

Medicare Compliance - Creation and Maintenance of Medicare Compliance Policies, Procedures and other Compliance Documents

PURPOSE

The purpose of this document is to implement the relevant provisions of 42 C.F.R. §§ 422.503(b)(4)(vi), and 423.504(b)(4)(vi), Chapter 9 of the Prescription Drug Benefit Manual (PDBM), and Chapter 21 of the Medicare Managed Care Manual (MMCM), as well as 42 CFR §438.608(a)(1)(i) in conjunction with State contracts applicable to dual products, which requires Part C and Part D sponsors to have an effective compliance program, including the maintenance of written policies and procedures and standards of conduct.

SCOPE

This policy and procedure applies to CVS Health® Colleague involved directly or indirectly with the administration or delivery of the Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), Prescription Drug Plan (PDP), Dual Special Needs Plans (DSNP), Institutional Special Needs Plans (ISNP), Chronic Condition Special Needs Plans (CSNP), and Medicare-Medicaid Plan (MMP) benefits¹, and applies only to CVS Health Sponsored Medicare plans.

POLICY

Aetna is a CVS Health® company (Company) and has established written policies and procedures, including a Medicare Compliance Plan to describe our compliance and ethical standards and practices, and our commitment to comply with all applicable federal and state laws and regulations. The Medicare Compliance Plan and other related documents implement the Medicare Compliance Program. These policies and procedures, in concert with the CVS Health® Code of Conduct (COC), direct employees, Directors, and First Tier, Downstream, and Related entities (FDR) employees in implementing the elements of the Medicare Compliance Plan.

Medicare Compliance Policies and Procedures are reviewed and updated at least annually, and when there are significant changes to applicable federal and state laws, regulations, or program requirements. The processes defined within this policy may be modified based upon the unique circumstances of specific plan contracts. The definitions/acronyms used within this policy are listed below.

¹ The policy applies to Medicare-Medicaid (MMP) plans to the extent required for the termination of the MMP demonstration and MMP contracts.

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DEFINITIONS:

1. **Aetna®:** The subsidiaries of Aetna Inc. that provide traditional and consumer-directed health insurance products and related services.
2. **BOD:** Board of Directors
3. **CMS:** U.S. Centers for Medicare and Medicaid Services
4. **CVS Health Code of Conduct:** The document that sets forth CVS Health standards of conduct and appropriate legal and ethical behavior. Colleagues and members of the Board of Directors, when acting in that capacity on behalf of CVS Health, must follow.
5. **Colleague:** Any full-time, part-time, temporary, or casual employee of CVS Health® subsidiaries and affiliates, along with paid interns and externs employed by CVS Health® subsidiaries and affiliates
6. **Chronic Condition Special Needs Plan (CSNP):** A special needs plan that restricts enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions as defined in 42 CFR 422.2.
7. **CVS Health®:** An enterprise brand that is used by CVS Pharmacy, Inc. and each of its operating subsidiaries and affiliates.
8. **Dual Special Needs Plans (DSNP):** A dual special needs plan is a Medicare Advantage Prescription Drug Plan (MAPD) designed to provide targeted care and limit enrollment to special needs individuals who are entitled to Medicare and Medicaid.
9. **First Tier, Downstream, or Related Entity (FDR):** First Tier, Downstream, or Related Entity as defined in 42 CFR 423.4, and as applicable.
10. **FWA:** Fraud, Waste and Abuse
11. **Institutional Special Needs Plan (ISNP):** A special needs plan is a Medicare Advantage Prescription Drug Plan (MAPD) that restricts enrollment to Medicare beneficiaries who require or are expected to need the level of services provided by long-term care facilities such as a skilled nursing facility for 90 days or longer.
12. **MA:** Medicare Advantage
13. **MAPD:** Medicare Advantage Prescription Drug
14. **MCC:** Medicare Compliance Committee
15. **MCO:** Medicare Compliance Officer
16. **MMCM:** Medicare Managed Care Manual
17. **Medicare-Medicaid Plans (MMP):** A Medicare demonstration plan available through 2025 for dual-eligible beneficiaries sponsored by both the Federal and State governments that combines the current Medicare and Medicaid programs into a single benefit offering.
18. **PDBM:** Prescription Drug Benefit Manual

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19. **Prescription Drug Plan (PDP):** A stand-alone Medicare plan offering Medicare prescription drug benefits (i.e., Part D).

PROCEDURE

1. Creation of New Medicare Compliance Policies and Procedures

Medicare Compliance may need to develop and implement a policy and procedure to address new or revised laws, regulations, or program requirements.

When a new policy is drafted:

- A. The appropriate Policy and Procedure Template is used. Desktop guides, or checklists, containing procedural details may be in place to further describe the policy activities.
- B. Requirements and responsibilities will be outlined in the draft policy.
- C. The draft policy will be reviewed and approved by the Medicare Compliance staff responsible for the affected area.
- D. The draft policy may be shared with other Medicare Compliance staff and/or business partners for review. This review is to ensure that there are no conflicts with other business or compliance policies and procedures.
- E. The draft policy will be reviewed by the Medicare Compliance Officer (MCO) or designee for comments and feedback. Medicare Legal Counsel reviews and approves policy content.
- F. Updates will be made to the draft policy. The MCO will conduct a final review of the draft policy and make any revisions, before issuing his/her approval. Once approved by the MCO, the policy can be implemented as a final policy and will be loaded to the CVS Health Policy and Procedure Portal.

2. Maintenance and Review of Existing Policies and Procedures

Existing Medicare Compliance Policies and Procedures and the Medicare Compliance Plan are reviewed at least annually. Revisions may be made based upon legal, regulatory, or program changes. When existing policies are updated:

- A. Updates are noted via track changes in the document.
- B. The revised document is submitted to the appropriate member or members of the Medicare Compliance Department for review and comment.
- C. The Policies and Procedures are loaded to the CVS Health Policy and Procedure Portal, and the MCO reviews the final draft policy and makes any revisions before issuing final approval.

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3. Storage and Communication of Policies and Procedures

- A. Medicare Compliance Policies and Procedures and other related documents (Code of Conduct and Medicare Compliance Plan) are maintained on the CVS Health Policy and Procedure Portal which is accessible on an ongoing basis to all employees.
- B. Medicare Compliance Policies and Procedures and the Code of Conduct are communicated to employees who support CVS Health Medicare business within 90 days of hire, annually thereafter, and when substantive changes are made.
- C. Policy changes may be circulated through various mechanisms: staff meetings; Medicare Compliance Committee (MCC) presentations; intranet postings, etc.

4. Record Retention

When a new or updated policy is finalized, obsolete policies are archived in accordance with our Records Retention Schedule and Centers for Medicare and Medicaid Services (CMS) requirements.

5. Other Related Compliance Documents

A. CVS Health Code of Conduct:

This document provides the overarching principles under which the Company operates, describes compliance expectations (e.g., obligation to report potential/actual non-compliance, Fraud, Waste and Abuse (FWA), or violations to COC or company policies, etc.) and the company's commitment to comply with all applicable federal and state standards. Medicare Compliance participates, as needed, in the company's ad hoc or periodic review and update of the COC. The COC is approved by the Board of Directors (BOD) when material changes are made to the content.

B. Medicare Compliance Plan:

The Medicare Compliance Plan is a document that provides an overview of our Medicare Compliance Program. The Medicare Compliance Program meets the obligations specified in regulatory and sub-regulatory guidance from CMS which were based upon the United States Federal Sentencing Guidelines seven elements for compliance plans. These elements are specifically defined within the CMS Compliance Program Guidelines found in Chapter 9 of the PDBM and Chapter 21 of the MMCM, as well as 42 CFR §438.608 in conjunction with State

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contracts applicable to dual products. The program is designed to prevent, detect and correct Part C and D Medicare noncompliance and FWA. The Company has established various policies, processes, and procedural guides which collectively compose the program. Medicare Compliance maintains the Medicare Compliance Plan and it is reviewed at least annually.

PROPRIETARY

Medicare Compliance –Risk Assessment, Auditing, Monitoring and Issue Management Policy and Procedure

PURPOSE

The purpose of this document is to implement the relevant provisions of 42 C.F.R. §§ 422.503(b)(4)(vi), and 423.504(b)(4)(vi), Chapter 9 of the Prescription Drug Benefit Manual (PDBM), and Chapter 21 of the Medicare Managed Care Manual (MMCM), as well as 42 CFR §438.608(b)(v). in conjunction with State contracts applicable to dual products, which requires Part C and Part D sponsors to have an effective compliance program, including the implementation and operation of an effective system for routine monitoring and auditing, identifying compliance and Fraud, Waste, and Abuse (FWA) risks with prompt responses, as necessary.

SCOPE

This policy and procedure applies to CVS Health® Colleague involved directly or indirectly with the administration or delivery of the Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), Prescription Drug Plan (PDP), Dual Special Needs Plans (DSNP), Institutional Special Needs (ISNP), Chronic Condition Special Needs Plans (CSNP), and Medicare-Medicaid Plan (MMP)² benefits, and applies only to CVS Health Sponsored Medicare plans.

POLICY

Aetna is a CVS Health® company (Company) and will comply with all applicable federal and state laws and regulations regarding the establishment of its Medicare Compliance Program and Work Plan(s). In order to identify potential or actual compliance and/or FWA risks, a process to audit and monitor its Medicare functions and Medicaid functions applicable to dual products, including those performed by First Tier, Downstream, and Related entities (FDRs), was established and is maintained. This includes monitoring and auditing for compliance with Medicare regulatory and sub-regulatory guidance, Medicaid regulatory and sub-regulatory guidance applicable to dual products, contractual requirements, applicable federal and state laws, and adherence to policies and procedures. The Company ensures prompt response when risks are identified. In addition, the overall effectiveness of the Medicare Compliance Program is assessed on a periodic basis. Desk reference guides or other information may be in place to define further procedural actions of

² The policy applies to Medicare-Medicaid (MMP) plans to the extent required for the termination of the MMP demonstration and MMP contracts.

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each of the processes described in this policy. The processes defined within this policy may be modified based upon the unique circumstances of specific plan contracts.

In addition to the Medicare Compliance activities within this policy, the Internal Audit Department or other areas may conduct risk assessments and subsequently develop audit plans. These areas maintain their own policies and procedures associated with these processes. Medicare Compliance collaborates with these areas to leverage internal resources and enhance multi-disciplinary collaboration and visibility.

DEFINITIONS:

1. **Aetna®:** The subsidiaries of Aetna Inc. that provide traditional and consumer-directed health insurance products and related services.
2. **BOD:** Board of Directors
3. **CAPs:** Corrective Action Plans
4. **CMS:** U.S. Centers for Medicare & Medicaid Services.
5. **CVS Health Code of Conduct:** The document that sets forth CVS Health standards of conduct and appropriate legal and ethical behavior. Colleagues and members of the Board of Directors, when acting in that capacity on behalf of CVS Health, must follow.
6. **Chronic Condition Special Needs Plans (CSNP):** A special needs plan that restricts enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions as defined in 42 CFR 422.2.
7. **Colleague:** Any full-time, part-time, temporary, or casual employee of CVS Health® subsidiaries and affiliates, along with paid interns and externs
8. **CVS Health®:** An enterprise brand that is used by CVS Pharmacy, Inc. and each of its operating subsidiaries and affiliates.
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10. **First Tier, Downstream, or Related Entity (FDR):** First Tier, Downstream, or Related Entity as defined in 42 CFR 423.4, and as applicable.
11. **FWA:** Fraud, Waste and Abuse
12. **HPMS:** Health Plan Management System
13. **Institutional Special Needs Plan (ISNP):** A special needs plan is a Medicare Advantage Prescription Drug Plan (MAPD) that restricts enrollment to Medicare beneficiaries who require or are expected to need the level of services provided by long-term care facilities such as a skilled nursing facility for 90 days or longer.

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14. **MA:** Medicare Advantage
15. **MAPD:** Medicare Advantage Prescription Drug
16. **MEDICs:** Medicare Drug Integrity Contractors
17. **MCC:** Medicare Compliance Committee
18. **MCO:** Medicare Compliance Officer
19. **MMCM:** Medicare Managed Care Manual
20. **Medicare-Medicaid Plans (MMP):** A Medicare demonstration plan available through 2025 for dual-eligible beneficiaries sponsored by both the Federal and State governments that combines the current Medicare and Medicaid programs into a single benefit offering.
21. **MFCUs:** Medicaid Fraud Control Unit
22. **Office of the Inspector General (OIG):** The Office of the Inspector General within the U.S. Department of Health and Human Services serves as the government agency that handles investigations of Medicare Fraud, Waste, and Abuse (FWA).
23. **PDBM:** Prescription Drug Benefit Manual
24. **Prescription Drug Plan (PDP):** A stand-alone Medicare plan offering Medicare prescription drug benefits (i.e., Part D).
25. **SAM:** System for Award Management

PROCEDURE

1. **System to Identify Compliance Risks**
 - A. **Operational Assessments.** Medicare Compliance coordinates with other internal areas to conduct an annual baseline risk assessment relating to Medicare compliance and FWA risk areas. Medicare functional requirements are assessed, and consideration may be given to size of the department, complexity of work, past compliance issues, degree of regulatory change, auditing and monitoring results, and areas of interest by regulators or other external parties. These assessments are designed to review, rank risk and prioritize the Medicare functional requirements to develop the annual Medicare Compliance Work Plans (Work Plan). The Medicare Compliance Officer (MCO) is integral to this process, and the results of the risk assessment are reviewed with the Medicare Compliance Committee (MCC).
 - B. **First Tier Assessments.** In addition to operational business area risks, a First Tier Risk Assessment is completed. The assessment uses a methodology unique to each First Tier Category (e.g. Sales Partner, Part C Provider, Supplier/Vendor, and Delegates) to determine the First Tier Entities that will be evaluated, ranked and scored. Assessments are done using risk drivers specific to the First Tier Category. Other considerations are also given, including recommendations received, past audits, etc. Using a stratified prioritization and

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selection process, a reasonable number of entities are added to the Work Plan for a targeted evaluation during the calendar year.

- C. **Re-assessments.** Since risks change and evolve with changes in the law, regulations, CMS requirements and operational matters, the operational and first tier risk assessments are re-evaluated at least semi-annually to assess the accuracy of the baseline assessment. In addition, off-cycle risks are addressed as they arise.

The results of both the Operational and First Tier Assessments are reviewed with the MCC.

2. Annual Medicare Compliance Work Plan

A. Development:

Using the results of the risk assessment, the MCO, with participation of the Medicare Compliance and Compliance Center of Excellence (COE) staff as needed, will develop an annual Work Plan. The Work Plan defines the schedule of the monitoring and auditing activities for the prioritized risk areas. The Work Plan outlines the schedule of activities for the calendar year as well as the type of activity, its objective, frequency, etc. The Work Plan contains the schedule of monitoring and auditing activities for each calendar year.

Auditing and monitoring activities are assigned based on knowledge and expertise of the reviewers, as well as resource availability and timing needs. The Work Plan may also include additional activities in response to audit and/or monitoring results, such as conducting follow-up reviews of areas found to be non-compliant. Follow-up reviews are conducted to determine if the implemented corrective actions have fully addressed the problems.

Medicare Compliance collaborates with business partners for completion of these activities, including the audits, monitors or follow-up reviews, where applicable.

B. Execution of the Work Plan:

The Medicare Compliance staff has access to personnel, documents, legal counsel, operational units, and FDRs as needed to support the Work Plan activities.

The activities directed by the Work Plan are led or overseen by Medicare Compliance to ensure compliance with Medicare regulations, Medicaid

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requirements applicable to dual products, and other applicable requirements. The methodology and scope will include appropriate methods for selecting facilities, pharmacies, providers, claims, and other areas for audit, as applicable; determining appropriate sample sizes; extrapolation of audit findings in compliance with generally accepted auditing standards; application of targeted or stratified sampling methods; and the use of special targeted techniques based on aberrant behavior. Where there is specific operational, clinical and/or compliance-related expertise that is required, the audit lead will solicit the assistance of other operational and clinical staff to assist in the review. When audit team proficiency cannot be achieved internally, the targeted audit will be outsourced to an external review organization for completion. In all cases, the audit lead is independent of the area/function being audited, allowing for an unbiased audit opinion.

The Work Plan is dynamic and may need to be modified as higher risks/priorities arise, however, any changes made to it must be approved by the MCO.

C. Tracking & Reporting Results:

Work Plan progress, including the FDR audits and monitoring events, will be tracked by the MCO. The results of all Work Plan activities are regularly reported to the MCO, along with the status of any corrective actions. The results of the Work Plan monitoring and audits are reflected in standard reporting formats that include objectives, scope and methodology, findings, recommendations, and distribution to key stakeholders.

The MCO or designee(s) provide updates on the Work Plan, including any approved changes, to the MCC, and when appropriate to any of the following: the CVS Health Chief Compliance Officer, the Chief Executive Officer for Medicare, Senior Leadership, and Board of Directors (BOD) or a subset thereof. These reports may be in the form of an oral report, written report and/or dashboard view. See CIG-063823 COMP203 – Medicare Compliance-Lines of Communication Policy and Procedure for additional details on communication with key constituents.

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3. Audit of the Medicare Compliance Program

The Medicare Compliance Program will be audited by a third party as required by CMS to assess compliance with CMS Medicare Compliance Program Effectiveness standards. Results of the Compliance Program audit are shared with the MCO, the CVS Health Chief Compliance Officer, the MCC, Senior Leadership and the BOD or Audit Committee of the BOD, as applicable. Any identified deficiencies result in corrective actions for issue resolution.

4. OIG/SAM Exclusion and Debarment Screenings

Various business areas conduct Office of the Inspector General (OIG) and System for Award Management (SAM) sanction and debarment screenings of employees, temporary employees, consultants, governing body members and First Tier entities and state sanction and debarment screenings applicable to dual products. These areas maintain their own policies and procedures/workflows to ensure pre-hire/contracting and monthly screening occur and any potential matches are investigated with appropriate actions taken.

In addition, Medicare contracts with First Tier entities require that they perform the same pre-hire/contracting and monthly OIG and SAM verifications against the same lists for their employees and Downstream entities. Attestations or other methods of verification may be implemented within the business to evaluate their compliance. Otherwise, compliance is assessed for the applicable First Tier entities that are selected for an audit in the annual Work Plan. Monitoring events designed to assess OIG and SAM compliance may also be scheduled. In the event that a First Tier entity is unable to evidence compliance with this requirement, corrective actions will be taken in accordance with contractual provisions.

5. Special Investigations Unit(s) (SIU)

SIU(s) is responsible for the identification of potential FWA, timely initiation of investigations, and, where potential FWA is identified, reporting such to the Medicare Drug Integrity Contractor's MEDIC(s), Medicaid Fraud Control Unit MFCU(s) for dual products, and/or law enforcement as warranted. Medicare Compliance supports reporting of concerns to the SIU. See COMP203 – Medicare Compliance-Lines of Communications Policy and Procedure which identifies the various methods available for reporting FWA concerns to Medicare Compliance and the SIU. In addition, Medicare Compliance, including the MCO, is accessible

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to the SIU on an ongoing basis. The SIU interacts frequently with Medicare Compliance, with FWA information, such as case file trends, emerging schemes and case metrics, routinely presented to the MCC.

A. Data Analytics:

Data analytics are performed as a means to prevent and identify potential FWA. The SIU utilizes information technology platforms and software products, and proactively data mines for fraudulent or abusive billing patterns regularly. The suite of products utilized within the SIU enables capabilities including but not limited to predictive analytics, top-down analysis, rules based and anomaly detection. A combination of rules-based examinations and predictive analytics is executed on claims on a daily/weekly/monthly basis to generate leads. Both pre-payment and post-payment analytics are executed.

B. Referrals to MEDIC or MFCU:

SIU coordinates and collaborates with the MEDIC(s), as well as the MFCU(s) for dual products, on potential FWA investigations. Specifically, if during an investigation SIU identifies a case involving potential fraud, waste or abuse meeting any of the below criteria, SIU will refer the case to the MEDIC, and/or to the MFCU for dual products, in accordance with the guidance for such submissions.

- 1) Suspected, detected or reported criminal, civil, or administrative law violations;
- 2) Allegations extending beyond Part C and D plans, involving multiple health plans and states, or widespread schemes;
- 3) Allegations involving known patterns of fraud;
- 4) Patterns of fraud, waste or abuse that threaten the life or well-being of beneficiaries; and
- 5) Schemes with large financial risk to the Medicare program or beneficiaries.

SIU collaborates on cases with other functional areas (e.g., Investigative Services, Agent Oversight), as needed. The SIU also processes any Requests for Information (RFI) that may be received from the MEDIC(s) and/or other authoritative bodies (e.g., OIG, CMS, States, law enforcement, etc.).

C. Responding to CMS-Issued Fraud Alerts:

On occasion, CMS will issue Fraud Alerts via their Health Plan Management System (HPMS) notification system. Upon receipt of the Alert, Medicare

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Compliance will distribute through a distribution and tracking process to all impacted parties (e.g., SIU) for processing.

D. Providers with History of Complaints:

SIU maintains case files for a period of ten (10) years in accordance with our record retention policy and procedure.

At the launch of each investigation, the SIU reviews case history to determine whether prior complaints were made, and the nature of any prior complaints. Completion of this activity may result in either a case re-opening or new case assignment.

6. Conducting a Timely and Reasonable Inquiry of Detected Offenses

A. Timeliness of Investigation:

The Company will conduct a timely, reasonable inquiry into evidence of misconduct, non-compliance, and/or suspected FWA related to payment or delivery of items or services. The Company is committed to initiating investigations into potential compliance issues (including misconduct) or suspected FWA in a timely manner, not later than 14 calendar days from identification. Three main mechanisms receive and investigate these potential issues as described below and outlined in CIG-063823 COMP 203 – Medicare Compliance Lines of Communications Policy and Procedure.

- 1) **CVS Health Ethics Line (Ethics Line):** General compliance and ethics concerns are received through multiple reporting channels such as the Ethics Line (1-877-CVS-2040 (1-877-287-2040): TTY: 711), the Ethics Line intranet website, the Compliance email box, etc. The Company ensures prompt and complete review and/or investigation of all compliance and ethics matters received through the various reporting channels. A system is used to record compliance and ethics concerns received through these mechanisms.
- 2) **Special Investigations Unit (SIU):** Potential FWA investigations are received by the SIU through a variety of available mechanisms and are initiated within two (2) weeks. In the event the SIU or MCO determines that the Company does not have the time or resources to investigate an instance of potential fraud or abuse in a timely manner, the SIU will refer the matter to the MEDIC within 30 days of the date the potential fraud or abuse was identified. SIU will refer the matter to the MFCU(s) for dual products as required by the States. In addition, other investigative units

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ensure timely processing of potential FWA cases, as applicable. A system is used to record potential FWA concerns received by the SIU.

- 3) **Medicare Compliance:** Issues are received by, identified by, or directed to the Medicare Compliance team through a variety of available mechanisms. Potential issues may originate from a variety of sources (e.g., self-evaluations, regulatory inquiries, CTMs, CMS, employee referrals, etc.). Issues received by Medicare Compliance require initial investigation to be initiated no later than two (2) weeks after the date that the potential issue was identified. A system is used to record concerns received through these mechanisms.

B. Documentation:

Case investigations are recorded in the manner and practice prescribed by the policies that are in place for each of the above systems. Medicare Compliance inquiries are well-documented as outlined in this Medicare Compliance procedure:

- 1) Upon identification of a potential issue, Medicare Compliance creates a Potential Issue in our tracking system. The record is assigned to a Business Owner.
- 2) The Business Owner, in partnership with Medicare Compliance, investigates the issue to confirm whether an issue of noncompliance exists. If noncompliance is confirmed, corrective actions are requested. If, after investigation, no issue of noncompliance is substantiated, the matter is closed and reported, as necessary, to the person or entity that reported the potential issue.
- 3) Medicare Compliance staff provides issue status reports to the MCO, as needed.

7. Corrective Actions

Corrective actions to address non-compliance or suspected FWA are developed and implemented on a case-by-case basis. Corrective actions are taken based upon an assessment of the issue, including root cause analysis, impact of the issue (number of members, claims, CTMs, etc.), and duration of the issue. Corrective Action Plans (CAPs) are designed to correct the underlying problem, prevent future instances or continued noncompliance, and will include timeframes for specific achievements. For CAPs requested by Medicare Compliance, the MCO or his/her designee oversees the CAP status for each issue. This oversight includes

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reviewing to determine the reasonableness of the plan of action and tracking progress through resolution.

A. CAP implementation:

- 1) General Compliance and Ethics issues: In accordance with the Code of Conduct, and related policies, corrective actions may include (i) employee discipline (e.g., coaching, written warnings, suspension and other actions up to and including employee termination), (ii) new and/or revised policies/procedures/workflows, and (iii) employee training.
- 2) Additional corrective actions may include overpayment recovery, payment suspension, Prescription Drug Event correction/deletion, and other actions up to and including contract termination. Potential FWA issues are referred to CMS or to the MEDIC by the MCO, his/her designee, the SIU or another party, as necessary.
- 3) Issues of non-compliance require remediation. CAPs should be reviewed to determine the reasonableness of the plan of action. In addition, the CAPs should be tracked through completion.
- 4) CAPs to address non-compliance by an FDR are monitored by the appropriate business area/oversight committee, as applicable. Medicare Compliance maintains a FDR Oversight Committee that oversees FDR CAPs, high risk FDRs, etc.

B. Medicare Compliance Procedures:

- 1) When requested by Medicare Compliance, CAPs are added to the Medicare Compliance issue tracking database.
- 2) Status meetings between the MCO and/or a Medicare Compliance designee and the Business Owner(s) may occur to ensure progress on the CAP.
- 3) CAPs must address the root causes of any deficiency to correct the underlying problem and prevent future reoccurrences. These may include interim and long-term solutions.
- 4) Upon completion of the CAP, Medicare Compliance will validate the effectiveness of the corrective actions through review of supportive documentation such as through testing results, schedule a follow-up review, or develop and implement ongoing monitoring activities.
- 5) Medicare Compliance maintains and/or has access to documentation of all deficiencies and corrective actions taken.
- 6) Routine reporting of the status/progress of CAPs are provided to the MCO and other governing bodies (e.g., MCC, etc.) and when appropriate to any of the following: the CVS Health Chief Compliance Officer, the Chief Executive Officer for Medicare, Senior Leadership, and Board of

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Directors or subset. These reports may be in the form of an oral or written report.

8. Procedures for Self-Reporting Potential FWA and Significant Non-Compliance

In the event that potential FWA is identified (including at the FDR level), the Company promptly refers the issue to the MEDIC, as well as the MFCU for dual products, in accordance with applicable guidance.

In the event of an instance of significant non-compliance, the MCO or his/her designee will report such incident to CMS, as well as the State for dual products, as soon as possible after discovery, in accordance with relevant regulatory requirements and guidance.

In certain situations, the Company engages CMS, as well as the States overseeing dual products, in order to report key information proactively (e.g., upcoming provider terminations, changes to FDR contracts for key functions, etc.). PBM changes are reported to the CMS Account Manager at least 60 calendar days prior to the effective date of the new contract or the date the new PBM would begin providing services to beneficiaries, whichever is earlier. In instances of a PBM contract change occurring within less than 60 days, the Company must notify CMS within 5 days of signing the new contract. Other significant FDR changes are evaluated by the MCO for similar proactive reporting.

9. Auditing by CMS or its Designee

In accordance with our contracts with CMS, the Company provides access to any regulatory agency or auditor acting on behalf of the federal government to conduct a desk review, an on-site audit or other activities. In addition, contracts with First Tiers include provisions ensuring the external entity adheres to the same requirements. Responses to requests for information or information requested by the MEDIC or the MFCU for dual products will be responded to within the timeframe required. If additional time is needed, the Company will communicate such needs directly with requestor.

Medicare Compliance - Lines of Communication Policy and Procedure

PURPOSE

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SCOPE

This policy and procedure applies to CVS Health® Colleague involved directly or indirectly with the administration or delivery of the Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), Prescription Drug Plan (PDP), Dual Special Needs Plans (DSNP), Institutional Special Needs Plans (ISNP), Chronic Condition Special Needs Plans (CSNP) and Medicare-Medicaid Plan (MMP)³ benefits, and applies only to CVS Health Sponsored Medicare plans and to all CVS Health® Colleagues involved in Medicaid services for Duals Products.

POLICY

Aetna is a CVS Health® company (Company) and will comply with all applicable federal and state laws and regulations regarding the establishment of a compliance program, including standards for effective lines of communication and ensuring confidentiality between the Medicare Compliance Officer (MCO), members of the MCC, employees, managers and governing body, and FDRs. The lines of communication will be accessible to all, be user-friendly, and allow for anonymous and confidential good faith reporting. This reporting includes potential or actual compliance issues and/or Fraud, Waste and Abuse (FWA) as well as suspected or actual violations relating to the Medicare program. In addition, the Company has adopted a policy of non-intimidation and non-retaliation and enforces a no tolerance policy for retaliation or retribution for good faith reporting of compliance or FWA

³ The policy applies to Medicare-Medicaid (MMP) plans to the extent required for the termination of the MMP demonstration and MMP contracts.

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concerns. The processes defined within this policy may be modified based upon the unique circumstances of specific plan contracts. The definitions/acronyms used within this policy are listed below.

DEFINITIONS:

1. **Aetna®:** The subsidiaries of Aetna Inc. that provide traditional and consumer-directed health insurance products and related services.
2. **BOD:** Board of Directors
3. **CMS:** U.S. Centers for Medicare & Medicaid Services.
4. **CVS Health Code of Conduct:** The document that sets forth CVS Health standards of conduct and appropriate legal and ethical behavior. Colleagues and members of the Board of Directors, when acting in that capacity on behalf of CVS Health, must follow.
5. **Colleague:** Any full-time, part-time, temporary, or casual employee of CVS Health® subsidiaries and affiliates, along with paid interns and externs employed by CVS Health® subsidiaries and affiliates.
6. **Chronic Condition Special Needs Plans (CSNP):** A special needs plan that restricts enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions as defined in 42 CFR 422.2.
7. **CVS Health®:** An enterprise brand that is used by CVS Pharmacy, Inc. and each of its operating subsidiaries and affiliates.
8. **Dual Special Needs Plans (DSNP):** A dual special needs plan is a Medicare Advantage Prescription Drug Plan (MAPD) designed to provide targeted care and limit enrollment to special needs individuals who are entitled to Medicare and Medicaid.
9. **First Tier, Downstream, or Related Entity (FDR):** First Tier, Downstream, or Related Entity as defined in 42 CFR 423.4, and as applicable.
10. **FWA:** Fraud, Waste and Abuse
11. **HPMS:** Health Plan Management System
12. **Institutional Special Needs Plan (ISNP):** A special needs plan is a Medicare Advantage Prescription Drug Plan (MAPD) that restricts enrollment to Medicare beneficiaries who require or are expected to need the level of services provided by long-term care facilities such as a skilled nursing facility for 90 days or longer.
13. **MA:** Medicare Advantage
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15. **MCC:** Medicare Compliance Committee
16. **MCO:** Medicare Compliance Officer
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18. **Medicare-Medicaid Plans (MMP):** A Medicare demonstration plan available through 2025 for dual-eligible beneficiaries sponsored by both the Federal and

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State governments that combines the current Medicare and Medicaid programs into a single benefit offering.

19. **PDBM:** Prescription Drug Benefit Manual

20. **Prescription Drug Plan (PDP):** A stand-alone Medicare plan offering Medicare prescription drug benefits (i.e., Part D).

21. **SIU:** Special Investigations Unit

PROCEDURE

1. Communications from the Medicare Compliance Officer
 - A. The Medicare Compliance Officer (MCO) communicates key initiatives and changes to Medicare supporting employees. This may occur through Medicare Compliance Regulatory communications, the Company's intranet site, training programs, verbal and written communications, and telephonic announcements.
 - B. The Company's intranet includes information about the methods available for reporting compliance and FWA issues and concerns, as well as the MCO contact information. The Medicare Compliance Policies and Procedures, the Medicare Compliance Plan, and the CVS Health Code of Conduct (COC) are accessible through the CVS Health Policy and Procedure Portal.
 - C. Medicare Compliance may periodically develop and post intranet-based communications (e.g., newsletters, etc.) to be accessed by employees. Such communications may include key reporting requirements and information about the various methods available for reporting.
 - D. Medicare Compliance will distribute statutory, regulatory and sub-regulatory changes (including Health Plan Management System (HPMS) Memos) through a distribution and tracking process. Distribution lists are maintained on an ongoing basis and are verified at least annually to ensure communications are accurately directed. Business leads are expected to communicate guidance, as applicable, to relevant FDRs.
 - E. The MCO ensures the reporting of Medicare-and applicable Medicaid-related compliance issues on a regular basis to the MCC, the Chief Executive Officer for Medicare, Senior Leadership, CVS Health Chief Compliance Officer, the Board of Directors (BOD) or a subset thereof, as well as to any accountable business leads as necessary.

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2. Communicating with and Reporting to Medicare Compliance

As described in the COC, employees, the BOD, and FDR employees are required to report suspected or detected noncompliance, and potential FWA. The Company has developed various methods of communicating with Medicare Compliance, including reporting compliance/FWA concerns.

A. Medicare Compliance Reporting Mechanisms:

- 1) Directly to the MCO: the name, and contact information for the MCO is displayed on the Medicare Compliance intranet.
- 2) Email correspondence to designated Medicare Compliance mailbox: MedicareCompliance@Aetna.com
- 3) Medicare Compliance phone line: 215-775-6801 (May leave an anonymous message)
- 4) Medicare Compliance Colleagues and SNP Plan Compliance Officers: Medicare Compliance personnel are identified on the Medicare Compliance intranet. Confidential e-mails or telephonic contacts may be directed at this staff. Additionally, reporting may occur during staff ongoing interactions with the associated business units as part of normal business operations.

B. CVS Health Ethics Line (Ethics Line) hotline:

The Company has also established a toll-free hotline, the Ethics Line, which is accessible to all parties 24 hours a day/7 days a week for reporting of potential compliance and ethics issues and/ or potential FWA.

- 1) The Ethics Line provides for anonymous and confidential reporting (to the greatest extent possible).
- 2) Cases are reviewed and monitored by Medicare Compliance when appropriate. Medicare Compliance may collaborate or lead investigations with other departments. Case trends may also be reported to the MCC, as needed.
- 3) The Ethics Line contact information is displayed throughout the enterprise, as well as on the intranet, in the COC, and in compliance training information. Ethics Line allows for three ways to anonymously report; by calling 1-877-CVS-2040 (1-877-287-2040); TTY: 711, by writing to: Chief Compliance Officer, CVS Health, One CVS Drive, Woonsocket, RI 02895 or submit a question or concern via web at www.CVSHealth.com/EthicsLine.

C. Special Investigations Unit(s) (SIU):

SIU has established and monitors various reporting mechanisms to ensure that potential FWA can be easily reported by employees, the BOD, employees of FDRs, and members. Reporting can be initiated via the intranet, e-mail or by

Medicare Compliance - Lines of Communication Policy and Procedure

calling a hotline. Calls to the hotline may be made anonymously. SIU and Medicare Compliance collaborate with other functional units, as necessary. SIU activities are routinely reported to the MCC.

D. No tolerance policy:

The Company has a no-tolerance policy for intimidation and retaliation which is publicized on the intranet and other communications (e.g., compliance training, Code of Conduct, etc.). Parties who report potential Compliance issues are kept in confidence to the greatest extent possible.

3. Recording, Responding To, and Tracking Reports

- A. Medicare Compliance ensures that compliance questions and reports of suspected or detected noncompliance or potential FWA are responded to appropriately. This may include oversight and coordination with other areas to investigate reported concerns. Appropriate actions will be taken in accordance with CIG-063819 Medicare Compliance Policy 202 - Risk Assessment, Auditing and Monitoring, and Issue Management Policy and Procedure.
- B. Medicare Compliance ensures the recording and tracking of reports of suspected or detected noncompliance or potential FWA, either directly or through collaboration with other areas. This may be used to identify trends and potential systemic issues.
- C. Reported case details are maintained in accordance with our Record Retention Policy.

Medicare Compliance and Fraud, Waste, and Abuse Training Policy and Procedure

PURPOSE

The purpose of this document is to implement the relevant provisions of 42 C.F.R. §§ 422.503(b)(4)(vi), and 423.504(b)(4)(vi), Chapter 9 of the Prescription Drug Benefit Manual (PDBM), and Chapter 21 of the Medicare Managed Care Manual (MMCM) as well as 42 CFR §438.608(a)(1)(iv) in conjunction with State contracts applicable to dual products, which requires Part C and Part D sponsors to have an effective compliance program, including policy and procedures for facilitating compliance and Fraud, Waste, and Abuse (FWA) training and Code of Conduct (COC) distribution.

SCOPE

This policy and procedure applies to CVS Health® Colleague involved directly or indirectly with the administration or delivery of the Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), Prescription Drug Plan (PDP), Dual Special Needs Plans (DSNP), Institutional Special Needs Plans (ISNP), Chronic Condition Special Needs Plans (CSNP), and Medicare-Medicaid Plan (MMP)⁴ benefits, and applies only to CVS Health Sponsored Medicare plans and to all CVS Health® Colleagues involved in Medicaid services for dual products.

POLICY

Aetna is a CVS Health® company (the Company) and will comply with all applicable federal and state laws and regulations regarding the establishment of a compliance plan, including implementation of effective compliance and FWA training. The training will include Standards of Conduct distribution through the CVS Health Code of Conduct (COC) to all Medicare supporting employees, governing bodies, and First Tier, Downstream or Related Entities (FDRs). The training materials are reviewed and updated, at least annually, and more often if needed to reflect changes to related laws, regulations, policy, or guidance. The processes defined within this policy may be modified based upon the unique circumstances of specific plan contracts. The definitions/acronyms used within this policy are listed below.

⁴ The policy applies to Medicare-Medicaid (MMP) plans to the extent required for the termination of the MMP demonstration and MMP contracts.

Medicare Compliance and Fraud, Waste, and Abuse Training Policy and Procedure

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7. **CVS Health®:** An enterprise brand that is used by CVS Pharmacy, Inc. and each of its operating subsidiaries and affiliates.
8. **DMEPOS:** Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
9. **Dual Special Needs Plans (DSNP):** A dual special needs plan is a Medicare Advantage Prescription Drug Plan (MAPD) designed to provide targeted care and limit enrollment to special needs individuals who are entitled to Medicare and Medicaid.
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22. **SIU:** Special Investigations Unit

PROCEDURE

1. **Employees**

- A. Medicare-supporting employees are provided general compliance and FWA training through the Company's COC and related training on the COC. The COC training provides details on general compliance and FWA and provides colleagues with information on accessing the CVS Health Policy and Procedure Portal for additional Compliance policies and procedures. The COC and related training is provided to employees within 90 days of hire and at least annually thereafter.
- B. Medicare Compliance participates, as needed, in the Company's annual or periodic review of training materials. Updates can be made to address significant changes to laws, regulations, policy, and guidance, as needed.
- C. Training is delivered through the Company's online learning center. Employees are instructed to complete the training initially upon hire and then annually through system-generated e-mail notifications (i.e., initial notices and then subsequent reminders).
- D. Training completion is monitored by the CVS Health Compliance Training team. Disciplinary actions are taken, as needed, to enforce completion of this required training.
- E. Training records are maintained for a period of no less than ten (10) years and will include time, attendance, topic, certificates of completion (if applicable), and test scores of any tests administered (if applicable).

2. **Board of Directors**

The governing body, Board of Directors (BOD), completes general compliance and FWA training, which includes the COC and associated compliance policy information, within 90 days of appointment and then annually thereafter. Training completion is tracked by the CVS Health Legal Department, Corporate Services team.

3. **FDR Employees**

- A. General Compliance and Fraud, Waste, and Abuse Information:
 - 1) In accordance with CMS requirements, the company has developed criteria to determine which entities are FDRs.

Medicare Compliance and Fraud, Waste, and Abuse Training Policy and Procedure

- 2) Applicable FDR employees are required to receive a COC, Compliance Program policy and procedures, and compliance and FWA training and information within 90 days of hire or contracting and each calendar year thereafter.
- 3) FDRs are deemed to have met the FWA training requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS. However, deemed FDRs are not exempt from the general compliance program requirements.
- 4) Notices are provided to FDRs of the Medicare Compliance Program FDR expectations through various mechanisms such as newsletters, e-mail notifications, fax blasts, website/web portal postings, manuals, etc. In addition, the Company communicates the COC and Medicare Compliance Policies and Procedures to FDRs within 90 days of contracting, with updates as necessary, and annually thereafter.
- 5) FDRs are required to retain evidence of compliance program requirement for a period of no less than ten (10) years, and to make this evidence available to the Company and/or CMS, upon request (i.e., for FDR audits or monitoring events, etc.).

4. Medicare Enrollees

Education is provided to Medicare enrollees about the identification and reporting of FWA through various mechanisms such as website postings, mailings, etc.

5. Specialized Medicare Compliance Training

- A. Additional, specialized, or refresher training may be delivered by either a business area, Medicare Compliance, or both, depending on the training objective.
- B. Operational areas deliver new hire training, training when there are significant changes to procedures, or refresher training when there is an upcoming annual event (e.g., Annual Enrollment Period). Medicare Compliance may develop and deliver specialized focused training if there are issues or trends that have been identified. Topics covered and required attendees will be defined on a case by case basis.