

**GOVERNMENT PROGRAMS COMPLIANCE AND FRAUD,
WASTE AND ABUSE PROGRAM**

September 2012

OPENING STATEMENT

To our Employees and Contractors:

At PacificSource Community Health Plans, Inc. and PacificSource Community Solutions (hereafter “PacificSource”), we are committed to our corporate vision of being the leading community health plan in our service areas. We strive towards this vision under the guidance of our mission and corporate values.

To that end, we have implemented an integrated Compliance Program and Fraud Waste and Abuse (FWA) Plan. The Compliance Program is the framework and foundation by which we articulate our commitment to comply with State and Federal laws, regulations, and our internal policies and procedures. The Compliance Program has the full support of our Board of Directors, our CEO, and our entire Executive Management Group (EMG).

Whether we work intimately within government programs as part of our daily charge, or whether we only touch government programs at a cursory level, compliance is everyone’s responsibility. We want you to familiarize yourself with this document, and use all the tools at your disposal to maintain our high standard of compliance and ethical behavior. We thank you for your continued support in our ongoing commitment to serve our members in the best and most ethical manner.



JOHN DEWENTER
Chairman, PCHP Board of Directors



KEN PROVENCHER
President and CEO



DAN STEVENS
SVP Government Programs



TRJET TRAN
Compliance Officer

Table of Contents

OPENING STATEMENT	2
MEET OUR COMPLIANCE DEPARTMENT	4
WHO DOES THIS APPLY TO?	4
WHAT ARE MY EXPECTATIONS?	4
DISSEMINATION	4
OUR COMPLIANCE PROGRAM AT A GLANCE	5
COMPLIANCE POLICIES	7
POLICY NUMBER C-1: COMPLIANCE WITH FEDERAL & STATE LAWS	8
POLICY NUMBER C-2: COMPLIANCE OFFICER, COMPLIANCE COMMITTEE & GOVERNING BODY	12
POLICY NUMBER C-3: COMPLIANCE TRAINING & EDUCATION	19
POLICY NUMBER C-4: EFFECTIVE LINES OF COMPLIANCE COMMUNICATION, REPORTING & NON-RETALIATION	24
POLICY NUMBER C-5: PERSONNEL CORRECTIVE ACTIONS	29
POLICY NUMBER C-6: COMPLIANCE MONITORING & AUDITING	34
POLICY NUMBER C-6A: EXCLUSION & BACKGROUND CHECK	46
POLICY NUMBER C-6B: FDR COMPLIANCE OVERSIGHT	50
POLICY NUMBER C-7: COMPLIANCE INVESTIGATION & CORRECTIVE ACTION PLAN	55
FAQ	63
REFERENCES	66

MEET OUR COMPLIANCE DEPARTMENT

Our Compliance Department consists of professionals who collectively have over 35 years of healthcare experience, over 15 years of compliance experience, and academic backgrounds in law, business, and healthcare.

WHO DOES THIS APPLY TO?

This Compliance and FWA Program applies to all PacificSource employees, officers, directors, and Board and Committee members who handle any government programs line of business, such as Medicare and Medicaid. In addition, if you are a first tier, downstream or related (FDR) entity that contracts with PacificSource to perform a core Medicare or Medicaid service, this Compliance and FWA Program also applies to you.

WHAT ARE MY EXPECTATIONS?

You are required to read and be familiar with this Compliance and FWA Program at the time of your hire, appointment or contracting, and annually thereafter. You should learn to recognize potential noncompliant and FWA issues that may arise during your work, report them to the appropriate channel, and assist in remediating them. You should strive to improve your department's process to minimize compliance risks to PacificSource, our members, and our State and Federal regulatory agencies. Ultimately, you can be a champion and an advocate for compliance, and be a part of our culture of compliance.

DISSEMINATION

This Compliance and FWA Program is disseminated in accordance to the following schedule:

At time of hire: Human Resources shall disseminate the Compliance and FWA Program, including the Standards of Conduct, to employees within **90 days** of hire. Employees shall sign an acknowledgment of receipt.

Annually: The Compliance Department shall disseminate the Compliance and FWA Program, including the Standards of Conduct, to employees **annually** thereafter, and when there are substantial updates. Due to administrative constraints, we do not require a signed acknowledgment of receipt.

FDR: The contract administrator shall disseminate the Compliance and FWA Program, including the Standards of Conduct, to applicable FDRs within **90 days** of contracting and **annually** thereafter. FDRs must sign an acknowledgment of receipt.

PacificSource may use various dissemination methods, including:

- Hard copies
- Electronic copies
- Posting on company intranet

The respective disseminating party shall document that this has been done, including any record of acknowledgment of receipt, and provide evidence to the Compliance Department for retention.

OUR COMPLIANCE PROGRAM AT A GLANCE

The Compliance Program and the content contained herein are a series of incorporated policies, procedures, and guidance by which our government programs are governed. These policies implement the Compliance and FWA Program. The FWA Plan and Standards of Conduct are also incorporated within the Compliance Program. If an applicable policy exists outside of the Compliance Program, it will be referenced accordingly.

The Compliance and FWA Program is made up of 7 core elements. Each core element has its own policy and procedure that implement that particular element. For your convenience, here is a summary of each element:

Element 1 (Compliance with State and Federal Laws): We must comply with applicable laws and regulations that pertain to government programs, such as HIPAA, Federal False Claims Act, and the Social Security Act.

Element 2 (Compliance Officer and Compliance Committee): We must maintain a Compliance Officer and a Compliance Committee to oversee the enforcement and effectiveness of the Compliance and FWA Program.

Element 3 (Compliance Training): We must administer effective training and education for all employees, Board and Committee members, and applicable FDRs at the time of hire, appointment or contracting, and annually thereafter.

Element 4 (Effective Lines of Communication): We maintain effective lines of communication to ensure that you can report compliance and FWA issues to the appropriate channel, including anonymous and confidential reporting.

Element 5 (Disciplinary Standards): In order to be effective, we must maintain disciplinary standards to ensure that people who commit a compliance or FWA violation are subject to appropriate corrective actions, up to and including termination of employment or contract.

Element 6 (Monitoring and Auditing): We adopt the doctrine of “trust but verify”. We conduct routine monitoring reviews and audits of our internal operations and external business partners to ensure that they are performing in accordance with State and Federal guidelines.

Element 7 (Compliance Investigation & Corrective Action Plan): Lastly, upon discovery of a potential noncompliant or FWA issue, we will initiate a thorough investigation of the incident. We then track

deficiencies and instances of noncompliance by formal Corrective Action Plans (CAP) to ensure that they are remedied and are not likely to reoccur.

COMPLIANCE POLICIES



POLICY NUMBER C-1: COMPLIANCE WITH FEDERAL & STATE LAWS

POLICY

PacificSource Community Health Plans, Inc. and PacificSource Community Solutions, Inc. (hereinafter “PacificSource”) will comply with applicable Federal and State laws and statutes, Code of Federal Regulations, and sub-regulatory guidance.

Applicability

This policy applies to all applicable PacificSource Health Plans’ employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)").

PROCEDURE

PacificSource administers its government programs in accordance with the following statutes, laws, regulations, and agency requirements that are promulgated by the Federal and State government. Applicable covered persons are required to maintain current knowledge of these requirements, and implement and integrate the requirements within the operational, administrative and compliance areas.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)): This statute prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business, including Medicare and Medicaid. This can take many forms, such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt, or the sale or purchase of items at a price that is not consistent with fair market value. It also may include the routine waiver of co-payments and/or co-insurance.

The offense is classified as a felony and is punishable by fines of up to \$25,000, imprisonment for up to five years, civil money penalties up to \$50,000, and exclusion from participation in federal health care programs.

Anti-Money Laundering: Money laundering involves hiding the origin of unlawfully gained money, for example through drug transactions, bribery, terrorism or fraud. PacificSource is committed to complying fully with all anti-money laundering laws and regulations. We will conduct business only with reputable customers involved in legitimate business activities, with funds derived from legitimate sources.

Antitrust Laws: These laws are designed to protect competition by prohibiting monopolies, price fixing, predatory pricing and other practices that restrain trade. We never discuss pricing, suppliers or territories with competitors, nor make agreements with them on these or other competitive issues. We gain information about competitors only in legal and ethical ways. Improperly obtained competitor proprietary information cannot be used to the advantage of PacificSource.

Beneficiaries Inducement Statute (42 U.S.C. § 1320a-7a(a)(5)): Medicare marketing guidelines prohibit PacificSource from offering rebates or other cash inducements of any sort to beneficiaries. The guidelines prohibit us from offering or giving remuneration to induce the referral of a Medicare beneficiary, or to induce a person to purchase, or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare program.

Civil Monetary Penalties and Exclusions: In addition to criminal penalties, the United States Government may also impose civil monetary penalties and exclude a person or entity from participation in Medicare, Medicaid and all other Federal health care programs.

Code of Federal Regulations: PacificSource must comply with Federal regulations that implement and oversee the Medicare and Medicaid programs. These regulations include:

42 CFR §400: Overview

42 CFR §403: Special programs

42 CFR §411: Benefit and payment exclusions

42 CFR §417: Health maintenance organizations, competitive medical plans, and health care prepayment plans

42 CFR §422: Medicare Advantage program. This is the authoritative regulation that implements the Medicare Advantage Program under the Social Security Act.

42 CFR §423: Prescription drug program. This is the authoritative regulation that implements the Prescription Drug Program under the Social Security Act.

42 CFR §430: Medicaid program. This is the authoritative regulation that implements the Medicaid Program under the Social Security Act.

42 CFR §1001: OIG program exclusions

42 CFR §1003: OIG civil money penalties, assessments and exclusions

Contractual Commitments: PacificSource contracts with government agencies such as the Centers for Medicare and Medicaid Services (CMS), the Oregon Health Authority (OHA), the Division of Medical Assistance Programs (DMAP), and the Addictions and Mental Health Division (AMH) to administer the Medicare and Medicaid programs, respectively. We are bound by the terms and conditions of those contracts. Non-compliance with contractual obligations may result in the suspension or termination of our contracts with CMS and OHA.

Federal Criminal False Claims Statutes (18 U.S.C. §§287, 1001): Federal laws makes it a criminal offense for anyone who makes a claim to the United States government knowing that it is false, fictitious, or fraudulent. This offence carries a criminal penalty of 5 years in imprisonment and a monetary fine.

Federal False Claims Acts (31 U.S.C. §§ 3729-3733): The Federal False Claims Act (FCA) prohibits any person from engaging in any of the following activities:

1. Knowingly submit a false or fraudulent claim for payment to the United States Government;
2. Knowingly make a false record or statement to get a false or fraudulent claim paid or approved by the Government;

3. Conspire to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or
4. Knowingly make a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

Violations may result in a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustained due to the violation.

The FCA defines “knowingly” broadly to mean a person who: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, even without a specific intent to defraud.

The FCA also allows an individual to file a *qui tam* action that entitles the individual to receive between 15-30 % of a settlement or action stemming from the suit. Under the FCA, individuals are protected from being discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in their employment as a result of filing a *qui tam* action. Remedies include reinstatement with the same seniority, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.

Federal Food, Drug and Cosmetic Act: This Act authorizes the FDA to oversee drugs and medical devices.

Fraud Enforcement and Recovery Act of 2009 (FERA): This law reinforces criminal violations of certain federal fraud laws, federal false claim laws, including financial institution fraud, mortgage fraud, and securities and commodities fraud.

Health Insurance Portability and Accountability Act (HIPAA): This act protects the confidentiality and integrity of protected health information. The HIPAA Privacy Rule provides federal protections for personal health information held by PacificSource and its business partners and gives patients an array of rights with respect to that information.

The Security Rule specifies a series of administrative, physical, and technical safeguards for PacificSource and its business partners to use to assure the confidentiality, integrity, and availability of electronic protected health information.

OIG List of Excluded Individuals and Entities (LEIE) & GSA System for Award Management (SAM): Federal law prohibits the payment by Medicare, Medicaid or any other federal health care program for any item or service furnished by a person or entity excluded from participation in these federal programs. No Part C or D Sponsor or FDR may submit for payment any item or service provided by an excluded person or entity, or at the medical direction or on the prescription of a physician or other authorized person who is excluded. The Office of Inspector General (OIG) maintains the LEIE and the General Services Administration (GSA) maintains the SAM.

Oregon Administrative Rules (OARs): PacificSource must comply with applicable OARs that govern the Medicaid program, such as 410-120 and 410-141, *et. al.*

Patient Protection and Affordable Care Act: This law requires health insurers to sell insurance to individuals regardless of their health status or any pre-existing medical conditions, requires individuals who don't have health insurance to purchase health insurance or face a penalty, and created a health insurance exchange system that allows individuals to purchase standardized, state-regulated health care plans that are eligible for federal subsidies.

Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn): This statute, which is also articulated in §1877 of the Social Security Act, prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies. The statute prohibits the submission of claims to Medicare for those referred services.

Social Security Act: Title XVIII of the Social Security Act implements the Medicare Advantage Program (§1851-1859) and the Prescription Drug Program (§1860D-1860D-31), and serves as the statutory foundation by which these two Medicare programs are governed. In addition, and when applicable, PacificSource complies with Original Medicare requirements under §1811-1848. Title XIX of the Social Security Act implements the Medicaid program (§1900-1946).

State Laws: As an insurance company, PacificSource Community Health Plans, Inc. is licensed under Chapter 732 of the Oregon Revised Statutes and is required to comply with all laws applicable to health insurers contained in the Insurance Code. We are subject to oversight by the Oregon Insurance Division. We are subject to annual filings, audits, and other oversight measures. Changes to the company's Articles of Incorporation must be approved by and filed with the Oregon Insurance Division, and many types of transactions require prior approval by the agency. PacificSource's Finance Department and Legal Affairs and Compliance Department are responsible for these filings.

Sub-Regulatory Guidance: CMS and DMAP issue sub-regulatory guidance such as HPMS memos, manuals, instructions, and memos. PacificSource shall comply with such guidance.

References

- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (§50.1)

Schedule

Effective Date	April 2012
Approval Date	April 2012
Revision Date	August 2012
Line(s) of Business	Medicare, Medicaid
Department Owner	Triet Tran, Director & Compliance Officer
EMG Owner	Dan Stevens, SVP Government Programs



POLICY NUMBER C-2: COMPLIANCE OFFICER, COMPLIANCE COMMITTEE & GOVERNING BODY

POLICY

PacificSource Community Health Plans, Inc. and PacificSource Community Solutions, Inc. (hereinafter “PacificSource”) maintain a Government Programs Compliance Officer and a Government Programs Compliance Committee. The Compliance Officer and Compliance Committee are accountable to members of the Executive Management Group (EMG), and report to the Board of Directors on the activities and status of the Compliance Program at least quarterly.

The Compliance Officer is vested with the day-to-day operations of the compliance program, is an employee of the organization, and reports to a member of EMG. In no event shall the Compliance Officer be an employee of PacificSource’s first tier, downstream and related entity (FDR), or serve dual roles in operational areas.

The Compliance Committee advises the Compliance Officer, and assists in the implementation of the Compliance Program. The Board of Directors is accountable for and exercise reasonable oversight over the effectiveness and implementation of the Compliance Program, and maintains current knowledge about the content and operation of the Compliance Program.

Applicability

This policy applies to all applicable PacificSource Health Plans’ employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)").

PROCEDURE

Compliance Officer

Reporting & Accountability: The Government Programs Compliance Officer reports to and is directly accountable to the Senior Vice President of Government Programs, a member of the organization’s EMG.

The Compliance Officer reports *at least quarterly* to the Compliance Committee, Audit Committee and the Board of Directors on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance Program. This is done to ensure that committee members, senior management, and including Board members are knowledgeable about the content and operation of the compliance program, and that senior management and the Board exercise reasonable oversight with respect to the implementation and effectiveness of the compliance program. The Compliance Officer has the authority to provide unfiltered, in-person reports to the Board of Directors.

The Compliance Officer also provides quarterly compliance reports to the CEO of PacificSource Health Plans, either directly or through the SVP of Government Programs. However, the Compliance Officer has the authority to provide unfiltered, in-person reports to the CEO of PacificSource Health Plans.

Roles & Responsibilities: The Compliance Officer maintains the following, but not limited, roles and responsibilities:

1. Implement the Compliance Program, including defining the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all personnel and FDRs.
2. Provide compliance reports *at least quarterly* to the Board of Directors, CEO, Compliance Committee, and Audit Committee on the status of the Compliance Program, the identification and resolution of potential or actual instances of noncompliance, and the compliance oversight and audit activities.
3. Interact with business owners and operational units and being involved in and aware of the daily business activities. The Compliance Officer implements this by engaging in operational meeting, such as the Government Operations Committee, Medicare Advantage Project Steering Committee, Medicare Product Strategy Workgroup, Manager Forum, and DMAP Workgroup.
4. Create and coordinate (or delegates) educational training programs to ensure that officers, directors, managers, employees, FDRs, and other individuals working in the government programs are knowledgeable about the Compliance Program, written Standards of Conduct, compliance policies and procedures, and all applicable statutory and regulatory requirements.
5. Develop and implement methods and programs that encourage managers and employees to report program noncompliance and suspected FWA and other misconduct without fear of retaliation.
6. Maintain the compliance reporting mechanism and closely coordinate with the internal audit department, where applicable.
7. Respond to reports of potential instances of FWA, coordinate internal investigations and develop appropriate corrective or disciplinary actions, if necessary.
8. Coordinate personnel issues with Human Resources to ensure that covered persons are checked against the OIG exclusion lists and GSA debarment lists monthly. PacificSource may require the FDRs to provide signed attestation/certification of their compliance with this requirement, subject to validation.

9. Maintain documentation for each report of potential noncompliance or FWA received from any source, which describes the initial report of noncompliance, the investigation, the results of the investigation, and all corrective and/or disciplinary action(s) taken as a result of the investigation.
10. Oversee the development and monitoring of corrective action plans.
11. Coordinate potential fraud investigations/referrals with the appropriate National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), collaborate with other sponsors, State Medicaid programs, Medicaid Fraud Control Units (MCFUs), commercial payers, and other organizations, where appropriate, when an FWA issue is discovered that involves multiple parties.
12. Has the authority to:
 - Interview employees regarding compliance issues.
 - Review and retain company contracts and other documents.
 - Review the submission of data to CMS and State agencies to ensure accuracy and compliance with CMS and DMAP reporting requirements.
 - Seek independent advice from legal counsel.
 - Report misconduct to CMS and DMAP or law enforcement.
 - Conduct and direct internal audits and investigations of any FDRs.
 - Recommend policy, procedure and process changes.

Training & Maintaining Current Knowledge: The Compliance Officer maintains current and comprehensive knowledge of Federal and State regulations and program requirements through various methods, including reading HPMS memos, manuals, attending industry-sponsored conferences, and interacting with other plans' compliance officers.

In addition, the Compliance Officer participates (or delegates) in important government-sponsored conferences and workgroups such as:

- Spring/Fall CMS Medicare Advantage and Prescription Drug Plan Conference
- CMS-sponsored Center for Program Integrity (CPI) NBI MEDIC Fraud Work Group Quarterly Meetings
- United States Attorney's Office Health Care Fraud Working Group
- Monthly Issues Management with CMS Regional Officer
- Idaho Department of Insurance Fraud Conference

Compliance Committee

Purpose: The Government Programs Compliance Committee is responsible for advising the Government Programs Compliance Officer and assisting in the implementation and administration of the Compliance

Program. The Committee oversees compliance for all government program lines of business, including the Medicare and Medicaid programs.

Reporting & Accountability: The Compliance Committee is accountable to the SVP of Government Programs. Through the Compliance Officer, the Compliance Committee reports at least quarterly to the Board of Directors on the status and effectiveness of the Compliance Program.

Membership¹: The Compliance Committee maintains memberships from a variety of backgrounds, including Pharmacy Services, Health Services, Legal, Human Resources, Operations, Finance, Internal Audit, and representatives from the Executive Management Group. Committee members have decision-making authority in their respective business area of expertise.

EXECUTIVE SPONSOR	
Dan Stevens	COO, Senior VP of Government Programs
COMMITTEE CHAIR	
Triet Tran	Director, Government Programs Compliance Officer
MEMBERS	
Josh Bishop	Director of Medical and Pharmacy Services
Erick Doolen	CIO, Senior VP of Operations
Andy Duffield	Internal Audit Manager
Mari Enders	Grievance and Appeals Team Leader
Mike Gianotti	Finance Manager
Jane Hannabach	Director of Operations
Kristi Kernutt	VP of Legal Affairs and General Counsel
Nancy Lumpkin	Human Resources Manager
Jennifer Moss Lewis	Marketing & Communications Manager
Debbie Smith	Provider Network Compliance Coordinator
Dan Stevens	COO, Senior VP of Government Programs
Triet Tran	Director, Government Programs Compliance Officer
Brad Westphal	Senior Products Regional Manager
Lisa Zent	Provider Network Manager

Membership considerations, including the addition and removal of committee members, can be made by any committee member at any time. An assessment of the adequacy of the current membership representation shall be conducted on an annual basis.

Meeting Protocol: The committee shall meet at least quarterly. Meetings shall be documented by minutes. Relevant documentations submitted to the committee shall be retained in accordance with CMS record retention requirements.

Roles & Responsibilities: The Committee maintains the following, but not limited, roles and responsibilities:

¹ Membership listing may be modified from time to time without requiring Compliance Committee approval of updates to this policy.

1. Meet at least quarterly.
2. Develop strategies to promote compliance and the detection of potential violations.
3. Review and approve compliance and FWA training, and ensure that training and education are effective and appropriately completed.
4. Assist with the creation and implementation of risk assessment and monitoring and auditing work plan.
5. Assist in the creation, implementation and monitoring of effective corrective actions.
6. Develop innovative ways to implement appropriate corrective and preventative action.
7. Review the effectiveness of the system of internal controls designed to ensure compliance with regulations in daily operations.
8. Support the Compliance Officer's needs for sufficient staff and resources to carry out his/her duties.
9. Ensure up-to-date compliance policies and procedures.
10. Ensure that there is a system for employees and FDRs to ask compliance questions and report potential instances of noncompliance and FWA confidentially or anonymously without fear of retaliation.
11. Review and address reports of monitoring and auditing of areas at risk for noncompliance or FWA and ensure that corrective action plans are implemented and monitored for effectiveness.
12. Provide regular and ad hoc reports on the status of compliance with recommendations to the governing body.

Governing Body

The Board of Directors exercises reasonable oversight in the development and implementation of the Compliance Program, and is ultimately accountable for compliance. On an annual basis, the Board of Directors shall adopt a resolution stating the organization's commitment to lawful and ethical conduct.

The Board of Directors delegates certain responsibilities to the Audit Committee and Compliance Committee. Please see the Board of Director's charter for a detailed description of the scope of delegation of activities. The Board (or a designated committee of the same) maintains the following, but not limited, roles and responsibilities:

1. Approve the Standards of Conduct. This may not be delegated.
2. Understand the compliance program structure.
3. Be informed about compliance enforcement activities such as notices of non-compliance, warning letters, and other formal sanctions.
4. Be informed of compliance program outcomes, including results from internal and external audits.
5. Receive regularly scheduled updates, measurable evidence, and data from the Compliance Officer and Compliance Committee showing that the compliance program is detecting and correcting noncompliant issues on a timely basis.
6. Review results from the assessment of the Compliance Program's performance and effectiveness.
7. Be knowledgeable about the content and operation of the compliance program through updates, training and education on the structure and operation of the Compliance Program.

In addition, the Board acts as a policy-making body that exercises oversight and control over policies and personnel to ensure that management actions are in the best interest of the organization and its enrollees.

The policy-making body also controls the appointment and removal of the executive manager, who is the Senior Vice President of Government Programs, a member of the organization's EMG. Please see the *PacificSource Health Plans By-Laws and Bylaws of PacificSource Community Health Plans, Inc.* for a description.

CEO & EMG Engagement

The CEO of PacificSource Health Plans, who is also the CEO/President of PacificSource Community Health Plans, Inc., or the SVP of Government Programs (who serves as the most senior leader of those lines of business), and applicable EMG members shall ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority and resources necessary to operate a robust and effective compliance program. The CEO/SVP of Government Programs receives periodic reports from the Compliance Officer of risk areas facing the organization, the strategies implemented to address those risks, and the results of those strategies. The CEO/SVP of Government Programs is advised of all governmental compliance enforcement activity, including Notices of Non-Compliance and formal enforcement actions.

Audit Committee

The Compliance Officer reports *at least quarterly* to the Audit Committee on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance Program. Please see the *PacificSource Health Plans Audit Committee Charter* for a description of the committee's functions.

References

- 42 CFR §422.503(b)(4)
- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (\$50.2)
- PacificSource Health Plans By-Laws and Bylaws of PacificSource Community Health Plans, Inc.
- PacificSource Health Plans Audit Committee Charter

Schedule

Effective Date	May 2012
Approval Date	May 2012
Revision Date	September 2012
Line(s) of Business	Medicare, Medicaid
Department Owner	Triet Tran, Director & Compliance Officer
EMG Owner	Dan Stevens, SVP Government Programs



POLICY NUMBER C-3: COMPLIANCE TRAINING & EDUCATION

POLICY

PacificSource Community Health Plans, Inc. and PacificSource Community Solutions, Inc. (hereinafter “PacificSource”) administer effective training and education for all covered persons who are responsible for the administration or delivery of a government programs at the time of hire or contracting, and annually thereafter. Training and education cover general compliance training, specialized compliance training, and fraud, waste and abuse (FWA) training.

Applicability

This policy applies to all applicable PacificSource leased employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)").

PROCEDURE

Responsibility

Compliance Department: Creates general and FWA training content for all covered persons; administers training to Board of Directors, and committee members (including the Pharmacy and Therapeutics (P & T) Committee, Compliance Committee, and Audit Committee); creates the Specialized Training Checklist for high-risk departments; administers ad-hoc specialized training to high-risk departments; posts compliance posters in high-visible common areas and disseminates compliance tips to raise compliance awareness.

Human Resource: Administers general and FWA training to employees; maintains records of time, attendance and results of training.

Sales Department: Creates (or delegates) agent/broker training content and administers (or delegates) training for agents and brokers; maintains records of time, attendance and results of training.

Operational Departments: Create and administer specialized training for their employees; administer training to FDRs (or ensure that FDRs complete their own training); maintain records of time, attendance and results of training.

FDRs: Create and administer the training for their employees; maintain records of time, attendance and results of training; submit attestation/certification of their compliance with this requirement, subject to validation of compliance.

Provider Network: Administers compliance training to providers.

General Compliance Training

PacificSource administers effective general training and education to covered persons who are responsible for the administration or delivery of a government programs benefit in accordance with the following schedule:

Employees and EMG: Within **ninety (90) days** of hire, and annually thereafter as a condition of employment.

Board and Committee Members: Within **ninety (90) days** of appointment, and annually thereafter.

FDRs: Within **ninety (90) days** of contracting, and annually thereafter. PacificSource may require the FDRs to administer its own training, and provide signed attestation/certification of their compliance with this requirement, subject to validation of compliance.

Agents/Brokers: During the initial and annual sales appointment process. In no event may an agent or broker be appointed or market to a beneficiary without completing training.

Providers: Within **ninety (90) days** of contracting, and annually thereafter.

Pharmacies: For network pharmacies, we require the pharmacy benefits manager (PBM) to administer the training to its network pharmacies.

All records of time, attendance and results of training will be documented by the respective departments responsible for administering the training. General compliance training materials are updated annually, and contain topics such as:

- Description of the Compliance Program, including a review of compliance policies and procedures, the Standards of Conduct, and the organization's commitment to business ethics and compliance with all government program requirements.
- How to ask compliance questions, request compliance clarification or report potential noncompliance, emphasize confidentiality, anonymity, and non-retaliation for compliance related questions or reports of potential noncompliance or FWA.
- Requirement to report potential compliance and FWA issues.
- Examples of reportable compliance and FWA issues.
- Disciplinary guidelines for non-compliant or fraudulent behavior, communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported.

- Attendance and participation in formal training programs as a condition of continued employment and a criterion to be included in employee evaluations.
- Policies related to contracting with the government, such as the laws addressing fraud and abuse or gifts and gratuities for government employees.
- Potential conflicts of interest and the disclosure requirement.
- HIPAA, the CMS Data Use Agreement, and the importance of maintaining the confidentiality of personal health information.
- Monitoring and auditing process and work plan.
- Laws that govern employees and the compliance program.

Specialized Compliance Training

PacificSource requires covered persons to receive specialized training and education based on their specific responsibilities in high risk government business areas in accordance with the following schedule:

Employees: Within **ninety (90) days** of hire, and annually thereafter as a condition of employment. This includes employees who change job functions within the organization.

FDRs: Within **ninety (90) days** of contracting, and annually thereafter. PacificSource may require the FDRs to administer its own training, and provide signed attestation/certification of their compliance with this requirement, subject to validation of compliance.

All records of time, attendance and results of training will be documented by the respective departments responsible for administering the training. Specialized training topics in high risk areas include, but are not limited to:

1. Sales and marketing
2. Coverage/organization determination, grievance, exceptions and appeals
3. TrOOP
4. Negotiated price available to members
5. Bid
6. Payment reconciliation
7. Part C & Part D reporting
8. Manufacturer rebate
9. Pharmacy & provider network
10. Compliance program and operation

11. Employer group waiver plan (EGWP)
12. Call center
13. Claims
14. Enrollment and disenrollment
15. Health services
16. Premium billing
17. Health information technology security and authentication

Please refer to the individual department's Specialized Compliance Training Certification for a detailed listing of required specialized training content. On an as-needed basis, the Compliance Department will conduct training in specific departments covering high risk topics. In addition, the Compliance Department will provide ongoing training to the Compliance Committee, Audit Committee, and Board of Directors through formal training, regulatory updates, industry best practices, and information obtained from government agency and industry conferences and workgroups.

FWA Training

PacificSource administers effective FWA training and education to covered persons who are responsible for the administration or delivery of a government program benefit in accordance with the following schedule:

Employees and EMG: Within **ninety (90) days** of hire, and annually thereafter as a condition of employment.

Board and Committee Members: Within **ninety (90) days** of appointment, and annually thereafter.

FDRs: Within **ninety (90) days** of contracting, and annually thereafter. PacificSource may require the FDRs to administer its own training, and provide signed attestation/certification of their compliance with this requirement, subject to validation of compliance.

Providers: Providers who have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse. However, these providers still must receive compliance training.

Pharmacies: For network pharmacies, we require the pharmacy benefits manager (PBM) to administer the training to its network pharmacies.

Agents/Brokers: During the initial and annual sales appointment process. In no event may an agent or broker be appointed or market to a beneficiary without completing training.

All records of time, attendance and results of training will be documented by the respective departments responsible for administering the training. General compliance training materials are updated annually, and contain topics such as:

- Laws and regulations related to FWA (i.e. False Claims Act, Anti-Kickback statute, HIPAA).
- Obligations of FDRs to have appropriate policies and procedures to address FWA.
- A process for reporting suspected FWA.
- Protections for those who report suspected FWA.
- Types of FWA that can occur in the settings in which employees work.

Measure of Effectiveness

Training effectiveness is measured by a number of methods, including:

- Test results indicating number of attendees passing on the first try.
- Decrease in compliance issues or findings in a business area.
- Increase in compliance awareness.
- Increase in compliance inquiry and reporting.

References

- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (\$50.3)

Schedule

Effective Date	May 2012
Approval Date	May 2012
Revision Date	August 2012
Line(s) of Business	Medicare, Medicaid
Department Owner	Triet Tran, Director & Compliance Officer
EMG Owner	Dan Stevens, SVP Government Programs



**POLICY NUMBER C-4: EFFECTIVE LINES OF COMPLIANCE COMMUNICATION, REPORTING & NON-RETALIATION
POLICY**

Effective Lines of Communication

PacificSource Community Health Plans, Inc. and PacificSource Community Solutions, Inc. (hereinafter “PacificSource”) maintain effective lines of communication to ensure confidentiality between the Compliance Officer, Compliance Committee, employees, managers and governing body, and first tier, downstream and related entities (FDRs). The lines of communication are accessible to all, allow compliance issues to be reported when they arise and provide a means for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

Reporting

In order to ensure ethical conduct, all covered persons have an obligation to raise concerns they might have about conduct that falls short of compliance standards, and report issues to the appropriate channel. They are also expected to assist in the investigation and resolution of compliance and fraud, waste or abuse (FWA) issues. Failure to do so may result in disciplinary actions, up to and including termination of employment or contract.

Non-Retaliation

To create a work environment where employees and individuals feel comfortable addressing and reporting of any instances of non-compliance or FWA, unfair or unethical acts, PacificSource maintains a non-intimidation and non-retaliation environment that allows individuals to make good faith reports against any person or action by PacificSource or its FDRs, without repercussion or fear of retaliation. Those who retaliate against an individual who makes a good faith effort to report a compliance or FWA issue will be subject to corrective action.

Applicability

This policy applies to all applicable PacificSource leased employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)”).

PROCEDURE

Compliance Communication

The Compliance Officer routinely communicates compliance and FWA requirements throughout applicable areas of the organization using various channels, such as email, internet website, and other methods.

Regulatory Guidance Updates: The Compliance Department disseminates updated regulatory guidance and instructions, including CMS HPMS memorandums and manuals, to applicable business departments. We track and document this process to ensure that new regulations and instructions are properly implemented. Business owners are responsible for taking follow-up actions to ensure compliance with the new requirements. Areas of deficiency must be communicated to the Compliance Department immediately.

We conduct monitoring reviews appropriately pursuant to the implementation of such new regulatory requirements. The Compliance Department also tracks and documents regulatory guidance through the CMS user group calls, and communicates this to business owners when applicable. Please refer to the “*CMS Communication Dissemination Process*” for detail.

Compliance Posters: We routinely disseminate compliance posters, tips, and FAQs and post them in high-visible common areas to raise awareness of compliance requirements, FWA implications, non-retaliation, and reporting protocols.

Regulatory Interpretations: You can request clarification on a regulatory or compliance question, or request an interpretation of the rule by contacting the Compliance Officer directly, any member of the Compliance Department, or by emailing: ComplianceInterpretation@pacificsource.com.

Exit Interview: Employees who depart from PacificSource’s employ are given an Exit Interview Questionnaire, which asks the departing employee to evaluate the effectiveness and availability of the organization’s line of communications, and to report any compliance and FWA concerns. The Exit Interview is administered to the entire organization.

Member & FDR Communication

The Compliance Department, Sales Department and Marketing Communications communicate compliance and FWA requirements to beneficiaries and existing members through various methods, including member website, marketing materials, and member newsletters.

In addition, PacificSource maintains a public website accessible to FDRs that contain information on FWA training and reporting: <http://medicare.pacificsource.com/>.

Reporting Requirement

All covered persons must report a compliance or FWA issue within **7 calendar days** of discovering the potential violation.

Method of Reporting

PacificSource maintains various lines of communication to ensure confidentiality in reporting. The communication channels are accessible to all. Any covered person may report a compliance or FWA issue, concern, or violation through the following methods:

1. Report to your immediate supervisor.
2. Report directly to the Government Programs Compliance Officer:

Triet Tran
541-706-5077
ttran@pacificsource.com

3. Report anonymously to EthicsPoint 24 hours a day/7 days a week:

1-888-265-4068
<https://secure.ethicspoint.com/domain/media/en/gui/16499/index.html>
www.ethicspoint.com

4. Report to any member of the Executive Management Group.
5. Report to any member of the Human Resources Department.
6. Report to:

Kristi Kernutt, General Counsel
541-225-1967
legalnotices@pacificsource.com

Chris Jenkins, Associate General Counsel
541-225-2727
legalnotices@pacificsource.com

7. Internal Audit Manager

Andy Duffield
541-225-2826
aduffield@pacificsource.com

8. If you are a PacificSource vendor, in addition to any of the methods outlined above, you may report to your PacificSource contract administrator.

Please refer to our official policy on reporting:

<http://psweb/resources/EthicalReporting/SitePages/Whistleblower%20Policy.aspx>

Reporting Protocols

When reporting, please be sure to provide enough information about the situation to allow us to investigate it, such as:

- Your name and contact information (optional)
- Description of the incident
- Business area(s) involved
- Names of individuals involved
- Date when event or incident occurred
- Whether this is a one-time incident or reoccurring event

The Compliance Department, Human Resources, or the appropriate department investigating the incident will document all reports of a compliance or FWA issue, concern, or violation, and shall initiate an investigation within 2 weeks of receiving the report. When appropriate and possible, you will be provided a response on the outcome of the investigation. Please refer to the *Policy Number C-7: Compliance Investigations* for a detailed description of the investigative process.

Non-Retaliation

No employees will be discriminated or retaliated against in any way for bringing a question or good faith complaint. All employees are required to support both the letter and spirit of this commitment. Those who retaliate against an individual who makes a good faith effort to report a compliance or FWA issue will be subject to PacificSource's corrective action policy.

Furthermore, if you are filing a *qui tam* action under the Federal False Claims Act, you are protected by law from being discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in your employment as a result of filing a *qui tam* action.

If you suspect that you are being retaliated against for making a good faith report of a compliance or FWA issue, you may contact any person(s) outlined in this policy, including the Compliance Officer or a member of Human Resources.

Your allegation of retaliation will be investigated by the appropriate personnel, and those who are found to have violated PacificSource's non-retaliation Policy will be subject to the disciplinary policy.

Coordination with Human Resources

For issues that have an impact on personnel matters, Human Resources will be engaged appropriately to handle compliance or FWA issues that impact such personnel matters.

Exit Interview

Employees who depart from PacificSource's employ are given an Exit Interview Questionnaire, which asks the departing employee to evaluate the effectiveness and availability of the organization's line of communications to report compliance and FWA concerns. Human Resources will review each Exit Interview Questionnaire for compliance reporting, and inform the Compliance Department appropriately.

Documentation & Investigation

The Compliance Department will document and retain all reports of compliance and FWA issue in their original content. Please see the *Policy Number C-7: Compliance Investigations* for a detailed description of the investigative process.

References

- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (§50.1.5, 50.1.7)
- Policy Number C-7: Compliance Investigations
- Whistleblower Policy:
<http://psweb/resources/EthicalReporting/SitePages/Whistleblower%20Policy.aspx>
- <http://medicare.pacificsource.com/>
- <https://secure.ethicspoint.com/domain/media/en/gui/16499/index.html>

Schedule

Effective Date	June 2012
Approval Date	June 2012
Revision Date	
Line(s) of Business	Medicare, Medicaid
Department Owner	Triet Tran, Director & Compliance Officer
EMG Owner	Dan Stevens, SVP Government Programs



POLICY NUMBER C-5: PERSONNEL CORRECTIVE ACTIONS

POLICY

PacificSource is an at-will employer and reserves the right to terminate any employee for any reason at any time. PacificSource maintains various corrective actions to ensure that employees who commit an Actionable Activity are fairly treated in a consistent manner. Employees who commit an Actionable Activity will be subject to corrective actions up to and including dismissal and risk potential reporting to law enforcement/regulatory agencies.

Applicability

This policy applies to all applicable PacificSource leased employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)”).

PROCEDURE

Definition

“Actionable Activity” means any activity or inactivity that is inconsistent with the PacificSource values, mission, or culture, including but not limited to:

- Violation of a PacificSource policy or and procedure, including the Code of Conduct and Employee Handbook
- Violation of a compliance, fraud, waste and abuse (FWA) State or Federal requirement, including failure to report
- Work performance and/or attendance issues
- Workplace violence, harassment, discrimination, or retaliation
- Disclosure of confidential information

“Covered Person” means an employee, officer, director, contractor, or first tier, downstream and related (FDR) entity.

Approach to Corrective Actions

In building a high performance and compliant work culture, and one free of harassment and discrimination, PacificSource will take a proactive approach to addressing Actionable Activities in the work place. The company’s intent is to address issues quickly, and in a manner which minimizes risk to the organization, increases the likelihood of the covered person’s success or remediation, and has a deterrent effect on future behavior.

The types of corrective actions taken will depend on the individual situation. The principle of "reason, record and circumstance" will be applied to each situation giving rise to the corrective action.

Types of Corrective Actions

Whenever any form of corrective action is taken, the supervisor must first consult with HR. The supervisor and HR will then decide on the type of corrective action to be taken. PacificSource maintains the following, but not limited types of corrective actions, arranged in order of severity. PacificSource reserves the right to initiate any corrective action deemed appropriate, and does not have to follow a particular sequence of order. In addition, we may require that the person retake compliance training.

I. Verbal Warning

- a. The supervisor meets with the covered person to outline the problem(s) and state the supervisor and the Company's expectations. HR may attend as appropriate.
- b. The supervisor writes a written summary of the issue using the Company's corrective action form that outlines the agreement and documents the meeting. Both the covered person and the supervisor must acknowledge receipt and date of the document. If the covered person refuses to acknowledge the document, the supervisor should reference that on the document.
- c. The supervisor sends the original corrective action document to HR to be filed in the covered person's personnel file.

II. Written Warning

- a. The supervisor meets with the covered person to outline the problem(s) and state the supervisor and The Company's expectations. HR may attend as appropriate.
- b. The supervisor writes a written summary of the issue using The Company's corrective action form that outlines the agreement and documents the meeting. The verbal warning should be referenced in the written warning, if applicable. A timeframe for meeting those expectations should be specifically outlined. Both the covered person and the supervisor must acknowledge receipt and date of the document. If the covered person refuses to acknowledge the document, the supervisor should reference that on the document.
- c. The supervisor sends the original corrective action document to HR to be filed in the covered person personnel file.

III. Final Written Warning

- a. A meeting will take place with the covered person and the supervisor. A written detail of the problem will be presented with a history of the previous attempts to rectify the problem, e.g. verbal and/or written warnings. Notice will be given to the covered

person at this time that this is a final warning and immediate corrective action is required. All present must acknowledge and date the document.

- b. The supervisor sends the original corrective action document to HR to be filed in the covered person's personnel file.

IV. Termination

- a. No terminations will occur without the prior consent of the VP of Administration, or a person delegated by the VP of Administration with such authority. A meeting will take place with the covered person and his/her supervisor. A written detail of the problem will be presented with a history of the previous attempts to rectify the problem, e.g. verbal and/or written warnings. A member of HR will conduct the exit interview and provide the covered person's final paycheck and any documents regarding continuing benefits.

Obligation to Report

PacificSource requires all covered persons to report and disclose issues that may be deemed an actionable activity, such as a compliance or FWA issue. Covered persons are also expected to assist in the investigation and resolution of these issues. Failure to report a compliance issue may result in corrective actions, up to and including termination of employment or contract.

Please refer to policy on Effective Lines of Compliance Communication, Reporting & Non-Retaliation Policy and our Whistleblower Policy for detail on reporting requirements.

Coordination with Compliance

When an individual is subject to corrective action, Human Resources will review the case for compliance violations to ensure that issues impacting compliance are resolved appropriately in addition to the personnel issue. The Compliance Department will be notified of a compliance issue for further compliance action, if any.

Publicizing Corrective Action Standards

PacificSource publicizes corrective action guidelines through various mediums, including during initial employee orientation, at annual compliance training, and in compliance posters and public bulletins. In addition, employees and supervisors are encouraged to discuss corrective action guidelines during regular staff meetings.

Examples of Non-Compliant Activities

The following are some examples of noncompliant behavior:

- Bid: Overstating or understating bid data to obtain higher premiums from members or higher reimbursement from the government.
- Call center: Intentionally providing beneficiaries with inaccurate information.
- Claims: Submitting claims to the government for services that were never rendered, failure to pay providers at the correct rate, paying providers who are on the Medicare opt-out or OIG exclusion list.
- Enrollment and disenrollment: Improperly enrolling members to obtain higher reimbursement from the government, improperly disenrolling members due to high medical expenses or other medically-related reasons.
- Exceptions and appeals: Not approving members for medically necessary services.
- Health services: Failing to approve members for medically necessary services.
- Premium billing: Billing members at the incorrect premium amount, not providing members with the required grace period to pay their bills.
- Pharmacy: Denying members their transition supply, applying utilization management rules that have not been approved, inappropriately denying drugs that are should be covered.
- Provider network: Not credentialing providers in accordance with credentialing laws and regulations, contracting with providers who are on the Medicare opt-out or OIG exclusion list.
- Sales and marketing: Misleading beneficiaries, violating a CMS marketing rule, allowing agents and brokers to conduct illegal marketing activities.

References

- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (\$50.5)
- C-4. Effective Lines of Compliance Communication, Reporting & Non-Retaliation Policy
- Whistleblower Policy
- PacificSource Employee Handbook

Schedule

Effective Date	July 2012
Approval Date	July 2012
Revision Date	
Line(s) of Business	Medicare, Medicaid, Commercial
Department Owner	Nancy Lumpkin, Human Resources Manager Triet Tran, Director & Compliance Officer
EMG Owner	Paul Wynkoop, VP of Administration Dan Stevens, SVP Government Programs

POLICY NUMBER C-6: COMPLIANCE MONITORING & AUDITING

POLICY

PacificSource Community Health Plans, Inc. and PacificSource Community Solutions, Inc. (hereinafter “PacificSource”) maintain an effective system for routine monitoring and auditing of operational areas to evaluate the organization’s compliance with regulatory requirements and the overall effectiveness of the Compliance Program.

Applicability

This policy applies to all applicable PacificSource Health Plans’ employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)”).

PROCEDURE

Compliance Workplan

Annually, the Compliance Department conducts a risk assessment of operational areas and develops a workplan. The workplan contains, among others, monitoring activities to be conducted for that year. The Compliance Department oversees and executes ongoing monitoring activities in high risk areas, and oversees corrective actions and implementation plans pursuant to a compliance finding.

Risk Assessment

As a precursor to creating the annual compliance workplan, the Compliance Department conducts a formal risk assessment of compliance and operational issues based on the following, but not limited, criteria:

- CMS audit scope
- CMS areas of concern (i.e., marketing, enrollment, agent/broker oversight, credentialing, quality assessment, appeals and grievance, benefit/formulary administration, transition, protected classes, utilization management, claims processing accuracy, and FDR oversight)
- Oregon Health Authority (OHA), Division of Medical Assistance Programs (DMAP), and the Addictions and Mental Health Division (AMH) areas of concern
- CMS conferences
- CMS audit guide
- CMS Enforcement Letters
- CMS Corrective Action Plans
- CMS Regional Office feedback

- HPMS memos
- Impact to beneficiary access to care, safety and protection
- New/updated guidance and regulation
- OIG Workplan
- Results from prior monitoring & auditing activities
- Assessment of all operational areas
- Business owner feedback
- Past compliance issues
- Internal CAPs
- Complaint Tracking Module (CTM)
- Extent of FDR delegated activities
- Industry conferences
- Company/department size, resources, structure, business model
- Complexity of work

Relative to monitoring of FDRs, if it is impractical or cost prohibitive to monitor all FDRs, we will perform a risk assessment to identify the highest risk FDRs, and select a reasonable number of FDRs for review. We will also assess the need to conduct an onsite review versus desktop. High-risk FDRs may undergo an onsite review.

We then conduct interviews with business owners and EMG members to assess their areas of concern, and incorporate those areas into the workplan when appropriate. We then rank the areas by risk, in accordance with the following methodology:

RISK RATING	VALUE	EXPLANATION
3	High	The issue has high or significant compliance impact, and is a regular government focus. The issue has a direct member or financial impact and affects beneficiary protection and access to care. Plans have been fined, sanctioned or terminated due to deficiencies due to these issues. It is a mandate to review the majority of high-risk issues. It is a strong recommendation to review the rest of the high-risk issues. Inactivity may lead to significant risk.
2	Medium	The issue has medium or moderate compliance impact. The issue has slight financial or member impact. It is recommended that it be reviewed. Inactivity may lead to moderate risk.
1	Low	The issue has low compliance impact. It has either been reviewed previously, or is not a focus of the government. Inactivity does not pose a significant or moderate risk.

The compliance workplan is then submitted to the Compliance Committee for approval, and reported to the PacificSource Community Health Plans, Inc.'s Audit Committee and both companies' Boards of Directors. While the workplan reflects our best effort to assess risks to the organization and mitigate those risks, we recognize that operational and compliance risks and the regulatory landscape are

constantly changing. To that end, the workplan is routinely reviewed and revised from time to time to meet those changing needs.

Monitoring Reviews

The Compliance Department conducts two types of monitoring reviews: 1) automated monitoring reviews that are routine and measure operational performance in key, high risk areas, and 2) comprehensive monitoring reviews that require an analysis of policies and procedures, interviews with key stakeholders, universe requests, sample extractions, detailed data analysis, and testing based on internal and CMS methodologies.

All monitoring reviews are conducted in accordance with regulations and requirements and are measured by performance scorecards. When deficiencies are detected pursuant to a monitoring review, follow-up monitoring reviews may be conducted to measure the effectiveness of any corrective action. Services of independent external auditors may be retained to assist in the auditing of high-risk areas, including FDRs performing a high-risk function.

Automated monitoring reviews follow the following protocols:

1. Each month, the Compliance staff extracts metrics and data from internal systems, business owners, and populated CMS audit universe templates.
2. The data is analyzed and calculated based on CMS requirements, and populated in the Routine Automated Monitoring Reviews Report.
3. Deficiencies and any downward trends (from the previous reporting months) are shared with business owners for correction. If there is a continued pattern of deficiencies, Compliance will initiate a CAP.
4. Compliance may validate the accuracy of the data through ad-hoc sample testing and during our comprehensive monitoring reviews.

Comprehensive monitoring reviews follow the following protocols:

Phase I: Work Assignment

1. The Compliance Officer will provide business owners with at least 2-4 weeks advance notice before going into an area, with a cc to the FDR if applicable. For a review that impacts an FDR, the FDR will be provided at least 30 days advance notice of the review, or within a timeframe stipulated in the FDR contract.
2. The Compliance Officer assigns a Review Team and Lead Reviewer to conduct the review, and rolls out the monitoring workbook to the Review Team. The Review Team is made up of staff personnel from the Compliance Department. Independent contracted auditors may be used to

assist the Review Team when necessary. Workbooks are available to Federal and State regulatory agencies upon request.

3. The role of the Lead Reviewer is to:
 - a. Manage and coordinate the end-to-end phases of the project.
 - b. Develop strategies, in conjunction with the Review Team, to execute the project in an accurate and efficient manner.
 - c. Assign work to members of the Review Team in a fair and efficient manner.
 - d. Be aware and knowledgeable of all work performed by other members of the Review Team.
 - e. Ensure that all work is completed timely and accurately by the Review Team.
 - f. Scrutinize the work of the Review Team to meet a satisfactory level of acceptance.
 - g. Be the point of contact for the Compliance Officer to receive status updates.

Phase II: Research & Strategy

4. The Review Team:
 - a. Reviews the workbook in detail in order to command an expert knowledge of the workbook and all the pertinent regulations contained therein.
 - b. Develops and formulates review strategies, including methods of critique and scrutiny.
 - c. Identifies all relevant business owners as accurately and completely as possible.
 - d. Develops document requests and deadlines.
 - e. Develops all other project documents prior to meeting with business owners.

Phase III: Entrance Meeting

5. The Review Team schedules an Entrance Meeting with the manager/director of the business unit to go over the following:
 - a. Scope of the review
 - b. Ownership
 - c. Document request
 - d. Project deadlines
 - e. Business owner's preferred method to deal with FDRs:
 - i. (Preferred Method) Review Team works directly with the FDR and keeps the business owner in the loop, or
 - ii. Review Team works through the business owner
 - f. Business owner's preferred method to provide requested documents, policies and procedures, universes, and samples:
 - i. Business owner provides the data/document to the Review Team, or
 - ii. Review Team gets access to the system and pulls the data/document itself
 - g. Criteria for a Met, Met with Note, Not Met, and Recommendation
 - h. CAP process, including:
 - i. Types of findings that would require a CAP

- ii. CAP timeframe
- iii. CAP tracking and closure process

Phase IV: Review Protocol

6. The Review Team conducts the review.
7. To avoid scope creep, the review should not deviate from the workbook unless out-of-scope issues are discovered that pose significant risk to the member or the organization.
8. The Review Team should resolve business owner delays, delinquencies or pushback, and escalate to the Compliance Officer when necessary. Anticipated delays that will jeopardize the review deadline must be communicated to the Compliance Officer as soon as possible.
9. The Review Team provides bi-weekly updates (or a greater frequency if needed) to the Compliance Officer on the status of the review, issues detected, and risks and concerns.
10. Document all positive and negative findings, including reason for findings, working papers, policies and procedures reviewed, universes and case samples, and any other supporting documentation in a centralized location located in the Compliance Department's SharePoint webpage.

Phase V: Findings

11. The Review Team conducts the review and keeps business owners informed of tentative findings throughout the review.
12. Business owners are given an opportunity to correct findings before our published findings if the findings do not impact issues that would require validation.
13. We will apply a 10% error threshold to sample case reviews, when appropriate. Findings are categorized as followings:
 - a. Met: The requirement/element under review meets the regulatory standards
 - b. Met with Note: The requirement/element under review substantially meets the regulatory standards. Errors and deficiencies were detected, but were either within the 10% tolerance, or were corrected prior to our published findings. No CAP is issued pursuant to this.
 - c. Not Met: The requirement/element under review did not meet regulatory standards, and will require a CAP.
 - d. Recommendation: The requirement/element under review meets the regulatory standards. Compliance is making a recommendation to enhance it based on best practice standard.

Phase VI: Status Update

14. Close to the review ECD, the Compliance Officer meets with the Review Team to go over tentative findings. During the meeting, the Review Team must be prepared to:
 - a. Discuss all positive and negative findings in detail
 - b. Provide rationale, justification and logic to support findings
 - c. Provide recommendation and conclusion of findings
 - d. Articulate all findings in a clear, concise, and complete manner

Phase VII: Publication

15. The Review Team drafts a Compliance Monitoring Report and send to the Compliance Officer for review. By the time the Compliance Officer receives the first draft, the Review Team has already ensured that business owners are aware of the findings, and whenever possible, agree with the findings and recommendations.
16. Upon review of the draft report by the Compliance Officer, the Review Team sends the draft report to business owners for review.
17. The Review Team disseminates the final report to:
 - a. Business owners
 - b. The EMG over the business unit
 - c. The EMG of Government Programs

Phase VIII: Corrective Action Plan

18. All deficiencies and findings pursuant to a monitoring review will require a corrective action plan (CAP).
19. All deficiencies and findings, especially those that have a member impact, will be assessed to determine whether they need to be disclosed to Federal and State regulatory agencies in accordance with the agency's reporting and disclosure protocols.
20. We may conduct follow-up reviews to validate that the CAP has been remediated satisfactorily.

Reporting

All monitoring and auditing activities are reported to the Compliance Committee, PacificSource Community Health Plans, Inc. Audit Committee, and applicable members of EMG. Results are also reported via compliance scorecards and other forms of compliance reporting measures. The respective Board of Directors will also receive a summary of the monitoring and auditing activities.

Measuring Compliance Effectiveness

The overall effectiveness of the Compliance Program is measured by the use of performance dashboards, scorecards, metrics reporting, and other similar measures. We measure program effectiveness by parameters such as:

- Results and trends from comprehensive monitoring reviews (i.e., number of Mets and Not Mets)
- Results and trends from routine monitoring reviews and quantitative measurement tools in high-risk areas such as agent/broker oversight, compliance program effectiveness, enrollment and disenrollment, Part C CDAG and access to care, Part D ODAG, Part D formulary administration, Part D LEP
- Number of CAPs opened
- Effectiveness of CAP in resolving issues
- Number of reoccurring CAPs impacting the same issue
- FDR compliance
- CMS notices of non-compliance, warning letters and sanctions
- Marketing material approval rates
- Number of detected or self-reported issues
- Number of issues disclosed to CMS
- Number of disciplinary actions
- Trend analysis over a monthly, quarterly, semi-annual, or annual period
- Compliance training completion and test score results
- Trend in CTM cases
- Self-assessments and surveys

The effectiveness of the Compliance Program is evaluated frequently, at least annually. The results are reported to Compliance Committee, PacificSource Community Health Plans, Inc. Audit Committee, and applicable members of EMG. The respective Boards of Directors will also receive a summary of the results.

FWA Data Analysis

The Compliance Department, Pharmacy Services and the PBM conduct data analysis through the use of data mining tools to prevent, detect, and correct noncompliance and FWA. We utilize payment integrity tools to detect FWA schemes, algorithms and aberrant patterns and behaviors at the member and provider level, such as:

- Fraud alerts
- Retrospective DUR claim audits
- Concurrent DUR claim audits
- Member drug abuse audits
- Pharmacy audits

On a monthly basis, the Compliance Department conducts claim analysis of providers identified through national and State fraud alerts. On a quarterly basis, the PBM and Pharmacy Services review member,

physician, and pharmacy prescriptions and claims for potential FWA issues, such as high quantities of controlled substances, high cost utilization, multiple prescriber utilization, and multiple pharmacy dispensing. Audited reports reviewed include:

- Medicare Retail Pharmacy Audit Summary Report
- Medicare Audited Claim Detail
- Medicare Rights Notice Audit Results
- Medicare Part D Top Member Report
- Medicare Part D Top Physician Report
- Medicare Part D Top Member & Physician Report
- Member Multi Pharmacy/Multi Physician Report

Please refer to ESI's "*Concurrent Drug Utilization Review Policy and Procedures (Policy Number: CLININTC-03-37)*", "*Concurrent DUR Overview*" document, and "*Retrospective Drug Utilization Review Policy and Procedures (Policy Number: CLININTC-03-40)*" for additional reference. In addition, we utilize the payment integrity services of Thompson Reuters to perform data mining on claims, which includes the following:

- Payment analysis
- Drug utilization analysis
- Provider utilization analysis
- Prescribing and referral pattern analysis
- Geographic zip analysis

Provider Fraud Alert Investigation

The following procedures are established to review, investigate and analyze provider fraud alerts.

1. On a monthly basis, the Compliance Department checks the following websites for national fraud issues:
 - a. <http://www.justice.gov/>
 - b. <http://www.stopmedicarefraud.gov/index.html>
2. If fraud alerts are issued directly to plans (i.e., through HPMS or CMS), initiate investigation within 1 week of the issuance.
3. Verify the suspect provider's information, including NPI, through:
 - a. <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>
 - b. <http://www.medicare.gov/find-a-doctor/provider-search.aspx>
 - c. <http://www.oig.hhs.gov/exclusions/index.asp>
 - d. Secretary of state website
 - e. State licensing/medical board website
 - f. <http://www.ama-assn.org/ama/pub/education-careers/becoming-physician/medical-licensure/state-medical-boards.page>
4. Verify the provider's contract status with Provider Network.

- a. If no match, retain screen print or document “no match” finding and follow Step 8.
 - b. If positive match, document in Step 7
5. Run claim analysis against the following systems:
 - a. Facets (medical)
 - b. Compass (pharmacy)
6. If no match, retain screen print of “no match” finding and follow Step 8.
7. If positive match:
 - a. Create impact analysis to claim dollar, member, and provider.
 - b. Report all positive match findings to FWA Committee with recommendation to recover/recoup, suspend/terminate provider, and other appropriate actions.
 - c. The FWA Committee then follows its procedure in accordance with [insert FWA charter here]
8. Provide monthly summary report to the Compliance Officer.

SIU/Fraud Committee

Purpose: The Fraud Committee serves dually as the company’s Special Investigation Unit (SIU) and fraud workgroup, and oversees the implementation and enforcement of detected FWA issues stemming from sources such as data mining and claim monitoring and audits.

Reporting & Accountability: The committee is a subcommittee of the Compliance Committee. The Compliance Officer (or a delegate) oversees the Fraud Committee and reports to the Compliance Committee on its behalf.

Membership: The Fraud committee maintains memberships from a variety of backgrounds, including Pharmacy Services, Health Services, Provider Network, and Claims.

EXECUTIVE SPONSOR	
Dan Stevens	COO, Senior VP of Government Programs
COMMITTEE CHAIR	
Triet Tran	Director, Government Programs Compliance Officer
MEMBERS	
Rhonda Busek	Director Medicaid Programs
Connie Riffle	Pharmacy Services
Lorna Christensen	Medical Services
Chris Jenkins	Associate General Counsel
Debbie Smith	Provider Network Compliance Coordinator
Susie Sottosanti	Government Programs Claims
Triet Tran	Director, Government Programs Compliance Officer
Brian Wetter	IT Manager
Mari Willhite	Commercial Operation Claims

Roles & Responsibilities: The Fraud Committee maintains the following, but not limited, roles and responsibilities:

1. Triage, review and analyze FWA issues stemming from sources such as data mining, claim monitoring and audits, and Federal and State fraud alerts.
2. Make recommendations to recoup, suspend or terminate suspect providers, members, or any individual(s) found to have violated a FWA issue.
3. Make recommendations to refer matters to the NBI MEDIC, CMS, OIG, DOJ, law enforcement, State Medicaid Fraud Control Units (MCFU), State licensing boards, the National Practitioner Data Bank (NPDB) when applicable, and assist law enforcement by providing information needed to develop successful prosecutions.
4. Reduce or eliminate benefit costs due to FWA.
5. Ensure proper value of health services, including correct pricing, quantity, and quality.
6. Utilize real-time systems that ensure accurate eligibility, benefits, services, refills, and pricing and that identify potential adverse drug interactions and quality of care issues.
7. Monitor fraudulent or abusive paid claims and take appropriate actions when necessary.
8. Prevent illegal activities.
9. Identify members with drug addiction problems and other overutilization issues and take appropriate actions when necessary.
10. Provide fraud awareness training to applicable individuals.
11. Support the Compliance Department in its duty to carry out FWA activities.
12. Report to the Compliance Committee through the Compliance Officer on results and plan of action on suspect FWA cases.
13. Make recommendation to initiate recovery and recoupment of claim dollars.
14. Make recommendation to suspend, sanction or terminate a provider.

Reporting: Anyone can report compliance or FWA concerns to any member of the SIU. Anonymous reporting can also be done 24 hours a day/7 days a week to:

EthicsPoint

1-888-265-4068

<https://secure.ethicspoint.com/domain/media/en/gui/16499/index.html>

Audit Workplan

As part of developing the annual work plans, the Compliance Department and Internal Audit will coordinate their activities and work plans to ensure that high-risk areas are adequately covered, and that the work plans are administered in a timely and efficient manner throughout the year.

As part of this coordination, the Compliance Department and Internal Audit will share monitoring review results and audit findings and other areas of concerns in order to adequately address those issues. Subsequent to a Compliance Department monitoring review, and when applicable and appropriate, Internal Audit will audit the business owners and verify that the solutions put in place are satisfactory to remediate the deficiency. Internal Audit will review, audit and verify activities such as process improvements, business efficiency analysis, root cause analysis, internal controls, and any other parameters that may impact the business area's compliance and business operations. Before closing a CAP that is subject to a validation audit, the Compliance Department will seek recommendation and input from Internal Audit on closing the CAP.

Please refer to the "*PacificSource Health Plans Audit Plan*" for a detailed description of the Internal Audit Department's auditing principles and protocols.

Annual Compliance Program Assessment

On an annual basis, PacificSource shall audit the effectiveness of the compliance program through the use of third-party independent auditors or Internal Audit personnel who are not a part of the Compliance Department. The results shall be reported to the Compliance Committee, Audit Committee, and Board of Directors.

References

- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (\$50.6)
- ESI Concurrent Drug Utilization Review Policy and Procedures (Policy Number: CLININTC-03-37)
- ESI Concurrent DUR Overview document,
- ESI Retrospective Drug Utilization Review Policy and Procedures (Policy Number: CLININTC-03-40)
- PacificSource Community Health Plans, Inc. Audit Plan

Schedule

Effective Date	April 2012
Approval Date	April 2012
Revision Date	August 2012
Line(s) of Business	Medicare, Medicaid

Department Owner	Triet Tran, Director & Compliance Officer Andy Duffield, Internal Audit Manager
EMG Owner	Dan Stevens, SVP Government Programs



POLICY NUMBER C-6A: EXCLUSION & BACKGROUND CHECK

POLICY

PacificSource shall not hire, contract with, or allow any individual who has been sanctioned or excluded from participating in Medicare or Medicaid programs to work in such programs.

All new and existing employees, board members and officers, and contractors are to immediately disclose to PacificSource any debarment, exclusion or any other event that makes them ineligible to perform work related directly or indirectly to Federal health care programs.

In addition, PacificSource will conduct other background checks prior to an offer of employment, such as criminal records, driving records, and education and professional credentials.

PacificSource will not contract with or pay claims to providers who have been sanctioned or excluded from participating in Medicare or Medicaid programs, or who have opted-out of the Medicare program.

All contracted providers are to immediately disclose to PacificSource any debarment, exclusion or any other event that makes them ineligible to perform work or receive payment for work related directly or indirectly to Federal health care programs.

Applicability

This policy applies to all applicable PacificSource leased employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)”).

PROCEDURE

Exclusion List

The OIG’s List of Excluded Individuals/Entities (LEIE) and GSA’s System for Award Management (SAM) search utilizes the government’s database for individuals and businesses excluded or sanctioned from participating in Medicare, Medicaid or other federally funded programs. Bases for exclusions include convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance loans. Any applicant, board member or officer appearing on this list will not be considered for employment or appointment.

At Time of Hire/Appointment:

Step 1: Prior to any offer of employment or appointment, a member of HR will check the OIG LEIE and GSA SAM for all candidates, board members and officers.

Step 2: The LEIE search is performed via an internet database, <http://exclusions.oig.hhs.gov/>. The LEIE search is performed via an internet database. The SAM search is performed via <https://www.sam.gov/portal/public/SAM/>. The search is conducted using the first and last name of the applicant. The results are then printed and retained in the individual's confidential personnel file.

- *Match:* If a search of the database results in a match with a name in the database, verify the identity of the individual by entering the social security number.
 - Before taking adverse action, HR will provide the applicant a pre-adverse action disclosure that includes a copy of the LEIE match, and a copy of "A Summary of Your rights Under the Fair Credit Reporting Act."
 - Once the decision is made not to hire the applicant, HR will provide the applicant notice that the action has been taken in an adverse action notice.
- *No Match:* If a search of the database results in no name matches, the message will state no record found and the individual's confidential reference file will reflect this.

Monthly Review:

Step 1: Each month, HR will check the LEIE and SAM for all employees, board members and officers to ensure that no existing individuals are on the list.

- *Match:* If any individual is on such list, PacificSource shall require the immediate removal of such individual from any work related directly or indirectly to all Federal health care programs, and may take appropriate corrective actions, up to and including termination of employment or contract.
- *No Match:* The individual's confidential reference file will reflect this.

Other Background Checks

HR also conducts other background checks, including criminal records, driving records, and education and professional credentials. For applicants who have adverse background records, HR in collaboration with the hiring supervisor will determine whether the applicant is eligible for employment with PacificSource, based on the specific role and job function, and the nature of the adverse event or record.

Fair Credit Reporting Act (FCRA)

The FCRA requires PacificSource to provide specific notice, authorization and adverse action procedures for all background checks. The FCRA is designed primarily to protect the privacy of consumer report information and to guarantee that the information supplied by consumer reporting agencies is as accurate as possible. It ensures that individuals are aware that consumer reports may be used for employment purposes, the individuals agree to such use, and individuals are notified promptly if information obtained may result in a negative employment decision.

Notification

All applicants, board members and officers must complete the Background Authorization form that authorizes HR to conduct background checks. If a decision is made not to hire an applicant due to the applicant being listed on the LEIE or SAM, or due to an adverse background record, HR will provide the applicant with a pre-adverse action disclosure that includes a copy of the adverse background record and a copy of "A Summary of Your rights Under the Fair Credit Reporting Act." Once the decision is made not to hire the applicant, HR will provide the applicant notice that the action has been taken in an adverse action notice.

Provider & FDR Verification

Medical Providers: Provider Network will check medical providers against the following data sources at the time of credentialing, re-credentialing, and claim payment to ensure that PacificSource does not contract with or reimburse providers who are ineligible to perform work or receive payment for work related directly or indirectly to Federal health care programs:

1. Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)
2. General Services Administration (GSA) System for Award Management (SAM)
3. Medicare Exclusion Database (MED)
4. Medicare Opt-Out

Please refer to Provider Network's credentialing and re-credentialing policy for detail.

Any Medicare claims received from providers, including non-contracted providers, will be checked weekly against the 4 data sources. Provider Network will also verify the providers' Medicare eligibility and enrollment status, and Medicare assignment status. Provider Network will rely on sources such as the National Plan and Provider Enumeration System (NPPES) and www.Medicare.gov to obtain the NPI, taxonomy and PTAN numbers. If a provider is found not be eligible for Medicare payment, the claim will not be paid.

Pharmacy Providers: Pharmacy Services, through its PBM, also screens pharmacies and pharmacists against the exclusion list. Please refer to ESI's "*OIG Prescriber Exceptions Process (Policy Number: MED-D.CP.22.02)*" for a detailed description of this process.

Agents/Brokers: As part of the appointment process, the Sales Department screens agents and brokers against the OIG and GSA list before the agents are allowed to market and sell on behalf of PacificSource. This screening is also conducted monthly for all contracted agents and brokers.

Attestation: On an annual basis, the Compliance Department will require FDRs performing a core government programs function to attest and certify their compliance with this requirement. The attestation and certification are subject to validation by the Compliance Department.

Self-Disclosure

All covered persons are required to immediately disclose to HR any exclusion or other events that make them ineligible to perform work related directly or indirectly to a government health care program. FDRs are to disclose such information to their PacificSource contract administrator. Failure to disclose may result in appropriate corrective actions, up to and including termination of employment or contract.

References

- 42 CFR §422. 204(b)(4), 752(a)(8)
- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (§50.6.8)
- ESI OIG Prescriber Exceptions Process (Policy Number: MED-D.CP.22.02)
- OIG: <http://exclusions.oig.hhs.gov/>
- GSA: <https://www.sam.gov/portal/public/SAM/>
- Medicare Opt-Out: <https://www.noridianmedicare.com/partb/enroll/optout/index.html>
- NPPES: <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>
- CMS Memo: Excluded Providers (June 29, 2011)
- CMS Medicare Exclusion Database (MED) User Manual (Version 1.0)(May 20, 2011)

Schedule

Effective Date	July 2012
Approval Date	July 2012
Revision Date	August 2012
Line(s) of Business	Medicare, Medicaid
Department Owner	Josh Bishop, Director of Medical & Pharmacy Services Nancy Lumpkin, Human Resources Manager Triet Tran, Director & Compliance Officer Lisa Zent, Provider Network Manager
EMG Owner	Paul Wynkoop, VP of Administration Dan Stevens, SVP Government Programs Peter McGarry, VP of Provider Network



POLICY NUMBER C-6B: FDR COMPLIANCE OVERSIGHT

POLICY

PacificSource Community Health Plans, Inc. and PacificSource Community Solutions, Inc. (hereinafter “PacificSource”) are ultimately responsible for actions delegated to first tier, downstream and related (FDR) entities. To that end, PacificSource maintains adequate and effective oversight over the FDRs to ensure that they comply with applicable regulatory requirements. In addition, this policy outlines certain expectations PacificSource requires of its FDRs.

Applicability

This policy applies to all applicable PacificSource Health Plans’ employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)").

PROCEDURE

Definition

Contract Administrator: The business owner responsible for the implementation, operations, oversight and monitoring, and day-to-day relationship with the FDR.

FDR Assessment & Core Services

In determining whether an entity is an FDR (and thus the function is delegated) for the purpose of exercising compliance and operational oversight over the entity, the Contract Administrator, in conjunction with the Compliance Department, shall consider the following attributes:

- Whether the entity performs a core service
- Whether the function is a service PacificSource is required to do or provide under its contract with Medicare and Medicaid, applicable federal regulations or guidance
- Whether the function directly impacts enrollees
- Whether the entity has interaction with enrollees
- Whether the entity has access to beneficiary information or personal health information
- Whether the entity has decision-making authority
- Whether the function places the entity in a position to commit health care fraud, waste or abuse
- The risk that the entity could harm enrollees or violate Medicare program requirements

Once identified as an FDR, PacificSource shall exercise oversight over the FDR who performs a delegated, core service on behalf of PacificSource. A core service is an administrative or health care function related to PacificSource’s Medicare and Medicaid contract, and includes such activities as:

- Sales and marketing
- Health care services
- Utilization management
 - Quality improvement
- Enrollment, disenrollment, membership functions
 - Outbound enrollment verification
 - Applications processing
- Claims administration, processing and coverage adjudication
- Generation of claims data
- Pharmacy benefit management
 - Processing of pharmacy claims at the point of sale
 - Administration and tracking of enrollees' drug benefits, including TrOOP balance processing
 - Negotiation with prescription drug manufacturers and others for rebates, discounts or other price concessions on prescription drugs
- Appeals and grievances
- Hotline operations
- Customer service
- Bid preparation
- Provider network management
 - Licensing and credentialing
- Coordination with other benefit programs such as Medicaid, state pharmaceutical assistance or other insurance programs

Pre-Delegation Assessment

Prior to delegating a core service to an FDR, the Compliance Department and the Contract Administrator shall perform, when appropriate, an FDR pre-delegation assessment and review. The review will cover topics such as the FDR's experience in the delegated area, its operational performance, policies and procedures, compliance program infrastructure and adherence, compliance monitoring and auditing, HIPAA Privacy and Security, record retention, reportable metrics, and proof of concept demonstration.

In determining whether to conduct the review, the Compliance Department and the Contract Administrator shall assess the FDR's specific functions, the risks associated with the FDR and functions, and the size and magnitude of the contract.

Compliance Program Dissemination

Within **90 days** of contracting, and on an annual basis, the Contract Administrator, working in conjunction with the Compliance Department, shall distribute PacificSource's Compliance Program and Standards of Conduct to all applicable FDRs. The FDRs may be required to sign an acknowledgment of receipt of the Compliance Program.

FDR Compliance Program

PacificSource also requires certain high-risk FDRs to maintain its own effective compliance program consisting of the 7 core elements. The Compliance Department will (based on our risk assessment) review the FDR's compliance program at the time of contracting, and annually thereafter. PacificSource may require the FDRs to provide signed attestation/certification of their compliance with this requirement, subject to validation for compliance.

Federal & State Laws

Applicable FDRs must comply with applicable laws and regulations that pertain to government programs, such as HIPAA, Federal False Claims Act, and the Social Security Act. Please see *Policy Number C-1: Compliance with Federal & State Laws* for a detailed list of such laws.

Training

Applicable FDRs must administer effective training and education to all applicable employees who are responsible for the administration or delivery of a government program at the time of hire and annually thereafter. Training and education must cover general compliance training, specialized compliance training, and FWA training. Please see *Policy Number C-3: Compliance Training* for a detailed description of the training requirements.

Compliance Investigation & Reporting

Applicable FDRs are expected to disclose to PacificSource potential issues of noncompliance and FWA in a timely manner. FDRs are also expected to cooperate with PacificSource in the investigation and resolution of such issues. Upon discovery of an incident or report of a potential noncompliant or FWA issue, the FDR is expected to initiate a thorough investigation of the incident. All applicable deficiencies and instances of noncompliance must be tracked and monitored by formal corrective action plans (CAP) to ensure that they are remedied and are not likely to reoccur. Please see *Policy Number C-4: Effective Lines of Compliance Communication, Reporting & Non-Retaliation* for a detailed description of the reporting process.

In addition, the FDR must maintain effective lines of communication within its organization to ensure that its employees to raise compliance issues, and provide a means for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

Lastly, the FDR must support a non-intimidation and non-retaliation environment that allows individuals to make good faith reports without repercussion or fear of retaliation. Those who retaliate against an individual who makes a good faith effort to report a compliance or FWA issue will be subject to the FDR's disciplinary actions.

Disciplinary Standards

Applicable FDRs must maintain disciplinary standards to ensure that their employees who commit a compliance or FWA violation are subject to disciplinary and corrective actions, up to and including termination.

Monitoring & Auditing

PacificSource requires applicable FDRs to conduct self-monitoring and self-auditing of its operational performance, remedy all identified areas of deficiency, and disclose them to PacificSource. In addition, the Contract Administrator is obligated to oversee and routinely monitor the FDR's work performance and compliance relative to its delegated functions.

The Compliance Department also routinely monitors and assesses the FDR's operational performance as it relates to compliance measures. Please see *Policy Number C-6: Compliance Monitoring & Auditing* for a detailed discussion of the monitoring and oversight activities.

General Oversight

Performance Metrics: Applicable FDRs are required to provide and report to the Contract Administrator (and the Compliance Department as appropriate) operational performance metrics that reflect the FDR's compliance with regulatory and business standards.

Routine Meetings: Applicable FDRs are expected to maintain regular operational or management meetings with the Contract Administrator (and the Compliance Department when appropriate) to ensure issue resolution, process enhancements, and coordination of communication.

Post-Implementation: On a risk basis, the Compliance Department may conduct a post-implementation review approximately **60 days** after the initial go-live date. This is done to ensure that the FDR is performing in accordance with State, Federal and PacificSource standards and business expectation, and that issues are identified and remediated early in the contract relationship.

FDR Contract Repository

The Compliance Department maintains a centralized repository of copies of all applicable FDRs and contracts pertaining to the government programs. The repository only includes copies of non-provider contracts from FDRs who perform a delegated, core service on behalf of PacificSource. All other FDR contracts, such as provider contracts, shall continue to be maintained by their respective Contract Administrator. The Finance Department shall continue to serve as the repository for the original contracts.

Upon executing a signed contract with an FDR, the Contract Administrator shall forward a copy of the signed contract to the Compliance Department, along with the delegated service description. The Contract Administrator is also responsible for forwarding a copy of any amendments or updates to the contract thorough the year. The repository can be located at <http://psweb/Dept/RM/default.aspx> under "FDR Contract Repository".

References

- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (§40)
- Policy Number C-1: Compliance with Federal & State Laws
- Policy Number C-3: Compliance Training
- Policy Number C-4: Effective Lines of Compliance Communication, Reporting & Non-Retaliation
- Policy Number C-6: Compliance Monitoring & Auditing Policy

Schedule

Effective Date	September 2012
Approval Date	September 2012
Revision Date	
Line(s) of Business	Medicare, Medicaid
Department Owner	Triet Tran, Director & Compliance Officer
EMG Owner	Dan Stevens, SVP Government Programs

POLICY NUMBER C-7: COMPLIANCE INVESTIGATION & CORRECTIVE ACTION PLAN

POLICY

Upon discovery of an incident or report of a potential noncompliant or fraud, waste and abuse (FWA) issue, the Compliance Department will initiate a thorough investigation of the incident. All applicable deficiencies and instances of noncompliance are tracked and monitored by formal corrective action plans (CAP) to ensure that they are remedied and are not likely to reoccur.

Applicability

This policy applies to all applicable PacificSource leased employees, officers, and directors, including applicable contractors and first tier, downstream and related (FDR) entities (hereafter “covered person(s)”).

PROCEDURE

Sources of Incident Reporting

The Compliance Department investigates all incidents and reports of noncompliant or FWA issues that may come from formal and informal communication channels. In addition, incidents and reports of noncompliance or FWA issues may also come from various sources, including:

- Regulatory agencies such as CMS, DMAP, OHA, OIG, NBI MEDIC, DOJ, law enforcement
- National fraud alerts
- Complaint Tracking Module (CTM)
- Prospective claim review
- Retrospective data mining
- Employee reporting
- Member reporting
- First tier, downstream and related entity (FDR) reporting
- Compliance monitoring/audit findings
- Opt-out & exclusion list screening
- Employer client reporting
- EthicsPoint
- HR exit interviews

To that end, PacificSource maintains these open lines of communication channels and routinely monitors them for reports of potential incidents.

Investigative Process

All incidents and reports are investigated within **2 weeks** of the date the incident was identified or reported. If a department or individual (other than the Compliance Department) receives a reported incident, that department or individual is responsible for gathering the relevant facts and referring the matter over to the Compliance Department when applicable.

Upon initiating an investigation, the issue or incident will be assigned to a Compliance Department investigator. The investigator will complete a Compliance Investigation Form to document its course of action. During the investigation process, the Compliance Department will utilize any of the following methods:

- Interviews
- Review of process and system
- Review of policies and procedures
- Risk analysis
- Root cause analysis
- Beneficiary, financial, or operational impact analysis
- Validation of sample cases

Disclosure to CMS

In the spirit of transparency, and pursuant to CMS requirement, the Compliance Department will disclose to the CMS Regional Office applicable incidents of noncompliance and FWA that impact beneficiary safety and access to care, and which impact 50 or more beneficiaries. We will provide the Regional Office with regular updates on the status and outcome of corrective action plans and any follow-up monitoring activities that may be done to ensure that the issue is not likely to reoccur.

Referral, Disclosure & Coordination with External Agencies

The Compliance Department will refer matters over to Federal and State regulatory agencies and law enforcement, including the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), under certain circumstances, including:

- Incidents it does not investigate due to resource constraints
- Potential criminal, civil, or administrative law violations
- Allegations involving multiple health plans, multiple states, or widespread schemes
- Allegations involving known patterns of fraud
- Pattern of fraud or abuse threatening the life or well being of beneficiaries
- Scheme with large financial risk to the Medicare and Medicaid program or beneficiaries

The referral will include certain information, if it is available, such as:

- Organization name and contact information
- Summary of the Issue
 - Information on who, what, when, where, how, and why

- Any potential legal violations
- Specific Statutes and Allegations
 - List of civil, criminal, and administrative code or rule violations, state and federal
 - Detailed description of the allegations or pattern of FWA
- Incidents and Issues
 - List of incidents and issues related to the allegations
- Background information
 - Contact information for the complainant, the perpetrator or subject of the investigation, and beneficiaries, pharmacies, providers, or other entities involved.
 - Names and contact information of informants, relators, witnesses, websites, geographic locations, corporate relationships, networks.
- Perspectives of Interested Parties
 - Perspective of Plan, CMS, beneficiary
- Data
 - Existing and potential data sources
 - Graphs and trending
 - Maps
 - Financial impact estimates
- Recommendations in Pursuing the Case
 - Next steps, special considerations, cautions

Cases to the NBI MEDIC are referred within **30 days** when possible of the date the incident was identified or reported.

NBI MEDIC: Health Integrity, LLC,
 9240 Centreville Rd.
 Easton, MD 21601
 Attn: NBI MEDIC
 1-877-7SafeRX (1-877-772-3379), (410) 819-8698
http://www.healthintegrity.org/html/contracts/medic/case_referral.html
http://www.healthintegrity.org/html/contracts/medic/documents/Hi_MEDIC_ComplaintForm_20111109.pdf

PacificSource will provide additional information pursuant to the MEDIC's request within **30 days**, or within a timeframe required by the MEDIC. In addition, the Compliance Department may disclose incidents of significant or serious compliance and FWA violations to CMS, the NBI MEDIC, the OIG, and the Department of Justice when appropriate and warranted.

In addition, the Compliance Department will refer report and coordinate with State Medicaid Fraud Control Units (MCFU) on issues impacting Medicaid.

General: <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/contact-directors.pdf>

<http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>

<http://www.cms.gov/FraudAbuseforConsumers/Downloads/smafraudcontacts.pdf>

<http://www.namfcu.net/states>

Oregon: Medicaid Fraud Control Unit of Oregon
Office of the Attorney General
1515 SW 5th Avenue
Suite 410
Portland, OR 97201
Phone: (503) 229-5725
Fax: (503) 229-5459
<http://www.doj.state.or.us/index.shtml>

DHS Fraud Investigations Unit (for member-related fraud)
PO Box 14150
Salem, OR 97309

Idaho: State of Idaho Office of the Attorney General
700 W. Jefferson Street, Suite 210
P.O. Box 83720
Boise, Idaho 83720-0010
Phone: (208) 334-4100, (208) 334-2400
Fax (208) 854-8071
welfraud@dhw.idaho.gov
http://www.ag.idaho.gov/medicaidFraud/medicaidFraud_index.html

Fraud Alerts

Upon receipt of a fraud alert from CMS, OIG, the MEDIC, or any State and Federal government agency, the Compliance Department shall investigate the matter, analyze the claim system for potential impact, and deny, reverse and recoup impacted claims based on internal analysis. Compliance will work with Pharmacy Services and the PBM to identify potential fraudulent claims and correct PDE data submissions.

Provider Network, working in conjunction with the Compliance Department, shall review the contractual agreements with the identified providers and may initiate termination if law enforcement has issued indictments against those providers.

Suspect Provider List

On a monthly basis, the Compliance Department provides Provider network with an updated list of 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, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal health care program requirements. As part of its credentialing process, Provider Network screens providers against the list and may deny participation based on a match.

Coordination with Human Resources

For issues that have an impact on personnel matters, Human Resources will be engaged appropriately to handle compliance or FWA issues that impact such personnel matters.

Documentation & Provider File Maintenance

The Compliance Department will retain documentation of investigations, including the original documentation of reports of noncompliance and FWA violations. The Compliance Department will retain investigative documents on providers who were the focus of an internal investigation. In addition, we will also maintain files on applicable providers who have been the subject of complaints, investigations, violations, and prosecutions stemming from enrollee complaints, fraud alerts, NBI MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal health care program requirements.

Investigative Findings

At the conclusion of the investigation into the incident, the Compliance investigator will document the findings. If it is determined that the incident does not warrant a formal corrective action plans (CAP), the Compliance investigator will document the rationale supporting this decision. Otherwise, a formal corrective action plans (CAP) will be implemented and tracked until remediation.

Corrective Action Plan

CAPs are generated due to deficiencies and incidents of noncompliance, and may arise from various sources, including:

- Routine monitoring
- Internal audits
- External audits
- Investigations
- Self-disclosure
- Reporting
- Regulatory agency initiatives

Upon discovery of a compliance or FWA issue, the Compliance Department will initiate an investigation into the matter. We will then determine whether the issue warrants opening a formal CAP.

Considerations to opening a CAP include, but are not limited to:

- Nature of violation
- History of violation or recurrence
- Risk to beneficiary access to care and protection
- Risk of government sanctions, fines, and corrective actions
- Likelihood of recurrence
- Root cause (i.e., manual/human error, process/systemic problem)

CAP Process

If a formal CAP is required, the Compliance Department will enter all relevant information into the CAP Database system: <http://psweb/Dept/RM/CAPS/CAP%20TEST/Forms/AllItems.aspx>. The CAP will then follow the following process:

1. Compliance will notify business owners of the opening of a CAP by sending an email with a link to the SharePoint site and CAP form. Once the CAP form is initiated, business owners will generally have 1 week from the date the CAP is opened (or the number of days indicated in the form due date field of the form) to investigate the errors or deficiencies and to complete the appropriate sections of the CAP form. The business owner will be largely responsible for completing the Interim Activities and Corrective Action Plan sections of the form. By the form due date, these sections, and any other sections requiring business owner input, should be completed. This allows Compliance to ensure that the root cause of the non-compliance will be addressed and that the corrective action is appropriate.
2. Compliance may open multiple Corrective Actions if numerous deficiencies are found within the same business area. When possible, Compliance will combine issues into one CAP form. However, for clarity, tracking and documentation purposes multiple CAPs may be needed.
3. The CAP is sent electronically to the business owner of the affected area, and may also be distributed to the associated supervisor, manager and/or executive. This electronic communication will contain a link to the SharePoint site and CAP form.
4. Once the CAP form is completed, it is then reviewed by the compliance owner for appropriateness and completeness of the proposed corrective actions and timelines. If any adjustments to the CAP are required, the compliance owner will discuss the issue(s) with the business owner(s) and reach agreement on appropriate corrective action. If the CAP form is not completed timely, follow-up requests will be made to management of the affected area. All follow-up attempts for information will be documented by the compliance owner within the comments section of the CAP form. If the CAP form is not complete, the CAP will be reported as at risk as described in the reporting section below.

CAP Timelines

The standard timeline for issue resolution of a CAP is 30 days. However, there may be operational and other circumstances which will require longer timelines. Compliance will work with the business owners on a mutually-acceptable achievable timeframe while being mindful of the potential risks and urgencies created by the non-compliance.

CAP Tracking

Compliance will track and maintain the status of the CAP on a continuous basis. While the CAP is open, the status will be set as *On Track*, *At Risk* or *Late*. At risk status indicates that the CAP will likely not meet the resolution deadline due to lack of form completion, business owner attention or other circumstances. Business owners will be required to update the CAP as corrective action items are completed. The SharePoint system will generate due date reminders 7, 3 and 1 day prior to the resolution due date. These reminders will be sent to the business owner and the compliance owner. Once the plan has been effectuated and all errors and deficiencies addressed the CAP form will be marked as completed and closed.

CAP Escalation

CAPs that are untimely will be escalated to the next level of management, including executive management staff if appropriate. Failure to resolve a CAP timely and in its entirety may result in disciplinary action up to and including termination or dismissal of the responsible party, or termination of contract.

CAP Reporting

The Compliance Officer will report to the Compliance Committee relevant open and closed CAPs that were initiated within the last 30 days. Special emphasis will be given to those CAPs that are at risk or late.

CAP Closure

If it is determined that the issue has been remediated, the Compliance Department will close out a CAP. Depending on the type and nature of the issue, the criteria for closing out a CAP may include:

- Supporting documentation
- Validation of corrective measure
- Training and education
- Disciplinary actions taken

If an issue has a negative member impact, the member shall be made whole when appropriate. If the issue has a negative impact to CMS, DMAP, or a State or Federal regulatory agency, those entities shall be made whole when appropriate.

Violations that stem from an employee or FDR's failure shall be handled in accordance with the disciplinary guidelines and enforcement standards.

If a CAP is subject to a validation audit by Internal Audit, the Compliance Department will seek recommendation and input from Internal Audit before closing the CAP.

Ongoing Monitoring & Auditing

Depending on the nature, extent and risk of the issue, the Compliance Department may conduct, or require business owners to conduct, ongoing monitoring reviews to measure the effectiveness of the resolution and to ensure that the issue is not likely to reoccur.

Subsequent to a Compliance Department monitoring review, and when applicable and appropriate, Internal Audit may audit the business owners and verify that the solutions put in place are satisfactory to remediate the deficiency. Internal Audit will review, audit and verify activities such as process improvements, business efficiency analysis, root cause analysis, internal controls, and any other parameters that may impact the business area's compliance and business operations.

References

- Chapter 9: Prescription Drug Benefit Manual-Compliance Program Guidelines (§50.1.6, 50.7)
- <http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf>
- <http://psweb/Dept/RM/CAPS/default.aspx>
- <http://psweb/Dept/RM/CAPS/Investigations%20Forms/Forms/AllItems.aspx>

Schedule

Effective Date	June 2012
Approval Date	June 2012
Revision Date	August 2012
Line(s) of Business	Medicare, Medicaid
Department Owner	Triet Tran, Director & Compliance Officer
EMG Owner	Dan Stevens, SVP Government Programs

FAQ

REPORTING

If I am aware of a potential compliance or FWA issue, do I have an obligation to report it?

Yes. Not only is it our policy to require you to report all potential issues of noncompliance and FWA, but government regulations require it as well.

Can I get in trouble for making a good faith report?

No. Our policy protects you from being retaliated against for making a good faith report of a potential compliance or FWA issue. In addition, government regulations prohibit anyone from retaliating against you in the same manner.

What are some examples of compliance or FWA issues that should be reported?

Bid: Overstating or understating bid data to obtain higher premiums from members or higher reimbursement from the government.

Call center: Intentionally providing beneficiaries with inaccurate information.

Claims: Submitting claims to the government for services that were never rendered, failure to pay providers at the correct rate, paying providers who are on the Medicare opt-out or OIG exclusion list.

Enrollment and disenrollment: Improperly enrolling members to obtain higher reimbursement from the government, improperly disenrolling members due to high medical expenses or other medically-related reasons.

Exceptions and appeals: Not approving members for medically necessary services.

Health services: Failing to approve members for medically necessary services.

Premium billing: Billing members at the incorrect premium amount, not providing members with the required grace period to pay their bills.

Pharmacy: Denying members their transition supply, applying utilization management rules that have not been approved, inappropriately denying drugs that are should be covered.

Provider network: Not credentialing providers in accordance with credentialing laws and regulations, contracting with providers who are on the Medicare opt-out or OIG exclusion list.

Sales and marketing: Misleading beneficiaries, violating a CMS marketing rule, allowing agents and brokers to conduct illegal marketing activities.

This is not an exhaustive list. You may contact the Compliance Department further guidance. Remember, it is always better to over-report than under-report.

Do I have to do any investigation or extensive research before reporting an issue?

No. As long as you have a reasonable basis for believing a compliance issue has occurred, once reported, we will do the fact finding and investigation.

Will I be notified of the outcome of an issue I reported?

All efforts will be made to notify you of the outcome. Due to confidentiality reasons, you may not always be notified of the outcome. Rest assure, however, that your issue will be thoroughly investigated.

How often is the Compliance and FWA Program updated?

We are constantly reviewing and making enhancements to our program on a routine basis to meet changing business and regulatory needs. At a minimum, the Compliance and FWA Program is updated annually.

What is the difference between the “Compliance Program” and the “Standards of Conduct”?

The Standards of Conduct is a subset of the Compliance Program, and addresses personnel matters such as ethical behavior and your duty to report compliance issues. The Compliance Program is the larger, more global infrastructure by which activities are governed.

Is the Compliance Department only to be contacted when there is an issue?

No. We encourage you to openly ask questions, seek a regulatory interpretation, or go over an issue of fact that you are unsure about.

Will results from monitoring and auditing activities be shared with government agencies?

We sometimes disclose issues to the government results from our monitoring and auditing activities, depending on the risk and severity of the findings.

What is the difference between a “compliance” issue and a “fraud, waste and abuse” issue?

Fraud, waste and abuse issues are subsets of compliance issues, and usually involve a financial or monetary impact to the government and tax payers. Compliance issues are a broader categorization.

Is an FWA issue more severe than a compliance issue?

No. The severity of the issue will depend on the facts and circumstances.

Why is there such an emphasis on compliance?

Health care is a highly regulated industry that is prone to fraud and illegal behavior. Each year, the government and tax payers lose hundreds of millions of dollars to fraudulent, wasteful and abusive

practices in medical and administrative expenditures. To help protect the health care system, tax payers, and State and Federal government agencies, we maintain a strong and vigilant compliance program aimed at combating some of these issues.

Where can I get more information on compliance?

You are always encouraged to contact the Government Programs Compliance Department, or visit us at:

<http://psweb/Dept/RM/default.aspx>

<http://medicare.pacificsource.com/Company/Compliance.aspx>

REFERENCES

<http://medicare.pacificsource.com/Company/Compliance.aspx>

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

<http://www.stopmedicarefraud.gov/index.html>

<https://oig.hhs.gov/>

<http://www.justice.gov/>

<http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/index.html>

<http://www.namfcu.net/>