HOMETOWN HEALTH POLICY		Current Version Effective Date:	05/01/18
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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.007 is to establish a proactive, robust and ongoing monitoring and auditing program to assess compliance with internal processes and procedures and to implement corrective action plans to comply with federal, state and other applicable regulations. This includes the oversight of FDR entities. This policy also ensures effective lines of communication exist between the Compliance Manager, Compliance Committee, staff, and other plan stakeholders involved in the oversight of Medicare Part C, Part D and commercial insurance operations.

Policy: Consistent with the Renown Health Network Policy governing compliance auditing and monitoring, RENOWN.CCD.010, Hometown Health develops, implements and maintains an auditing and monitoring program to prevent, detect and deter non-compliance and potential criminal or improper conduct. Upon completion of auditing and monitoring activities, the Compliance department, with the assistance of operational business owners, shall verify that a corrective action plan is developed and implemented by the business areas and FDRs.

I. Risk Assessment

The Compliance Officer will conduct a formal baseline assessment of operational, compliance and FWA risk areas through an organizational risk assessment.

Risks identified by the organizational risk assessment is ranked to determine the risk areas with the greatest impact on Hometown Health plan operations and is prioritized with the auditing and monitoring strategy.

II. Information Gathering and Analysis

The Compliance Officer will gather information regarding compliance and performance incidents that have occurred during the auditing and monitoring period under review. Reported misconduct and non-compliance will be used to inform the Program as it relates to the auditing and monitoring work plan.

III. Auditing and Monitoring Work Plan, Schedule and Methodology

The Compliance Officer shall develop an auditing and monitoring work plan upon completion of the organizational risk assessment. The work plan includes compliance audits of Hometown Health's operational areas, compliance audits of its FDR entities, external audits in which Hometown Health is engaged by federal and state regulatory agencies, and include a combination of remote desktop audits, onsite audits and unannounced audits or "spot checks." The Compliance Officer may coordinate with various departments to develop a work plan. The work plan includes:

- Audits to be completed
- Audit schedules
- Announced or unannounced audits
- Internal or external audit
- Audit methodology
- Required resources
- Type of audit (remote desktop or onsite)
- Responsible person
- Final audit report due date
- Follow up and corrective action plans from findings

The work plan must include a process for responding to all auditing and monitoring results and for conducting follow-up reviews of areas found to be non-compliant to determine if corrective actions have addressed the root cause. Corrective action and follow-up is led and/or overseen by the Compliance Officer and, if necessary, findings are self-reported by Hometown Health to the applicable regulatory entity. The work plan includes a schedule of the auditing and monitoring activities for the fiscal year.

(a) Auditing and Monitoring of the Hometown Health Operations and Compliance Program

The Compliance Officer is responsible for auditing and monitoring operational areas to ensure compliance with Medicare and commercial insurance regulations. Hometown Health will devote adequate resources to the audit function to meet the goals of the auditing and monitoring work plan. The Compliance department will remain independent from operational areas to preserve the audit function. Staff from operational areas may assist in audit activities provided that the assistance given is compatible with the independence of the audit function.

The effectiveness of the Hometown Health Compliance Program will be assessed through audit on an annual basis, as recommended by the OIG and CMS. The results of the compliance program effectiveness assessment is shared with the Hometown Health Compliance Committee, the Board, and the Renown Health Audit and Compliance Committee, if necessary. To ensure independence of this review, the Hometown Health compliance department staff may not conduct the formal audit of the effectiveness of the Hometown Health Compliance Program.

(b) Auditing and Monitoring FDR and Delegated Entities

The work plan includes the number of FDR and delegated entities that will be audited each year and how these entities will be identified for auditing. The monitoring of FDR and delegated entities for the Program requirements will include an evaluation to confirm that the entity is imposing requirements, auditing and monitoring, implementing corrective action, and monitoring adherence with corrective action of its downstream entities.

IV. Ongoing Monitoring and Auditing

Hometown Health will perform monitoring and auditing to test and confirm compliance with Medicare and commercial insurance regulations, applicable federal and state laws and internal standards to prevent, detect and deter non-compliance and potential criminal and/or improper conduct.

The work plan will address the risks associated with Medicare and commercial insurance benefit administration. The work plan will include oversight of FDR, delegated entities, FWA investigations, sanction screening and all external reviews Hometown Health may be subject to by federal and state regulatory agencies. The work plan is coordinated, overseen and executed by the Compliance Officer. The Compliance Officer will provide reports of completed audits to the Compliance Committee (which include Hometown Health's CEO, CFO, CMO and other senior leadership), Renown's Chief Compliance Officer, Hometown Health Board of Directors and Renown Health Audit and Compliance Committee, if necessary.

Monitoring activities refer to regular reviews performed as part of normal operations to confirm ongoing compliance. Department leaders are responsible for ensuring compliance with policies and procedures including Medicare and commercial insurance regulations, sub-regulatory guidance, contractual agreements and all other applicable federal and state laws, regulations and statutes.

Performance monitoring connected to Medicare Parts C, D and commercial insurance benefit administration may be delegated to the Performance department with oversight responsibility by the Compliance department.

V. Disclosure of Auditing and Monitoring Results

The Compliance Officer will provide a formal report of completed audits to the Compliance Committee (which includes Hometown Health's CEO, CFO, CMO and other senior leadership), Renown's Chief Compliance Officer, Hometown Health Board of Directors and Renown Audit and Compliance Committee, if necessary.

VI. Attorney/Client Privilege

The Compliance Officer has the discretion to engage legal counsel to assist in establishing the method of conducting an audit, when appropriate, to maintain any legal privileges. In the event an audit or review indicates a potential violation, the Compliance Officer or designee will take appropriate action to:

- Conduct an investigation
- Impose disciplinary action
- Implement corrective action
- Modify health plan policy, procedure or current practice
- Report to applicable government agencies
- Return overpayments received by Hometown Health in error
- Adjust prescription drug event (PDE) data

VII. 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.

VIII. To effectively monitor adherence to applicable laws, statutes and regulations, Hometown Health should 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.

IX. 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).
- **Auditing:** A formal review to assess compliance with a particular set of standards (*e.g.*, policies and procedures, laws and regulations).
- **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/).
- **Corrective Action:** A measure taken to mitigate, remediate and prevent the reoccurrence of the deficiencies, issues, defects or undesirable conditions identified through auditing or monitoring activities.
- **Corrective Action Plan (CAP):** A formal document completed by the business owner and the Compliance department to record the action taken, the responsible person and applicable deadlines to remedy areas of high risk or non-compliance.
- **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. Medicare Advantage Plans are also known as Medicare + Choice Plans.
- **Monitoring:** Regular and ongoing reviews performed as part of normal plan operations. Monitoring may occur to confirm ongoing compliance and to ensure that corrective action is completed and are effective to mitigate and/or remediate identified high risk areas.
- **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 or Part D sponsor by common ownership or control.
- **U.S. Department of Health and 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/).
- **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”)
- RENOWN.CCD.010 – Auditing and Monitoring
- URAC Health Plan CORE Standard P-CORE 4 – Regulatory Compliance (Ver. 3.0)
- URAC Health Plan Standard P-CP 1 – Compliance Program: Internal Controls (Ver. 7.1)
- USA, Department of Justice, Criminal Division, Fraud Section. (n.d.). Evaluation of Corporate Compliance Programs

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Contributors:

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