HOMETOWN HEALTH POLICY		Current Version Effective Date:	05/01/18
Title:	Effective Lines of Communication	Next Review Date:	05/01/20
Category:	Compliance	Creation Date:	06/12/16
Number:	Hometown.HCP.009	Revision History: 04/28/17 11/28/17 04/27/18	
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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.009 is to develop effective lines of communication between the Compliance Officer and Hometown Health staff. This policy will also establish the methods to communicate routinely with delegated entities and other organizational stakeholders regarding regulations, guidelines, requirements, compliance policies & procedures or other information applicable to their job function.

Policy: The Hometown Health Compliance Officer will take an active approach to develop a collaborative environment both among its staff, delegated entities, compliance committees, senior leadership and Board of Directors. Hometown Health encourages staff to seek clarification from the Compliance Officer, members of the compliance committee and/or compliance department in the event of any confusion of questions regarding Hometown Health policy, practice and procedure.

I. Routine Communication with Staff

The Compliance Officer shall establish methods to communicate on a routine basis with staff regarding regulations, guidelines, requirements, compliance policies & procedures and other information applicable to their duties. The communication will inform impacted staff of new or updated regulatory information from CMS or other relevant federal or state regulatory agencies.

The Compliance Officer will establish routine communication to provide opportunities for staff to seek clarification from the Compliance Officer or members of the compliance department of any confusion or question regarding company policy, practice or procedure. The Compliance Officer will document questions and responses, if appropriate, in order to share with other staff. The Compliance Officer may hold periodic in-person meetings with staff to review new or updated regulations to ensure the information is understood, implemented, and to promote compliance.

The Compliance Officer may solicit staff input to develop a communication and reporting system directed towards its targeted audience.

II. Escalation of Issues to the Compliance Department

Issues of suspected or actual non-compliance must be escalated to the Compliance Department. Examples of non-compliance may include but are not limited to:

- Performance outside of standards, *i.e. CMS untimely appeal decision notifications, non-payment of interest on claims, lack of prior authorization notifications, etc.*
- Reoccurrence of or lack of sustained improvement for previously identified errors
- Fraud, waste and abuse
- HIPAA privacy or security incidents

III. Communication with Delegated Entities

The Compliance Officer will establish a method to communicate on an as needed basis with entities to which health plan functions have been delegated. Communication should occur when regulations, guidelines, requirements, compliance policies & procedures or other information applicable to the delegated plan function have been introduced or updated. The Compliance Officer and the business owner responsible for the performance of the delegated plan function, will distribute the communication to the delegated entity Communication will be timely and the delegated entity will be instructed to seek clarification from the Compliance Officer or the business owner in the event of any confusion or has any question regarding the company policy, practice or procedure.

IV. Communication with Compliance Committees, Senior Leadership, and Board of Directors

The Compliance Officer will communicate at least quarterly with the Hometown Health Compliance Committee, and when regulations, guidelines, requirements, compliance policies & procedures have been introduced or updated. The Compliance Officer or appointed designee, such as the chairperson of the respective committee, will distribute the information during regularly scheduled committee meetings or through other effective means of communication.

The Compliance Officer will communicate at least monthly with senior leaders of the organization (*i.e.*, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Associate General Counsel and Renown Health Chief Compliance Officer), and when regulations, guidelines, requirements, compliance policies and procedures have been introduced or updated. This communication may be ad hoc or during regular meetings between the Compliance Officer and the senior leadership team.

The Compliance Officer will communicate at least three times per year with the Hometown Health Board of Directors. This communication will include significant updates regarding the

Hometown Health Compliance Program and changes to laws and regulations that significantly impact the company's health plan operations. Criteria to be considered by the Compliance Officer for escalation to the Board of Directors shall include but not be limited to:

- Audit findings of internal audits, FDR audits, and FWA audits
- Engagement in and report of audit findings for external or regulatory agency audits, i.e. CMS, State of Nevada Division of Insurance, etc.
- Enforcement actions such as CMS notices of non-compliance, warning letters, intermediate sanctions, civil money penalties or State of Nevada Division of Insurance consent to fines

The Compliance Officer has the express authority to make in-person reports at their sole discretion to the Chief Executive Officer, Renown Health Chief Compliance Officer and to the Hometown Health Board of Directors.

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

VI. 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.

VII. 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 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 runs 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. **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 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).
- **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")
- 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")
- URAC Health Plan CORE Standard P-CORE 4 – Regulatory Compliance
- URAC Health Plan Standard P-CP 1 – Compliance Program: Internal Controls
- USA, Department of Justice, Criminal Division, Fraud Section. (n.d.). Evaluation of Corporate Compliance Programs

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Contributors:

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