HOMETOWN HEALTH POLICY		Current Version Effective Date:	05/01/18
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Category:	Compliance	Creation Date:	02/26/07
Number:	Hometown.HCP.001	Revision History: 02/28/13 04/17/15 08/19/16 04/28/17 11/28/17 04/27/18	
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 ("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"), in the same manner and to the extent set forth in Hometown Health's policies, standard work and/or work aids; and

4) Network Providers, in the same manner and to the extent set forth in Hometown Health's policies & procedures.

Purpose: The purpose of Hometown.HCP.001 is to establish the policies & procedures that govern the Hometown Health Compliance Program ("Program").

Policy: The Program is part of the Renown Health Corporate Compliance Program. The Program implements policies, standard work and/or work aids to oversee the delivery of Medicare Advantage Plan ("MA") and/or MA Part C ("Part C"), Prescription Drug Plan ("PDP") and/or Part D, commercial insurance products and applies to plans which are sponsored by Hometown Health, including but not limited to: MA, PDP and Employer Group Waiver Plans ("EGWP") offered under Senior Care Plus ("SCP"), Medicare Supplement plan, individual and family plans, large and small employer group plans, self-funded plans, third-party administration, prescription benefit administration, Worker's Compensation, Healthy Tracks and other products sold under Hometown Health. The Federal and Nevada False Claims Act prohibits anyone from knowingly submitting a false claim or knowingly causing a false claim to be submitted to the federal government or its agents (*i.e.*, Medicare fiscal intermediary or carrier) for payment and/or approval. The False Claim Act prohibits anyone from knowingly making, using or causing to be made or using a false record or statement in order to receive payment on a false or fraudulent claim by the federal government or its agents.

I. The Program covers general topics applicable to Medicare and commercial insurance products. This policy supplements Renown Health Network Policies on corporate compliance:

- Compliance Policies & Procedures (Hometown.HCP.001);
- Scope and Objectives (Hometown.HCP.002);

- Compliance with Laws and Conflicts of Authority (Hometown.HCP.003);
- Compliance Program Officer and Committee (Hometown.HCP.004);
- OIG/GSA Exclusion Screening (Hometown.HCP.005);
- Education and Training (Hometown.HCP.006);
- Auditing and Monitoring (Hometown.HCP.007);
- Compliance Violation Reporting (Hometown.HCP.008);
- Effective Lines of Communication (Hometown.HCP.009);
- Oversight of Delegated Entities (Hometown.HCP.010);
- Risk Assessment (Hometown.HCP.011);
- The False Claims Act (Hometown.HCP.012);
- Anti-Kickback Statute (Hometown.HCP.013);
- The Beneficiary Inducement Law (Hometown.HCP.014);
- Detecting, Correcting and Preventing Fraud, Waste and Abuse (Hometown.HCP.015);

*** Note:** For Enforcement and Disciplinary Action policy and procedure, refer to RENOWN.CCD.025 – Disciplinary Action and Programmatic Corrections.

II. The Program is developed by the Hometown Health Compliance Manager and approved by the Renown Health Corporate Compliance Officer. The Program policies and procedures are reviewed annually by the Hometown Health Compliance Manager, in conjunction with the Renown Health Corporate Compliance Officer, at a minimum of once every twelve (12) months. Revisions to the Program include material changes to applicable State and Federal laws, regulations and statutes, and Program guidance.

III. The Program policies and procedures will be made available to all employees within 90 days of hire with Hometown Health and on an ongoing basis.

IV. 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.

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

VI. To monitor adherence to applicable laws, statutes and regulations, Hometown Health notifies 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:

- **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/).

- **Downstream Entity:** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with MA organization or Part D benefit, below the level of the arrangement between 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 CFR §§422.2, 423.4).

- **Employer Group Waiver Plan ("EGWP"):** A group Medicare Part D prescription drug plan option that is offered to retirees who have been promised prescription drug coverage as part of their Other Post-Employment Benefits. (http://egwpinfo.com/)

- **First-Tier Entity:** Any party that enters into a written arrangement, acceptable to CMS, with a 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 CFR §§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.

- **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.

References:

- 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")
- Prescription Drug Benefit Manual, Chapter 9 ("Compliance Program Guidelines")
- 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
- RENOWN.CCD.025 – Disciplinary Action and Programmatic Corrections
- Requirements Relating To Health Care Access, 45 C.F.R. Subtitle A, Subchapter B
- URAC Health Plan CORE Standard P-CORE 4 – Regulatory Compliance
- URAC Health Plan Standard P-CP 1 – Compliance Program: Internal Controls
- 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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Contributors:

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