters
- Compliance Trainings
- Medicare Compliance Share Point
- FDR Compliance Packet
- FDR Newsletters
- Verbal Reporting during internal and external meetings/committees
- Written Reports
- Medicare Compliance Mailboxes available to constituents to ask questions and/or to report suspected compliance concerns/misconduct
- CVS/Aetna Ethics Line available to constituents to report suspected compliance concerns/misconduct

Formal mechanisms include the CVS/Aetna Corporate Compliance communications that are widely publicized and accessible to all (e.g., employees, FDRs, etc.) that include methods for anonymous and confidential (to the greatest extent possible) good faith reporting of potential compliance and FWA issues as they are identified. These mechanisms are publicized in various manners (e.g., website, Code, and training materials). A no-tolerance policy for retribution or retaliation against any good faith reporting is strongly enforced by Mercy Care and CVS/Aetna.

Ethics Line

The CVS Ethics Line is available to internal and external constituents for reporting compliance violations or business conduct/integrity problems, toll-free at 1-877-287-2040 in the U.S.* (available 24 hours a day, 365 days a year). Anonymous reporting is permitted. The Ethics Line is publicized during the annual CVS Health Code of Conduct and Compliance Training, compliance communications issued by Corporate Compliance and on the Corporate Compliance website available to employees. Medicare Compliance routinely publicizes the availability of the Ethics Line for reporting in the Compliance and FDR newsletters distributed to internal and external constituents.

Corporate Compliance Communications

The Corporate Compliance department maintains a Compliance & Integrity internet site at:

<https://heartbeat.cvshealth.com/sites/our-company/our-organization/compliance-integrity-group/compliance-integrity>.

This site is available to all employees and contains Compliance contact information, information about the Code of Conduct and Ethics Line, as well as other important resource information.

Medicare Compliance Communications

Medicare Compliance develops and distributes quarterly MCA Compliance newsletter to Mercy Care employees and will issue ad-hoc newsletters to communicate urgent topics requiring employee awareness and education. An FDR newsletter is issued at least twice a year to promote FDR awareness and education. Medicare Compliance provides ongoing communication of new/revised statutory, regulatory, or sub-regulatory guidance, and changes to compliance

policies/procedures or standards of conduct, including member communication and education requirements to business partners.

Leadership Communications

Both CVS/Aetna and Mercy Care Leadership use various communication strategies and tools such as monthly newsletters and emails to disseminate information and keep employees apprised of new and existing business initiatives, training reminders, employee recognition, and other important information.

Section 5. Routine Monitoring & Identification of Compliance Risks

Immediate identification and remediation of compliance risk issues is critical. Reporting Standards of Conduct violations and suspected non-compliance is everyone's responsibility. This is accomplished through on-going proactive operational processes and continuous oversight and monitoring activities conducted throughout the calendar year. This Program utilizes CMS requirements and audit protocols to conduct on-going risk assessment, monitoring and auditing of internal business units and FDRs delegated for the Medicare Part C and Part D operational functions. These processes help to identify, prevent, detect, and correct Medicare Parts C and D program non-compliance and fraud, waste, and abuse (FWA) in a timely and well-documented manner. In addition to the activities performed by Medicare Compliance, the Health Plan business areas and FDRs supporting MCA are expected to test compliance of their operations against CMS requirements by conducting routine audits, oversight, and monitoring. When areas of non-compliance are identified, this must be immediately reported to Medicare Compliance. Medicare Compliance will assist in determining the remediation actions required and determining if CMS disclosure is required.

Tracking of identified Compliance Risk and FWA Issues

When risk and/or suspected FWA issues are identified, through either internal or external parties, Medicare Compliance will track and investigate the issue. Risk issues are logged and tracked by Medicare Compliance on the Medicare Compliance Risks/FWA Issues Tracking Log, which is maintained on the Medicare Compliance SharePoint. Within three business days of identification, Medicare Compliance begins conducting investigation of the issue received with the applicable business managers and/or FDRs.

Part C and D fraud allegations are logged and tracked by both Aetna SIU and Medicare Compliance. Health Plan identified incidents involving potential MCA FWA are elevated to CVS/Aetna SIU for proper investigation and timely reporting to the MEDIC. CVS/Aetna SIU provide routine updates for all open cases and notification of closed cases.

Medicare Compliance will assist in determining the corrective actions and timeframes required for remediation of identified risk issues and will monitor timely corrective action implementation. Medicare Compliance tracks the risk issue until it is deemed to be remediated and retains documentation supporting the investigation and resolution actions for reporting and auditing purposes. Risk issues are categorized by the month identified and name of the issue. Medicare Compliance determines if a risk issue requires CMS disclosure based on the type of issue, duration, and level of member impact (access to services/drugs).

Risk Assessment

On an annual basis, Medicare Compliance conducts a baseline operational risk assessment of the business units and FDRs supporting the MCA line of business. This process includes the awareness of current business operations, consultation with business management as needed, and the application of regulatory requirements and areas of focus (e.g., CMS audit protocols/findings and new regulatory guidance). This assessment is designed to review and rank the risk level (e.g., high, medium, low) to prioritize the key regulatory risks for our Medicare line of business. Risk assessments are re-evaluated at least quarterly to account for significant changes to the regulatory environment and/or organizational or procedural changes, as well as to re-evaluate the accuracy of the baseline assessment.

In addition, to the process described above Medicare Compliance uses these additional assessment methods to identify compliance risks and FWA issues:

- Identifying internal and external operational risks areas, based on consultation with business management regarding changes in regulation, material changes affecting operations & systems and/or delegation to an FDR to perform business operations,
- Monitoring, including a review of the monthly MCA Part C and D operational dashboard metric results for performance and compliance measures

- CMS Compliance Notices, Negative Performance Points or decrease in MCA Star Ratings
- Results from internal compliance audits, CMS audits and monitoring projects, changes to CMS Audit protocols and annual reports issued by CMS or the Office of Inspector General (OIG)
- FDR oversight and monitoring and audit results
- MCA Compliance Issues Log and internal Warning/Notices of Non-Compliance Issued
- Trends identified through MCA member complaints, grievances and/or CMS CTM complaints filed
- Identified suspected FWA incidents, CMS Fraud Alerts and MEDIC reporting
- Marketing oversight of agent compliance (testing, certification, payment, complaint allegations etc.),
- Industry information, including newsletters, CMS and/or other industry webinars & conferences hosted to support regulatory requirements, etc.

Health Plan and FDR operations identified as high risk will be subject to on-going routine audits, oversight, and monitoring. Medium risk areas are subject to increased oversight and monitoring, and audits. Low risk areas are routinely monitored and may be subject to ad-hoc focused audit when deemed necessary. Medicare Compliance reserves the right to conduct ad-hoc focused audits as new risks are identified. The results of the operational risk assessment contribute to the development of the audit schedule and other compliance program objectives for monitoring and oversight.

"Monitoring" vs. "Auditing": What is the Difference?

It is important to distinguish between monitoring activity and auditing activity. 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. An audit is a formal review of compliance with a particular set of standards and elements (e.g., policies and procedures, laws, and regulations) used as baseline measures.

Monitoring

Internal monitoring activities include regular reviews confirming ongoing compliance and taking corrective actions if a problem is identified. Each operational business area and FDR is accountable to conduct self-monitoring (e.g., performance metrics monitoring, quality assessments, etc.) and immediately communicate risks identified to the MCO. Medicare Compliance monitors and works with the operational business areas and FDRs to help identify and resolve problems before they escalate into a situation of non-compliance. This process includes the collection and analysis of Part C and Part D performance data (dashboards and other reporting data). In addition, risk issues may come to Medicare Compliance from other sources such as CMS CTMs and congressional agencies. Compliance risks identified during routine monitoring activities are logged and tracked on the Medicare Compliance Risks/FWA Issues Tracking Log for proper investigation and resolution. Medicare Compliance reserves the right to issue a warning notice and/or notice of non-compliance depending on the level of risk and non-compliance identified.

Audit Schedule and Auditing

Medicare Compliance develops an MCA monitoring and audit schedule each calendar year. The audit schedule includes the monitoring and auditing activities Medicare Compliance has planned for the upcoming calendar year. The audit schedule is subject to change as new risk areas are identified and based on the outcome of the quarterly risk assessments conducted. The audit schedule is presented to the Mercy Care Audit and Compliance Committee and Medicare Compliance Committee for approval.

Internal auditing is a formal review of compliance with a particular set of standards (policies, procedures, laws, and regulations) used as base measures. Medicare Compliance personnel are proficient in their assignments for monitoring and auditing and any associated CMS regulations or guidance related to the areas under review. In addition, the staff has full access to data/personnel and processes to complete their work assignments.

Medicare Compliance conduct audits using current Medicare Part C and D program manuals and CMS Audit Protocols to test compliance with Medicare requirements, contractual agreements, and policies and procedures. Medicare Compliance coordinates and oversees each audit, which includes advance notification to the operational business units and/or FDRs scheduled for audit.

- The audit notice outlines the scope of the audit and expected deliverables required to conduct the audit. Audits are conducted via live webinar and/or desk review depending on the scope of the audit. Upon audit completion, a detailed audit report summarizing the results is issued.
- The audit report outlines the areas of compliance, findings, and observations and explains corrective actions required, as applicable. A post-audit discussion of the findings and corrective actions required is held with the business management when deemed necessary by the auditor. If any issues of potential fraud, waste, and abuse are identified during an audit, Medicare Compliance makes a referral to Aetna/CVS SIU for investigation.
- If an audit identifies deficiencies the operational business unit(s) and/or FDR will be required to provide a Corrective Action Plan describing the remediation action and timeframes required to correct the identified deficiencies. Medicare Compliance monitors timely implementation of the corrective actions and requests documentation to validate the actions implemented have cured the deficiencies.
- Validation may include testing or other applicable methods to support remediation. Following an audit, Medicare Compliance will evaluate and assign a risk level to determine if another ad-hoc audit is needed in addition to on-going monitoring. Medicare Compliance retains all audit documentation.
- Medicare Compliance communicates audits results to the Medicare Compliance Committee, Mercy Care Audit and Compliance Committee, and the Delegation Oversight Committee. Copies of final audits reports are posted to the Medicare Compliance SharePoint and in Board Effects for the Mercy Care Audit and Compliance Committee members.

Per CMS requirements an examination of the performance of the Program effectiveness is to be conducted annually, by parties outside of Medicare Compliance to avoid self-policing and is a critical activity. The outcome of the evaluation and any follow up actions are shared with Mercy Care Leadership, Mercy Care Audit and Compliance Committee and the Medicare Compliance Committee.

Audits by CMS or CMS Designees

Mercy Care is committed to cooperating with audits conducted by CMS or its designees for the MCA contract whether conducted as an onsite, via webinar, or as a desk review. The MCO is the point of contact for CMS audits and may assign a designee for CMS audit activities. The MCO is responsible for ensuring the coordination of all CMS audit requests and deliverables. Contracted FDRs must also participate in regulator audits and are contractually required to comply with access to records and maintaining records to support regulatory audits.

Relationships

Under the Plan Management Services Agreement with CVS/Aetna, the following departments within corporate shared services may help to support the efforts of this Compliance Program.

- Internal Audit Department may conduct enterprise-wide risk assessment that includes Medicare systems, process, or operational business areas. In these situations, Medicare Compliance may engage with Internal Audit to understand the scope of the audit and assist, as applicable. A copy of the audit report issued by Internal Audit is requested.
- CVS/Aetna SIU is responsible for preventing, detecting, and correcting FWA activities applicable to Mercy Care's Medicare contract. Medicare Compliance collaborates with SIU to support their activities. CVS/Aetna SIU maintain Anti-Fraud Plans and FWA policies.

- Corporate Investigative Services and other units as required.

CMS Annual Readiness Assessment

Each fall, CMS issues their annual Readiness Checklist summarizing the Part C and D regulatory requirements that Medicare Advantage Prescription Drug Plans must apply and comply with in the coming calendar year under their contractual obligation with CMS. Management of the operational business units supporting MCA must review their department's current processes, policies, desktops, and systems to determine compliance with the CMS checklist requirements. If a business area or FDR identifies they will be unable to comply with a regulatory requirement by the beginning of the new calendar year they must notify the MCO immediately to discuss and develop a corrective action plan. Medicare Compliance is required to have a discussion with CMS Plan Manager regarding the Health Plan's readiness and must disclose any areas of non-compliance and corrective actions for remediation.

Section 6. Disciplinary Standards and Enforcement

CVS/Aetna and Mercy Care have implemented procedures that encourage good faith participation in the Program. These expectations are defined in the Code and/or Compliance Policies and Procedures and are enforced through Company policies. Various resources (e.g., required trainings, intranet postings) reiterate and remind employees about the expectations and the consequences for failing to comply.

I. Disciplinary Standards

The Company's disciplinary policies and procedures address the following:

- a. Code and/or Compliance Policies and Procedures
- b. Misconduct (includes definition, examples of misconduct, reporting expectations, and types of disciplinary actions). Unethical, illegal, and noncompliant behavior (e.g., not meeting training and/or reporting expectations) are considered acts of misconduct.
- c. Addressing Misconduct (includes guidance for managers to work with the appropriate area to investigate and take timely, consistent, effective, and appropriate action for misconduct, and details of types of disciplinary actions).

II. Methods to Publicize Disciplinary Standards

- a. Embedded in the Code and/or Compliance Policies and Procedures
- b. Policies are posted on Company's internal policy and procedure portal(s)
- c. General Compliance and FWA Training
- d. Publication of articles highlighting key compliance expectations on Company Intranet sites
- e. Leading with Integrity – quarterly compliance videos and facilitated discussions at staff meetings
- f. Expectations, including available resources, are communicated through onboarding and annual training provided to employees, as well as FDRs

III. Enforcing Disciplinary Standards

- a. Disciplinary actions, up to and including termination of employment, may occur if the employee does not follow the Code or Company policies, does not cooperate or assist in an internal investigation, as needed, or neglects to report a violation of the Code, the law, or Company policies (e.g., unethical or noncompliant behavior, reporting compliance issues or assisting in their resolution as needed).
- b. Disciplinary actions that may be taken for non-compliant business practices include (but are not limited to) the following:
 - Verbal and/or written consultations
 - Internal Notices of Non-Compliance
 - Internal Corrective Action Plans
 - Mandatory Management Action Plans
 - Notice to cure and/or contract terminations for FDRs
- c. Disciplinary actions that may be taken for non-compliant behavior for an employee include (but are not limited to) the following:
 - Coaching;
 - Training (e.g., Code of Conduct, Sexual Harassment, Civil Treatment, and Information Security);
 - Written Disciplinary Warnings for Misconduct;
 - Suspension without pay;

- Financial consequences (e.g., employee will be charged equipment replacement fees in negligent situations such as a laptop theft, restrictions in incentive compensation plan participation or reductions in bonus or merit payments);
- Reporting relationship change or transfer to another position;
- Notification to external entities such as law enforcement/regulatory agencies and licensing boards; and
- Termination of employment.

d. Actions taken to address substantiated misconduct situations is determined based on factors including (but not limited to) the following:

- Severity of behavior
- Impact on employees and Aetna
- Whether there was intent
- Previous disciplinary history
- Other facts specific to each situation

e. The Company strongly enforces a no-tolerance policy for retaliation or retribution against any employee or FDR employee who in good faith reports suspected noncompliance or FWA, regardless of whether the report is made within Aetna or to a governmental agency

f. The CVS Health model used for applying disciplinary actions to employees provides for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined to have occurred.

g. Records are maintained in accordance with the Record Retention Policy for a period of no less than ten years and include the date the violation was reported, description of violation, dates of investigation, a summary of the findings, the disciplinary action taken and the date this action was applied.

Section 7. Procedures for Prompt Response to Compliance Issues

When a possible instance of non-compliance or FWA is suspected, detected, reported, or discovered internally or externally, a proper and thorough investigation will commence, and action will be taken to cure the issue and prevent reoccurrence.

I. Conducting a Timely and Reasonable Investigation of Detected Offences

- a. The MCO acts promptly to investigate detected offences and may delegate duties associated to the investigation, as needed.
- b. Regardless of how the issue was identified (e.g., Ethics Line, complaint, informal reporting, or external regulator audits), an investigation will begin within three business days of identification. The scope of the investigation is based on the evaluation of the initial and ongoing information with the goal of completing a timely and reasonable investigation based on the severity of the detected offense.

II. Corrective Actions

- a. Confirmed instances of noncompliance result in the development of internal corrective and preventative action plans to resolve identified deficiencies, correct the underlying problem that led to the deficiency, and conduct follow-up monitoring/validation review to ensure the actions implemented are effective for ongoing compliance. Corrective action plans describe the actions steps that will be implemented, timeframes and responsible parties involved in addressing the problem, deficiencies or FWA identified and include ramifications for failure to implement effective corrective actions.
- b. The MCO has responsibility for overseeing corrective action plans and the authority to escalate to executive leadership for immediate intervention if the corrective action plan is determined to be insufficient or untimely. This type of escalation may include requests for disciplinary actions and/or contract termination for FDRs.
- c. Medicare Compliance maintains documentation of all deficiencies and corrective actions taken.
- d. All non-compliant activities, including action steps taken to resolve, are reported during the Medicare Compliance Committee and Mercy Care Audit and Compliance Committee.

III. Instances of Potential FWA

- a. With respect to fraud, waste, and abuse (FWA), the CVS/Aetna Special Investigations unit (SIU) carries out the FWA prevention and detection activities for Mercy Care Advantage. Medicare Compliance reports all suspected healthcare fraud received from Mercy Care's internal employees to SIU for investigation. Medicare Compliance provides information requested by SIU to help investigate, track, and respond to all Medicare related fraud, waste, and abuse cases. SIU provides routine updates, the outcome of investigations and reporting to Medicare Compliance to support the Program. CVS/Aetna SIU responsibilities include:
 - SIU conducts thorough investigations of allegations of suspected FWA and identifies FWA by using multiple data mining techniques with subsequent data analysis and the necessary information to make informed decisions on the validity of the claims. SIU ensures a reasonable investigation is initiated within 2 weeks if receipt of potential FWA issues.
 - SIU utilizes the CMS FWA database to assist in thorough investigations and data analysis and conducts referrals to outside agencies as necessary (e.g., MEDICs, CMS, law enforcement, etc.).
 - Support CVS/Aetna and Mercy Care's reputation with members, plan sponsors, health care providers and law enforcement personnel as a carrier which is committed to combating the health care insurance fraud problem;

- Establish a professional liaison with other carriers, plan sponsors, health care providers, law enforcement agencies and other governmental agencies involved in the prevention of health care insurance fraud;
- Maintain a continuing database of information of cases investigated, relating to trends, insurance fraud practices and organizations involved in the review of completed cases.

b. Medicare Compliance, the Health Plan, and CVS/Aetna are committed to cooperating with the MEDICs to refer potential FWA and/or to provide information requested by the MEDICs within the timeframes specified. Medicare Compliance and the Health Plan also cooperate with other outside authorities (e.g., Medicaid Programs, Department of Insurances, CMS or its designees and law enforcement agencies, etc.) who are conducting FWA investigations, etc. (including compliance with requests regarding network providers identified as potentially abusive or fraudulent).

Medicare Compliance attends the Health Plan's monthly FWA Committee. This committee serves as a forum to review potential Mercy Care FWA activity in a timely manner. Medicare Compliance communicates identified MCA FWA incidents and MEDIC reporting to this committee, the Medicare Compliance Committee and the Mercy Care Audit and Compliance Committee.

All full-time, part-time, temporary employees, directors, contractors, and FDRs performing Medicare related work are required to complete Compliance and Fraud, Waste and Abuse training upon hire and annually thereafter. This required training provides examples of fraud, waste, and abuse and stresses the responsibility of every employee in identifying and reporting potential and/or suspected cases of healthcare fraud.

Employees may report suspected FWA via the following methods:

- CVS/Aetna Special Investigation Unit at aetnasiu@aetna.com or;
- SIU hot line 1-800-338-6361 or fax number: 1-860-975-9719
- Via the fraud reporting tool available in e.service
- Via the toll-free Ethics Line
- Directly to the Compliance Officer by phone or email
- Via the Medicare Compliance Mailbox: MercyCareAdvantageMedicareCompliance@Aetna.com

c. Delegated entities (FDRs) may use the Ethics Line to raise compliance concerns. The annual FDR Compliance Packet provided to FDRs explains how to access a copy of the CVS Code of Conduct and includes instructions and contact information for reporting compliance and FWA concerns.

d. Contracted providers (e.g., physicians, hospitals, medical facilities, laboratories, etc.) may raise fraud or compliance related concerns and questions through the toll-free Special Investigations Unit (SIU) hotline 1-800-338-6361 or directly to the Office of Inspector General HHS Tips Hotline 1-800-447-8477. These toll-free numbers are published in the Health Plan provider manuals and the provider websites.

e. Members may raise fraud or compliance related concerns and questions through the toll-free Special Investigations Unit (SIU) hotline 1-800-338-6361 or directly to the Office of Inspector General HHS Tips Hotline 1-800-447-8477, Medicare or AHCCCS. The Health Plan's websites include a Fraud and Abuse page and online form available for reporting suspected fraud and abuse directly to Compliance.

IV. Self-Reporting Potential Fraud or Non-Compliance

Medicare Compliance, the Health Plan, and CVS/Aetna recognize the importance of voluntarily self-reporting potential FWA and/or significant incidents of non-compliance to CMS and regulatory authorities. Medicare Compliance discloses identified risk and FWA issues to CMS in a timely manner based on the severity and

member impact of the issue identified. Risk issues identified that affect member access to benefits and services are immediately analyzed to identify root cause, duration, and number of members affected.

If, after conducting a reasonable inquiry into a potential issue, the MCO and/or SIU determine that potential FWA related to the Medicare Parts C or D programs has occurred, the matter will be promptly referred to the MEDIC. Consideration is given to reporting potentially fraudulent conduct to government authorities such as the Office of Inspector General (through the OIG's Provider Self-Disclosure Protocol), the Department of Justice, CMS, or other law enforcement agencies as applicable.

If, after conducting a reasonable inquiry into a potential issue, the MCO determines that an incident of significant Medicare program noncompliance has occurred, the MCO ensures reporting to CMS. When CMS disclosure is required it must occur within 2 business days of identification, even if the Health Plan and/or FDR are still determining root cause. The MCO will notify the CMS Plan Manager of the noncompliance identified and communicate additional actions requested by CMS. The MCO will provide CMS with remediation updates as specified until the issue is fully resolved to CMS' satisfaction. Additionally, the MCO will notify Mercy Care Leadership and the Medicaid Compliance Officer of the identified noncompliance and CMS disclosure so it can be determined if there is any impact to the Medicaid lines of business and if notification to AHCCCS Medicaid may also be required.

Medicare Compliance and Medicare Product have standing monthly meeting with CMS Plan Managers to discuss MCA business initiatives and proactively report other key information (e.g., upcoming provider terminations and changes to FDR contracts for key functions).

Section 8. Medicare Compliance Committee Charter

Medicare Compliance Committee Charter

The Medicare Compliance Committee (the “Committee”) is primarily responsible for compliance strategy and oversight of the Mercy Care Advantage (MCA) Medicare Compliance Program in preventing, detecting, and correcting non-compliance and fraud, waste, and abuse (FWA). The Committee’s purpose is to assist the Mercy Care Audit and Compliance Committee and Board of Directors to oversee, guide, and evaluate the effectiveness of Medicare Compliance Program and help ensure that the plan operates in accordance with federal and state regulations and sub-regulatory issuances. These issuances may include, but are not limited to, requirements published by the Centers for Medicare and Medicaid Services, the Office of Inspector General of the Department of Health and Human Services, or Arizona Health Care Cost Containment System. It is also the commitment of the Medicare Compliance Committee to promote and support a culture of compliance within the Mercy Care Organization.

Charter Review and Approval

The Mercy Care Audit and Compliance Committee include members of the Mercy Care Board of Directors who are accountable to review the Medicare Compliance Committee Charter on an annual basis and approve any changes made to the MCA Medicare Compliance Program and/or Charter.

Medicare Compliance Committee Membership and Chairperson

The Medicare Compliance Officer chairs the Medicare Compliance Committee. Committee membership is composed of voting and non-voting membership. Identified management staff and/or their alternate have voting privileges. Non-voting members include management staff from the operational business areas supporting the MCA line of business and have a responsibility to help support the Program requirements and foster a culture of compliance.

Voting Members

- Medicare Compliance Officer & Chair: Chris Macias
- Chief Operating Officer: Tad Gary
- Chief Financial Officers: Randy Ek, alternate Keith Chilton
- Chief Medical Officer: Dr. Singh Gagandeep, alternate Dr. Yaminikrishna Sabesan
- Director of Pharmacy: Rodney Hendershot, alternate Chaz Washington
- Director of Quality Management: Sandra Wendt, alternate Colleen Soeder
- Head of Medicare Product: Jeff Patton, alternate Shannon Richardson, or Noe Barrera

Non-voting Members attend from following business areas

- Aetna Special Investigations Unit
- Customer Service Operations
- Health Plan Operations (Enrollment, Grievance & Appeals, Claims, and Provider Relations)
- Long Term Care
- Medical Management
- Medicare Product & Marketing
- Medicare Sales

In addition, the Committee may have guests, such as invited presenters, who attend on a routine or ad hoc basis. Voting Members or their designated alternate must attend at least 75 percent of Committee meetings. There are no terms or term limits applicable to Committee Members.

Committee Conduct

A. Committee Meeting

The Committee will meet quarterly during each calendar year. The Committee may meet more frequently, or convene a special meeting, if it is deemed necessary by the Chair or the Voting Members. Members of the Committee can attend in person or by telephone using WebEx meeting technology.

B. Meeting Agenda

The Chair will develop an agenda for each Committee meeting and distribute prior to each meeting. Included with the agenda will be the minutes from the prior meeting and other materials for discussion. Meeting agendas will be integrated with the meeting minutes as part of the Committee retained records.

C. Call to Order, Quorum, and Voting

The Medicare Compliance Officer will convene the Committee. If the Medicare Compliance Officer is not able to attend a Committee meeting, the Medicare Compliance Manager will be designated to conduct the meeting and the Committee will proceed in completing its business as scheduled.

For the Committee to conduct its business, a quorum of Voting Members is necessary. The required quorum is the attendance of at least 50% of all Voting Members in person, by phone, or by other accepted means of communication. If the number of Voting Members is less than the 50% required, the lack of a quorum will be noted in the minutes and the Chair will terminate the meeting.

When a Voting Member is unable to attend the meeting, their designated alternate may attend and will count toward the quorum and be able to vote. New alternates designated must be approved in advance by the Chair. All Voting Members have equal voting privileges. Once a quorum is present, decisions are made by majority vote and the Chair will decide votes resulting in a tie.

Voting on matters presented to the Committee will take place after matters requiring a vote are discussed, and a motion to approve initiated. Voting will take place verbally, or if outside of scheduled meetings, using an alternative electronic polling mechanism as determined by the Chair. Regardless of the means used, the Committee Chair must take measures to assure that all Voting Members have had an opportunity to review matters and motions and register their votes.

D. Reports to the Committee

As part of its work, the Committee receives, and reviews routine and ad hoc reports prepared by Medicare Compliance and/or other operational business areas who have a role in supporting the Program. These reports include, but are not limited to the following:

- The detection of breaches in compliance, privacy, confidentiality, and Code of Conduct; the corrective and disciplinary actions taken; and issues deemed reportable to CMS and the status of such reporting.
- CMS notices, report data, and/or other CMS communications regarding MCA compliance including notices of non-compliance,.
- CMS memos, regulatory and sub-regulatory changes affecting MCA contract requirements.
- Audit updates including activity and status resulting from internal compliance audits and CMS audits and monitoring projects, findings, and subsequent corrective action plans.
- Internal monitoring of MCA operations, identified risk issues, and actions taken for remediation, effectiveness of these actions and issues deemed reportable to CMS.
- Compliance and FWA program requirements, required training, monitoring, and reporting activities.
- Oversight and monitoring of first tier, downstream, and related entities.
- MCA business initiatives, annual CMS contract renewal and benefit change activities.
- Operational or staffing changes deemed a “material change” affecting the MCA line of business.
- Ad hoc reports and data supplied by the operational business areas supporting MCA line of business.

E. Meeting Minutes and Committee Records

Minutes are documented for each Committee meeting. The Chair conducts a review of the minutes prepared and distributes to the Committee members prior to the next Committee meeting. The minutes are presented during the committee to allow for review and comment. If there are no requested changes, the Chair will call for adoption of the minutes by the Committee. The proceedings of Committee meeting are captured in the written minutes and Medicare Compliance oversees the secure storage of the meeting agenda, minutes, and meeting materials for no less than ten years in accordance with CMS record retention requirements.

F. Committee responsibilities:

1. Annually review and approve the MCA Compliance Program, Charter, Risk Analysis, Audit Schedule, and other key supporting documents of the Program. Regularly review and monitor ongoing activities of the Compliance Program, performance reports and other reports to identifying trends and risks. Participate in the annual evaluation of the effectiveness of the Medicare Compliance Program and make recommendations.
2. Assist the Medicare Compliance Officer and Mercy Care Board to foster and maintain a culture of compliance. Coordinate with appropriate business partners and FDRs to support the standards of conduct, policies and procedures, and the Program objectives.
3. Support and promote employee and FDR education and timely completion of Code of Conduct, compliance and fraud, waste, and abuse training and any other training activities identified to support compliance and adherence with pertinent laws, regulations, policies, procedures, and practices.
4. Support the strategies used to promote a culture of compliance and importance of detection and reporting of any identified potential non-compliance and/or FWA violations, using available reporting mechanisms.
5. Support ongoing monitoring, oversight and assessment of internal operational processes, systems, and controls used as part of daily operations for areas of risk, non-compliance or FWA.
6. Assist in the analysis of the regulatory environment and legal requirements with which MCA must comply. Help oversee timely implementation of new regulatory requirements and sub-regulatory guidance.
7. Monitor internal and external audits results and investigations for the purpose of identifying risk and deficient areas and support Medicare Compliance when corrective action plans are required to address non-compliance. Review concerns encountered by persons conducting formal audits and investigations, regarding significant difficulties encountered.
8. Support monitoring and oversight of the operational functions delegated to first tier, down steam, and related entities (FDRs) to help ensure regulatory and contract performance requirements are met. Support recommendations from the Delegation Oversight Committee when a corrective action plan is required to address identified FDR non-compliance.
9. Provide a forum for communication and a process that may be used, with consensus from the Committee, to assign responsibility to Committee members to assure reported deficiencies or concerns have appropriate corrective actions and appropriate oversight.
10. Perform any other activities consistent with this Charter and other governing laws, as this Committee or the Mercy Care Audit and Compliance Committees deems necessary or appropriate.

G. Additional Reporting Responsibilities

The Chair will provide routine Compliance reports to the Chief Executive Officer (CEO), Chief Operating Officer (COO), Mercy Care Arizona Collaboration and Information Team (ACI) and the Mercy Care Audit and Compliance Committee.

Medicare Compliance Program and Committee Charter Approval

- Mercy Care Audit and Compliance Committee approval received on November 9, 2021
- MCA Medicare Compliance Committee approval received on December 17, 2021