Compliance Plan Effective Date 11/1/2018

Policy Statement

Community Health Group (CHG) is dedicated to conducting business in an ethical and legal manner. CHG's Compliance Plan describes our comprehensive plan for the prevention, detection and reporting of Fraud, Waste and Abuse (FWA) across various categories of health care related fraud (e.g., internal fraud, electronic data processing fraud, external fraud). CHG's written policies, procedures and standards of conduct mandate that every CHG employee and any First Tier, Downstream and Related Entity (FDR) comply with all applicable Federal and State standards. CHG aggressively pursues allegations of health care FWA.

Purpose

The CHG Compliance Plan provides comprehensive prevention, detection and awareness training. The Compliance Program helps employees and FDRs understand and follow federal and state laws related to their jobs. This demonstrates CHG's commitment to conducting business honestly and responsibly to the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), members and the community at large, while at the same time advancing the mission of using resources to achieve optimum health care outcomes and providing exemplary service.

As a Medi-Cal Sponsor, DHCS contractor, Medicare-Medicaid Health Plan (MMP) and a Part D plan sponsor, CHG is responsible for the oversight and management of Medi-Cal benefits and the MMP benefits pursuant to its contracts with CMS and DHCS. CHG's program to detect, prevent, correct and control FWA and compliance issues with respect to CHG's operations have been incorporated into the components described in this Compliance Plan.

CHG is committed to complying with all applicable statutory, regulatory, and other requirements, sub-regulatory guidance, and contractual requirements, including, but not limited to, the following requirements related to the delivery of Medi-Cal and MMP benefits.

This Compliance Plan shall address the activities of all CHG employees, Board of Director (Board) members, officers, first tier entities, downstream entities and any other related entities (FDRs) involved in the delivery of, payment for or monitoring of benefits and services provided by CHG (including lessors of real property). CHG shall perform the functions specified in this Plan in connection with its own activities and the activities of CHG Partnership Plan, which has delegated compliance functions to CHG.

CHG allows any auditor acting on behalf of the federal and/or state governmentto conduct on-site audits, and will provide such auditors with any information needed to determine

compliance with the Medi-Cal and MMP regulations and contracts.

Corporate Compliance Program

CHG's Compliance Plan is overseen by the Compliance Officer. The Compliance Officer reports directly to CHG's Associate Chief Executive Officer, has a dotted reporting responsibility directly to the CEO and Board of Directors for compliance issues and leads the Compliance Committee.

Standards

The eight elements of CHG's Compliance Plan, which is intended to assure compliance with the foregoing, are:

(*1*) *Written Policies, Procedures, and Standards of Conduct that Articulate the Organization's Commitment to comply with all Applicable Federal and State Standards*

Written policies and procedures are found in the Human Resources' Personnel Policies and Procedures which are found on the organization's intranet. The standards of conduct are described in CHG's Code of Conduct ("Code of Conduct," "Standards of Conduct" or "Code").

Code of Conduct

The Code is intended to complement, but not replace, existing policies and procedures found in CHG's Personnel Policies and Procedures. If there is no existing policy on a particular subject matter, the Code shall become the applicable policy.

The Code is designed to serve several purposes:

- To assure that all employees in the work environment share in the responsibility for keeping CHG in compliance with all applicable laws, regulations, policies, procedures, medical and business practices;
- To communicate the commitment of CHG's management to compliance with laws, regulations, contractual obligations and business standards of care;
- To familiarize all employees and the Board with the basic legal principles and ethical standards of behavior expected throughout this organization;
- To ensure that issues of noncompliance and potential fraud and abuse are reported through appropriate mechanisms and that reported issues are addressed and corrected.

The Code is a "living document" that is updated periodically to respond to changing conditions. Therefore, CHG reserves the right to modify any or all of the Code at any time.

Policies and Procedures

In addition to the Code, CHG has specific policies that address the following:

Procedures for the identification of potential compliance issues in CHG's operations.

Procedures for the identification of potential FWA in CHG's provider network and among other FDRs.

A process to conduct a timely, reasonable inquiry if a potential violation of federal or state criminal, civil, administrative laws, rules and regulations is suspected, on a timely basis.

A process to refer violations of applicable federal and state criminal, civil and administrative laws, rules and regulations to appropriate law enforcement agencies for further investigation within a reasonable period (generally, no more than sixty (60) days after a determination that a violation may have occurred).

A process to insure that CHG, its FDRs, agents and brokers are marketing in accordance with applicable federal and state laws, including state licensing laws, DHCS policy and CMS policy.

A process to identify overpayments and underpayments at any level within CHG's network and properly provide for reporting and repayment of, where applicable, such overpayments in accordance with DHCS policy and CMS policy. CHG uses the Virtual Examiner (VE) system. The VE is a claim screening system that assesses the appropriateness of medical claims payments in the context of patients' medical claim history.

A process to identify improper coverage determinations, services or enrollment at any level within its network and properly report and repay, where applicable, any overpayments resulting from inaccurate enrollment numbers in accordance with DHCS policy and CMS policy.

A process to identify any claims that were submitted for services or drugs that were provided or prescribed by an excluded or debarred provider, and a process to report and properly repay any overpayments resulting from inaccurate payments in accordance with DHCS policy and CMS policy.

A process to insure full disclosure to CMS, upon request, of all CHG pricing decisions for Part D items or services, including data and pricing records. This policy should insure transparency in the pricing structure to include all rebate and negotiated price discounts applicable to Part D drugs and services and hold CHG and first tier entities, downstream entities, and related entities accountable for accurately reporting pricing information.

Policies and procedures for coordinating with DHCS, CMS and law enforcement, including policies to fully cooperate with any audits conducted by the above-mentioned entities, or their designees, and information requests, from law enforcement agencies to support health oversight activities.

Policies that emphasize confidentiality, anonymity and non-retaliation for compliance-related questions, or reports for potential non-compliance.

Procedures for corrective actions designed to correct any underlying problems that could result in Medi-Cal and/or Medicare program violations and prevent future misconduct.

Procedures to retain all records documenting any and all corrective actions imposed for conduct related to the administration or delivery of Medi-Cal or Medicare benefits and follow-up compliance reviews for future health oversight purposes and/or referral to law enforcement, if necessary.

Policies that ensure and document the review of the Office of Inspector General (OIG), System for Award Management (SAM), and General Services Administration (GSA) exclusion lists for all new employees, and at least monthly thereafter, to ensure that all current employees, Board members, Officers and FDRs that assist in the administration or delivery of benefits are not included on such lists. If any of the aforementioned parties are on such lists, CHG shall require the immediate removal of such parties from any work related directly or indirectly to federal health care programs, and shall take such further corrective actions as may be necessary. In addition, CHG shall implement a policy requiring all new and existing employees responsible for administering or delivering benefits to immediately disclose a debarment, exclusion or other event that makes them ineligible to perform work related directly or indirectly to a federal health care program.

Policies and procedures to notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medi-Cal program.

Policies and procedures for all CHG employees and contractors that provide detailed information about the federal False Claims Act (as set forth in 31 USC 3729), administrative remedies for false claims and statements (as set forth in chapter 31 of title 31 of the United States Code), California laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws. The policies and procedures shall address the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, and shall include detailed provisions regarding CHG's policies and procedures for detecting and preventing fraud, waste, and abuse. CHG's employee handbook will include a specific discussion of the laws discussed above, the rights of employees to be protected as whistleblowers, and CHG's policies and procedures for detecting and preventing fraud, waste, and abuse.

A process to comply with applicable record retention requirements.

A commitment to Pharmacy and Therapeutic Committee (P&T Committee) decisions that are made in accordance with DHCS and CMS regulations and guidance. In addition, the determination of clinical efficacy and appropriateness of formulary drugs should precede and be paramount to cost considerations. To implement the foregoing, CHG procedures incorporate the following:

P&T Committee members shall sign and continually update conflict of interest statements that divulge their relationship to any pharmacy benefit managers or pharmaceutical manufacturers, and

The P&T Committee should demonstrate a clear and transparent decision-making process when making formulary decisions; The P&T Committee should establish a process for reviewing exceptions and other utilization management processes. The policy should include provisions for Drug Utilization Review and Prior Authorization.

To implement the foregoing, CHG has policies, procedures and a disclosure protocol for:

Ensuring that officers, directors, and managers do not have a conflict that provides a potential unfair competitive or monetary advantage as a result of CHG performing its contracts: e.g., ownership, control or contractual arrangements with a drug manufacturer or other supplier that creates an incentive to include a certain drug on a formulary or ownership, control or contractual arrangement with a downstream entity that would create an incentive to use the entity.

Ensuring that CHG's judgment is not biased or in some way compromised (e.g., CHG's formulary decisions and/or choice of FDRs are not determined by ownership, control or any inappropriate contractual agreement).

Ensuring that ownership, control or contractual arrangements between third parties and CHG or CHG's directors, officers, managers or employees do not create a conflict;

Designating a system for employees, officers, directors and managers who are seeking employment from health providers, health plans or other sponsors to determine if this outside employment would create a conflict;

Designating a system for employees and others to bring potential conflicts to the attention of an appropriate individual;

Ensuring that conflicts do not arise because of CHG's access to proprietary data as a result of its Medi-Cal and/or Medicare responsibilities;

Ensuring that CHG's relationships with its FDRs do not violate the anti-kickback statute and/or other applicable federal or state laws or regulations: and

Ensuring that all DHCS and CMS reporting requirements for potential conflicts and appropriate lobbying disclosure requirements are satisfied.

The applicable department's Chief Executive approves all of CHG's employee policies and procedures. CHG's policies, procedures, and standards of conduct are consistent with the

requirements of all applicable federal and state standards. They include but are not limited to the following appendices included in this Plan:

- CHG's "Code of Conduct." See Appendix A;
- CHG's Policy on "Professional Conduct." See Appendix B;
- CHG's Policy on "Corrective/Disciplinary Action." See Appendix C;
- CHG's Policy on "Investigatory Suspension." See Appendix D;
- CHG's Policy on "Non-Retaliation/Whistleblowing." See Appendix E;
- CHG's Policy on "Health Care Fraud Prevention, Detection and Reporting." See Appendix F;
- CHG's Policy on "Managing Incidents of Suspected Fraud," which includes the internal procedure for referring suspected fraud to the appropriate government agency. See Appendix G;
- CHG's Policy on "Compliance with the Deficit Reduction Act of 2005," which informs employees regarding CHG's policies for combating fraud, waste and abuse; the state and federal False Claims Acts; and the protections afforded whistleblowers under such laws. See Appendix H;
- CHG's Policy on "Breach of Security," which complies with HIPAA regulations and requires that all CHG employees must preserve the integrity and the confidentiality of Protected Healthcare Information (PHI). PHI shall be safeguarded to the highest degree possible in compliance with the requirements of security, privacy rules and standards established under HIPAA. Any breach of security is reported with accordance to these procedures and guidelines. See Appendix I; and

CHG's contracted Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. (MedImpact) operates in a highly competitive environment and under complex and rapidly changing laws and regulations.

The Code of Conduct and the applicable policies and procedures are made available to employees at time of hire, when the standards are updated, and annually thereafter. As a condition of employment, CHG's employees certify that they have received, read, and agree to comply with all written standards of conduct. CHG also disseminates applicable standards of conduct and policies to its FDRs, and FDRs are required to distribute CHG's written standards of conduct or comparable standards to its employees at the time of hire, when the standards are updated, and annually thereafter.

(2) Compliance Officer, Compliance Committee and Governing Body

Compliance Officer

The Compliance Officer is an employee of CHG and not an employee of an FDR. The Compliance Officer is responsible for informing CHG staff of applicable regulatory and contract compliance standards, and assisting staff in designing systems, procedures, and documents that foster compliance. Internally the Compliance Officer coordinates CHG's Compliance Committee. As needed the Compliance Officer, or designee, participates in ad hoc work groups within the organization when an independent analysis of health plan compliance, related to the work group's purposes, is needed. As needed, CHG's Compliance Officer, or designee, participates in various health policy development workgroups to keep up-to-date with new legislation that may have compliance impact.

In addition to the foregoing, the Compliance Officer's duties include the following:

Developing and monitoring implementation and compliance with CHG compliance policies and procedures through the creation and implementation of the risk assessment process.

Provides reports, at least on a quarterly basis, or more frequently as necessary, to CHG's CEO, Compliance Committee, and the Board on the status of CHG's compliance program implementation, the identification and resolution of potential or actual instances of noncompliance, and CHG's oversight and audit activities.

Reporting periodically to CHG's CEO on risk areas facing the organization, the strategies being implemented to address them, and the results of those strategies. The Compliance Officer will advise CHG's CEO of all governmental compliance and enforcement activity, from Notices of Non-compliance to formal enforcement actions.

Creating and coordinating, or appropriately delegating, educational training programs to ensure that CHG's officers, directors, managers, employees, FDRs, Board members, and other individuals are knowledgeable of CHG's compliance program: its written standards of conduct, policies, and procedures, applicable statutory, regulatory, and other requirements.

Briefing the Compliance Committee and senior management on the status of compliance training.

Developing and implementing methods and programs that encourage managers and employees to report suspected potential fraud and other misconduct without fear of retaliation.

Maintaining the compliance reporting mechanism and closely coordinating with the internal audit department, where applicable.

Responding to reports of potential instances of FWA, including the coordination of internal investigations and the development of appropriate corrective or disciplinary actions, if necessary.

Ensuring that CHG's Human Resources Department coordinates personnel issues to ensure that the OIG and GSA and Medi-Cal exclusion lists have been checked monthly with respect to all employees (including temporary employees and volunteers), officers, Board members, officers, directors and managers to assure they are not included on such lists.

Ensuring that CHG's Credentialing Department coordinates the review of contracted providers against the OIG and GSA and Medi-Cal exclusion lists monthly.

Coordinating any personnel issue with respect to excluded providers with CHG's Human Resources Department, or legal or security department as appropriate.

Reporting any potential fraud or misconduct related to Medi-Cal and Medicare to DHCS and CMS, respectively, their designee and/or law enforcement, when and as appropriate, in accordance with applicable law.

Maintaining documentation, for each report of potential FWA received through any of the reporting methods (i.e. compliance hotline, mail, in-person), which describes the initial report of non-compliance, the investigation, the results of the investigation, and all corrective and/or disciplinary action(s) taken as a result of the investigation as well as the respective dates when each of these events and/or actions occurred and the names and contact information for the person(s) who took and documented these actions.

Coordinating potential fraud investigations with the internal audit department, and, where applicable, the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), including facilitating any documentation or procedural requests made of CHG.

Collaborating with other Medi-Cal programs, Medicare programs, Medicaid programs, Medicaid Fraud Control Units, and commercial payors when a fraud or abuse issue is discovered that involves multiple parties.

Overseeing the development and monitoring the implementation of corrective action plans.

The Compliance Officer has the authority to:

a. Report non-compliance related issues directly to CHG's CEO, as needed.

b. When suspected FWA is reported, CHG's Compliance Officer reports to the affected department Chief. The Compliance Department works to conduct the investigation and may include the internal department staff including corporate counsel as applicable.

c. The Compliance Officer will coordinate the submission of data to DHCS and CMS to ensure that it is accurate and in compliance with DHCS and CMS reporting requirements.

d. Seek advice from legal counsel when applicable.

e. Report misconduct to DHCS and/or CMS, their designees and/or law enforcement.

f. Investigate potential fraud and abuse issues by interviewing CHG employees and other relevant individuals regarding compliance issues.

g. Review company contracts and other documents pertinent to the Medi-Cal and Medicare programs.

h. Conduct and/or direct audits and investigations of any FDRs and of any area or function involved with Medi-Cal, MMP or Part D plans.

i. Recommend compliance policy, procedure, and process changes, in coordination with legal counsel when applicable.

Compliance Committee

CHG's Compliance Committee is comprised of the Associate Chief Executive Officer; Compliance Officer, Chair, Chief Financial Officer, Claims Director, Utilization Management Director, Case Management Director, Pharmacy Director, Director of Contracting, Director of Customer Experience, and Corporate Quality Director. The Chief Financial Officer shall serve as Vice-Chair, and in absence of the Compliance Officer convenes the Compliance Committee as needed. The Compliance Committee also includes members of senior management and other personnel from various departments who understand the vulnerabilities within their respective areas of expertise.

The Compliance Committee has a strong commitment to developing and maintaining an effective and proactive compliance strategy for CHG. The Compliance Committee responds promptly and efficiently to compliance related issues by:

- Providing continuous improvement and innovation to enhance our program.
- Promoting and maintaining a high level of regulatory compliance company-wide.
- Encouraging monitoring and risk assessment efforts in all departments.
- Raising awareness through education and communication.

- Encouraging use of compliance resources.
- Guiding implementation of the Antifraud Plan.
- Meeting at least on a quarterly basis, or more frequently as necessary.
- Developing strategies to promote compliance and the detection of any potential violations.
- Supporting the Compliance Officer's needs for sufficient staff and resources to carry out the duties.
- Ensuring CHG has appropriate, up-to-date compliance policies and procedures.
- Ensuring CHG has a system for employees and FDRs to ask compliance questions, and report potential instances of FWA confidentially or anonymously (if desired) without fear of retaliation.

- Ensuring CHG has a method for enrollees to report potential FWA.
- Reviewing and addressing reports of monitoring and auditing of areas in which CHG is at risk of FWA and ensuring that corrective action plans are implemented and monitored.
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The Compliance Committee oversees the Compliance Plan and determines and guides appropriate responses to reports of suspected health care fraud.

Board of Directors

The Board exercises such oversight by:

- Reviewing the Employee Code of Ethical Business Conduct,
- Understanding the compliance program structure,
- Remaining informed about the compliance program outcomes, including results of internal and external audits,
- Remaining informed about governmental compliance and enforcement activity such as Notices of Non-Compliance, Warning Letters and/or more formal sanctions,
- Receiving regularly scheduled, periodic updates from the Compliance Officer, and/or Associate CEO, and Compliance Committee;
- Reviewing the results of performance and effectiveness assessments of the compliance program,
- The performance and effectiveness of the compliance program may be assessed by any of the following methods or combinations therefore,

- Quantitative measurement tools to report, and track, and compare over time, compliance with key Medi-Cal and MMP operations, such as enrollment, appeals and grievances, and prescription drug benefit administration,

- Use of monitoring to track and review open/closed corrective action plans, Contractor, compliance, Notices of Non-Compliance, warning letters, DHCS sanctions, CMS sanctions, marketing material approval rates, training completion/pass rates, etc.;
- Implementation of new or updated Medi-Cal and Medicare requirements, including monitoring or auditing and quality control measures to confirm appropriate and timely implementation,

- Increase or decrease in the number and/or severity of complaints from employees, providers, and beneficiaries, including complaints received through the Complaint Tracking Module (CTM), marketing misrepresentations, Part A and Part B issues, etc.,

- Timely response to reported noncompliance and potential FWA issues, and effective resolution (i.e., non-recurring issues),

- Consistent, timely and appropriate disciplinary action; and

- Detection of noncompliance and FWA issues through monitoring and auditing: whether the root cause was determined and corrective action was appropriately and timely implemented and tested for effectiveness; detection of FWA trends and schemes via daily claims reviews, outlier reports, pharmacy audits, etc.; and actions taken in response to compliance reports submitted by FDRs.

The Board has delegated the following activities to the Compliance Committee and applicable staff/committees:

- Annual review of compliance policies and procedures that are developed and implemented by Compliance Officer and Compliance Committee,
- Approval of compliance policies and procedures,
- Review of Compliance Committee's development, implementation, and approval of FWA training,
- Review and approval of CHG's compliance risk assessment,
- Review of internal and external audit work plans and audit results,
- Review and approval of corrective action plans resulting from audits,
- Review and approval of appointment of the Compliance Officer,
- Review and approval of performance goals for the Compliance Officer, and
- Evaluation of the senior management team's commitment to ethics and the compliance program; and review of dashboards, scorecards, self-assessment tools, etc., that reveal compliance issues.

(3) Effective Lines of Communication between the Compliance Officer and Organization's Enrollees, Employees, FDRs, Agents, Directors, and Members of the Compliance Committee and the Board of Directors

CHG has an established a system that fosters effective lines of communication between the Compliance Officer and the organization's employees, FDRs, agents, directors, Board members, and members of the Compliance Committee regarding how to report compliance concerns and suspected or actual misconduct. The Compliance Officer regularly communicates appropriate information such as statutory, regulatory, and sub-regulatory changes and changes to policies and procedures and the Code of Conduct to employees, FDRs, managers, directors, Board members, and others. Communication is achieved through email distribution, CHG's internal website and meetings.

CHG has a system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from enrollees, employees, FDRs, Board members, agents and directors while maintaining confidentiality, allowing anonymity if desired (e.g. through its compliance hotlines), and ensuring non-intimidation and non-retaliation for good-

faith reporting.

CHG educates its enrollees about identification and reporting of potential FWA through enrollment packets, newsletters and its public website.

Compliance Hotline
Having a mechanism for reporting suspected health care fraud is one way CHG detects FWA and works to preserve health care resources to care for those who truly need and deserve them. CHG has a special toll-free voicemail telephone line for reporting suspected health care fraud: (800) 651-4459. Providers, enrollees and employees are encouraged to use this number to report suspected health care fraud. CHG's Compliance Officer, or designee, tracks and monitors this system. Reports may be made anonymously, if desired. A quarterly report is presented to the Compliance Committee.

CHG requires all employees, FDRs, Board members, agents and directors to report compliance concerns and suspected or actual misconduct. These concerns and risks are captured via independent mechanisms, which include the Compliance Hotline, employee exit interviews, emails, and other forums that promote information exchange. These mechanisms are available and easily accessible to CHG's employees, FDRs, Board members, agents and directors.

All reports of FWA are tracked, investigated, and responded to promptly, and corrective action taken as appropriate. Records of such reports are maintained for ten (10) years. (See Managing Incidents of Suspected Fraud Policy included as Appendix G in this Plan)

CHG has a zero-tolerance policy for retaliation or retribution against any employee or FDR who in good-faith reports suspected FWA. (See Non-Retaliation/Whistleblowing Policy included as Appendix E in this Plan) CHG publicizes its procedures for reporting compliance concerns and its non-retaliation policy and that of its FDRs throughout its facility and those of its FDRs. Information is available on CHG's website, is posted in employee common areas, and is included in compliance training.

CHG's Compliance Committee and/or Compliance Officer may consult with legal counsel for assistance in guiding CHG's response to reported potential or actual fraud.

CHG contracts with outside consultants who possess specific investigative expertise in fraud investigation, provide consultation in refining fraud prevention, detection, and investigation strategies and procedures, and conduct investigations as directed by CHG.

(4) Effective Training and Education between the Compliance Officer and Organization's Employees, FDRs, Agents, Directors, and Board Members

CHG conducts training and education between the Compliance Officer and organization's employees, managers, directors, Board members and FDRs. (See Health Care Fraud Prevention, Detection and Reporting Policy included as Appendix F in this Plan) The following is a description of CHG's compliance and antifraud training:

Education for Employees, Managers and Board Members

New employees (including temporary employees and volunteers), managers, Board members, and directors receive compliance and FWA training and instruction in CHG antifraud policies, including identification of the mechanisms available to report suspected fraud, during their new employee or Board orientation.

On a yearly basis, employees and managers whose positions involve work that, by its nature, may present significant opportunities to observe fraud receive specialized training. This includes job-appropriate aspects of fraud detection, reporting, and investigation.

CHG's Compliance Officer, or designee, conducts a mandatory employee annual compliance and FWA training program for all employees, Board members, managers, and directors. The training includes, but is not necessarily limited to, the following topics:

- U.S. health care spending and the impact of health care fraud.
- Overview of statutes and regulations pertaining to health care fraud and CHG's compliance program.
- Types of fraud encountered in the type of job being performed.
- Ways the fraud can be detected, including "red flags".
- The obligations of an employee concerning fraud.
- How to report the suspected fraud.
- How to preserve evidence.
- The need to maintain confidentiality and continuity of care.
- Discipline for non-compliant or fraudulent behavior.

Such training also includes fraud awareness training and instruction in CHG antifraud policies, including identification of the mechanisms available to report suspected fraud on a yearly basis.

This compliance and FWA training program is updated at least annually, or whenever there are material changes in the regulations, policy or guidance.

CHG will maintain records for ten (10) years of the time, attendance, topic and sign-in sheet or

certification of completion of training.

Education for FDRs

CHG contracts with FDRs that meet the FWA certification requirements through enrollment into the Medi-Cal or Medicare program. Enrolled Medicare FDRs are deemed to have met the training and educational requirements for FWA, pursuant to 42 CFR 422.503(b)(4)(vi)(C)(2).

CHG offers annual trainings to first tier contracted providers, and CHG's pharmacy benefit manager provides trainings to contracted downstream and related entities to comply with 42 CFR 422.503(b)(4)(vi)(C)(1) regulation requirements.

CHG training includes: how to identify and report FWA; expectations for reporting non-compliance and FWA; assistance in the resolution of issues; and assurance that compliance is timely, consistently, and effectively enforced.

In the unlikely event CHG has a contract with providers and suppliers who currently are not enrolled as providers or suppliers in the Medi-Cal or Medicare program, CHG provides education and training as follows:

Educates primary care providers about fraud through distribution of appropriate printed materials.

Presents antifraud information during new primary care provider orientation. Fraud prevention, detection, and reporting are all covered.

Posts antifraud information in the CHG Provider Manual and on its website.

Provides refresher training as appropriate.

FWA training for FDRs is further described in Section 8 (First Tier, Downstream & Related Entity Compliance), below.

(5) Procedures for Effective Internal Monitoring and Auditing Antifraud Program

CHG's antifraud program includes an internal monitoring and auditing program and an audit plan that identifies audits to be performed. CHG routinely monitors its antifraud program for areas for improvement. Through communication with its consultant, legal counsel, and others, and an analysis of cases of suspected fraud identified, CHG's Compliance Committee can identify areas for operational improvement. As appropriate, targeted changes to procedures and staff and/or contractor trainings are made.

The elements of CHG's antifraud program include, but are not limited to: training of CHG employees and contractors concerning the detection of health care fraud; CHG's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency.

CHG tracks performance indicators to measure the success of the antifraud program. Performance indicators to be tracked include the following:

- Number of cases of suspected fraud reports recorded by CHG,
- Number of cases investigated,
- Number of cases referred to law enforcement, and
- Number of cases prosecuted (to the extent this is known by CHG).

CHG prepares other reports concerning its antifraud efforts as directed by its Board of Directors or senior management.

CHG's procedures for internal monitoring and auditing test and confirm compliance with the Medi-Cal and Medicare regulations, sub-regulatory guidance, contractual agreements, and all applicable state and federal laws, as well as internal policies and procedures in order to protect against potential FWA.

Risk Assessments

CHG's Compliance Officer is responsible for monitoring and auditing CHG's compliance with the DHCS and CMS requirements and the overall effectiveness of the compliance program. The Compliance Officer monitors risk assessments and provides regular updates to the Compliance Committee, the CEO, senior leadership, and the Board of Directors. The monitoring of risk assessments includes the following:

Verifying the accuracy of claims exceeding $25,000 before they are processed for payment.

Using the Virtual Examiner (VE) system, which is a claim screening system that assesses the appropriateness of medical claims payments in the context of patients' medical claim history.

Contracting with an outside vendor specializing in hospital claim review and recovery. This vendor audits all CHG hospital claims (excluding per diem and case rate payments). Nurses review medical charts against charges to ensure proper coding and that the care charged was provided. This external process allows CHG to ensure payment is made solely on services provided, properly coded and documented.

Contracting with MedImpact Healthcare Systems, Inc., a Pharmacy Benefit Manager (PBM). They oversee the audit process and credentialing of the pharmacy network for CHG. The PBM's Provider Auditing Unit conducts desk verifications of network pharmacies on-site audits. During these review audits, claim history is audited and submitted claims are compared to prescriptions and documents at the pharmacy. Action is taken where pharmacies do not

produce appropriate documentation. If dollars paid out for services cannot be substantiated through proper pharmacy documentation, those dollars are recovered. These activities are designed to monitor CHG's pharmacy network and client networks under management by the PBM in order to provide accurate billing, efficient dispensing practices and to substantially reduce and/or eliminate FWA.

Examining the performance of the compliance program, including review of training, the reporting mechanism (e.g. compliance hotline log), investigation files, sanction screenings, certifications for receipt of standards of conduct, and conflict of interest disclosure/attestation.

Conducting follow-up review of areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

CHG also includes in its risk assessment a process for responding to all monitoring and audit results. As part of the risk assessments, a strategy is used to monitor and audit FDRs involved in the administration or delivery of the benefits.

Development of System to Identify Risks

CHG conducts an ongoing review of potential risks of noncompliance and FWA and re-evaluates the accuracy of the baseline assessment. Risks identified by the risk assessment are ranked to determine which risk areas have the greatest impact on CHG, and the auditing and monitoring strategy takes into account these priority risk areas. Risk areas identified through DHCS and CMS audits and oversight, as well as through CHG's own monitoring, audits and investigations are priority risks.

Development of the Monitoring and Auditing Work Plan

Once the risk assessment has been completed, the Compliance Officer will oversee the development of an auditing and monitoring work plan. Such work plan may include:

- The audits to be performed,
- Audit schedules, including start and end date,
- Announced or unannounced audits;
- Audit methodology,
- Necessary resources,
- Types of audit: desk or onsite,
- Person(s) responsible,
- Final audit report due date to compliance officer, and
- Follow up activities from findings.

In addition to determining its priority risk areas, CHG's audit work plan:

Includes a process to respond to all monitoring and auditing results,

Uses appropriate statistical methods in: (i) selecting sponsor facilities, providers, claims, and other areas for audit; (ii) determining appropriate sample size; (iii) and extrapolating audit findings using statistically valid methods that comply with generally accepted auditing standards to the full universe

Uses special targeted techniques based on aberrant behavior,

Assesses compliance with internal processes and procedures,

Examines the performance of the compliance program, including a review of training, reporting mechanisms (e.g., hotline log), investigation files, OIG/GSA exclusion list screenings, evidence of employee receipt of Standards of Conduct and conflict of interest disclosures/attestations, and sampling for evidence in support of attestations, if necessary.

Conducts follow-up review of areas previously found non-compliant to determine if the implemented corrective actions have fully addressed the underlying problem.

The work plan includes a schedule that lists all of the monitoring and auditing activities for the calendar year of CHG's operational areas and those of first tier entities. Audits may include desk and on-site audits.

Audit of CHG's Operations and Compliance Program

CHG arranges for an internal or external audit of the effectiveness of the compliance program annually and provides the results to the Compliance Officer, Compliance Committee, senior managers, and the Board. The following areas are reviewed:

Review Element	Sample Evaluation Questions
Policies and Procedures	Are policies and procedures specific and detailed in describing the mechanisms by which compliance objectives will be achieved? Is there proactive oversight of FDRs to ensure they are adhering to the Code of Conduct and the policies and procedures?
Compliance Officer and Compliance Committee	Does the responsible compliance position report to the CEO? Does the responsible compliance position have a regular pre-scheduled meeting with the governing board to report on activities of the compliance program (either directly or through a report delivered by the CEO)?
Training and Education of Employees and First Tier, Downstream and Related Entities	Is there evidence of a compliance training program which includes the code of conduct; expectations of the compliance program; and how the compliance program operates? Are new employees, board members and affiliates trained in compliance so that they could identify circumstances of fraud, waste and abuse?
Effective Lines of Communication	Are there accessible mechanism(s) for the governing board, management, employees and others associated with all programs to communicate

	compliance related concerns to the responsible compliance position? Do the accessible mechanisms include methods for anonymous or confidential communication?
Well Publicized Disciplinary Guidelines	Do disciplinary policies set out expectations for reporting compliance issues and for assisting in their resolution? Do disciplinary policies outline sanctions for failing to report suspected problems; participating in non-compliant behavior; or encouraging, directing, facilitating or permitting non-compliant behavior?
Internal Monitoring and Auditing	Does a system exist within the functional area to routinely conduct self-evaluation of risk areas, including internal audits and, as appropriate, external audits? Does the functional area routinely evaluate potential or actual non-compliance as a result of its self-assessments and audits?
Prompt Responses to Detected Offenses	Does a process exist within the compliance plan for responding to compliance issues as they are raised? Does a process exist within the compliance plan for investigating potential compliance issues?

Participants in the audit function are knowledgeable about DHCS and CMS operational requirements for the area under review and will have access to the relevant personnel, information, records, and areas of operation under review. Participants will not audit their own departments. External auditors will be used as necessary.

(6) Procedures for Ensuring Prompt Response to Detected Offenses and Development of Corrective Action Initiatives

CHG investigates and responds appropriately to reports of suspected fraud. Policy #5509.2, "Managing Incidents of Suspected Fraud" (included as Appendix G in this Plan), serves as the basis for investigation by CHG of suspected health care fraud. This policy also outlines how to report suspected fraud to the appropriate law enforcement agency, how to assist law enforcement investigations, and how to take appropriate responsive measures and corrective action when health care fraud is found to have occurred. CHG conducts timely, reasonable inquiries into evidence of misconduct related to payment or delivery of Medi-Cal or Medicare items or services, conducts appropriate corrective actions in response to any such misconduct, and implements procedures to voluntarily self-report potential fraud or misconduct related to the Medi-Cal or Medicare programs to DHCS or CMS, respectively, or its designee.

Conduct a Timely and Reasonable Inquiry of Detected Offenses

CHG conducts a timely and well-documented reasonable inquiry into any compliance incident or issue involving potential Medi-Cal or Medicare program noncompliance or potential FWA, including preliminary investigation by the Compliance Officer or designee. Inquiries are initiated as quickly as possible, but not later than two weeks after the date the potential noncompliance

or potential FWA incident was identified. If CHG does not have the time or resources to investigate the incident, it will refer the matter to the NBI MEDIC within 30 days from identification.

Corrective Actions

CHG undertakes appropriate corrective actions in response to potential noncompliance or potential FWA. To correct the underlying problem that results in program violations and to prevent future noncompliance, CHG conducts a root cause analysis and tailors the corrective action to address the particular FWA, problem or deficiency identified, with timeframes for specific achievements.

When corrective action is needed, CHG will ensure that corrective actions are taken by an FDR. To ensure that an FDR has implemented the corrective action and that the audit reports are effective, CHG will conduct independent audits or review the FDR's monitoring or audit reports and continue to monitor corrective actions after their implementation.

CHG documents all noncompliance, corrective action and monitoring activity. Failure to comply with such corrective action may result in discipline, including termination. (See Corrective/Disciplinary Action Policy included as Appendix C in this Plan)

*Investigation of FWA Issues*CHG's Compliance Department is responsible for efforts related to:

- Reducing or eliminating Medi-Cal, MMP and Part D benefit costs due to FWA;
- Reducing or eliminating fraudulent or abusive claims paid for with federal dollars;
- Preventing illegal activities;
- Identifying enrollees with overutilization issues;
- Identifying and recommending providers for exclusion, including those who have defrauded or abused the system to the NBI MEDIC and/or law enforcement;
- Referring suspected, detected or reported cases of illegal drug activity, including drug diversion, to the NBI MEDIC and/or law enforcement and conducting case development and support activities for NBI MEDIC and law enforcement investigations; and
- Assisting law enforcement by providing information needed to develop successful prosecutions.

Compliance Department investigators are accessible through multiple channels, such as phone, email and mail. Suspicions of FWA can be reported anonymously to the Compliance Department through CHG's hotline.

It is CHG's policy to thoroughly and objectively investigate any specific allegation of misconduct, fraud or abuse involving CHG employees, FDRs, accounts or operations. CHG holds individuals responsible for violations of CHG's policies, breaches of ethical behavior or illegal acts committed against CHG, on CHG's behalf, on CHG premises, or during hours of, or within the scope of CHG business operations. The source of any allegation of wrongdoing, whether the CHG hotline, an email, telephone or in person report, or any other source, is irrelevant to CHG's obligation to

investigate. CHG will conduct all investigations in a manner that protects the rights of those who may be the subject of allegations of wrongdoing as well as those who, in good faith, make such allegations.

CHG requires the cooperation of FDRs and Affiliates during any investigations that may involve (directly or indirectly) their organization or individuals associated with their organization. The investigation will be initiated by a representative of CHG and continue until the investigation is completed. Coordination of investigations which involve any regulatory agency will be handled in accordance with their requests.

Responding to CMS Issued Fraud Alerts

CMS issues alerts to Part D sponsors concerning fraud schemes identified by law enforcement officials. When a Fraud Alert is received, CHG reviews its contractual agreements with the identified parties. The Compliance Officer in consultation with legal counsel, will determine whether the contract may be terminated and forward to the Operations Committee for determination. CHG will also review its past paid claims from any entities identified in a fraud alert. CHG will make its best efforts to identify claims that may be or may have been part of an alleged fraud scheme and remove them from their sets of prescription drug event data submissions.

Identifying Providers with a History of Complaints

CHG will maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes enrollee complaints, NBI MEDIC investigations, OIG and/or DOJ investigations, U.S. Attorney prosecution, and any other civil, criminal, or administrative action for violations of federal health care program requirements. CHG will also maintain files that contain documented warnings (i.e., fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CHG will comply with requests by law enforcement, DHCS, CMS and their designees regarding monitoring of providers within CHG's network that DHCS and CMS have identified as potentially abusive or fraudulent.

Effectiveness Measures

CHG routinely monitors and identifies compliance risks through internal monitoring and audits and, as appropriate, external audits, to evaluate CHGs and FDRs' compliance with DHCS and CMS requirements and the overall effectiveness of the compliance program.

Use of Data Analysis for Fraud, Waste and Abuse Prevention and Detection

CHG:

- Identifies items or services that are being over utilized;
- Identifies problem areas within the plan such as enrollment, finance, or data submission;
- Identifies problem areas at the FDR (e.g., PBM, pharmacies, pharmacists, physicians, other health care providers and suppliers); and

- Uses findings to determine where there is a need for a change in policy.

CHG reviews data analysis performed to identify pharmacies and other FDRs that require further review. See Section 8, First-Tier, Downstream, & Related Entity Compliance, below.

(7) Enforcement of Standards through Well-Publicized Disciplinary Guidelines

CHG's Code of Conduct provided to all employees is intended to provide general ethical conduct standards to follow and to assist CHG in meeting its compliance goals. The Code and our personnel policies and procedures specify the disciplinary measures that can be taken for non-compliance, including oral or written warnings or reprimands, suspensions or termination.

Employees may be subject to discipline and contractors to termination for failing to participate in CHG's compliance efforts including, but not limited to:

- Conduct of an employee or FDR that leads to a violation of federal or state law, or conduct that results in violation of any other requirement relating to participation in Medi-Cal or Medicare;
- The failure of an employee or FDR to perform any required obligation relating to compliance with the Compliance Plan or applicable law, such as the completion of required training; or
- The failure of any employee or FDR to report suspected violations of the Compliance Plan or applicable law to an appropriate person, or to assist in the resolution of reported compliance issues.

CHG maintains a "zero tolerance" policy towards any illegal conduct. Any employee or FDR engaging in a violation of any laws or regulations (depending on the magnitude of the violation) may be terminated from employment or their contract.

CHG shall accord no weight to an employee's or FDR's claim that any improper conduct was undertaken for the benefit of the CHG. Such conduct is not for CHG's benefit and is expressly prohibited.

The standards established in the Compliance Plan shall be consistently enforced through disciplinary proceedings. These shall include the following:

- Prompt initiation of education to correct the identified problem; and
- Disciplinary action, if any, as may be appropriate given the facts and circumstances of the investigation including oral reprimand, written reprimand, demotions, reductions in pay, discharge and termination.

In determining the appropriate discipline for any violation of the Compliance Plan or applicable laws, CHG shall not take into consideration a particular employee's economic benefit to the

organization.

CHG publicizes its disciplinary standards widely to its employees and FDRs. CHG maintains disciplinary records for ten (10) years that capture the dates of the violation and the investigation, a summary of the findings, the disciplinary action taken, and the date it was taken.

(8) First Tier, Downstream & Related Entity Compliance

CHG's Compliance Officer oversees compliance monitoring for all FDRs. The Compliance Plan is a resource designed to assist our employees and FDRs with understanding and complying with CHG's Compliance Program and requirements. This Plan will:

- Demonstrate CHG's commitment to responsible corporate conduct;
- Set forth the FDRs compliance requirements;
- Publicize mechanisms for reporting FWA and compliance issues;
- Communicate information about CHG's Code of Conduct and the compliance policies in place to detect, prevent, correct, and monitor FWA and inefficiencies;
-

What is an FDR?

CHG utilizes CMS current definitions to define First Tier, Downstream, and Related Entities, but has modified them to apply to both Medi-Cal and Medicare, as follows:

First Tier Entity is any party that enters into a written arrangement, acceptable to DHCS or CMS, with a Medi-Cal Sponsor, MMP or Part D plan sponsor or applicant to provide administrative services or health care services to a Medi-Cal or Medicare eligible individual under the Medi-Cal program, or the MMP.

Downstream Entity is any party that enters into a written arrangement, acceptable to DHCS or CMS, with persons or entities involved with the Medi-Cal benefit, Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medi-Cal Sponsor or applicant, Medicare Advantage Organization 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.

Related Entity means any entity that is related to a Medi-Cal Sponsor, MMP Sponsor by common ownership or control and:

- Performs some of the Medi-Cal Sponsor's, MMP Sponsor's management functions under contract or delegation;
- Furnishes services to Medi-Cal or Medicare enrollees under an oral or written agreement; or
- Leases real property or sells materials to the Medi-Cal Sponsor, MMP Sponsor at a cost

of more than $2,500 during a contract period.

Affiliate is a person, provider or entity who provides care, services or supplies under the Medicaid program, or a person who submits claims for care, services or supplies for or on behalf of another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

CHG's Compliance Officer and Compliance Committee, with consultation from legal counsel and business owners of the applicable FDR functions, will evaluate and categorize all vendors with which it contracts to determine whether they satisfy the criteria for FDRs. Factors to be considered include: whether the function is something the sponsor is required to do or to provide under its contract with DHCS or CMS, the applicable federal regulations, DHCS guidance or CMS guidance, to what extent the delegated entity has interaction with enrollees, either orally or in writing; whether the delegated entity has decision-making authority (e.g., enrollment vendor deciding time frames) or whether the entity strictly takes direction from the sponsor; and the risk that the entity could harm enrollees or otherwise violate Medi-Cal or Medicare program requirements or commit FWA.

FDR & Affiliate Compliance Requirements

CHG's commitment to compliance includes ensuring that our First Tier, Downstream and Related Entities (FDRs) and Affiliates are in compliance with applicable state and federal regulations. CHG contracts with these entities to provide administrative and healthcare services to our enrollees, we are ultimately responsible for fulfilling the terms and conditions of our contract with the DHCS and CMS and meeting the Medicare and Medicaid program requirements. Therefore, CHG requires each FDR and Affiliate to comply with the compliance and FWA expectations below. Failure to meet the requirements may lead to a Corrective Action Plan, retraining, or the termination of a contract and relationship with CHG.

First Tier entities are responsible for ensuring that their downstream and related entities are in compliance with this policy and applicable Federal and State statutes and regulations.

FDRs and Affiliates must maintain supporting documentation of compliance with the requirements below for a period of ten (10) years and must furnish evidence to CHG upon request for monitoring and auditing purposes.

Annual FDR and Affiliate Compliance Attestation

An authorized representative from each FDR and Affiliate is required to complete the CHG FDR and Affiliate Compliance Attestation on behalf of his or her organization upon contract and on an annual basis to attest to compliance with the standards of conduct, compliance policies, compliance and FWA training, OIG and GSA exclusion screening, and publication of FWA and compliance reporting mechanisms requirements.

An authorized representative is an individual who has responsibility directly or indirectly for all

employees, contracted personnel, providers/practitioners, and vendors who provide healthcare or administrative services under Medi-Cal and/or Medicare. Authorized representatives may include, but are not limited to, a Compliance Officer, Chief Medical Officer, Practice Manager/Administrator, Provider, an Executive Officer or similar related positions. CHG will send a notification to each FDR and Affiliate to communicate the deadline for completion of the annual Attestation. All FDRs and Affiliates must complete Attestations within the designated timeframe.

Standards of Conduct and Compliance Information

CHG requires each FDR and Affiliate to establish and sustain a culture of compliance. CHG FDRs and Affiliates must either: (1) establish and publicize comparable Standards of Conduct that meet CMS requirements set forth in 42 CFR 422.503(b)(4)(vi)(A) and 42 CFR 423.504(b)(4)(vi)(A) and reflect a commitment to preventing, detecting, and correcting non-compliance; or (2) adopt and distribute to all employees and contractors CHG's Standards of Conduct which is included as Appendix A in this Plan.

In addition to the Standards of Conduct, each FDR and Affiliate must distribute compliance information to all employees and contractors upon hire/contract and annually thereafter. CHG provides compliance information in this Plan that can be utilized. If an FDR or Affiliate opts to use different material, it must include at minimum, a description of the Compliance Program, instructions on how to report suspected non-compliance, the requirement to report potential non-compliance and FWA, disciplinary guidelines for non-compliant behavior, a non-retaliation provision, a FWA training requirement, and an overview of relevant laws and regulations (such as the Deficit Reduction Act of 2005, False Claims Act, and HIPAA).

FDRs and Affiliates must maintain records (i.e., attestations, logs, etc.) for ten (10) years to document that each employee and contractor has received, read, understood, and will comply with the written standards of conduct and compliance policies upon hire/contract and annually thereafter.

OIG and GSA Exclusion Screening

Federal law prohibits the payment by Medicare, Medi-Cal or any other federal healthcare program for any item or service furnished by a person or entity excluded from participation in these federal programs. Therefore, prior to hire and/or contract and monthly thereafter, each FDR and Affiliate must perform a check to confirm that employees and contractors are not excluded to participate in Federally-funded healthcare programs according to the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists.

The websites below should be utilized to perform the required screening:

OIG List of Excluded Individuals/Entities (LEIE): https://exclusions.oig.hhs.gov

GSA database of excluded individuals/entities: https://www.sam.gov/portal/SAM/

If an employee or contractor is on an exclusion list, he or she must be removed from any work

related directly or indirectly to federal healthcare programs and appropriate corrective action must be taken.

FDRs and Affiliates must maintain evidence of exclusionary checks (i.e., logs or other records) to document that each employee and contractor has been screened in accordance with current regulations and requirements.

Reporting Fraud, Waste, Abuse and Compliance Issues

CHG FDRs and Affiliates have a responsibility to report any alleged compliance, FWA, and/or conflict of interest issues that involves CHG. FDRs and Affiliates may confidentially report a potential violation of our compliance policies or any applicable regulation by utilizing the following methods:

CHG Reporting

CHG's 24/7, confidential and anonymous hotline: 1 (800) 651-4459

Medicare Reporting

Office of Inspector General at 1-800-HHS-TIPS (1-800-447-8477), TTY 1-800-377-4950 or by mail at US Department of Health and Human Services, Office of Inspector General, ATTN: OIG HOTLINE OPERATIONS, PO Box 23489, Washington, DC 20026

Centers for Medicare and Medicaid (CMS) at 1-800-Medicare (1-800-633-4227), TTY 1-877-486-2048 or by mail at Medicare, attention: Beneficiary Contact Center, P.O. Box 39, Lawrence KS, 66044

For additional information on how to detect and report Medicare fraud, you may access this link at www.stopmedicarefraud.gov.

California Medi-Cal Reporting

California Department of Justice: hotline 1-800-722-0432

Department of Health Care Services: hotline 1-800-822-6222 or email fraud@dhcs.ca.gov

CHG requires each FDR and Affiliate to publicize confidential reporting mechanisms for all employees and contractors. If an FDR/Affiliate does not maintain a confidential reporting mechanism, the CHG Confidential Hotline information must be distributed to encourage reporting of potential compliance issues, FWA, conflict of interests, violations of compliance policies and/or any applicable regulation.

Monitoring and Auditing

CHG routinely monitors and periodically audits first tier entities to ensure compliant administration of the Medicare and Medi-Cal contracts, as well as applicable laws and regulations. Each first tier entity is required to cooperate and participate in the monitoring and auditing

activities. If a first tier entity performs its own audits, CHG may request the audit results affecting CHG business. In addition, first tier entities are expected to routinely monitor and periodically audit their downstream entities.

CHG will evaluate whether the first tier entities are applying appropriate compliance programs to downstream entities with which they contract. CHG will obtain a summary of the audit work plan and audit results that relate to the services the FDR perform. If CHG determines that an FDR or Affiliate is not in compliance with the requirements set forth in this policy, the FDR or Affiliate will be required to develop and submit a Corrective Action Plan (CAP). CHG will assist the FDR or Affiliate in addressing the issues identified.
All monitoring and auditing activities must be documented and retained for a ten (10) year period. CHG may require evidence of monitoring and auditing for future oversight and/or auditing purposes.

Oversight of Delegated Activities

Through a formal process of approval called Delegation, CHG may give a provider entity the authority to perform certain functions on its behalf. These delegated or administrative functions may include the following functions:

- Claims Processing,
- Credentialing/Re-credentialing, and
- Utilization Management.

Prior to entering into a written contractual agreement with an outside entity, CHG reviews the entity's ability to perform all delegated functions to our standards, which are detailed in the following policies:

- Delegated Claims Processing Oversight, Policy No. 7808;
- Delegated Credentialing, Policy No. 7700.1; and
- Delegated Utilization, Policy No. 7271.

CHG remains ultimately accountable for all services provided to its membership by provider entities, although functions may be delegated. CHG oversees and evaluates the performance of its delegated groups by:

- Reviewing required periodic reports submitted by the group;
- Reviewing encounter data for capitated services and/or delegated services submitted by the group;
- Tracking and analyzing provider and member complaints, and other performance indices; and
- Conducting periodic and annual on-site reviews of systems, staff, and policies and

procedures.

Annual review of delegated entities may result in a required corrective action plan to ensure that the delegated group meets our requirements within a specific timeframe. In the event CHG identifies an issue that may result in an adverse member event and/or noncompliance with our standards, we reserve the right to monitor any delegated entity on a more frequent basis or to terminate the contract for failure to comply with our quality standards.

Pharmacy Services Antifraud Activities

CHG actively employs several measures to prevent and detect potential fraudulent pharmacy related activities by pharmacies, practitioners, prescribers, and members. Antifraud activities used to detect potential fraud are conducted as part of CHG's antifraud plan under the purview of the Compliance Committee.

The first line of defense is the electronic, on-line pharmacy claims adjudication system. Each pharmacy claim is subjected to a series of edits that not only ensure the appropriate provision of benefits to eligible members, but also create a sentinel effect for potential fraud. In addition to the edits that ensure appropriate claims adjudication, there are a series of drug utilization review (DUR) edits that check for drug dosage, ingredient duplication, age precaution, gender conflict, therapeutic duplication and others. Additional edits, such as quantity and refill limitations, are also implemented in general and with a higher degree of specificity with drugs that have a high potential for abuse.

Members suspected of fraudulent or drug-seeking behavior may be limited to a specific pharmacy and/or to a specific prescriber. Specific therapeutic classes (e.g. narcotic analgesics) may be electronically blocked except as prescribed according to a pain management plan.

CHG's pharmacy benefits manager (PBM) regularly runs a series of reports that are designed to detect patterns that may suggest billing errors, irregular billing practices, and/or fraud. These "desk audits" may trigger on-site audits. On-site audits are also triggered by any irregular billing practices discovered during the normal course of business, complaints and inquiries reported to CHG, and irregularities discovered in the analysis of utilization reports. CHG also periodically produces ad hoc member, pharmacy, or prescriber-centric reports when there is reason to suspect that things are not as they should be or upon discovery of potential fraudulent behavior in other areas such as emergency department utilization. Any discovery made through this process is reported to the Compliance Committee and appropriate action taken is based on the Committee's recommendation.

CHG's PBM maintains a pharmacy credentialing plan to credential a pharmacy prior to network inclusion and periodically thereafter. The process validates, among other elements, current licensure and monitors the pharmacy's status with DHCS and CMS.

In addition to the foregoing measures, CHG shall employ additional measures as specified in Chapter 9 of the CMS Drug Benefit Manual, entitled “Part D Program to Control Fraud, Waste and Abuse.” Our contracted Pharmacy Benefits Manager also has a compliance plan that complies with the Medicare Part D requirements and is consistent with our Plan.

Compliance References: Federal and state false claims acts; Anti-kickback statute; Prohibition on Inducements to Beneficiaries; Health Insurance Portability and Accountability Act; Code of Federal Regulations; 42 42 C.F.R. Sections 400, 403, 411, 417, 422, 423, 1001, 1003; civil monetary penalties and exclusions; Federal Sentencing Guidelines