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<tr><td colspan="2">HOMETOWN HEALTH POLICY</td><td>Current Version Effective Date:</td><td>05/01/18</td></tr>
<tr><td>Title:</td><td>Compliance Violation Reporting</td><td>Next Review Date:</td><td>05/01/20</td></tr>
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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.008 is to establish the process for reporting, investigation and responding to potential compliance violations.

Policy: Consistent with the Renown Health Network Policy governing compliance violation reporting, RENOWN.CCD.020, Hometown Health Plan shall develop, implement and maintain processes for individuals and entities to report potential compliance violations to the Compliance Officer, train and educate its workforce to identify non-compliance and the proper reporting mechanisms, outline the investigatory process to be performed by the Compliance department and respond to reports of non-compliance with emphasis on Renown Health's strict policy of non-retaliation for reporting compliance violations in good faith.

I. Types of Non-Compliance

Types of non-compliance issues that staff should be aware of include:

(a) Violation of the Renown Health Code of Conduct, Hometown Health Compliance Program Guidelines, Renown Health and Hometown Health policies & procedures;

(b) Violation of any law, regulation, sub-regulatory guidance (*i.e.*, Medicare Managed Care Manual, CMS Memoranda, etc.) or rule (*i.e.*, including safety and security guidelines);

(c) Theft or criminal conduct;

(d) HIPAA/HITECH Privacy and Security;

(e) Fraud, waste and abuse (FWA), financial or accounting misconduct, questionable auditing practices, bribery, falsification of company records or conflicts of interest;

(f) Abusive or retaliatory behavior, threats of workplace violence, sexual discrimination, harassment, or other serious misconduct by managers or colleagues.

II. Reporting Suspected Non-Compliance

Individuals are required to report in good faith any activity, practice or arrangement that is believed to be wrongful conduct within two (2) business days of discovery. Reports may be made via any of the following reporting methods:

(a) To the direct manager within the chain-of-command (*e.g.*, team lead, supervisor, manager, director and/or senior leader);

(b) To the Hometown Health Compliance Officer (775-982-3025);

(c) To the Renown Health Compliance Officer (775-982-5596);

(d) To the Hometown Health Human Resources Business Partner (775-982-3711);

(e) By submitting a compliance concern by clicking on the Compliance Concern icon located on the Hometown Health “Inside Renown” Web page; or

(f) By submitting a compliance concern via the Confidential Reporting Line (800-611-5097).

***Note:** The Confidential Reporting Line is available twenty-four hours a day, seven days a week and 365 days a year. Reports may be made anonymously and will be handled as confidentially as allowed by law. Renown Health and Hometown Health have a zero tolerance policy for retaliation, retribution and/or harassment against staff for reporting compliance violations in good faith.

III. Education and Training

Consistent with Hometown Health Policy governing compliance education and training, HOMETOWN.HCP.006, Hometown Health requires participation in compliance training to ensure staff is knowledgeable about their compliance duties and responsibilities. All Hometown Health staff will receive training on general compliance topics and on FWA within 90 days of hire and annually thereafter as a condition of employment with Hometown Health. The training will include the following elements:

(a) Examples of how to ask compliance questions, request compliance clarification, how to report and how to detected non-compliance. Training should emphasize confidentiality, anonymity, and non-retaliation for questions or reports of non-compliance or potential FWA;

(b) Requirement to report to a leader, Hometown Health's Compliance Officer or Renown's Chief Compliance Officer of actual or suspected Medicare program non-compliance or potential FWA;

(c) Review of the disciplinary guidelines for non-compliant or fraudulent behavior;

(d) Processes for sponsors and FDR staff to report suspected FWA to the FDR entity Hometown Health and/or Renown management directly;

(e) Protections for Hometown Health and/or Renown management and FDR staff who report suspected FWA; and

(f) Types of FWA that can occur in the settings in which Hometown Health, Renown Health, and FDR staff work.

IV. Investigating Reports of Non-Compliance

The Compliance Officer or his/her designee will make a reasonable inquiry into all compliance reports, incidents, and potential FWA to determine the need for an investigation. All inquiries and reports of suspected or actual non-compliance will be documented in the Compliance Program incident management system. The investigation of reported non-compliance will be initiated and overseen by the Hometown Health Compliance Officer. The Hometown Health Compliance Committee will be available to provide assistance to the Compliance Officer, as needed. Depending on the nature and severity, the Compliance Officer may utilize staff assistance, members of the Compliance department or Human Resources department, and internal or outside legal counsel and auditors to assist in conducting an investigation.

Steps to conduct an investigation:

(a) Take reasonable steps to stop ongoing non-compliance and mitigate the risk;

(b) Take steps to secure and prevent the destruction of documents and other evidence relevant to the investigation;

(c) Perform a diligent review of relevant documents, applicable standards, laws and regulations;

(d) Interview individuals with relevant information;

(e) Maintain documentation of the investigation to include the nature of the non-compliance and the investigation procedures;

(f) Recommend steps for remediation to include an estimate of the nature and extent of liability or financial overpayment.

a. If members were adversely affected by this non-compliance, additional investigation must be made to assess which members were affected, and what impact was made.

b. If a large number of members were affected, or if the potential/actual member impact is deemed serious, the Compliance Officer will report the matter to CMS or the appropriate regulatory agency.

V. Responding to Reports of Non-Compliance

(a) The Hometown Health Compliance Officer will respond to reports of non-compliance within two (2) business days of receiving the report. Upon conclusion of the investigation, if it is discovered that a significant incident of Medicare program or commercial health plan non-compliance has been found, the Compliance Officer will report the incident to CMS or the appropriate federal/state regulatory agency as soon as practicable.

For FWA issues, if Hometown Health does not have sufficient resources to investigate the report of non-compliance, the Compliance Officer will report the matter to the NBI MEDIC. FWA concerns should be referred to NBI MEDIC within 30 days of the date the potential fraud or abuse is substantiated.

(b) Reports made through the Confidential Reporting Line may be made anonymously. Staff are not required to provide their identity when making a report. However, if the staff would like a follow-up status of their report and subsequent investigation, staff are encouraged to provide their identity. An interview specialist will log the staff's concern and assign a "reference number." The reference number is used to obtain an update on the status.

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

VII. To effectively monitor adherence to applicable laws, statutes and regulations, Hometown Health will 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.

VIII. To monitor adherence to applicable laws, statutes and regulations, Hometown Health will 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 healthcare. 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 healthcare 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 the MA organization or Part D benefit, below the level of the arrangement between a MA organization 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 the 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 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/).
- **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 Drug Integrity Contractor ("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.
- **U.S. Department of Health and 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/).
- **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).
- **Waste:** Occurs when poor or inefficient practices result in unnecessary healthcare expenditures to a Government program.

References:

- Commercial insurance regulations relating to health care access, 42 C.F.R. Parts 140 through 159
- 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.006 – Education and Training
- Medicare Advantage program regulations, 42 Code of Federal Regulations Part 422
- Medicare Managed Care Manual, Chapter 21 ("Compliance Program Guidelines")
- Medicare Prescription Drug Benefit program regulations, 42 Code of Federal Regulations Part 423
- 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.020 – Compliance Violation Reporting
- URAC 7.3 Standards – CORE 4 and CR 10
- USA, Department of Justice, Criminal Division, Fraud Section. (n.d.). Evaluation of Corporate Compliance Programs

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