Advocate Health Advisor's Compliance Policy

Delivery of Policy:
This Policy is provided to all employees within 90 days of hire, when updated and annually. Advocate Health Advisors (AHA) and Compliance Officer maintain discretion in distribution method. Examples: Hard Copy, Electronic, Intranet

Commitment to comply with Federal and State standards

Advocate Health Advisors Medicare Compliance is responsible for ensuring compliance with Federal Regulations at 42 C.F.R. §§422.503 and 423.504 and state regulations and CMS standards.

Updates to this document incorporate changes in applicable laws, regulations and other programrequirements.

STANDARDS OF CONDUCT – MEDICARE COMPLIANCE PROGRAM

Values

- Operate with the highest integrity.
- Be the top educated professionals in our field.
- Follow legal, moral and ethical guidelines.
- Provide a top performing environment to work.
- Deliver industry leading service to our agents and clients.

FWA TRAINING
All Employees are required to take AHIP within the first 90 days of hire and each calendar yearthereafter which includes Fraud, Waste and Abuse Training*.

The training covers the following:

- How to identify FWA
- An overview of the industry efforts in detecting fraud
- Legal tools to combat FWA
- Understand both the human and financial cost of FWA
- Review CMS FWA training requirements
- Who commits FWA
- Reporting FWA; loopholes and obligations

Compliance is everyone's responsibility:

When someone commits fraud against Medicare, it affects everyone. If you suspect someone of committing insurance fraud against AHA or think you may be a victim, please report the suspicious activity. Alert our compliance team email at compliance@advocatehealthllc.com or call 1-800-709-5513 and ask for a Compliance Team Member. All calls and e-mails are confidential and may be anonymous. For more information about insurance fraud, visit www.insurancefraud.org.

Any and all claims will be properly investigated.

Advocate Health Advisors' whistleblower policy is as follows:

Employees are encouraged, in the first instance, to address such issues with their managers or the HR Specialist, as most problems can be resolved swiftly. If for any reason that is not possible or if an employee is not comfortable raising the issue with his or her manager or HR, AHA's Compliance Officer does operate with an open-door policy. Management has the added responsibility for demonstrating, through their actions, the importance of this Code. In any business, ethical behavior does not simply happen; it is the product of clear and direct communication of behavioral expectations, modeled from the top and demonstrated by example. Again, ultimately, our actions are what matters. To make our Code work, managers must be responsible for promptly addressing ethical questions or concerns raised by employees and for taking the appropriate steps to deal with such issues. Managers should not consider employees' ethics concerns as threats or challenges to their authority, but rather as another encouraged form of business communication. At AHA, we want the ethics dialogue to become a natural part of daily work.

COMPLIANCE POLICIES AND PROCEDURES

Compliance expectations

Purpose: To describe the procedures to be followed to establish and maintain an effective compliance program, to ensure compliance with Medicare program regulations, as well as procedures to prevent, detect and correct fraud, waste and abuse (FWA) and Medicare program noncompliance.

It is AHA's intent to require that all employees become licensed agents as well as to certify with at least one credible Medicare Advantage Carrier. With this comes greater understanding of our industry and of compliance regulations including FWA administered through AHIP which is also required.

Apply and follow the seven elements of an effective Compliance Program and have named officer(s) responsible to update policies, track progress, oversee compliance actions and opportunities, enforce, educate and monitor employees and vendors.

- Demonstrate commitments to comply with Federal and State Standards
- Describe compliance expectations
- Implement operation of compliance program

- Provide guidance on dealing with compliance issues
- Identify how to communicate compliance issues
- Describe how compliance issues are investigated and resolved
- Include policy of non-intimidation and non-retaliation
- Review and update policies at least annually
- Develop necessary policies as needed to document required processes

Implement Operation of Compliance Program

The Medicare Compliance Program is the foundational document upon which all compliance policies and procedures are based.

Review and Self-Assessment of the Compliance Program

• The Medicare Compliance Program is reviewed annually to ensure compliance with CMS guidance as communicated through manuals and regulatory changes.

• Additionally, the Medicare Compliance Department conducts an annual Medicare Compliance Program Effectiveness self-assessment. The self-assessment is used to analyze the strengths and weaknesses of the Compliance Program. The self-assessment is conducted mid-year and is completed prior to the start of the fourth quarter. The information obtained from the self-assessment is used as a guide for the annual review of Compliance adherence.

Revisions to the Compliance Program

• The Medicare Compliance Team proposes revisions to the Medicare Compliance Program, when necessary, at the Medicare Compliance Committee meetings for review and comment. The Medicare Compliance Team empowers topic specific subgroups to serve as forums for reviewing CMS guidance, compliance policies and procedures, compliance training, compliance deficiencies, corrective action plans, compliance monitoring, auditing reports, operational issues, and strategies for operational compliance and detecting and preventing fraud, waste and abuse (FWA).

Review and Approval of the Compliance Program

• Recommended updates or revisions to the Medicare Compliance Program made by the Medicare Compliance Team are proposed and submitted internally to all Team Members and Executive Owner/Leadership/CEO for review and final approval.

Dissemination of the Compliance Program

• The Compliance Program is disseminated through direct delivery of updated documentation through email to the designated point of contact.

• The recipient of the notice has thirty (30) days to attest to the review of the program. If at the

end of sixty (60) calendar days from the initial distribution Advocate Health Advisors has not received confirmation of review, is deemed to have been approved.

• Advocate Health will disseminate/distribute carrier or CMS specific changes in guidance, rules, regulations, policies and best practices to all agents within ten (10) business days.

Leadership Oversight

• Executive Leadership is responsible for the oversight of the Medicare Compliance Program; however, the day-to-day responsibility for operation and oversight of the Medicare Compliance Program is delegated to the Medicare Compliance Officer. The Medicare Compliance Officer reports and provides pertinent compliance information, data, and statistics to leadership on a quarterly basis.

• The Medicare Compliance Officer will provide periodic in-person reports to Leadership

- **The Compliance Officer's Role:** Operational policies and procedures for each program area are developed, updated and overseen by the respective experts and departments for those specific program areas. In addition to operational policies, each operational area establishes and implements its own compliance policies specific to their respective area, to include the compliance and FWA risks of that area. The Compliance Officer may provide support in these efforts. The Compliance Officer solicits input from operational department leaders when developing organization-wide Standards of Conduct and Compliance Policies and Procedures.
- The Advocate Health Advisor's Compliance Officer has express authority to make in-person reports to the CEO in the Compliance Officer's sole discretion.

Guidance for dealing with Compliance Issues

Reporting Violations of the Medicare Compliance Program

• No persons shall have authority to act contrary to any provision of the Medicare Compliance Program or to condone any such violation by others. Any persons with knowledge of suspected violations of law or violations of provisions of the Medicare Compliance Program is required to promptly report such violation, as directed.

Non-retaliation Policy

A key part of AHA is our policy of non-retaliation and non-intimidation for individuals who report a Medicare Compliance or fraud, waste or abuse concern. You can rely on our commitment of non-retaliation and non-intimidation when you report a potential concern in good faith.

- Anonymous Reporting – Communication to the Compliance Department can be made anonymously through the Fraud, Waste and Abuse Reporting form, phone, or email.

- AHA requests that if a reporter desires to remain anonymous, he/she provide enough information to allow Advocate to investigate the issue.
- Prohibition Against Intimidation and/or Retaliation – AHA strictly prohibits intimidation and/or retaliation against anyone who, in good faith, reports a detected or suspected violation of Medicare compliance, ethical standards or FWA. Any individual who retaliates against or intimidates an individual who, in good faith, reports a compliance or fraud, waste, or abuse concern is subject to disciplinary action up to, and including, termination.

Clarification of the Medicare Compliance Program

• Individuals with questions or uncertainties regarding any aspect of the Medicare Compliance Program, including related policies or procedures, should seek immediate clarification from the Chief Compliance Officer. They can also seek clarification by email at: alissa.morris@Advocatehealthllc.com, or in person, with any member of the compliance staff, at Advocate Health Advisor's Main Office, Venice, FL

Communication of Compliance Issues

Code of Ethical Conduct and the Medicare Compliance Program. To report any activity that is against the Advocate Health Advisors' Code of Conduct or Compliance Policies and Procedures, any employee may use any of the following reporting methods: anonymously contacting the Compliance officer through email or phone 1-800-709-5513; or in person, to any member of the compliance staff, at Advocate Health Advisors, Venice, FL or by email compliance@Advocatehealthllc.com.

Investigation and Resolution of Compliance Issues

AHA will direct the Compliance Team to follow up on allegations of feasible allegations of suspected non-compliance issues by initiating a timely and comprehensive investigation to decide on the validity of such allegations and take appropriate actions if verified. AHA is required to report compliance concerns and suspected or actual violations related to the Medicare program and FWA violations to their sponsors via the sponsor hotline or email. The investigation will ensue as quickly as possible but no later than two (2) weeks after identification or reporting of suspected actual non-compliance or FWA.

- Employees or persons who report suspected acts of misconduct to the Compliance Officer, the Compliance Hotline, or other supervisory employees shall have their confidentiality secured to best possible degree. Reporting an allegation that the reporter was involved in does not support confidentiality or anonymity for that person. Reporting may be taken into consideration in the penalty phase of the investigation. Federal Whistleblower Regulations will be followed (see Whistleblower Policy, Code of Conduct)
- The Compliance Officer will have oversight in the execution of all internal investigations. He or she shall have the authority to seek outside counsel as needed.

- The Compliance Officer will commence an investigation only after understanding the full allegation and relevant regulations, laws, and policies and procedures.
- The Compliance Officer will initiate the investigation by completing an initial review to ascertain whether there is sufficient evidence to pursue a full investigation.

  The Compliance Officer should:

  a) Log the complaint and notify the plan sponsor in question, if applicable, via their Compliance hotline or email.
  b) Conduct an impartial review of relevant facts;
  c) Restrict the inquiry to those necessary to resolve the issues; and
  d) Conduct the inquiry with as little visibility as possible while gathering pertinent facts relating to the issue.
     - If the Compliance Officer finds that there is enough evidence of any criminal, civil, or administrative law to proceed with a full investigation, the investigation must be turned over to legal counsel.
     - For investigations that do not involve legal counsel, the Compliance Officer will determine if Advocate Health, LLC has sufficient resources to conduct the investigation, who or what they are, or whether external resources are required.
     - The Compliance Officer will be responsible for making sure all evidence is secured and remains part of the investigation file.
     - The Compliance Officer should ensure that the following objectives are accomplished:
       a) Fully debrief complainant;
       b) Notify appropriate internal parties;
       c) Identify cause of problem, desired outcome, affected parties, applicable guidelines, and possible regulatory or financial impact;
       d) Provide a complete list of findings and recommendations; o Determine the necessary corrective action measures, (e.g., policy changes, operational changes, system changes, personnel changes, training/education); and
       e) Document the investigation.
- Upon conclusion of the investigation, the Compliance Officer will organize the information in a manner that enables the Advocate Health Advisors to determine if an infraction did, in fact, occur.
- The Compliance Officer will track the investigation, responsible parties, and due dates in a compliance log. The log will include the resolution of the investigation as closed or fully resolved.
- The Compliance Officer will be responsible for reporting the results of all investigations to Executive Leadership and Compliance Committee.

DEFINITIONS:

Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between fraud and abuse depends on specific facts and circumstances, intent and prior knowledge, and available evidence among other factors.

FDR: First Tier, Downstream or Related Entity.

- **First Tier Entity (FTE):** Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization ("MAO") or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. (See *42 C.F.R. §* Page **2** of **4)**

- **Downstream Entity:** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See *42 C.F.R. § 423.501*).

- **Related Entity:** Any entity that is related to an MAO or Part D sponsor by common ownership or control and (1) Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an oral or written agreement; or, (3) Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period. (See *42 C.F.R. § 423.501*).

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Compliance Contact:

Alissa Morris

Compliance Officer

(941) 473-0800

1-800-709-5513

compliance@advocatehealthllc.com