HOMETOWN HEALTH POLICY		Current Version Effective Date:	05/01/19
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Scope: Hometown Health Compliance Policies and 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.015 is to establish a proactive, robust and ongoing detection, correction and prevention program for fraud, waste and abuse and to comply with federal, state and other applicable regulations. This policy also ensures that an effective line of communication exists between the Special Investigations Unit, the Compliance Department, Compliance Committee, staff and other plan stakeholders involved in the oversight of Hometown Health's federal and state health care programs, such as Medicare Advantage and Prescription Drug Plan.

Policy: Consistent with Hometown Health and Renown Health's policy governing compliance auditing and monitoring (RENOWN.CCD.010 and HOMETOWN.HCP.007) Hometown Health (also referred to as "company") is committed to the detect, prevent and correct fraud, waste and abuse ("FWA") by staff, Board members and the company's entities through the Compliance Program ("Program"). The company will identify, resolve, recover funds, report and when appropriate, take legal actions if suspected FWA has occurred.

I. General Policy and Procedures

The Special Investigations Unit is responsible for overseeing FWA to include developing FWA training, communication and to ensure that all reports of suspected FWA have been investigated and, if necessary, reported to the proper authorities. The Compliance Department will provide oversight and assistance with FWA regulatory reports to state and/or federal agencies, as needed. The Manager of Compliance will communicate FWA as described in HOMETOWN.HCP.009.

To effectively monitor adherence to applicable laws, statutes and regulations, the company conducts periodic review and analysis to determine if there are any changes that impact compliance.

The company will cooperate and coordinate with NBI MEDIC, CMS, law enforcement and others for detecting and preventing FWA and may provide information in connection with their audit and/or investigation to the government agency.

All staff and entities have a critical role to play in the lawful and ethical conduct of the company's business. The goal is to have all staff and entities take the time to understand the principles behind the laws and regulations that underlie the company's policies in order to be aware of conduct that is lawful and appropriate.

All staff and entities is required to comply with all federal and state laws, statutes and regulations regarding FWA.

The FWA Program should be reviewed annually by the Chief Compliance Officer, the Special Investigations Unit, and the Compliance Manager in conjunction with Hometown Health as necessary.

II. Detection

The Program is designed to support the company's efforts in detecting FWA and abuse as detailed below.

a) Education and Training. All Hometown staff will receive FWA education and training upon hire and annually thereafter. The education and training will include the following FWA topics: (For a more detailed description of the training, see Hometown.HCP.006.)

   i. Examples of FWA by providers, vendors and staff

   ii. A dedicated hotline to report suspected or actual FWA

   iii. Information on how to contact the Compliance Manager to report FWA

   iv. How to report suspected FWA to Hometown Health

b) Risk Assessment. The Special Investigations Unit and the Compliance Manager, in conjunction with the business owners, should identify FWA risk areas. Risk will be based on those identified areas during the risk assessment (*see* Risk Assessment, Hometown.HCP.011).

c) Auditing and Monitoring for FWA. The Program will include procedures for pre-payment and post-payment methods to investigate suspicions of FWA and inappropriate payments made by the plan. Data analytics or data analysis software should also be implemented where applicable to monitor potential FWA activity and to identify unusual patterns in the delivery of Medicare Parts C and/or D benefits (*e.g.*, queries for pharmacy patterns, provider billing, drug utilization, etc.). The Program will include procedures to respond to fraud alerts that are issued through the Health Plan Management System (HPMS) and will include procedures to respond to advisories that are issued through HEAT Medicare Strike Force cities (HEAT is the joint HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team).

III. Prevention

a) Entities

Hometown Health has included provisions in its agreements with subcontractors that require compliance with state and federal laws regarding FWA. At a minimum, entities are required to establish and maintain internal controls designed to detect and prevent suspected or actual FWA that may be committed by the entities' employees, vendors, providers or other third party affiliations. Entities are required to ensure that their staff and others performing work on their behalf receive training and guidance as it relates to FWA.

b) Delegation Oversight Committee

To support ongoing monitoring of compliance with statutory, regulatory and contractual requirements including those that relate to FWA for Hometown Health's entities, *see* Oversight of Delegated Entities, Hometown.HCP.010.

IV. Correction

Once non-compliance has been detected, it must be promptly reported and corrected. This includes suspected or actual violations and developing a plan to correct the issue.

a) Reporting

All Hometown staff and entities are required to report any suspicion of fraud, waste or abuse to their supervisor, The Special Investigations Unit, the Compliance Manager or to the anonymous Compliance Hotline, so that reports can be investigated and corrected, as needed.

Hometown Health encourages staff and its entities to report any issues or concerns related to compliance or ethical obligations under laws, regulations, and Hometown Health's policies, including laws governing Federal reimbursement programs, such as Medicare. Reports may be made confidentially and anonymously via Hometown Health's Compliance Hotline at 1-800-611-5097 or online. All reports will be followed up by the Special Investigations Unit and, and where applicable, by additional appropriate individuals.

To the extent possible and appropriate under the circumstances, the company will maintain the confidentiality of the identity of anyone who reports a suspected violation of law or policy or who participates in the investigation. However, the need to conduct an adequate investigation and to take corrective action may require disclosure of certain information. In some circumstances, the Company may be required by law to identify a person who makes a report or who is a witness. Staff and Hometown Health entities should be aware that members of Hometown Health's Special Investigation Unit, Compliance Department and members of the Legal Department, as well as others are legally obligated to act in the best interest of the Company.

b) Non-retaliation

The Renown Health Non-Retaliation Policy (Renown.CCD.065) prohibits any act of retaliation or retribution against staff who reports a possible violation, in good faith. Additionally, Federal and Nevada law prohibits retaliation against staff for disclosing or reporting a potential violation. Hometown Health will not retaliate against staff and/or an entity for good faith reporting.

c) NBI MEDIC

The Special Investigations Unit, and/or the Compliance Manager, if necessary, will coordinate or refer to NBI MEDIC the investigation of suspected fraudulent actives of misconduct relating to Part D or MA that could include:

i. Suspected, detected or reported criminal, civil and/or administration violations;

ii. Allegations extend beyond Part C and/or Part D programs that involve multiple health plans, multiple states and/or widespread schemes

iii. Allegations involving known patterns of fraud

iv. Schemes with large financial risk to the Medical Program and/or beneficiaries

The Special Investigations Unit will initiate an investigation of suspected fraudulent activities or misconduct within two (2) weeks from detection or will refer the matter to NBI MEDIC. The Special Investigations Unit will retain the NBI MEDIC acknowledgment letter and resolution letter in accordance with Renown Health's record retention policy, RENOWN.CCD.550.

V. Violation

Hometown Health will work with designated State and Federal agencies, the Medicare Drug Integrity Contractor ("MEDIC") and law enforcement to pursue and prosecute individuals or organizations who may be involved in activities that fall under the FWA umbrella.

Hometown Health takes compliance with this policy, and the laws and regulations underlying this policy serious. Staff and entities who fail to comply with this policy, or who negligently and/or willfully fail to detect and report suspected FWA violations will be subject to disciplinary action, including but not limited to:

- additional education/training
- written warning letter
- probation
- suspension
- termination of employment

Hometown Health may, where appropriate, terminate employment without having imposed any less severe disciplinary measures.

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).

- **Delegated subcontractor:** Any party, including an agent or broker that enters into an agreement with a delegated entity that contracts to provide some service or material necessary for the performance for the delegated entity's contract.

- **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).

- **Entity:** Means all of Hometown Health and Renown Health's FDRs, delegated entities, subcontractors and network providers.

- **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/).

- **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).

- **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.

- **Mental Health Parity and Addiction Equity Act ("MHPAEA"):** A federal law that generally prevents group health plans and health insurance issuers that provide mental health or

substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

- **National Benefit Integrity Medicare Drug Integrity Contractor ("NBI MEDIC"):** An organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI Medic's primary role is to identify potential FWA in Medicare Parts C and D programs on a national level.
- **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 or Part D sponsor by common ownership or control.
- **Waste:** Occurs when poor or inefficient practices result in unnecessary healthcare expenditures to a Government program.

References:

- Anti-Kickback Statute 42 USC §1320a-7b(b) and NRS §§439B.420-430
- Certifications and Program Integrity, 42 C.F.R. Part 438, Subpart H
- Requirements Relating To Health Care Access, 45 C.F.R. Subtitle A, Subchapter B
- 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
- Exceptions, 42 C.F.R. 1001.952 ("Safe Harbor")
- Federal False Claims Act, 31 U.S.C. §§ 3729–3733
- Federal Register / Vol. 64, No. 219 / Monday, November 15, 1999 /Notices ("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, 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
- Nevada Revised Statutes - Submission of False Claims to State or Local Government, §357.010 et seq.
- Prescription Drug Benefit Manual, Chapter 9 (“Compliance Program Guidelines”)
- RENOWN.CCD.550 - Records Retention
- RENOWN.CCD.065 – Non-Retaliation
- RENOWN.CCD.085 – Preventing and Detecting Fraud, Waste and Abuse
- RENOWN.FMM.004 – Gifts, Gratuities and Business Courtesies
- Social Security Act §§ 1128, 1156 and 1902
- Voluntary Medicare Prescription Drug Benefit, 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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