ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS (CPE)
COMPLIANCE OFFICER QUESTIONNAIRE (CO-Q)

Name of Sponsoring Organization:

MA-PD/PDP Contract Numbers:

Name and Title of Person Completing Questionnaire:

Date of Completion:

Directions for Completing the Compliance Officer Questionnaire:

This questionnaire will assist CMS with understanding the sponsoring organization's mechanisms for overseeing the performance and effectiveness of the compliance program from the compliance officer's perspective.

The responses to these questions may be discussed during the onsite portion of the CPE audit.

We recognize that your time is valuable and appreciate your availability to provide responses to our questions regarding the compliance program.

If multiple individuals are responsible for the operations and oversight of the compliance program (e.g. Corporate Compliance Officer, Medicare Compliance Officer, SVP of Audit and Compliance) and have different responses to the questions, please consolidate responses and incorporate into one document.

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Please specifically note the following when completing the questionnaire:

- "You" refers to your organization, not necessarily a specific person.
- "Employees" refer to employees, including senior management, who support your Medicare business.
- "Compliance Officer" refers to the compliance officer who oversees the Medicare business.
- "CEO" refers to the Chief Executive Officer of the organization or the most senior officer, usually the President or Senior Vice President of the Medicare line of business.
- "Compliance Program" refers to your Medicare compliance program.
- If the Medicare contract holder is a wholly owned subsidiary of a parent company, references to the governing body, CEO and highest level of the organization's management are to the board, CEO and management of the company (parent or subsidiary/contract holder) that the organization has chosen to oversee its Medicare compliance program.
- "FDRs" refer to the organization's first-tier, downstream and related entities contracted to perform an administrative or healthcare service to enrollees on behalf of the Sponsor.
- Unless specific reference is made in the question to the term "governing body", it means either the full board or a committee of the board of directors delegated to conduct oversight of the day-to-day operation of the Medicare compliance program on behalf of the full governing body.

1. How long have you been employed with the sponsor and served as the Compliance Officer of the Medicare line of business?

2. Briefly describe your background and how it relates to your role as an effective Compliance Officer for the sponsor.

3. Provide a general view of your responsibilities as the Compliance Officer.

4. Do you have any other responsibilities in addition to being the Compliance Officer for this organization? If yes, please describe those positions and responsibilities.

5. What are some of the tools used to keep the compliance department up-to-date on tasks and assignments that have been delegated to both operational and FDRs?

6. What resources do you use on a regular basis to keep the organization current on CMS compliance, audit, and enforcement information and activities?

7. Please describe how you oversee the call routing process to ensure incoming requests are properly classified and processed in accordance with 42 CFR Parts 422 and 423 Subpart M requirements.

8. Provide an example of a compliance issue you had to deal with during the audit review period that involved a Medicare operational area and/or a first-tier, downstream or related entity (FDR) and impacted a significant number of your enrollees from receiving their health or drug benefits time in accordance with CMS requirements. Describe what happened and how you handled it.

9. Provide an example of a time when communicating compliance issues to the compliance committee, senior management or governing body regarding was challenging. Briefly discuss how you handled it.

10. Describe a recent experience you had with a miscommunication with an employee(s) when dealing with suspected, detected or reported incidents of noncompliance or fraud, waste and abuse (FWA)? How did you or the compliance department solve the problem?

11. During the audit review period, have you ever had to make a decision when no or limited internal or CMS policy was available to provide guidance on how to handle the issue? Describe what happened and how you handled it.

12. What has been your experience in dealing with poor compliance performance of Medicare operations within your organization? Provide an example.

13. In your position as Compliance Officer, what types of decisions do you make at your level without consulting with senior management ultimately responsible for the Medicare Advantage and/or Part D contract with CMS? What are some of indicators that tell you to escalate the decision or issue to senior management?

14. CMS understands that every compliance issue is not presented to senior management or the governing body. Explain the criteria used by the compliance department for escalating issues to the CEO and senior management that present high-impact risks to the organization. Include how/when the parties are advised of operational and regulatory compliance activities (e.g. critical discussions with the CMS Account Manager, Notices of Non- Compliance, Civil Money Penalties, Marketing/Enrollment Sanctions, etc.).

15. How do you keep your organization current on CMS regulations, policy requirements and expectations for various operational areas?

16. How do you measure employee, FDRs and governing body member awareness and understanding of the compliance program?

17. What mechanisms are in place to communicate operational area concerns/issues to the compliance department?

18. What have been major obstacles with executing an effective compliance program which you have had to overcome in your role as the Compliance Officer? How did you deal with them?

19. What indicators tell you, as the compliance officer, that the Medicare compliance function/system is working well with finding and fixing compliance issues and fraud, waste and abuse incidents? Are they effective for your organization?

20. What suggestions or changes would you make to encourage transparency and strengthen the communication between your organization and CMS (e.g. Central Office, Regional Office, and Account Manager) as it relates to compliance issues?

21. Are there any recent initiatives or upcoming initiatives to improve the current state of your organization's compliance culture?

22. Do you have any questions or comments for CMS?