HOMETOWN HEALTH POLICY		Current Version Effective Date:	05/01/19
Title:	Compliance Program Scope and Objectives	Next Review Date:	05/01/20
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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.002 is to describe the scope and objectives of the Hometown Health Compliance Program ("Program").

Policy: Hometown Health will develop and promote compliance with Federal and State laws, regulations, statutes and accreditation requirements. The Program's goal is to detect, prevent and correct non-compliance.

I. The Program's goal is to detect, prevent and correct non-compliance, and to promote compliance with State and Federal laws, regulations, statutes and accreditation requirements. To accomplish this, the Program shall consider contractual obligations between Hometown Health and CMS to sponsor MA and PDP plans exclusively for its Medicare eligible beneficiaries and their dependents. Additionally, as a provider of commercial insurance products in the State of Nevada and health plan accreditation status with URAC, Hometown Health is committed to comply with the terms and conditions of its contracts with CMS, the State of Nevada and URAC including implementing a compliance program set forth by the following regulations:

(a) DHHS OIG Compliance Program Guidance for Medicare+Choice Organizations (Federal Register / Vol. 64, No. 219 / Monday, November 15, 1999);

(b) Medicare Managed Care Manual, Chapter 21 ("Compliance Program Guidelines");

(c) Prescription Drug Benefit Manual, Chapter 9 ("Compliance Program Guidelines");

(d) Medicare regulations governing Parts C and D (42 C.F.R. 422, 423);

(e) Commercial insurance regulations relating to health care access (42 C.F.R. 140 through 159);

(f) Nevada Revised Statutes governing commercial insurance regulations in the state of Nevada (Title 57, Chapters 679A through 689C);

(g) URAC Health Plan Standard P-CORE 4 – Regulatory Compliance;

(h) URAC Health Plan Standard P-CP 1 – Compliance Program: Internal Controls;

(i) URAC Health Plan Standard CORE-16 - Confidentiality of Individually Identifiable Health Information;

(j) URAC Health Plan Standard OPS 12 – Breach Notification and Management;

(k) URAC Health Plan Standard CORE-6 – Delegation Review Criteria;

(l) URAC Health Plan Standard CORE 7 – Delegation Review;

(m) URAC Health Plan Standard CORE 8 – Delegation Contracts; and

(n) URAC Health Plan Standard CORE 9 – Delegation Oversight.

II. The Program should follow the eight fundamental elements of an effective compliance program:

(a) <u>Compliance Standards and Code of Conduct</u>
Develop and distribute written policies, procedures and Code of Conduct to comply with applicable Federal and State laws, regulations, statutes and accreditation requirements which define compliance expectations that:

i. implement the operation of the compliance program;

ii. provide guidance to employees and others in dealing with suspected, detected or reported issues of non-compliance;

iii. identify how to communicate compliance issues to appropriate compliance personnel;

iv. describe how suspected, detected or reported issues of non-compliance are investigated and resolved; and

v. develop a policy of non-intimidation and non-retaliation for good faith participation in the Program to include: reporting potential issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

As a division of Renown Health, Hometown Health has adopted Renown Health's Code of Conduct.

(b) Compliance Officer and Compliance Committee

Designate a Compliance Officer and a Compliance Committee with the responsibility of implementing and overseeing the Program. The Compliance Officer and Compliance Committee will report directly to the Renown Chief Compliance Officer, to Hometown Health Board of Directors and to other senior management as designated by the Chief Compliance Officer.

(c) Education and Training

Establish, implement and provide an effective education and training program(s) to all persons. Compliance education and training should occur upon hire and annually thereafter. This element is consistent with Renown Health Network Policy RENOWN.CCD.015.

(d) Communication and Reporting

Establish and implement an effective line of communication to ensure confidentiality between Hometown's Compliance Officer, members of the Compliance Committees, employees/managers, Hometown and Renown Health's Boards and all FDRs. Hometown's lines of communication are accessible to all and allow for anonymous and confidential good faith reporting of compliance issues. This element is consistent with Renown Health Network Policies RENOWN.CCD.020 and RENOWN.CCD.065.

(e) Publicized Disciplinary Guidelines

Develop and publicize disciplinary standards through the implementation of policies & procedures to encourage good faith participation in the Program. The Program articulates expectations for reporting and assisting in the resolution of compliance issues, identifying non-compliance or unethical behavior and provides for consistent enforcement of standards when non-compliance or unethical behavior is identified. This element is consistent with Renown Health Network Policy RENOWN.CCD.025.

(f) Auditing and Monitoring

Consistent with Renown Health Network Policies RENOWN.CCD.010 and RENOWN.CCD.050, Hometown Health has a system for identifying compliance risks through auditing and monitoring that:

i. develops of an audit work plan;

ii. implements targeted audits based on audit work plan risk rating;

iii. performs routine internal monitoring of compliance risk areas by business unit;

iv. performs periodic internal auditing to validate results of monitoring;

v. conducts external audits of FDR entities;

vi. engages and participates in internal audits performed by Renown Health or other applicable internal entities; and

vii. engages with and participates in external audits performed by CMS, URAC, Nevada Division of Insurance, independent audit firms and/or other applicable external agencies.

(g) Prompt Responses Through Investigations and Corrective Action
The Program establishes and implements systems to respond to potential issues of non-compliance, illegal and unethical conduct, and fraud, waste and abuse (FWA) and report to the Compliance Officer. Potential issues of non-compliance are responded to through compliance reports. Inquiries, investigations and any corrective action, if necessary, are implemented to ensure appropriate remediation and resolution. This element is consistent with Renown Health Network Policy RENOWN.CCD.025.

(h) Risk Assessment
The Compliance Officer performs a comprehensive assessment of Hometown Health's Compliance Program and the organization's operational performance. The assessment should include an independent and objective review of the Program to measure its effectiveness of compliance and to engage in continuous improvement in the performance of operations.

III. Hometown Health maintains a FWA program to promote the prevention, detection and resolution of FWA that does conform to State and Federal law, Renown Code of Conduct and the Program. Hometown Health performs a detailed analysis of reported instances of FWA in order to recover improper payments made to providers for substantiated claims of FWA. The FWA program is consistent with Renown Health Network Policy RENOWN.CCD.085.

IV. Hometown Health is committed to the oversight and management of delegated entities. As a sponsor of Medicare and commercial insurance products, Hometown Health contracts with delegated entities to administer insurance functions on behalf of the company. Hometown Health recognizes that as sponsor, it is accountable to regulatory agencies for the function and activities that have been delegated and the company should ensure that these functions are performed in compliance with applicable standards, regulations and Program requirements.

V. Hometown Health may not make Medicare payments for items or services furnished or prescribed by an excluded or precluded provider or entity. Hometown Health also should not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider,

supplier, staff or delegated entity excluded by the DHHS OIG or GSA or precluded by CMS. Per RENOWN.CCD.035, Hometown Health reviews the DHHS OIG List of Excluded Individuals and Entities (LEIE list located at https://oig.hhs.gov/exclusions/exclusions_list.asp, https://exclusions.oig.hhs.gov/), the GSA Excluded Parties List System (EPLS located at http://www.epls.gov/) and the System for Award Management (SAM located at https://www.sam.gov/portal/SAM/##11) prior to the hiring or contracting any new staff, temporary staff, volunteer, consultant, governing body member, and delegated entity and periodically ensures that no staff or entities are excluded or become excluded from participation in federal programs. After the initial screening of entities against the entire LEIE and EPLS at the time of hire or contracting, Hometown Health reviews the LEIE supplement file and EPLS updates monthly.

VI. Hometown Health shall provide guidance to company representatives, receive reports of suspected or actual HIPAA/HITECH incidents and report those incidents to Renown Corporate Compliance and Privacy Officer for resolution. Hometown Health's HIPAA/HITECH activities is consistent with Renown Health Network Policies RENOWN.CCD.705 through RENOWN.CCD.790.

VII. Hometown Health is committed to reporting compliance violations. If credible evidence of misconduct is discovered and it is determined that misconduct may have resulted in violation of criminal, civil, or administrative law; legal counsel should be notified to determine self-reporting requirements and appropriate next steps. Hometown Health voluntarily self-reports potential fraud or misconduct related to the Medicare program to CMS or its designee such as the NBI MEDIC. HIPAA/HITECH breaches are documented and reported to the Renown Compliance Officer. Hometown Health's reporting procedures are consistent with Renown Health Network Policy RENOWN.CCD.050.

VIII. 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.

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

X. To monitor adherence to applicable laws, statutes and regulations, Hometown Health notifies its delegated contractors of changes impacting compliance, including but not limited to, 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).

- **U.S. Department of Health & 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/)

- **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).

- **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/).

- **Government Services Administration ("GSA"):** An independent agency of the United States government, it combines the Central Contractor Registration (CCR/FedReg), Online Representations & Certifications Application (ORCA) and the Excluded Parties List System (EPLS) into one main contractor database. This database was named System for Award Management or better known as the SAM registration.

- **Health Insurance Portability and Accountability Act ("HIPAA"):** HIPAA sets the standard for protecting sensitive patient data.

- **The Health Information Technology for Economic and Clinical Health Act ("HITECH"):** Provides HHS with the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of health IT, including electronic health records and private and secure electronic health information exchange.

- **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).

- **Waste:** Occurs when poor or inefficient practices result in unnecessary healthcare expenditures to a Government program.

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")
- 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
- Prescription Drug Benefit Manual, Chapter 9 ("Compliance Program Guidelines")
- Renown Health Compliance Program
- Renown Health Code of Conduct
- RENOWN.CCD.010 – Auditing and Monitoring
- RENOWN.CCD.015 – Compliance Education and Training
- RENOWN.CCD.020 – Compliance Violation Reporting
- RENOWN.CCD.025 – Disciplinary Action and Programmatic Corrections
- RENOWN.CCD.035 – Exclusion Screening
- RENOWN.CCD.050 – Government Investigations
- RENOWN.CCD.065 – Non-Retaliation
- RENOWN.CCD.070 – Operational Management Responsibilities
- RENOWN.CCD.085 – Preventing and Detecting Fraud, Waste and Abuse
- RENOWN.HIM.016735 - Designated Record Set Policy
- RENOWN.CCD.777 - Personal Representatives
- RENOWN.CCD.782 - Safeguarding Protected Health Information -- Disposal
- RENOWN.CCD.730 - Uses and Disclosure of Psychotherapy Notes
- RENOWN.CCD.735 - Patient Right to Access Inspect and Copy
- RENOWN.CCD.780 - Using PHI for Research Purposes
- RENOWN.CCD.750 - Patient/Member Request for Additional Privacy Protection
- RENOWN.CCD.755 - Patient/Member Right to Access Protected Health Information
- RENOWN.CCD.750 - Accounting for Disclosures of Protected Health Information
- RENOWN.CCD.765 - Patient Filing a HIPAA Complaint

- RENOWN.CCD.767 - Mitigating Privacy Violations
- RENOWN.CCD.770 - Minimum Necessary
- RENOWN.CCD.775 - Business Associates
- RENOWN.CCD.780 - HIPAA and Research
- RENOWN.CCD.781 - De-Identification of Protected Health Information
- RENOWN.CCD.782 - Safeguarding Protected Health Information and its Disposal
- RENOWN.CCD.783 - Safeguarding Protected Health Information Transmitted via Facsimile
- RENOWN.CCD.785 - Limited Data Sets
- RENOWN.CCD.790 - Patient Privacy - Breach Notification
- 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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