HOMETOWN HEALTH POLICY		Current Version Effective Date:	05/01/18
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Number:	Hometown.HCP.011	Revision History: 04/28/17 12/01/17 04/24/18	
Author:	Manager of Compliance		

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.011 is to establish the requirement to perform a risk assessment of Hometown Health ("company").

Policy: The Compliance Officer will conduct an annual formal baseline risk assessment of its major fraud, waste, and abuse (FWA) areas that take into account all Medicare business operational areas.

I. General Policy & Procedures

The Compliance Officer will conduct an annual risk assessment, consistent with Hometown.HCP.002, to include: Hometown Health's Compliance Program, the company's operational processes, regulatory requirements and risks by its other entities and FDR. The assessment will include an objective audit to measure compliance and to engage in continuous improvement. Risk assessments will be periodically reviewed to evaluate the accuracy of the baseline measurements used to identify and quantify risk.

II. Organizational Risk Assessment (Commercial and Medicare Business Operational Areas)

A. The Medicare portion of the assessment will include both Medicare Part C and Part D operational areas to include:
- Call Center
- Claims Processing and Payment
- Compliance Program
- Coordination of Benefits / TrOOP
- Correspondence
- Customer Service

- Delegation Oversight
- Enrollment
- Fiscal Soundness Reporting
- Formulary Administration
- Fraud, Waste and Abuse / Special Investigations Unit
- Grievances (Part C and Part D)
- Marketing Materials
- Network Management
- Part C Organizational Determinations
- Part C Reconsiderations
- Part D Coverage Determinations
- Part D Redeterminations
- Performance Management
- Pharmacy Operations
- Program Audit Readiness
- Quality Improvement and Assurance

B. The Commercial Regulatory Risk Assessment portion of the assessment will include operational areas subject commercial insurance regulation, including but not limited to:
   - Affordable Care Act
     - Grandfather Status
     - Extension of Dependent Coverage of Children to Age 26
     - Rescission Provisions
     - Lifetime Limits and Restrictions on Annual Limits
     - Preexisting Condition Exclusions
     - 90-day Waiting Period Limitation
     - Summary of Benefits and Coverage (SBC) and Uniform Glossary
     - Patient Protection Provisions
     - Preventive Services Provisions
     - Internal Claims and Appeals and External Review
   - Genetic Information and Nondiscrimination Act (GINA)
   - HIPAA Provisions
   - Special Enrollment
   - HIPAA Nondiscrimination
   - Wellness Program
   - Multiemployer Plan Guaranteed Renewability (MEWA)
   - Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA)

  - Lifetime and Annual Limits
  - Financial Requirements and Quantitative Treatment Limitations
  - Coverage in all Classifications
  - Cumulative Financial Requirements and Treatment Limitations
  - Non-quantitative Treatment Limitations
  - Disclosure Requirements
- Michelle's Law
- Newborns Act
  - Newborns' Act Substantive Provisions
  - Disclosure Provisions
- Women's Health and Cancer Rights Act of 1998 (WHCRA)

III. Delegated Entity Risk Assessment

Consistent with Hometown.HCP.010, an objective risk assessment of each entity will be performed on an annual basis.

IV. Risk assessments will include an evaluation of other industry-wide risk areas determined by review of governmental and agency regulatory reports, *e.g.*, CMS Part C and Part D Program Audit and Enforcement Report, HHS OIG Work Plan, U.S. Department of Justice publications, Health Care Compliance Association guidelines, URAC standards, etc.

V. Inquiries that relate to this Hometown Health Network Policy or matters that are not specifically addressed by this policy will 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 will notify its entities of changes impacting compliance, including parity of health care services such as mental health and/or substance use disorder parity ("MHPAEI"), as applicable.

Definitions:

- **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 an 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).
- **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.
- **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 accreditations, certifications, and designations address health care management, health care operations, health plans, pharmacy quality management, and providers. 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).

References:

- Attachment I-A Medicare Advantage and Prescription Drug Compliance Program Effectiveness Self-Assessment Questionnaire (SAO) (Rev. 5 10-2015), available at https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/Compliance-Program-Effectiveness-Self-Assessment-Questionnaire.pdf
- Commercial insurance regulations relating to health care access, 42 C.F.R. Parts 140 through 159
- Department of Health & Human Services, Centers for Medicare & Medicaid Services, Centers for Medicare, Medicare Drug & Health Plan Contract Administration Group, HPMS Memorandum, "Release of the Medicare Advantage Contract Amendment," October 5, 2012
- 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 Contract Amendment (Rev. January 1, 2015), available at https://www.cms.gov/medicare/medicare-advantage/medicareadvantageapps/downloads/model_contract_amendment_10_05_12.pdf
- 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.775 – Patient Privacy – Business Associates
- URAC 7.3 Standards CORE 9
- USA, Department of Justice, Criminal Division, Fraud Section. (n.d.). Evaluation of Corporate Compliance Programs
- U.S. Department of Labor Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions

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Contributors:

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