First Tier, Downstream and Related Entity, Marketplace Delegate And Subcontractor Compliance Guide

McLaren Health Plan, Inc.

McLaren Health Plan Community

McLaren Health Advantage

McLaren Advantage

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McLaren's Compliance Program

This Compliance Guide encompasses McLaren Health Plan, Inc., McLaren Health Plan Community, McLaren Health Advantage, their subsidiaries and all product lines. All entities will be referred to as "McLaren" in this document.

McLaren's Compliance Program is designed to:

- Reduce or eliminate fraud, waste, abuse, and acts of non-compliance;
- Ensure McLaren's compliance with applicable regulations; and
- Reinforce McLaren's commitment to zero-tolerance for such activities.

McLaren has a legal requirement to provide information and education to those individuals, entities, businesses and providers with whom we work. The Centers for Medicare and Medicaid (CMS), the Michigan Department of Health and Human Services (MDHHS) and various other agencies provide guidance and regulatory oversight of our Compliance Program.

Introduction to the First Tier, Downstream, and Related Entity (FDR), Marketplace Delegate and Subcontractor Compliance Guide

This Compliance Guide is a resource designed to assist our FDRs, Marketplace Delegates and Subcontractors with understanding of the McLaren Compliance Program and requirements by:

- Demonstrating McLaren's commitment to responsible corporate conduct;
- Setting forth the FDR, Marketplace Delegate and Subcontractor compliance requirements;
- Publicizing mechanisms for reporting fraud, waste, abuse and compliance issues;
- Communicating information about McLaren's Standards of Conduct and the compliance policies in place to detect, prevent, correct, and monitor fraud, waste, abuse and non-compliance;
- Defining and providing examples of fraud, waste and abuse; and
- Providing information about relevant laws and regulations.

I. What is an FDR, Marketplace Delegate or Subcontractor?

McLaren uses the CMS current definitions to define "FDR":

First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provided administrative services or healthcare services to a Medicare eligible individual under the Medicare Advantage program or Part D program.

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Related Entity means any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and:

a. Performs some of the Medicare Advantage Organization or Part D Plan Sponsor's management functions under contract or delegation;
b. Furnishes services to Medicare enrollees under an oral or written agreement; or
c. Leases real property or sells materials to the Medicare Advantage Organization or Part D sponsor at a cost of more than $2,500 during a contract period.

42 CFR 156.340 Defines the **Marketplace Delegate** as any party, including an agent or broker that enters into an agreement with a Qualified Health Plan (QHP) issuer to provide administrative services or health care services to qualified individuals, employers, or employees and their dependents.

Marketplace Downstream Entity means any party, including an agent or broker that enters into an agreement with a delegated entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer. The term "downstream entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, employers, or employees and their dependents.

The MDHHS definition of **Subcontractor** is any person or entity that performs required, ongoing administrative or Health Benefit management functions.

A **Health Benefit Manager** is any entity that arranges for the provision of health services covered, excluding transportation, under a written contract or agreement with McLaren.

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II. FDR, Marketplace Delegate and Subcontractor Compliance Requirements

McLaren's commitment to compliance includes ensuring that our FDRs, Marketplace Delegates and Subcontractors comply with applicable state and federal regulations. McLaren contracts with these entities to provide administrative and healthcare services to our enrollees. We are ultimately responsible for fulfilling the terms and conditions of our contract with CMS and meeting their program requirements. Therefore, McLaren requires each FDR, Marketplace Delegate and Subcontractor to comply with the compliance and fraud, waste and abuse expectations listed in the guidance. Failure to meet the requirements may lead to a Corrective Action Plan (CAP), retraining, or the termination of a contract and relationship with McLaren Health Plan.

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

FDRs, Marketplace Delegates and Subcontractors must maintain supporting documentation of compliance with the requirements listed in this guidance for a period of ten years, and must furnish evidence of such compliance to McLaren upon request for monitoring and auditing purposes.

A. Annual FDR and Subcontractor Compliance Attestation

An authorized representative from each FDR and Subcontractor is required to complete the McLaren FDR or Subcontractor Compliance Attestation (on behalf of his/her organization). This is done upon execution of a contract and on an annual basis to attest to compliance with the Standards of Conduct, compliance policies, fraud, waste and abuse training, OIG and GSA exclusion screening, and publication of fraud, waste and abuse and compliance reporting mechanism requirements.

An authorized representative is an individual who has responsibility -- directly or indirectly -- for all employees, contracted personnel, providers/practitioners, and subcontractors who provide healthcare or administrative services under Medicaid and/or Medicare. Authorized representatives may include, but are not limited to, the company Chief Executive Officer, Chief Operating Officer, Compliance Officer, Chief Medical Officer, Practice Manager/Administrator or similar related positions.

McLaren will send a notification to each FDR and Subcontractor to communicate the deadline for completion of the annual Attestation. All FDRs and Subcontractors must complete the Attestations within the designated timeframe.

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B. Standards of Conduct and Compliance Information

McLaren requires each FDR, Marketplace Delegate and Subcontractor to establish and sustain a culture of compliance. McLaren's FDRs, Marketplace Delegates and Subcontractors must either:

> •Establish and publicize comparable Standards of Conduct that meet CMS requirements set forth in 42 CFR 422.503(b)(4)(vi)(A) and 42 CFR 423.504 (b)(4)(vi)(A) and reflect a commitment to preventing, detecting, and correcting non-compliance; or
>
> •Adopt and distribute to all employees and contractors McLaren's Standards of Conduct, which is Appendix 1 of this Guide.

In addition to the Standards of Conduct, each FDR, Marketplace Delegate and Subcontractor must distribute compliance information to all employees and contractors upon hire/contract and annually thereafter. McLaren provides compliance information in this Guide that can be used. If an FDR, Marketplace Delegate or Subcontractor opts to use different material, McLaren must approve it in advance of use and it must include at a minimum:

- A description of the Compliance Program;
- Instructions on how to report suspected non-compliance;
- The requirement to report potential non-compliance and fraud, waste and abuse;
- Disciplinary guidelines for non-compliant behavior;
- A non-retaliation provision;
- Fraud, waste and abuse training requirements; and
- An overview of relevant laws and regulations (see section on Relevant Laws and Regulations).

FDRs, Marketplace Delegates and Subcontractors much maintain records (e.g., attestations) to document that each employee and contractor has received, read, understood, and will comply with the written Standards of Conduct and compliance policies upon hire/contract and annually thereafter.

C. General Compliance and Fraud, Waste and Abuse Training

FDRs, Marketplace Delegates and Subcontractors are required to complete general compliance and fraud, waste and abuse training within 90 days of contract/hire and annually thereafter. The training requirement extends to all employees and contractors that are involved in McLaren products. Each FDR, Marketplace Delegate and Subcontractor will be required to attest that all employees and contractors have met the training requirement via:

- Accessing the CMS training presentation at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf, and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf or
- CMS Deemed fraud, waste and abuse training through enrollment into Parts A or B of the Medicare program.

Each FDR, Marketplace Delegate and Subcontractor is responsible for maintaining evidence of fraud, waste and abuse training, which may include training logs, attestations and training programs. McLaren reserves the right to perform a random sampling audit to ensure FDR, Marketplace Delegate and Subcontractor compliance.

D. OIG and GSA Exclusion Screening

Federal law prohibits the payment by Medicare, Medicaid or any other federal healthcare program for any item or service furnished by a person or entity excluded from participation in these federal programs. Therefore, **prior** to hire or contract and **monthly thereafter**, each FDR, Marketplace Delegate and Subcontractor must perform a review to confirm that employees and contractors are not excluded from parting in federally funded healthcare programs according to the OIG and GSA exclusions lists.

The websites utilized to perform the required screenings are:

- OIG List of Excluded Individuals/Entities (LEIE): http://oig.hhs.gov/exclusions/exclusions_list.asp
- General Services Administration (GSA) database of excluded individuals/entities: https:///www.sam.gov/portal/public/SAM/#1

If an employee or contractor appears on an exclusion list, he or she must be removed from any work directly or indirectly related to federal healthcare programs, and appropriate corrective action must be taken.

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

E. Reporting Fraud, Waste, Abuse, and Compliance Issues

McLaren's FDRs, Marketplace Delegates and Subcontractors have a responsibility to report any alleged compliance, fraud, waste and abuse, and/or conflict of interest issues that involve McLaren.

FDRs, Marketplace Delegates and Subcontractors may confidentially report a potential violation of McLaren compliance policies or any applicable regulation by utilizing the following methods:

McLaren Reporting

- McLaren's 24/7 confidential and anonymous hotline (866) 866-2135, **Or**
- email at mhpcompliance@mclaren.org, **Or**
- in writing to: Compliance Officer, McLaren Health Plan, G-3245 Beecher Rd, Flint, MI 48532.

Medicare Reporting

- Office of Inspector General at (800) HHS-TIPS (447-8477) TTY 800-377-4950, **Or**
- in writing to: U.S. Department of Health and Human Services, ATTN: Hotline, P.O. Box 23489, Washington, DC 20026, **Or**
- online at: www.oig.hhs.gov/fraud/report-fraud.

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

Medicaid Reporting

- Office of Inspector General, P. O. Box 30062, Lansing, MI 48909, **Or**
- by phone at: (855) MI-FRAUD (643-7283), **Or**
- online at: www.michigan.gov/fraud.

McLaren requires each FDR, Marketplace Delegate and Subcontractor to publicize confidential reporting mechanisms for all employees and contractors. If an FDR, Marketplace Delegate or Subcontractor does not maintain a confidential reporting mechanism, the McLaren Confidential Hotline, and email information must be distributed to encourage reporting of potential compliance issues, fraud, waste, abuse, conflict of interests, violations of compliance policies and/or any applicable regulation.

III. McLaren's Standards of Conduct

The McLaren Health Plan Standards of Conduct provides guidance to FDRs, Marketplace Delegates and Subcontractors regarding the ethical and legal standards of our Compliance Program. We expect that every FDR, Marketplace Delegate and Subcontractor respect these principles and conduct business with, and on behalf of McLaren in accordance with them. Failure to follow the Standards of Conduct may lead to termination of a contract and relationship with McLaren. The McLaren Standards of Conduct is included as Appendix 1.

IV. Fraud, Waste and Abuse

What is fraud, waste and abuse?

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste is the excessive, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.

Abuse means practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost or, in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards of care. It includes enrollee practices that result in unnecessary cost.

A. Common methods of fraud waste and abuse

Fabrication of claims: In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct fictitious claims, or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed.

Falsification of claims: In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim, for obtaining a payment to which he or she is not entitled.

Unbundling: In unbundling, a provider submits a claim reporting a comprehensive procedure code (e.g., resection of small intestine) along with multiple incidental procedure codes (e.g., exploration of abdominal and exploration of the abdomen) that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

Fragmentation: In fragmentation, a provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (antepartum care, vaginal delivery and obstetric care) that includes the three components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

Duplicate claim submissions: In duplicate claim submissions, a provider submits claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

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Fictitious Providers: There has been fraud where perpetrators obtain current membership information from operatives working in billing offices of legitimate providers (usually hospitals), and submit claims for services.

B. Indicators of Fraud

There are many indicators of fraud which, if noticed by McLaren staff, FDRs, Marketplace Delegates or Subcontractors, should be brought to the attention of the Compliance Department. Examples of the most common indicators are:

- Addition of services to bill;
- Claims for more than one pharmacy for the same member in a short period of time;
- Claims that have been handwritten or changes made by hand;
- Diagnosis is inconsistent with age or sex;
- Eligibility file date of birth does not match date of birth on claim (indication ID card has been shared);
- Impossible or unlikely services for age or sex;
- Inconsistency between provider type and/or specialty and services rendered
- Indication that coinsurance has been waived (which, in some circumstances is not permitted by contract or law);
- Large distance between provider and member locations;
- Provider with more than a few lost or stolen checks;
- Provider demanding immediate payment for claims;
- Reluctance or failure to submit medical records when requested;
- Submission of identical claims for more than one member or family member.

V. Relevant Laws and Regulation

A. Deficit Reduction Act

As a participant in the Medicaid Program, McLaren must comply with the terms of the Deficit Reduction Act of 2005 (the “DRA”). The DRA (and specifically Section 6033, entitled “Employee Education About False Claim Recovery” which was effective January 1, 2007), requires any organization that receives $5 million or more in Federal Medicaid funds annually, including payments from managed care organizations such as McLaren Health Plan, to adopt a compliance program in accordance with Federal law, and to inform its employees and any contractor or agent of the terms of the False Claims Act. Any organization that does not comply with the requirements may be denied Medicaid reimbursement.

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B. False Claims Act (FCA)

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistleblowers) can help reduce fraud against the government. The act allows everyday people to cooperate with the government to sue groups or other individuals that are defrauding the government through programs, agencies or contracts (the act does not cover tax fraud). Examples of violations of the FCA are:

- Knowingly presenting a false or fraudulent claim for payment;
- Knowingly using a false record or statement to get a claim paid.

C. FCA Penalties

Those who defraud the government, can end up paying triple the damage done to the government or a fine for every false claim (currently between $5,500 and $11,000 per claim). These monetary fines are in addition to potential jail time, revocation of licensure and/or becoming an individual excluded from participating or receiving money from Medicare or Medicaid.

D. FCA Whistleblower Protections

If the government moves forward with a case an individual reported, that individual is generally entitled to receive a percentage of any recovered funds once a decision has been made.
Federal statutes and related State and Federal laws shield employees from retaliation for reporting illegal acts of employers. An employer cannot retaliate in any way, such as discharging, demoting, suspending or harassing the whistleblower.

E. Stark Law

Also known as, "Physician Self-Referral" 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, unless an exception applies. The statute prohibits the submission of claims to Medicare for those referred services.

F. Anti-Kickback Statute

The Anti-kickback Statue provides for criminal penalties for certain acts which affect Medicare and Medicaid or any other Federal or State funded program. If an individual solicits or receives any remuneration in return for referring an individual to a person (doctor, hospital) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any goods or services from any healthcare facilities, programs or provider.

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VI. Health Insurance Portability and Accountability Act (HIPAA) and HITECH Act

A. HIPAA Privacy

The HIPAA Privacy Rule requires providers to take reasonable steps to protect and safeguard the Protected Health Information ("PHI") of members/patients. A member's PHI is subject to the protections established by the Privacy Rule, and under the contractual relationship between McLaren and the member, and under the contractual relationships between McLaren and the provider, FDR or Subcontractor. PHI includes information regarding enrollment with McLaren, medical records, claims submitted for payment, etc. Such PHI must be safeguarded and held in strict confidence to comply with applicable privacy provisions of State and Federal laws.

B. HIPAA Security

The HIPAA Security Rule requires covered entities to adopt national standards for safeguards to protect the confidentiality, integrity, and availability of electronic protected health information (e-PHI) that is collected, maintained, used or transmitted by a covered entity. McLaren must ensure that FDRs and Subcontractors have the appropriate administrative, technical and physical safeguards in place to protect the data that is being electronically accessed by staff, employees, FDRs, and Subcontractors. All must:

- Ensure the integrity and confidentiality of the information by protecting against
    - Any reasonably anticipated threats or hazards to the security or integrity of the information; and
    - Unauthorized uses or disclosures of the information.

This can be accomplished by establishing appropriate policies and procedures that outline compliance with the Rule and expectations of staff, employees and contractors in complying with the Rule.

A member's PHI must be safeguarded, and only those employees of the covered entity, who have a business reason to access the information, should be permitted to do so.

Examples of PHI are a:

- Member's name
- Address
- Member's contract number
- Date of Birth
- Social Security Number
- Description of Services

McLaren Health Plan

Standards of Conduct

A Guide to Ethics and Compliance

Appendix 1

Approved by the Board of Directors June 21, 2016

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The primary purpose of McLaren Health Plan (MHP) is to arrange for the provision of health care services in the communities we serve. Therefore, the integrity of everyone connected with this organization is especially important.

Employees of MHP must conduct business with integrity and honesty. Therefore, it is important that all employees of MHP always discharge their duties to the best of their ability, in the best interest of the members, and in the best interest of MHP.

Understanding your obligations, as an employee of MHP, is the highest priority. This Standards of Conduct (SOC) document is intended to provide you with guidelines in written format.

Our Standards of Conduct

I. General Principles

All MHP employees and contractors shall conduct their daily activities in accordance with the following general principles of conduct:

1) Job duties are performed in full compliance with both the letter and the spirit of Federal and State law. No employee shall take any action that he or she believes is in violation of any statute, rule or regulation. All employees are expected to have a practical working knowledge of Federal and State laws and regulations that affect their job responsibilities, and to ask their immediate supervisor for guidance when questions arise.
2) Conduct activities with integrity and honesty. MHP employees shall strive for excellence in performing their duties.
3) Avoid any conduct that could reflect adversely upon the integrity of the company, its officers, directors or other employees.
4) Be a positive influence and good corporate citizens in the communities where MHP provides services. Treat members, providers, contractors, and fellow employees fairly and with respect.
5) Report to your supervisor or to the MHP Compliance Officer any suspicion of illegal or unethical practices of MHP employees, contractors or agents.
6) Abide by the MHP Compliance Plan and all other applicable policies and procedures.

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II. Avoiding Conflicts of Interest

MHP employees and contractors shall:

1) Understand and abide by MHP's Conflict of Interest policy.
2) Avoid situations that could create, or appear to create, a conflict of interest unless such a situation has been reported to management, approved and properly disclosed as required by the Conflict of Interest policy.
3) Avoid any financial, business, or other activity that competes with the business interests of MHP, interferes or appears to interfere with the performance of your duties, or involves the use of MHP property, facilities, or resources, except to the extent consistent with the Conflict of Interest policy.

III. Business and Financial Practices

MHP employees and contractors shall:

1) Conduct all MHP business transactions in accordance with management's general or specific directives, as specified by applicable MHP policies and procedures, and in full compliance with governing Federal and State laws, rules, and regulations.
2) Avoid offering or accepting any form of bribe, payment, gift or item of more than a nominal value to or from any person or entity with which MHP has or is seeking a business or regulatory relationship.
3) Avoid unfair competition or deceptive trade practices, including misrepresentation of MHP's products or operations. MHP employees and contractors shall not make false or disparaging statements about competitors or their products.
4) Comply with applicable antitrust laws. There shall be no discussions or agreements with competitors regarding price or other terms for products, prices paid to suppliers or providers, dividing customer or geographic markets, or joint action to boycott or coerce certain customers, suppliers, or providers.

IV. Workplace Standards

MHP employees and contractors shall, at all times while on the job or otherwise representing MHP:

1) Conduct yourselves professionally and treat all fellow employees, members, contractors, or other individuals you encounter in the course of your duties, with appropriate courtesy, dignity, and respect.

2) Avoid any type of behavior or conduct that can be construed as discrimination or harassment due to age, ethnicity, gender, religion, national origin, disability sexual orientation, or covered veteran status. Any form of harassment, sexual or otherwise, including the creation of a hostile working environment, is completely prohibited.
3) Follow safe work practices and comply with all applicable safety standards and health regulations.

V. Financial Reporting and Information Security

At MHP, we create, collect and maintain a large amount of data to conduct our business. We are responsible for ensuring that information, including financial data, is secure and reported accurately according to the following standards:

1) Any time you contribute data to an external or internal report you must be thorough, complete and accurate to assure that others who use or review the information are not misled.
2) MHP management maintains a system of internal controls to provide reasonable assurance that MHP meets financial and other data reporting obligations.
3) We are all responsible for protecting our member, provider and employee information, as well as information that is proprietary to MHP. Security is everyone's responsibility.
4) Keeping accurate records is important to MHP and our business. Billing laws, accreditation standards and Federal and State regulations set specific guidelines for record keeping and record management.

VI. Prohibited Affiliations

MHP does not do business with individuals and organizations that have been excluded or sanctioned under Federal health care programs or other Federal contracts or who have other restrictions on their eligibility to work with government contractors.

1) We check all employees, board members, contractors, providers and delegated entities for exclusions or sanctions on a monthly basis. If you become aware that we have a relationship with an individual or company that is a prohibited affiliation, you should report it immediately to your supervisor or the Compliance Officer. Employees who have been suspended, excluded, or debarred from participation in any of the above named programs shall immediately inform the Human Resource Department and the Compliance Officer in writing.

VII. Preventing, Detecting and Correcting Fraud, Waste and Abuse (FWA)

MHP is strongly committed to the detection and prevention of FWA through reporting, investigating, monitoring and auditing providers, members, employees and contractors. MHP employees and contractors shall:

1) Comply with applicable laws, regulations, guidelines and MHP policies.
2) Immediately report suspected FWA conduct to the Compliance Department.
3) Cooperate fully with, and disclose all pertinent information with regard to any MHP investigation of suspected FWA conduct.

VIII. Anonymous Reporting

MHP employees and contractors may report suspected illegal activity or improper conduct anonymously by calling (866) 866-2135. MHP shall:

1) To the extent permitted by Federal and State law, take reasonable precautions to maintain the confidentiality of those individuals who report illegal activity or improper conduct, and of those individuals involved in the alleged violation, whether or not it turns out that improper acts occurred.
2) Failure to abide by this confidentiality obligation is a violation of this Code.

IX. Investigations and Duty to Cooperate

It is MHP's policy to promptly and thoroughly investigate all reports of illegal activity or improper conduct. Detection of potential or actual issues related to compliance, ethical conduct or other measurable areas of performance should result in the initiation of appropriate corrective action.

Any action, or lack of action, that prevents, hinders, or delays discovery and full investigation of suspected illegal activity or improper conduct is a violation of this Code, and may be a violation of Federal and/or State law.

1) Internal investigations will include interviews and review of relevant documents. MHP employees and contractors are required to cooperate fully with, and disclose all pertinent information with regard to any MHP investigation of suspected illegal activity or improper conduct.

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2) MHP, its employees and contractors shall cooperate with appropriate government investigations into possible civil and criminal violations of Federal and/or State law. It is important, however, that in this process, MHP is able to protect the legal rights of MHP and its personnel. To accomplish these objectives, any governmental inquiries or requests for information, documents or interviews must promptly be referred to the MHP Compliance Officer and the Vice President of Regulatory Affairs and General Counsel.

X. Protection from Retaliation

MHP ensures that employees and contractors may report or assist investigation of suspected illegal acts or improper conduct without threat of negative consequences. Therefore:

1) No retaliation, reprisals or disciplinary action will be taken or permitted against MHP employees or contractors for good faith participation in the Compliance Program, including but not limited to reporting potential issues to appropriate authorities, cooperating in the investigation of suspected illegal activities or improper conduct, and conducting self-evaluations, audits and remedial actions.
2) Failure to abide by this prohibition against retaliation or reprisals is a violation of this code, and may be a violation of Federal and/or State law.

XI. Disciplinary Action

MHP employees and contractors who engage in illegal activity or improper conduct, including violation of this Code or any other MHP policy, are subject to disciplinary action including oral or written warnings or reprimands, suspensions, termination, financial penalties and potential reporting of the conduct to law enforcement. If employees or contractors self-report their own illegal actions or improper conduct, MHP will take such self-reporting into account in determining appropriate disciplinary action.

XII. Marketing and Sales/Enrollment Activities

MHP will take appropriate steps to ensure that its marketing and sales personnel present clear, complete and accurate information to potential enrollees. This includes ensuring that the marketing information has been approved by, and complies with all requirements of, the Michigan Department of Health and Human Services (MDHHS) for Medicaid business, the Centers for Medicare and Medicaid (CMS) for Medicare business and the Michigan Department of Insurance and Financial Services (DIFS) for commercial business.

MHP employees and contractors shall:

1) Comply with applicable Federal and State laws, regulations, guidelines and MHP policy, including the Medicare Marketing Guidelines, with respect to all marketing, sales and enrollment activities.
2) Always place the best interests of potential enrollees and MHP above personal financial interests.
3) Present clear, complete, accurate information, and ensure that potential enrollees have the opportunity to make a well-informed enrollment decision. This includes utilizing only marketing materials and information that have been approved by, and comply with all Federal and State requirements as well as MHP requirements.
4) Avoid providing any information or engaging in conduct that might in any way misrepresent MHP or its programs, or mislead, confuse, coerce or pressure potential enrollees.
5) Never offer cash payments, gifts, bribes or kickbacks to any person or entity to induce enrollment in MHP plans or programs.
6) Never engage in door-to-door solicitation of Medicare or Medicaid contracted products or programs.

If you have questions or concerns about the Standards of Conduct, contact your immediate supervisor, the Human Resources Department or the Compliance Officer.

Remember, you can report a concern anonymously at (866) 866-2135.

XIII. McLaren Health Plan's Commitment to Compliance

McLaren has systems, policies and procedures in place to detect, correct, prevent and monitor issues of non-compliance.

1) Monitoring and Auditing

McLaren routinely monitors and periodically audits first tier entities to ensure compliance administration of the Medicare and Medicaid contracts as well as applicable laws and regulations. Each first tier entity is required to cooperate and participate in the monitoring and auditing activities. If a first tier entity performs its own audits, McLaren may request the audit results affecting McLaren's business. In addition, first tier entities are expected to routinely monitor and periodically audit their downstream entities.

If McLaren determines that a FDR or Subcontractor does not comply with any of the requirements set forth in this guidance, the FDR or Subcontractor will be required to develop and submit a Corrective Action Plan (CAP). McLaren will assist the FDR or Subcontractor in addressing the issues identified.

All monitoring and auditing activities must be documented and retained for a ten-year period. McLaren may require evidence of monitoring and auditing for future oversight and/or auditing purposes.

2) **McLaren Health Plan Investigations**

It is McLaren's policy to objectively and thoroughly investigate any specific allegation of misconduct, fraud or abuse involving McLaren employees, accounts or operations. McLaren holds individuals responsible for violations of McLaren's policies, breaches of ethical behavior or illegal acts committed against McLaren, on McLaren's behalf, on McLaren premises, or during hours of, or within the scope of McLaren business operations. The source of any allegation of wrongdoing, whether on the McLaren hotline, through an email, telephone or in person report, or any other source, is irrelevant to McLaren's obligation to investigate. McLaren will conduct all investigations in a manner that protects the rights of those who may be the subject of allegations of wrongdoing as well as those who, in good faith, make such allegations.

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

McLaren is required to refer potential fraud or misconduct related to the Medicare Prescription Drug Program to the HHS-OIG and the Medicare Drug Integrity Contractor (MEDIC). Potential fraud, waste and abuse related to the Medicaid program are reported to the Michigan Department of Health and Human Services, Office of Inspector General.

3) Non-Retaliation

McLaren is committed to a culture that promotes the prevention, detection, investigation and remediation of violations of the McLaren Standards of Conduct, as well as all applicable laws. To support this culture, McLaren has established a strict non-retaliation policy to protect employees and FDRs and Subcontractors who in good faith report known or suspected misconduct, fraud, waste and/or abuse. Each FDR and Subcontractor must adopt a policy of non-retaliation and publicize the policy to all employees and contractors.