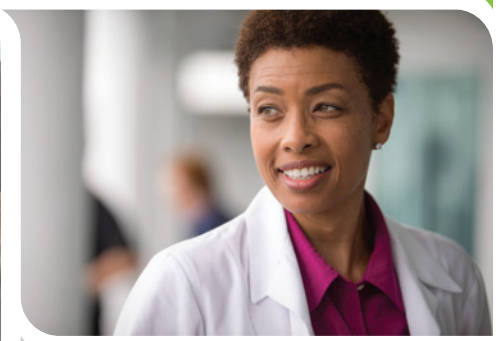
Compliance Policy

for Contracted Health Care Providers and Business Partners



Overview

Humana has compliance program requirements for those supporting its business: your organization, its employees and downstream entities. These requirements include, but are not limited to, the core elements of Humana's Compliance Program outlined in the Table of Contents on the next page. Your organization may be required to provide assurance that it understands and incorporates these components into its own compliance program or that it has a materially similar program.

Humana®

Effective 2016

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Introduction

Purpose

Humana's dream is "to help people achieve lifelong well-being." In pursuit of this ideal, Humana is committed to maintaining high ethical standards in the conduct of its business. The key to upholding these standards is through the daily decisions and actions of every Humana associate. We also require highly ethical conduct from our business relationships. Your strong commitment to compliance is the foundation of our business relationship.

The purpose of this policy is to aid our health care providers and business partners in fully understanding Humana's strong organizational commitment to conducting business ethically, with integrity, and in compliance with applicable laws, regulations and requirements. Humana requires of its health care providers and business partners a similar commitment to ethical conduct and assurance that they, and their employees and downstream entities supporting Humana business, comply with the guiding principles outlined within this policy.

Organization

This policy relays Humana's compliance requirements and expectations of its health care providers and business partners and addresses the requirements of the Centers for Medicare & Medicaid Services (CMS) pertaining to an effective compliance program and fraud, waste and abuse prevention, detection and correction. In addition, this policy references state- and product-specific requirements. The seven core elements of an effective compliance program are categorized into the following sections within this document: Framework, Communication, Oversight and Investigation. Under each of these sections is a description of Humana's elements-related requirements and processes, along with an outline of Humana's expectations of health care providers and partners in a "Health Care Provider and Business Partner Impact" segment.

Responsibility

Humana maintains ultimate responsibility for the effectiveness of its compliance program. As part of this responsibility, Humana requires all health care providers and business partners to adhere to and maintain policies to address the principles outlined in this document.

This can be achieved by your organization in any of the following ways:

a) Adopting all of the following: this Policy, Ethics Every Day for Contracted Health Care Providers and Business Partners, and CMS' fraud, waste and abuse (FWA) training and general compliance training

b) Adopting the CMS FWA training and general compliance training document and maintaining internal policies that:

   i. Are materially similar to this Policy and Ethics Every Day for Contracted Health Care Providers and Business Partners; and

   ii. Align with the guiding principles and requirements of these documents listed above

c) Completing the exception process if the requirement is not applicable

   » Exception requests must be made in writing to and receive approval from Humana's Enterprise Compliance Department.

In addition, Humana has ongoing monitoring, auditing and reporting processes to assess health care provider and business partner compliance. Humana updates this policy when there are material regulation, policy or guidance changes, and at least annually.

Notable changes (with page number)

This overview has been provided to list the key points of notable changes and the sections in which they are detailed.

Organizations performing any function for Humana may continue to use this Policy and Humana's standards of conduct document to meet the distribution requirements for these two policies or adopt materially similar policies. However, only the CMS training document* on FWA and general compliance may be used to meet the training requirements for those two topics.

- **Responsibility (1)**
- **Materials Distributed to Contracted Health Care Providers and Business Partners (3)**
- **Written Policies, Procedures and Standards of Conduct (4)**

* Appendix A: Resources details how to access the CMS training document.

Definitions (2)

Centers for Medicare & Medicaid Services (CMS): This now also clarifies CMS' role in health exchanges.

Your Relationships with Downstream Entities (4)

This section now further clarifies that agreements with Humana's downstream entities must be compliant, what the requirements of downstream entities of Humana are and the oversight role of Humana's contracted health care providers and business partners.

Noncompliance with Humana's Training Requirements (4 & 5)

This section now clarifies that the issuance of a formal corrective action plan can be another action taken to address noncompliance of a contracted health care provider or business partner.

Key Features of These Communication Options (5)

This section now clarifies that Ethics Help Line personnel are not just employed by a separate company, but that the company is independent from Humana.

Definitions

Associate – Refers to a Humana employee.

Audit – Refers to a formal review of compliance with a particular set of internal (e.g., policies and procedures) and/or external (e.g., laws and regulations) standards used as base measures.

Centers for Medicare & Medicaid Services (CMS) – An agency within the U.S. Department of Health and Human Services that is responsible for the administration of the federal Medicare and Medicaid programs and the federally-facilitated marketplace for the exchange product (FFM).

Conflicts of Interest – Personal, familial or business relationships that could amount to, but are not limited to:

- Competing with any of Humana's product offerings
- Providing services to a competitor of Humana
- Interfering with the performance of work duties

Please refer to Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners for examples.

Downstream Entity – An organization or individual that enters into an acceptable written arrangement below the level of the arrangement between Humana and a First Tier Entity. This continues down to the level of the ultimate provider of a service or product. Example: A management services organization contracted directly with Humana is a First Tier Entity. The hospitals and health care providers contracted with the management services organization as part of its network are downstream entities.

FDR: A first tier, downstream or related entity of Humana. This is a contracted entity that supports Humana business. Please refer to the separate definitions of First Tier, Downstream and Related Entity, as well as Health Care Providers and Business Partners, for clarifications.

FDR Employees and Downstream Entities – Individuals employed by, contracted with, or otherwise supporting an FDR, who are acting on behalf of Humana, either directly or indirectly. These include, but are not limited to, FDR employees, employed and contracted health care providers and pharmacists, board members, pharmacy and therapeutic committee members, volunteers, consultants and any contracted individuals.

First Tier Entity – An organization or individual that enters into an acceptable written arrangement with Humana to provide administrative or health care services. This includes any person or entity that is contracted by Humana to perform work in support of administration or delivery of Humana products and/or services. Additionally, when Medicare or Medicaid is involved and Humana is the Sponsor, the agreement must be acceptable to CMS. Example: A call center contracted directly with Humana is a first tier entity.

Health Care Providers and Business Partners – Any non-associate contracted, directly or indirectly, to perform a business function or provide goods or a service for or on Humana's behalf. These may also be referred to as first tier, downstream and related entities (FDRs). Some examples of business partners are health care providers, pharmacies, sales agents, sales agencies, vendors, suppliers, contractors and delegates.

Vendors and suppliers of administrative goods and services are considered Business Partners.

Humana – Refers to Humana Inc. and its wholly owned subsidiaries.

Monitoring – Reviews that are repeated regularly during the normal course of operations. These activities may occur to confirm:

- Ongoing compliance even in the absence of identified problems; or
- Corrective actions are undertaken and effective

Related Entity – Any entity that is related to Humana by common ownership or control and meets one of the following criteria:

- Performs some of Humana's management functions under contract or delegation; or
- Furnishes services to enrollees under an oral or written agreement; or
- Leases real property or sells materials to Humana at a cost of more than $2,500 during a contract period

Volunteer – Any individual who performs work for Humana related to the Medicare or Medicaid program, but is not employed by or contracted with Humana in any fashion, and not otherwise compensated for their work. An example is an unpaid student intern.

Key takeaways from this policy

Humana is committed to ethically conducting business and complying with this Policy and all laws, rules and regulations referenced in the appendices. This policy is aligned with the seven elements of an effective compliance program outlined by CMS:

Section I – Framework

Element I: Written Policies, Procedures and Standards of Conduct

- **Materials Distributed to Contracted Health Care Providers and Business Partners:** This Policy, standards of conduct (Ethics Every Day for Contracted Health Care Providers and Business Partners), and CMS' fraud, waste and abuse (FWA) training and general compliance training. Compliance with the three above documents is required and training must be provided to their employees and subcontractors.
  - » Organizations performing any function for Humana may meet the distribution requirements for the two Humana policies by using materially similar policies. However, only the CMS training document on FWA and general compliance may be used to meet the training requirements for those two topics.
- **Record Retention:** Documentation and records integral to meeting Policy requirements and activities must be maintained for a minimum of 10 years.
- **Requirements of Contracted Health Care Provider and Business Partners Subcontracting any of their Contractual Obligations:**
  - » Notify Humana when it seeks to subcontract any work in support of Humana so that Humana can issue its approval or rejection of the proposed relationship.
  - » Maintain written agreements with any subcontractors supporting functions the contracted health care provider or business partner is contracted to perform for Humana.
  - » Provide performance and compliance oversight of their subcontractors to assure they are meeting related requirements outlined in any contracts related to Humana as well as the Policy.

Element II: Compliance Officer, Compliance Committee and High Level Oversight

- Humana has designated personnel accountable for overseeing compliance responsibilities.
  - » Contracted health care providers and business partners must also have designated resources to fulfill compliance obligations.

Section II – Communication

Element III: Effective Training and Education

- This must be in place for Humana and its contracted health care providers and business partners on compliance, addressing fraud, waste and abuse, and, where applicable, Medicaid-related subject matter. The education must be formally tracked and conducted by contracted health care providers and business partners within 90 days of initial contract/employment and annually thereafter.

Element IV: Effective Lines of Communication

- Humana employees and its contracted health care providers and business partners are given access to its compliance officer for feedback and multiple methods for reporting suspected or detected noncompliance. Such reporting is required of all who support Humana's business. More than one available method offers anytime access, while all are confidential and allow for follow-up.
- Humana prohibits intimidation or retaliation against anyone making a good faith report of suspected violations of the Policy. Contracted health care providers and business partners are required to have and publicize one or more reporting options with these features and/or publicize Humana's reporting options, as well as comply with the prohibition on intimidation and retaliation.

Element V: Well-Publicized Disciplinary Standards

Humana and its contracted health care providers and business partners are required to widely publicize disciplinary standards and the requirement to report suspected violations.

Section III – Oversight

Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks

- **Monitoring and Auditing Work Plans:** Humana has these in place to assess compliance with this Policy and related requirements. Contracted health care providers and business partners are also required to have these plans and conduct corresponding oversight.
- **Exclusion Lists:** Screening against OIG and GSA exclusion lists must be conducted by Humana and contracted health care providers and business partners prior to hire/contract and at least monthly thereafter and, and records of screening activities must be retained for 10 years. Anyone or entity appearing on either list must be promptly removed from supporting Humana business.
- **Conflicts of Interest:** Statements of Humana associates' suspected conflicts are obtained by Humana within 90 days of hire, upon any related change or addition, and annually thereafter. Contracted health care providers and business partners must obtain these statements annually, and when there is a related change or addition, from those performing functions for them. Identified conflicts must be removed or approval to allow them must be granted. Humana reserves the right to request and review this information, as well as require a conflict to be removed, up to the person or entity supporting Humana ceasing to perform functions to meet contractual obligations to Humana.

Section IV – Investigation, Discipline and Correction

Element VII: Procedures and System for Prompt Response to Compliance Issues

Humana investigates suspected violations, takes applicable disciplinary action and implements any necessary, subsequent corrections to prevent future violations. Associates, as well as contracted health care providers and business partners, must also cooperate with any investigation and initiate disciplinary actions when applicable.

I. Framework

Written Policies, Procedures and Standards of Conduct

Humana has two principle documents at the core of its compliance program:

- Humana's standards of conduct, which outlines ethical expectations and can be accessed online from the Corporate Governance section of the Investor Relations page on **Humana.com**. There is also a supplemental document titled Ethics Every Day for Contracted Health Care Providers and Business Partners. It can be accessed on Humana's website.
- The Enterprise Compliance Plan outlines the fundamental elements of Humana's compliance program, including
  - » Required policies;
  - » Compliance officer and Compliance Committee requirements;
  - » Compliance and fraud, waste and abuse (FWA) training content and requirements;
  - » Communication and compliance officer access requirements;
  - » Behavior monitoring and disciplinary standard expectations;
  - » Requirements for monitoring and assessment of compliance with state and federal requirements and identification of compliance risks; and
  - » Requirements for identifying, responding to and correcting compliance issues.

Numerous policies, standards and procedures exist to support the Enterprise Compliance Plan. The core policies that apply to relationships with health care providers and business partners as they relate to compliance are outlined in this document.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected either to adopt the following for their employees and downstream entities:

a) Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners
b) This compliance policy
c) CMS' FWA training and general compliance training

Or to adopt the CMS FWA training and general compliance training and maintain their own, materially similar:

a) Version of Humana's standards of conduct
b) Policies that support the requirements and activities in this document

Supporting procedures may be developed and maintained for certain required activities. All health care providers and business partners are required to have appropriate policies and procedures in place to address FWA.

Record Retention

Health care providers and business partners must maintain documentation and records for requirements and activities outlined in this policy for a minimum of 10 years.

Your Relationships With Downstream Entities

Though Humana is ultimately responsible for any functions performed to support its business, there are also certain requirements that health care providers and business partners must adhere to when entering into a relationship with a downstream entity. The health care provider or business partner must:

- Notify Humana for approval to subcontract any services inside or outside of the United States
- Maintain compliant written agreements with downstream entities
- Maintain adequate oversight of the functions performed downstream
- Confirm that downstream entities adhere to core compliance requirements, including all requirements outlined in this document (such as providing compliance and FWA training to, and conducting exclusion screening of, their employees and those supporting the downstream entities, and monitoring and auditing of any further downstream entities)

Compliance Officer and Compliance Committee, and High Level Oversight

Humana has a chief compliance officer (CCO) who is a full-time Humana associate and chairs the Enterprise Compliance Committee. The CCO, on behalf of the Enterprise Compliance Committee, reports directly to the Audit Committee of the Board of Directors. The CCO reports indirectly to the chief executive officer (CEO), and administratively to the senior vice president and general counsel.

Humana has a separate compliance officer for Medicare and Medicaid who is also a full-time Humana associate and reports directly to Humana's chief compliance officer, has direct access to report any compliance matters to the Audit Committee of the Board of Directors or chief executive officer, and provides quarterly updates to the chief compliance officer on the Company's Fraud, Waste, and Abuse Program. The Medicare and Medicaid compliance officer chairs the Medicare and Medicaid Compliance Committee.

The CCO, chairman of the board and CEO, and the board of directors provide overall leadership and governance for the Enterprise Compliance Plan.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to have a designated compliance resource accountable for overseeing the organization's compliance responsibilities, including those outlined in this document. The personnel assigned must be adequately educated, trained, and qualified to perform compliance functions. Humana is not prescriptive regarding specific qualifications; however, organizations may choose to consider qualifications such as formal education, on the job training, industry experience, compliance experience, continuing education, conferences and seminars in determining adequacy.

II. Communication

Effective Training and Education

Humana requires its associates to annually review its standards of conduct. In addition, associates and members of the board of directors receive compliance and FWA training within 30 days of hire or election and annually thereafter. Associates working in areas of identified substantial risk receive specialized and focused training. These areas include, but are not limited to the following: Claims, Correspondence, Customer Service, Critical Inquiry, Billing and Enrollment, Sales, Underwriting, Grievance and Appeals and Pharmacy.

Health care providers and business partners are required to review Ethics Every Day for Contracted Health Care Providers and Business Partners and to complete the CMS general compliance and FWA training within 90 days of contract and annually thereafter. They are also required to provide standards of conduct and the CMS general compliance and FWA training to employees and any downstream entities. Health care providers and business partners may use their discretion in how training is administered; examples include classroom training, online training modules, or attestations that these audiences have read and received standards of conduct and/or compliance policies and procedures. Instructions for accessing the CMS general compliance and FWA training document are available in Appendix A. Regardless of the method used for training, health care providers and business partners are required to provide proof to Humana that the requirement has been met through completion of an acceptance statement and maintenance of documentation of the time, attendance topic, certifications of completion and test scores of any tests administered (if applicable).

Required Training and Education

All employees and downstream entities of health care providers and business partners are required to receive:

- CMS general compliance training (including Medicare compliance training, if applicable)
- CMS FWA detection, correction and prevention training

(Individuals with Humana system access are required to complete Humana's training(s) for FWA and general compliance and are not required to receive additional or separate training from your organization for that content.)

- Applicable, job-specific compliance training
- Training required in a particular state or by a Humana Medicaid and/or government contract may include, but is not limited to:
  - » Cultural competency training
  - » Health, safety and welfare education training
  - » Medicaid training
  - » Humana orientation training

Sufficient understanding of training received must be demonstrated to the health care provider or business partner prior to performing any functions included under a Humana contract, which may be accomplished through knowledge checks or other means. Humana will provide training content support and monitor completion of required training to those who have Humana system access.

Required Training Timelines

All health care providers and business partners without Humana system access must train on compliance and FWA within 90 days of hiring an employee or contracting with a representative, or downstream entity and annually thereafter. Those employees or downstream entities who receive Humana system security access are required to take Humana's training on ethics and compliance, including FWA, within 30 days of receiving such access and annually thereafter. Additionally, job-specific training must be provided by health care providers and business partners and completed within 30 days of hire or contract to properly perform the functions required.

Deemed Status

Humana recognizes that certain health care providers are deemed to have met FWA education and training requirements through:

- Enrollment into the Medicare program; or
- Accreditation as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

In the case of organizations with multiple locations, such as chain pharmacies, each individual location must be enrolled in Medicare Part A or B to be deemed.

Entities and individuals with deemed status for FWA training are still required to complete the CMS general compliance training.

Noncompliance With Humana's Training Requirements

The following will occur in the event that any employee or downstream entity of a health care provider or business partner is found to be noncompliant with respect to Humana's training requirements or an individual's singular actions demonstrate noncompliance with Humana's compliance expectations:

- Humana will give the organization written notice
- The health care provider or business partner must immediately remove and replace, at its own expense, such employee or downstream entity from supporting Humana-contracted work

If the health care provider or business partner discovers the noncompliance with training requirements, then the health care provider or business partner must remove and replace the employee or downstream entity and notify Humana. In the event that the health care provider or business partner fails to immediately remove and replace the noncompliant employee or downstream entity, as requested by Humana, then Humana may take disciplinary action. This can include a formal corrective action plan, up to termination of the contracted work upon written notice.

Changes Impacting Training

Humana will notify health care providers and business partners when there are changes to a process in a specific contract that require immediate, job-specific training and require the health care provider or business partner to act immediately to provide such training to its employees and any downstream entities.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Complete CMS's general compliance and FWA training within 90 days of contract and annually thereafter.
- Provide compliance policies and standards of conduct to employees and any downstream entities within 90 days of hire or contract and annually thereafter.
- Provide CMS's general compliance and FWA training to employees and any downstream entities within 90 days of hire or contract and annually thereafter. Training documentation should include the time, attendance, topic, certificates of completion (if applicable) and test scores of any tests administered.
- Verify as deemed via a contract between the health care provider and CMS, or a business partner and CMS, which, among other things, affirms the FWA training requirement has been met. Otherwise, remove and replace any employees and any downstream entities who do not receive FWA training within 90 days of hire or contract.
- Provide specialized compliance training on issues posing FWA risks based on an individual's job function when appropriate.

Effective Lines of Communication

Humana communicates with its associates through the company intranet to provide continual awareness of the importance of compliance. Humana also communicates regularly with its health care providers and business partners through a variety of methods, including contracts, administration manuals, newsletters, the Partner Compliance Portal, **Humana.com**, policy communication and annual compliance and FWA training.

Access and Availability of Compliance Officer

The Chief Compliance Officer, J. Gregory Catron, is available to address any suggestions or comments on maintaining ethical behavior, or identifying and preventing fraudulent or criminal misconduct. Associates, health care providers or business partners may contact Mr. Catron through the Ethics Office or call the Help Line at **1-877-5-THE-KEY (1-877-584-3539)**.

Mr. Catron is based in Humana's corporate headquarters: 500 West Main St., Louisville, KY 40202.

Requirement to Report

All Humana associates, members of the governing body, health care providers, and business partners are required to report compliance concerns and suspected or actual compliance and FWA violations to Humana.

Methods for Reporting Suspected or Detected Noncompliance to Humana

Suspected or detected violations of Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners or any related law or policy must be immediately reported by health care providers, business partners, or their employees or downstream entities to Humana through one of these methods:

- Telephonic: Ethics Help Line, **1-877-5-THE-KEY (1-877-584-3539)**
- Online: Ethics Help Line Web reporting site **www.ethicshelpline.com**
- Email: **ethics@Humana.com** (Ethics Office)

Suspected or detected FWA violations may also be reported directly to Humana's Special Investigations Referral department by calling **1-800-614-4126** or emailing **siureferrals@Humana.com**.

Key Features of These Communication Options

- Intake Neutrality: Non-Humana personnel (employed by a separate and independent company) staff the Ethics Help Line.
- Anonymous Reporting: Communication to the Ethics Help Line or Ethics Help Line Web reporting site can be made anonymously. Humana requests that if a reporter desires to remain anonymous, he/she provide enough information to allow Humana to investigate the issue.
- Prohibition Against Intimidation and/or Retaliation: Humana strictly prohibits intimidation and/or retaliation against any health care provider or business partner, or their employees or downstream entities, who, in good faith, reports a detected or suspected violation of ethical standards or FWA.
- Status Update: Regardless of the reporting method used, the individual reporting a suspected or detected violation will receive a confidential identification number that will allow for follow-up on the status of the issue reported, along with a recommended follow-up date.

Health Care Provider and Business Partner Impact

Health care providers and business partners may train their employees and downstream entities on their own ethics and compliance reporting processes; however, the reporting system must meet the following requirements:

- Maintain confidentiality (to the greatest extent possible)
- Allow for anonymity if desired
- Be available 24 hours a day
- Emphasize the policy of non-intimidation and non-retaliation for good faith reporting of compliance concerns, FWA and participation in the compliance program
- Emphasize that reports must be made to Humana

In addition, health care providers and business partners are expected to:

- Widely publicize the methods for reporting compliance and FWA concerns and the non-retaliation policy throughout facilities (examples include: posters, table tents, mouse pads, key cards and other prominent displays)
- Reinforce Humana's policy of non-intimidation and non-retaliation
- Report compliance concerns and suspected or actual compliance and FWA violations to Humana

III. Oversight

Monitoring and Auditing Work Plan

Humana maintains an Anti-Fraud Plan for continuous monitoring of potential fraud, waste, and abuse activity. Humana monitors and audits the activities of associates, members of its health plans and insurance policies, health care providers and business partners. In addition, health care providers and business partners are responsible for maintaining their own comprehensive plan for detecting, correcting, and preventing fraud, waste, and abuse.

Humana also conducts monitoring and auditing activities for its relationships with health care providers and business partners. The activities monitored and audited may include, but are not limited to, both operational performance and compliance requirements applicable to the functions performed and as described throughout this document.

Humana has developed separate monitoring and auditing work plans to address the risks associated with the health care provider and business partner relationships. The implemented work plans enable Humana to determine the nature, timing and extent of the monitoring and auditing process to be performed by Humana.

In order to monitor a health care provider or business partner's compliance obligations, Humana may periodically request the health care provider or business partner to complete a self-assessment, questionnaire or survey, submit documentation, and/or attest to applicable policy, procedure and compliance requirements. Humana may also perform an on-site or desktop audit, which may include inspection of the facilities, systems, books, procedures, audit work plans and results and records that relate to the services provided under the contractual agreement. Health care providers and business partners shall provide timely turnaround of these requests in accordance with the time period specified by Humana.

Disciplinary actions could result from Humana's conducted monitoring and auditing initiatives. These could include, but are not limited to: mandatory (re)training, corrective action plans or contract termination.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Monitor for fraud, waste, and abuse within their organizations and downstream entities
- Comply with any monitoring or auditing requests from Humana
- Develop and implement monitoring and auditing work plans for any functions supporting Humana business that the health care provider or business partner has further contracted to downstream entities

Exclusion Lists

Individuals and entities acting on behalf of Humana, either directly or indirectly, that appear on either the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (OIG) or the General Services Administration list of excluded parties contained within the System for Award Management (GSA) may not support any Humana business function. All health care providers and business partners, and their employees and downstream entities, are required to be screened against both the OIG and the GSA prior to hire or contract and monthly thereafter, and accurate records of such monitoring activity must be retained for a minimum of 10 years.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Query both the OIG and GSA for all employees and downstream entities prior to hire or contract and monthly thereafter
- Promptly remove any individual or entity appearing on either of these lists from any work related to Humana business functions
- Promptly report any such exclusions and actions to Humana

Conflicts of Interest

Humana requires each associate to complete a conflict of interest statement certifying that the individual is free from any conflicts of interest in performing his/her job function. Similarly, employees and downstream entities of Humana's health care providers and business partners must disclose any conflicts of interest annually and upon any change or addition to this status.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Communicate to their employees and downstream entities that any conflict of interest must be disclosed annually and upon receipt of any changes or additions
- Review potential conflicts of interest and either remove the conflicts or, if appropriate, grant approval to continue work despite the conflicts

IV. Investigation, Discipline and Correction

Violation of Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners and other policies and procedures could compromise Humana's integrity and reputation. A violation may also result in a required corrective action, termination of contract and/or reporting of the violation to appropriate regulatory and/or law enforcement authorities.

Humana initiates investigations of any reports of suspected or detected violations of Ethics Every Day for Contracted Health Care Providers and Business Partners and Humana policies and procedures, as well as suspected FWA, as quickly as possible, but not later than within two weeks of identifying the suspected or detected issue. All reported issues are treated confidentially to the greatest extent possible and documentation is maintained.

In the event that corrective actions are imposed on a health care provider or business partner, Humana will monitor and/or audit the health care provider or business partner to confirm that corrective actions have been implemented. Monitoring and auditing following implementation of the corrective action will also occur, as appropriate, to facilitate effective corrective actions.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Widely publicize the disciplinary standards, including the duty and expectation to report noncompliant and unethical behavior and suspected FWA
  - » Examples include: newsletters, regular presentations and department staff meetings, communications with downstream entities, general compliance training, intranet site, posters prominently displayed throughout employee work and break areas, and cafeteria table tents.
- Take prompt disciplinary action when there is noncompliant or unethical behavior by their employees or downstream entities or FWA is discovered, and report such action to Humana.
  - » Humana reserves the right to take additional action if deemed necessary.
- Cooperate fully with any investigation of an alleged violation and/or remedial actions.

Appendix A: Resources

CMS Medicare Parts C and D Fraud, Waste, and Abuse Training and General Compliance Training	1) Navigate to the link below; 2) Scroll to the "Downloads" section; 3) Click on "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training"; 4) Select "Open" or "Save"; the training is available in both PDF and PowerPoint formats http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
OIG Special Advisory Bulletin on Exclusion	Issued in May 2013, this answers common questions on this topic, including screening frequency, liability, how exclusions can be violated, and the administrative sanctions OIG can pursue against those who violated an exclusion http://oig.hhs.gov/exclusions/files/sab-05092013.pdf
CMS Compliance Program Policy and Guidance	The Related Links section of this Web page includes Chapters 9 of the Prescription Drug Benefit Manual and 21 of the Medicare Managed Care Manual https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ComplianceProgramPolicyandGuidance.html
Ethics Every Day for Contracted Health Care Providers and Business Partners	**http://apps.Humana.com/marketing/documents.asp?file=1112774**

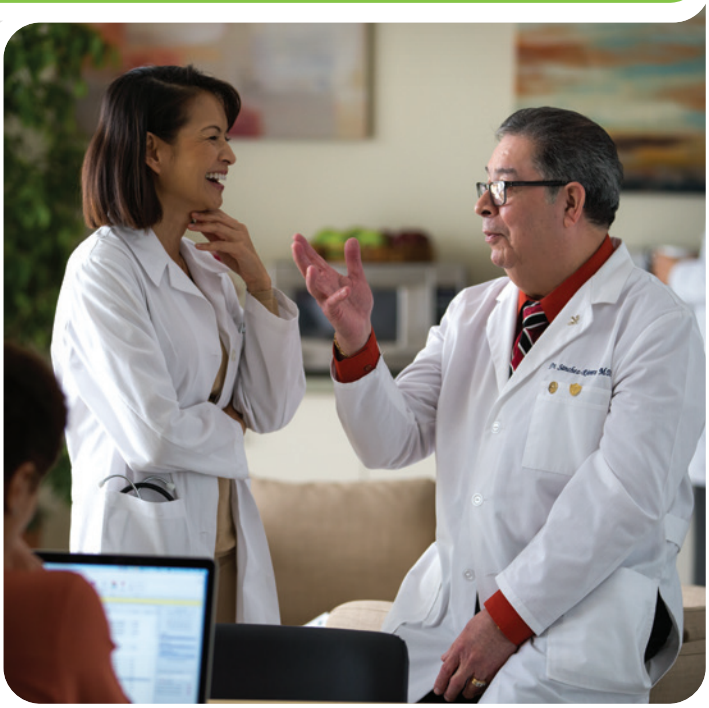
Appendix B: Summary of Applicable Laws and Regulations

Note: Depending on the function your organization performs, not all of the following laws and regulations may be applicable to it.

Title XVIII of the Social Security Act	Passed in 1965, the Social Security Act included Title XVIII, which became known as Medicare. Title XVIII includes Part A, which provides hospital insurance for the aged and disabled, and Part B, which provides medical insurance. To address the Part A and Part B benefits, Medicare offers a choice between an open-network single payer health care plan (known as Original Medicare) and plans administered by private companies approved by Medicare (Medicare Advantage, or Medicare Part C), where the federal government pays for private companies to administer health coverage. Medicare Part D covers outpatient prescription drugs exclusively through plans offered by Medicare-approved private insurance companies. Part D plans can either be stand-alone prescription drug plans or through included in a Medicare Advantage plan that offers prescription drugs. Humana offers part C and D plans, therefore, the laws and regulations related to Part C and D plans, many of which are listed below, impact your relationship with Humana. http://www.ssa.gov/OP_Home/ssact/title18/1800.htm
Regulations governing Medicare Parts C and D, and Medicaid, where applicable, found at 42 C.F.R. §§ 422 and 423 respectively	CCMS has outlined compliance program guidelines in its Prescription Drug Benefit Manual, Chapter 9 and Medicare Managed Care Manual, Chapter 21. That combined manual is an interpretation of the compliance program requirements and related provisions in C.F.R. §§ 422 and 423 for Medicare Advantage Organizations (MAO) and Medicare Prescription Drug Plans (PDP). As a result, Humana's compliance program incorporates the seven elements of an effective program as outlined by CMS. C.F.R. §§ 422.503: http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div8&view=text&node=42%3A3.0.1.1.9.11.5.4&idno=42 C.F.R. 422.504: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=c41f978c39319dbc1d0a601eba47dee%200&ty=HTML&h=L&r=SECTION&n=se42.3.422_1504 C.F.R. §§ 423.504: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=808d3484cc31371f557c19a256928842&ty=HTML&h=L&r=SECTION&n=42y3.0.1.1.10.11.5.5
Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119)	This extensive act is most known for the increased rights and protections it establishes for consumers, but it has many provisions, known as titles. The core elements of this act include, but are not limited to, the following: • Where/how to purchase coverage is being expanded • New benefits are offered for those eligible for coverage • There are shifts in who is eligible for receiving and retaining coverage and under what arrangements • Organizations offering insurance, like Humana, are subject to greater accountability The act will change payment (amounts) and reimbursement(s) for certain benefits, as well as increase the ability to appeal claims, which may impact enrollment and claims processing. This could ultimately affect your relationship with Humana and/or how your organization maintains records and/or tracks payments. There are other titles that could also impact your organization, although not directly in regard to Humana. Therefore, the act is available here for review: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
Federal Acquisition Regulation	This regulation prohibits gifts with greater than $15 fair market value from being given to, or received from, the government. The exceptions are: • Modest items of snacks and refreshments (such as soft drinks, coffee and donuts) offered other than as part of a meal if made available to everyone in attendance • Promotional or marketing materials (e.g., pens, pencils, note pads and calendars) valued at $15 or less • Tokens of appreciation (e.g., command coins or patches) with the command's/unit's logo, valued at $15 or less
Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191)	Per the U.S. Department of Labor, HIPAA was initially passed in 1996 to "improve portability and continuity of health insurance coverage." As a result, there are more consumer protections regarding options for coverage. http://aspe.hhs.gov/admnsimp/pl104191.htm Later "rules," or provisions, were passed in 2001 and 2003 to protect the privacy, confidentiality and security of individually identifiable health information. This includes the establishment of security standards for electronic protected health information. Your organization, as well as Humana, is required to have sufficient safeguards regarding this type of information, including who may access it, how much of it may be accessed by any individual and how it is retained and transmitted. http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html http://www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html

False Claims Acts (31 U.S.C. §§ 3729-3733	This act gives the federal government leverage against persons/entities involved in fraudulent activities with the government. This allows financial liability in the form of a civil penalty and damages to be imposed for submitting, or causing someone to submit, a false or fraudulent claim for government payment. http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37- subchapIII-sec3729.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37- subchapIII-sec3730.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37-subchapIII-sec3731.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37- subchapIII-sec3732.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37- subchapIII-sec3733.pdf
Federal Criminal False Claims Statutes (18 U.S.C. §§ 287,1001)	Section 1001 applies to anyone whose action(s) related to any claim(s) for government payment consist(s) of any of the following: • Falsifying, concealing, or covering up by any trick, scheme or device a material fact related to any claim(s) for government payment; • Making any materially false, fictitious or fraudulent statement or representation; • Making or using any false writing or document knowing it contains any materially false, fictitious or fraudulent statement or entry. Section 287 states that whoever makes or presents to the government a claim knowing that it is false, fictitious or fraudulent shall be imprisoned and subject to fines. The government is required to establish all of the following in regard to the action(s) of a false claim(s) case defendant. He/she: • Made or presented a false, fictitious or fraudulent claim to a department of the United States; • Knew the claim was false, fictitious or fraudulent; and • Did so with the specific intent to violate the law or with awareness that what s/he was doing was wrong. http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-partI-chap15-sec287.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-partI-chap47-sec1001.pdf
Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))	This federal statute prohibits any individual or entity from knowingly and deliberately offering, giving or receiving money or something of value in exchange for referrals of health care goods or services that will be paid for in whole or in part by Medicare or Medicaid. http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm#f
The Beneficiary Anti-Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))	This federal statute declares that any person who gives or offers to give anything of value* to a Medicare or Medicaid beneficiary that the person knows or should know is likely to influence a beneficiary's choice of a particular health care provider, practitioner or supplier to buy or rent a Medicare or Medicaid covered item from the provider, practitioner or supplier may be liable for civil money penalties of up to $10,000 for each wrongful act. http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXI-partA-sec1320a-7a.pdf * The OIG stated in guidance that there is a "nominal value" exception that allows a health care provider to give: • A gift to a beneficiary as long as the gift has a retail value of $10 or less • Multiple gifts of $10 or less over a 12-month period, as long as the total retail value of the gifts does not exceed $50 Any such gift must not be in cash or cash equivalents, so it should not be a gift card or gift certificate. Types of gifts and their value(s) are detailed in a Special Advisory Bulletin from the OIG: http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf
Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the federal government (42 U.S.C. §1395w-27(g)(1)(G)	The expectations of CMS and Humana in regard to screening government exclusion lists have been outlined in the oversight section on page 9 of this policy and in this federal provision: http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXVIII-partC-sec1395w-27.pdf

Civil monetary penalties of the Social Security Act (42 U.S.C. § 1395w-27 (g))	This provision of the Social Security Act describes the penalties that can be assessed to organizations that offer Part C and/or Part D plans should CMS determine they do not meet the requirements outlined in their contract(s) with CMS. Your organization is impacted by this act if it supports and/or sells any of Humana's Medicare Advantage or Prescription Drug products. Examples of such impactful provisions include, but are not limited to: • Enrolling an individual in any such plan without the prior consent of the individual or the individual's designee • Failing to re-enroll an eligible individual • Denying or discouraging an eligible individual from plan enrollment • Noncompliance with marketing restrictions surrounding these plans • Failing substantially to provide medically necessary items and services that are required (under law or contract) {to an individual covered under the contract http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXVIII-partC-sec1395w-27.pdf
Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn)	This statute: • Prohibits a physician from making referrals for certain designated health services 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 • Prohibits the entity from presenting, or causing to be presented, claims to Medicare (or billing another individual, entity or third party payer) for those referred services * Specific exceptions have been established, and the federal government has the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse. Please refer to the following link for a list of the established exceptions and additional information: https://www.cms.gov/PhysicianSelfReferral/
Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act	This act could be considered an extension of HIPAA, as it enabled the U.S. Department of Health and Human Services to promote and expand the adoption of health information technology. It addresses: • Use of electronic health records, including incentives for adopting them and requirements around their disclosure • How to secure protected health information appropriately • When and to whom notifications should made in regard to data breaches of unsecured protected health information (PHI) http://www.healthit.gov/policy-researchers-implementers/health-it-legislation-and-regulations
Fraud Enforcement and Recovery Act of 2009	This act improves the enforcement of various kinds of fraud related to federal assistance and relief programs, the recovery of funds lost to these frauds, and for other purposes. It increased resources for investigation and prosecution of fraud cases and made recovery under the False Claims Act, 31 USC § 3729 statute easier. http://www.gpo.gov/fdsys/pkg/PLAW-111publ21/pdf/PLAW-111publ21.pdf
CMS Data Use Agreement	Humana's Compliance Policy and Ethics Every Day for Contracted Health Care Providers and Business Partners incorporate the overarching aspects of the CMS Data Use Agreement to facilitate the proper safeguarding of all data, including CMS-related data, by Humana and health care providers and business partners, regardless of whether support is provided for Humana's Part C and/or Part D offerings. The overarching components of the CMS Data Use Agreement are as follows: **Disclosure**, use, or reuse of the data covered by the agreement between CMS and Humana must only be for the purpose(s) specified within the agreement, unless CMS provides appropriate authorization for any other purpose(s). • Any individual's access to the data must only be on a need-to-know basis • Data access must be limited to the minimum amount of data and minimum number of individuals necessary to achieve the purpose stated in the agreement **Sufficient Data Safeguards** for the storage and disclosure of data/information must be established from the following perspectives: administrative, technical and physical. Together these measures assure data confidentiality is protected and that unauthorized use or access to it is prevented. **Handling of Suspected or Detected Breaches** • This matter is addressed in the Effective Communications section of this policy under "Methods for Reporting Suspected or Detected Noncompliance to Humana" A signed CMS Data Use Agreement provides CMS with assurance of compliance with the requirements of the Privacy Act, the Privacy Rule, and CMS data release policies when CMS data is utilized by anyone outside of CMS. The agreement must be completed and updated when applicable by Humana. Upon CMS' receipt of the completed agreement, CMS provides Humana with, and/or access to, data containing, but not necessarily limited to, protected health information and individual identifiers from CMS' Systems of Record. It is your responsibility to consult with your legal counsel to determine when/if there are instances that the CMS Data Use Agreement applies to your organization.
All sub-regulatory guidance produced by CMS and HHS such as manuals, training materials, HPMS memos, and guides	Vast guidance resources are available on the following websites: **CMS:** https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html **U.S. Department of Health and Human Services:** http://www.hhs.gov/ http://www.hhs.gov/regulations/index.html



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