| HOMETOWN HEALTH POLICY | | Current Version Effective Date: | 05/01/18 |
|---|---|---|---|
| Title: | Beneficiary Inducement Statute | Next Review Date: | 05/01/20 |
| Category: | Compliance | Creation Date: | 02/26/07 |
| Number: | Hometown.HCP.014 | Revision History: 04/27/17 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.014 is to establish policies & procedures for compliance with certain aspects of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") related to beneficiary inducements ("Beneficiary Inducement") (42 U.S.C. § 1320a-7a(a)(5); Section 1128A(a)(5) of the Social Security Act).

---

**Policy:** It is the policy of Hometown Health to comply with the Beneficiary Inducement Statute.

I. Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5); Section 1128A(a)(5) of the Social Security Act) provides for civil monetary penalties ("CMPs") against any person (including a legal entity) that offers or transfers remuneration to a Medicare or state health care program beneficiary that a person knows or should know is likely to influence the beneficiary to order or receive from a particular provider, practitioner or supplier any item or service for which payment may be made, in whole or in part, by Medicare or a state health care program. Remuneration for purposes of the Statute includes the transfer of items or services for free or for other than fair market value.

II. Hometown Health and its employees, network providers and delegated entities will not provide remuneration to beneficiaries in violation of the Beneficiary Inducement Statute.

III. In the event Hometown Health identifies or discovers a potential violation of the Beneficiary Inducement (including any violation by a delegated entity or network provider) the company will investigate and remediate the potential violation, to include informing the government.

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

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

VI. To monitor adherence to applicable laws, statutes and regulations, Hometown Health will 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 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 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 Beneficiary Inducement Law, 42 U.S.C. §§ 1320a - 7a(a)(5)
- 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