HOMETOWN HEALTH POLICY		Current Version Effective Date:	05/01/18
Title:	False Claims Act	Next Review Date:	05/01/20
Category:	Compliance	Creation Date:	02/26/07
Number:	Hometown.HCP.012	Revision History: 04/28/17 04/27/18 04/18/15 10/25/12 08/19/16	
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.020 is establish policies & procedures for compliance with both the Federal and Nevada False Claims Act (31 U.S.C. §§ 3729–3733; NRS 357) ("False Claims Act").

Policy: It is the policy of Hometown Health to comply with the Federal and Nevada False Claims Act.

I. 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 used a false record or statement in order to receive payment on a false or fraudulent claim by the federal government or its agents.

II. When submitting claims, enrollment or other data to CMS for payment purposes, Hometown Health, as appropriate, will certify that the data is true and accurate to the best of the company's knowledge, information and belief.

III. To the extent Hometown Health cannot make the certification, as listed in section II above, the company will modify the certification and take appropriate steps to remediate the underlying issue. Hometown Health will not sign a certification that the company does not believe is true and accurate to the best of the company's knowledge, information and belief.

IV. In the event Hometown Health identifies or discovers a potential violation of the False Claims Act (including any violation by a delegated entity or network provider) the company will investigate and remediate the potential violation, as appropriate, to include reporting the violation to the government.

V. Hometown Health may require its delegated entity or network provider to certify that any data submitted to Hometown Health is true, accurate and complete.

VI. Inquiries that relate to this Hometown Health Policy or matters that are not specifically addressed by this policy should be directed to the Hometown Health Manager of Compliance.

VII. To 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 management protocols which impact compliance.

VIII. To monitor adherence to applicable laws, statutes and regulations, Hometown Health should 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 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).
- **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/).
- **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:

- 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 False Claims Act, N.R.S. §§ 357.010 - 357.250
- 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”)
- The False Claims Act, 31 U.S.C. §§ 3729 – 3733
- 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

Contributors:

- Philip Ramirez, Manager of Compliance – Hometown Health