HOMETOWN HEALTH POLICY		Current Version Effective Date:	05/01/18
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Scope: Hometown Health Compliance Policies & Procedures apply to the following individuals and entities:

1) All persons (management, staff, contractors, vendors) affiliated with Hometown Health and Hometown Health Management Corporation ("staff");

2) All members of the Board of Directors ("Board"), officers and managers of Hometown Health and Hometown Health Management Corporation;

3) First-tier, downstream and related entities ("FDR") as defined by the Centers for Medicare and Medicaid Services ("CMS") as set forth in Hometown Health's policies, procedures and standard of work and/or work aids; and

4) Network Providers as set forth in Hometown Health's policies & procedures and standard of work and/or work aids.

Purpose: The purpose of Hometown.HCP.004 is to outline: (1) duties and responsibilities of Hometown Health Compliance Manager to the Compliance Program ("Program"); (2) relationship of the Hometown Health Compliance Manager to the Hometown Chief Executive Officer ("CEO") to Renown Health Chief Compliance Officer ("CCO") and to Hometown Health Board of Directors ("Board"); and (3) structure, duties and responsibilities of Hometown Health Compliance Committee ("Committee").

Policy: Hometown Health maintains a Program under the direct authority of the CCO, the indirect authority of the CEO and with a reporting relationship to the Board. The Program is overseen and implemented by the Hometown Health Compliance Manager with assistance from the Committee.

I. Compliance Manager

The Hometown Health Compliance Manager is designated as the Compliance Officer for the health plan and is responsible for developing, implementing, overseeing the Program and monitoring plan-wide operations for Hometown Health. In doing so, the Compliance Manager, with input from the CCO and CEO, defines the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures and compliance expectations of all personnel and delegated entities.

II. Compliance Analyst

The Hometown Health Compliance Analyst supports the Program to ensure compliance with federal and state laws and regulations, contract provisions, accreditation standards, the Renown Health Code of Conduct, internal standards, and policies and procedures. The

Analyst will implement plan-wide initiatives, policies and procedures related to the Program and is responsible for Program oversight, risk assessment, analysis, communication, education and training, and auditing and monitoring. In the absence of the Compliance Officer, the Compliance Analyst serves as his/her designee.

III. Compliance Duties and Responsibilities

The Compliance Manager is responsible to:

(a) develop an organizational chart representing the reporting relationship between the Compliance Manager, Committees and Board;

(b) interact with the operational units at Hometown Health to develop awareness of business activity;

(c) develop compliance related policies and procedures, standard work and/or work aids;

(d) develop a compliance work plan specific to the auditing and monitoring of Medicare and commercial health plan operations;

(e) develop educational training programs to educate staff affiliated with Hometown Health about the Program, Code of Conduct, compliance policies and procedures and all applicable law, statutory and regulatory requirements;

(f) develop and implement programs that encourage managers and staff to report non-compliance and potential fraud, waste and abuse (FWA) without fear of retaliation;

(g) report to the Board, CCO, CEO, and Committee the status of the Program, including identification and resolution of suspected, detected or reported instances of non-compliance, compliance oversight and audit activities;

(h) maintain compliance reporting mechanisms and coordinate with the Renown Health Internal Audit Department, the Hometown Health Special Investigations Unit (“SIU”), and delegated entities;

(i) collaborate with departments to ensure agents and brokers, delegated entities and network providers are aware of and follow the requirements for Medicare, commercial sales and marketing activities;

(j) respond to reports of potential FWA and coordinate internal investigations with the SIU and/or Internal Audit Department;

(k) develop appropriate corrective or disciplinary actions for FWA instances. The Compliance Manager will coordinate internal investigations (*e.g.*, respond to a report of actual or suspected violation) and execute corrective action (*e.g.,* make necessary improvements to policies, procedures, standard work and/or work aids and/or make recommendations for disciplinary action);

(l) maintain documentation, for each report of FWA received through any of the reporting methods (*e.g.*, hotline, e-mail, in-person);

(m) report any potential fraud or misconduct related to the Medicare and commercial health plan programs to CMS designee (*i.e.*, NBI MEDIC), law enforcement consistent with Renown Health Network Policy RENOWN.CCD.085 and Hometown Health Policy HOMETOWN.HCP.015; and

(n) coordinate with the Human Resources office (or its designee) to ensure DHHS OIG and GSA exclusion lists have been verified to ensure that all staff, officers, directors, managers, delegated entities, and network providers are not excluded, sanctioned or otherwise debarred from participating in federal health care programs.

IV. Compliance Manager Authority

The Compliance Manager has the authority to:

(a) interview or delegate the responsibility to investigate staff and others regarding compliance issues and/or concerns;

(b) review company contracts and other documents pertinent to health plan programs;

(c) review or delegate the responsibility the submission of data to regulatory entities to ensure data is compliant with applicable reporting requirements;

(d) independently seek advice from legal counsel as needed;

(e) make in-person reports at the sole discretion of the Compliance Officer to the Renown Health Chief Compliance Officer, Chief Executive Officer, and to the Hometown Health Board of Directors;

(f) report potential FWA to regulatory entities its designee or to law enforcement;

(g) conduct and direct audits and investigations of any delegated entities;

(h) conduct and direct audits of any area or function involved with Medicare and commercial plans; and

(i) recommend policy, procedure, and process changes.

V. Compliance Committee and Workgroups

Hometown Health has one committee and three workgroups to assist with the implementation of the Program. Each committee and workgroup should meet quarterly and is chaired by the Compliance Manager or other appointed designee. The committee and workgroups are composed of stakeholders from applicable departments within Hometown Health.

(a) Compliance Committee. The purpose of the Compliance Committee is to take responsibility for leading and facilitating the development, implementation and operation of the Program in order to participate in Medicare and commercial health plan activities. This Committee will enforce and promote an organizational culture that encourages compliance with applicable laws, regulations, CMS contractual requirements, and URAC standards. This will be accomplished through risk analysis and ongoing monitoring and auditing of all MA and PDP plan activities as performed by Hometown Health and by delegated entities to whom Medicare and commercial health plan activities have been delegated.

(b) Fraud, Waste and Abuse Workgroup. The purpose of the FWA Workgroup is to serve as an oversight and decision empowering body regarding FWA activities of the Program. The Workgroup has been authorized by the Hometown Health Compliance Committee and serves as a formal communication body regarding FWA issues for the Hometown Health Compliance Manager and the Hometown Health Medicare and Commercial Compliance Committees.

(c) Delegation Oversight Workgroup. The purpose of the Delegation Oversight Workgroup is to oversee FDRs and delegated entities to ensure that delegated health plan functions are performed appropriately. This Workgroup has been authorized by the Hometown Health Compliance Committee and is charged with the responsibility to implement the process of pre- and post- delegation due diligence to ensure adherence to CMS, URAC and contractual compliance and performance standards.

(d) Policy & Procedure Workgroup. The purpose of the Policy & Procedure Workgroup is to oversee the creation, revision and retirement of Hometown Health policies and procedures to ensure that policies and procedures implemented by Hometown Health are consistent with Renown Health Network Policies and URAC standards and are reviewed/approved by leaders from across the organization. This Workgroup has been

authorized by the Hometown Health Compliance Committee and is charged with the responsibility to implement the process of policy and procedure review and approval.

VI. Compliance Committee/Workgroup Duties, Responsibilities and Authority

The Committee and Workgroups are responsible for advising and providing support to the Compliance Manager with the creation, implementation and operation of the Program. Committee and Workgroup structure, charter and agenda should be consistent with the direction from Renown on the corporate governance structure. The Committee and Workgroups are accountable for:

(a) active oversight, consultation and direction to the Committee and Workgroup chairperson in design, implementation and operation of the Program;

(b) resolve issues of interpretation and application regarding the Program;

(c) assist the Compliance Manager in carrying out duties and responsibilities as set forth in this policy;

(d) provide timely, consistent and effective enforcement of disciplinary standards when noncompliant or unethical behavior is identified;

(e) review and approve Hometown Health Policies and adopt Renown Health Network Policies, as applicable, to health plan operations;

(f) oversee the implementation and completion of the compliance training program for Hometown Health staff, including the Board of Directors;

(g) assist in the creation and implementation of the audit and monitoring work plan, as referenced in Hometown Health Network Policy HOMETOWN.HCP.007;

(h) provide a system to track and review compliance results in key operational areas as well as other risk areas;

(i) provide a system to ensure appropriate oversight of the contractual obligations of delegated entities, particularly those that have direct member impact;

(j) promote effective resolution to member complaints through root cause analysis and complaint trend reporting;

(k) ensure Hometown Health maintains a reporting systems for staff, members, providers and delegated entities to inquire about or report potential violations of the compliance

program and Code of Conduct confidentially, anonymously and without fear of retaliation;

(l) develop strategies to promote compliance and the detection of any potential violation;

(m) ensure the compliance department has sufficient staff and resources needed to perform and complete compliance duties;

(n) review and address reports for areas in which Hometown Health may be at risk for fraud, waste and abuse and ensure corrective action plans are implemented and monitored, when needed;

(o) collaborate with the Renown Health internal audit department, the Renown Health Audit and Compliance Committee and other departments and committees in discharging its duties and responsibilities;

(p) authority to review appropriate documents and other information in order to interview any employees, officers, directors, relevant contractors and agents for any compliance related issues and/or concerns;

(q) provide reports on status and recommendations to the Board and Hometown Health senior leadership;

(r) monitor adherence to applicable laws, statutes and regulations by conducting periodic review to determine if any changes in Hometown Health's benefits, policies & procedures and utilization management protocols impact compliance; and

(s) notify its delegated entities regarding changes impacting compliance, as described in section VI(r).

VII. Compliance Committee and Workgroup Meetings

(a) Meeting Schedule and Process. The Compliance Manager or appointed designee shall serve as the Committee chairperson and ensure an agenda is prepared and meeting minutes are maintained. The Committee and Workgroups should meet quarterly or more frequently as deemed by the Committee or Workgroup chairperson.

(b) Quorum. A majority of the members of the Committee and Workgroup will constitute a quorum for taking action.

(c) Reporting. Formal minutes (Committee only) or meeting notes (Workgroups only) shall be prepared and maintained for each meeting by the Committee secretary or other

appointed designee. Upon request, minutes or notes shall be provided to the CEO and to the Board.

(d) The minutes and notes will be maintained according to relevant federal and state regulations governing document retention. Committee activities should be reported to the Board quarterly. The Committee and Workgroup Chairperson may elect to escalate items to the senior leadership or to the Board as necessary, according to the schedule designated or on an ad hoc basis.

(e) Confidentiality. Issues addressed by the Committee and Workgroups are often sensitive and may involve the review of confidential information. Certain parts of the Committee and Workgroup minutes and notes may be attorney-client privileged. The Committee members are to:

i. treat such information as confidential;

ii. refrain from discussing any matter relating to the Committee or Workgroup outside of the established process; and

iii. refrain from using information obtained by the Committee or Workgroup other than for the purpose for which the information was collected.

VIII. Inquiries that relate to this Hometown Health Policy or matters that are not specifically addressed by this policy should be directed to Hometown Health Manager of Compliance.

IX. To monitor adherence to applicable laws, statutes and regulations, Hometown Health should conduct a periodic review and analysis to determine if there are any changes in its benefits, policies & procedures and utilization management protocols which impact compliance.

X. To monitor adherence to applicable laws, statutes and regulations, Hometown Health should notify its delegated contractors of changes impacting compliance, including parity of health care services such as mental health and/or substance use disorder parity (“MHPAEI”), as applicable.

Definitions:

- **Abuse:** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 C.F.R. 455.2).

- **Centers for Medicare and Medicaid Services ("CMS"):** The federal agency that administers the Medicare program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care. (https://cms.gov/).
- **Delegated Entity:** 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, qualified employers, or qualified employees and their dependents. (45 C.F.R. 156.20).
- **Downstream Entity:** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with a MA organization or Part D benefit, below the level of the arrangement between an MA organization or applicant or 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. (42 C.F.R. 422.2, 423.4).
- **First-Tier Entity:** Any party that enters into a written arrangement, acceptable to CMS, with an MA organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA organization program or Part D program. (42 C.F.R. 422.2, 423.4).
- **Fraud:** A false representation of a material fact, whether by words or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed, which deceives another. (Paraphrasing Black's Law Dictionary - http://thelawdictionary.org/fraud/).
- **Government Services Administration ("GSA"):** An independent agency of the United States government, it combines the Central Contractor Registration (CCR/FedReg), Online Representations & Certifications Application (ORCA) and the Excluded Parties List System (EPLS) into one main contractor database. This database was named System for Award Management or better known as the SAM registration.
- **Health Plan:** Health plan means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)). (45 C.F.R. 160.103).
- **Medicare Advantage ("MA" or "Part C"):** A Medicare program that provides additional choices among health plans. Those who subscribe to Medicare Parts A and B are eligible, except individuals who have End-Stage Renal Disease ("ESRD") unless certain exceptions apply. Medicare Advantage Plans are also known as Medicare + Choice Plans.
- **National Benefit Integrity Medicare ("NBI MEDIC"):** The purpose of the NBI MEDIC is to detect and prevent fraud, waste, and abuse in the Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level. (http://www.healthintegrity.org/contracts/nbi-medic/).

- **Office of Inspector General ("OIG"):** The department within the Department of Health & Human Services ("HHS") tasked with enforcement of waste, fraud, and abuse efforts in Medicare, Medicaid and more than 100 other HHS programs. (https://oig.hhs.gov).
- **Prescription Drug Plan ("PDP" or "Part D"):** A Medicare program to assist with the cost of prescription drugs for individuals who are eligible beneficiaries to receive Medicare prescription drug coverage. There are two ways to obtain Medicare prescription drug coverage: 1) through a Medicare Prescription Drug Plan or 2) through Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.
- **Related Entity:** Any entity that is related to MA and/or Part D sponsor by common ownership or control.
- **Utilization Review Accreditation Commission ("URAC"):** URAC has been the independent leader in promoting health care quality through accreditation of organizations involved in medical care services. URAC's accreditation is recognized nationwide by state and federal regulators. URAC accreditation standards appear in legislation and regulation at the state and federal government. (www.urac.org).
- **U.S. Department of Health & Human Services ("HHS"):** The mission of HHS is to enhance and protect the health and well-being of all Americans. HHS will provide effective health and human services and foster advances in medicine, public health, and social services. (http://www.hhs.gov/).
- **Waste:** Occurs when poor or inefficient practices result in unnecessary healthcare expenditures to a Government program.

References:

- Federal Register / Vol. 64, No. 219 / Monday, November 15, 1999 ("Department of Health and Human Services, Office of Inspector General, Publication of the OIG's Compliance Program Guidance for Medicare+Choice Organizations Offering Coordinated Care Plan")
- HOMETOWN.HCP.007 – Auditing and Monitoring
- HOMETOWN.HCP.015 – Preventing and Detecting Fraud, Waste and Abuse
- Medicare Advantage Program, 42 C.F.R. Part 422
- Medicare Managed Care Manual, Chapter 21 ("Compliance Program Guidelines")
- Nevada Revised Statutes governing commercial insurance regulations in the state of Nevada, Title 57, Chapters 679A through 689C
- Prescription Drug Benefit Manual, Chapter 9 ("Compliance Program Guidelines")
- RENOWN.CCD.085 – Preventing and Detecting Fraud, Waste and Abuse

- Requirements Relating To Health Care Access, 45 C.F.R. Subtitle A, Subchapter B
- URAC Health Plan Standard P-CP 1 – Compliance Program: Internal Controls
- Voluntary Medicare Prescription Drug Benefit program regulations, 42 C.F.R. Part 423
- USA, Department of Justice, Criminal Division, Fraud Section. (n.d.). Evaluation of Corporate Compliance Programs

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Contributors:

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