I. POLICY STATEMENT and PURPOSE

The Company is committed to compliance with all relevant federal, state, and local laws, regulations, and policies and procedures, including all applicable regulations of the Centers for Medicare & Medicaid Services (CMS). The law prohibits Medicare Advantage Organizations (MAOs) from employing or contracting with persons or entities that have been excluded from participating in federal health care programs (excluded parties). Medicare payment may not be made for items or services furnished or prescribed by any provider or entity that has been excluded from contracting with the federal government. In accordance with federal regulations, the Company will not use federal funds to pay for services, equipment, or drugs prescribed or provided by a health care provider, supplier, employee, or other party that has been excluded by the U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG) or the General Services Administration (GSA).

The Company has procedures in place to screen its workforce members, certain delegated entities, and others as described herein for such exclusion. The purpose of this Policy is to describe the Company’s obligations and processes for identifying excluded parties, oversight of the screening processes, and the procedures to be followed in the event an excluded party is identified.

II. SCOPE

This Policy applies to the Analytics, Appeals, Claims, Compliance, Credentialing, Information Technology, Legal, People and Culture, Pharmacy, Provider Contracting, Provider Data Management, Sales, Utilization Management, and Vendor Management Departments, and to the organization’s First-Tier entities.

III. DEFINITIONS

Excluded Party – Any individual or entity that is currently excluded, suspended, debarred, or ineligible to participate in any federal health care program, or convicted of a criminal offense related to the provision of health care items or services, and has not completed the exclusion period and been reinstated as eligible to participate in federal health care programs.

First Tier Entity – Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative or health care services to a Medicare-eligible individual under the MA program or Part D program.

Workforce – For purposes of this policy, the full- and part-time employees, contingent workers (consultants and contractors) volunteers, trainees, and governing body (Board) of the Company.
IV. OWNERSHIP & TRAINING

The Chief Compliance Officer (CCO) is responsible for the administration, oversight, and training of this policy.

V. PROTOCOLS

a. The OIG and GSA publish lists of individuals and entities that have been excluded from federal contracting.

i. The OIG’s List of Excluded Individuals and Entities (LEIE) identifies health care providers and suppliers (individuals and entities) the OIG has excluded from participation in Medicare, Medicaid, and all other federal health care programs.

ii. The U. S. Government’s System for Award Management (SAM) website contains the GSA’s list of debarment actions taken by various federal agencies, including exclusion actions taken by the OIG. (SAM contains GSA’s exclusion list formerly called the Excluded Parties List System, or EPLS).

b. The Company reviews both the LEIE and SAM prior to hiring or contracting any new workforce member, Board member, First Tier Entity, and certain healthcare providers and at least monthly thereafter, to ensure none of these persons or entities are excluded or become excluded from participation in federal programs. If contracted to do so by a client organization, the Company will also perform this screening for certain of the client’s contracted/affiliated entities, following the same procedures described herein.

c. Scope and Responsibility for Screening. The Company’s workforce applicants/members and First Tier entities are screened as follows:

i. Workforce. People and Culture’s recruitment process includes screening workforce applicants for exclusion prior to employment or contracting. People and Culture is also responsible for obtaining an exclusion disclosure form from prospective and current workforce members, and for providing workforce data for the monthly screening of current workforce members against the LEIE/SAM lists. (See Policy P&C16, “Workforce Exclusions and Sanctions Screening.”)

ii. Health Plan Providers. If contracted to do so by client health plan organizations, the Company’s Credentialing Department is responsible for screening prospective health plan providers (physicians and facilities) as part of its credentialing and re-credentialing processes, and for monthly screening of active providers. (See Policies CRD40, “Provider Practitioner Credentialing,” CRD54, “Ongoing Monitoring of Participating Providers,” and CRD-DOP04, “Ongoing
Monitoring of Providers – OIG and GSA Exclusion Reports, CMS Preclusion List.”) Health plan providers are also screened as part of certain operational processes:

1. The Information Technology team exports provider data to be screened. The Chief Compliance Officer and Legal agree upon the inclusion criteria.
2. The Claims Department screens providers prior to issuing member reimbursements.
3. The Appeals Department evaluates provider status and OIG/GSA guidance when the appeal includes an excluded provider.
4. The Utilization Management and Pharmacy Departments screen providers prior to approving authorizations for non-contracted providers.

iii. Health Plan Pharmacists/Pharmacies.

1. Health plan Pharmacy Benefits Managers (PBMs) are responsible for screening their currently contracted pharmacists/pharmacies on at least a monthly basis and timely notifying health plan members regarding excluded pharmacists/pharmacies. PBMs are required to take applicable actions, including provider termination, member notification, and claim denials, related to Part D providers. PBM(s) report any findings and actions taken relative to excluded providers to the Company’s Pharmacy Department, which escalates findings to the Company’s Compliance Department. (See Policy RX08, “Oversight of Pharmacy Benefit Management Delegated Services.”)

2. The Company’s Pharmacy Department is responsible for verifying claims denials for excluded providers/prescribers for dates of service on or after the effective date of exclusion, and oversight of the PBM to confirm screening activities and appropriate member notifications are completed. (See RX-DOP02, “Part D Excluded and Precluded Provider Identification, Claim Verification, and Member Notification Process.”)

iv. Sales Producers and Agencies. If contracted to do so by client health plan organizations, the Company’s Sales Department is responsible for screening prospective and currently contracted health plan sales Producers upon contracting/re-contracting, and for screening the Company’s contracted Sales Agencies. The Company’s Sales Department is also responsible for providing data for the monthly screening of active Producers and Agencies. (See Policies SLS16, “Producer Appointment and Termination” and SLS18, “Appointment and Oversight of Sales Agencies.”)
v. **Board Members.** The Legal Department’s Board member selection and appointment process includes screening non-employee Board members against the OIG/GSA lists prior to appointment and monthly thereafter.

vi. **Vendors.** The Company’s Vendor Management Office (VMO) screens potential vendors (including First-Tier vendors) as part of the vendor selection and contracting process. The VMO is responsible for providing data for the monthly screening of the Company’s current First-Tier vendors. (See Policy VMO01, “Vendor Management Program.”) First-Tier entities are required by contract to screen their workforce members and contracted entities to ensure none of these persons or entities are excluded or become excluded from participation in federal programs.

d. **Outsourcing.** All or part of the Company’s screening function may be outsourced to a contracted party that is appropriately qualified to provide such services. If outsourced, the Company oversees the work of the contracted party and ensures through the review of the party’s procedures and documentation that appropriate screening is performed according to Company requirements, appropriate data security is applied, and screening records are maintained and accessible by the Company.

e. **Verification of potential matches.** All potential matches discovered during each screening performed by or on behalf of the Company must be individually verified by comparing demographic information (which may include first name, middle initial, last name, date of birth, city, state, Social Security number, employer identification number, etc.) to verify whether the individual or entity is confirmed to be an excluded party. Verification may be performed internally by the functional unit responsible for screening, or by the contracted screening vendor. If evidence can be produced that the individual/entity is not an excluded party, such evidence must be documented.

f. **Actions required when an excluded party is identified.** The Company’s CCO (or designee) must be promptly notified of any individual or entity identified as (or reasonably certain to be) an excluded party. Notification may be made in person or via phone or email. Appropriate actions are required upon such identification.

i. The responsible party who identifies a potential/actual excluded party is required to provide to the Company’s CCO (or designee) the name of the identified party, the organization(s)/health plan(s) for which the party has performed (or is intended to perform) functions or services, and any other supporting documentation related to the screening.

ii. Any individual/entity that is the subject of a criminal investigation or proposed debarment or exclusion will be temporarily removed from direct responsibility for or involvement in any health care related programs, or not hired/contracted
iii. If the finding relates to the Company’s contracted individual/entity, the CCO (or designee) will take action to have the party terminated from doing business with the Company, in accordance with the Company’s applicable termination procedures, and will identify whether the excluded party received payment on or after the listed exclusion date. If the individual/entity performs functions or services on behalf of a client organization, the CCO (or designee) will provide the applicable client’s Compliance Officer with pertinent details of the finding and action taken.

iv. The OIG/SAM lists include individuals/entities with active sanctions. For any excluded provider confirmed by the Company, the Provider Data Management Department documents the claim reject date in the business operating system and applies an out-of-network agreement to deny claims with dates of service on or after the claim reject date.

v. The Company will attempt to recover any monies found to have been issued inappropriately to an excluded provider, pharmacy, or other entity using a report generated by the Analytics Department.

g. Provider Termination. Medicare plans and Part D plans must remove from their health plan/pharmacy network any contracted provider confirmed to be an excluded party, as soon as possible after discovery of such exclusion. Contracted health plan providers identified as excluded from Medicare participation will be terminated from the Company’s health plan network(s), following standard termination processes. (See Policy CNP05, “Provider Contract Termination.”)

h. Client Notification. The Company’s CCO (or designee) will notify its client health plan sponsors of any client-contracted provider identified through its exclusions screening process. The client plan is responsible for taking appropriate action with regard to credentialing and the provider’s contract status unless such activities are otherwise delegated to the Company. If the client plan’s members are impacted by the exclusion based on the claim lookback process, the Company will notify the client plan of those members for informational and oversight purposes.

i. Documentation requirements. Documentation of screening activities must be retained by the department or contracted screening vendor responsible for the screening process. Such documentation will be retained in accordance with the Company’s document retention policy (see Policy CMP13, “Document and Data Storage and Retention”) and made available upon request for audit or other purposes.
j. Compliance oversight. The Compliance Department verifies appropriate screening occurs in accordance with policy requirements, reviews the results of screening, and takes (or verifies) any necessary action related to termination of excluded individuals/entities from the Company’s employ/contract. The CCO reports screening results to the Company’s Compliance Committee and to the Audit Committee and/or Board at routine meetings of these governing bodies.

k. Failure to conduct appropriate screenings is a violation of Company policy, and the person or contracted party responsible for the screenings will be subject to disciplinary action.

VI. REGULATORY REFERENCES / CITATIONS

CMS Medicare Managed Care Manual, Chapter 21, Section 50

VII. RELATED POLICIES / PROCEDURES

CMP13 – Document and Data Storage and Retention
CNP05 – Provider Contract Termination
CRD40 – Provider Practitioner Credentialing
CRD54 – Ongoing Monitoring of Participating Providers
CRD-DOP04 – Ongoing Monitoring of Providers – OIG and GSA Exclusion Reports, CMS Preclusion List
P&C16 – Workforce Exclusions and Sanctions Screening
RX08 – Oversight of Pharmacy Benefit Management Delegated Services
RX-DOP02 – Part D Excluded and Precluded Provider Identification, Claim Verification, and Member Notification Process
SLS16 – Producer Appointment and Termination
SLS18 – Appointment and Oversight of Sales Agencies
VMO01 – Vendor Management Program

VIII. ATTACHMENTS

None

APPROVALS:

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<tr>
<th>Functional Unit Executive:</th>
<th>Printed Name</th>
<th>Signature</th>
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<tr>
<td>Erin Venable</td>
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<tr>
<td>Chief Legal Officer:</td>
<td>Gail Halterman</td>
<td>Gail Halterman</td>
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**Policy & Procedure**

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<th>Exclusion From Federal Healthcare Programs</th>
<th>Number &amp; Version:</th>
<th>CMP06 V.14</th>
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<td>Effective Date:</td>
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<td>Policy Owner (Title):</td>
<td>Chief Compliance Officer</td>
<td>Page Number:</td>
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**Version History:**

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<th>Date</th>
<th>Author</th>
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<td>01</td>
<td>Mar. 2004</td>
<td>D. Gribble</td>
<td>Original issue</td>
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<tr>
<td>02</td>
<td>May 2005</td>
<td>D. Gribble</td>
<td>General review</td>
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<tr>
<td>03</td>
<td>May 2006</td>
<td>M. Keys</td>
<td>General review; changed ‘Manager’ to ‘Director;’ added FDR procedure.</td>
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<tr>
<td>04</td>
<td>Mar. 2007</td>
<td>M. Keys</td>
<td>General review; no changes.</td>
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<tr>
<td>05</td>
<td>Dec. 2007</td>
<td>L. Pate</td>
<td>Updated to reflect new reporting and review process.</td>
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<tr>
<td>06</td>
<td>June 2014</td>
<td>J. Davis</td>
<td>Complete re-write for compliance with CMS guidance and to reflect current practices. Identified responsibilities, updated procedures, cross-referenced related policies/procedures. Formerly titled “OIG Exclusions Database Review.”</td>
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<td>07</td>
<td>Nov. 2015</td>
<td>J. Davis</td>
<td>General review; added the existing procedure of notification to health plan members if an excluded prescriber is identified; no other substantive changes.</td>
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<tr>
<td>08</td>
<td>Nov. 2016</td>
<td>J. Davis</td>
<td>General review; no substantive changes.</td>
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<tr>
<td>09</td>
<td>Feb. 2018</td>
<td>J. Davis</td>
<td>General review; removed sample of attestation form, no substantive changes.</td>
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<tr>
<td>10</td>
<td>Feb. 2019</td>
<td>J. Davis</td>
<td>General review; removed reference to retired RX policy; no substantive changes.</td>
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<tr>
<td>11</td>
<td>Apr. 2020</td>
<td>J. Davis</td>
<td>Modified to clarify current policies and practices; revised ‘workforce’ definition; added screening of Board members; modified procedures related to PBM and contracted entities, updated Compliance oversight section.</td>
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<td>Feb. 2021</td>
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<td>Minor administrative edits.</td>
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<tr>
<td>13</td>
<td>Feb. 2022</td>
<td>E. Meade</td>
<td>Revised Protocols to align with current practices, including the addition of client communications, claims denial, PBM responsibilities, and provider terminations; updated related policies.</td>
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<td>14</td>
<td>Feb. 2023</td>
<td>E. Meade</td>
<td>Minor edits for clarity; added Information Technology responsibility. No other substantive changes.</td>
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