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Alerts

Healthcare Providers, Agents, and Brokers: Please Stop, Look, and Listen Before Entering Into Suspect Medicare Advantage Plan Marketing Arrangements

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Attorneys

Michael A. Dowell

Introduction

Special Fraud Alerts

The Office of Inspector General (OIG) of the U.S. Department of Health & Human Services (HHS) issues **Special Fraud Alerts** regarding healthcare fraud and abuse patterns or practices it has recently identified and intends to investigate and prosecute.

Special Fraud Alerts provide guidance on potential violations of federal fraud and abuse laws, including the federal anti-kickback statute, and encourage the healthcare industry to review internal practices to ensure compliance in the identified risk areas.

Suspect Marketing Arrangements

One such recent Special Fraud Alert warns about certain **marketing arrangements** involving the Medicare Advantage program.

These marketing arrangements involve questionable payments and referrals between Medicare Advantage plans ("MA Plans"), healthcare providers ("Providers"), agents, brokers, and third-party marketing organizations ("TMOs), " such as field marketing organizations. The OIG expressed concern that the marketing arrangements may mislead Medicare enrollees into enrolling in MA Plans.

The OIG also cautioned that such arrangements may cause them to choose specific MA Plans or Providers that may not meet the enrollees' needs due to improper steering of Medicare enrollees to a particular MA Plan or Provider based on financial incentives for the Provider or a third party, rather than the most appropriate MA Plan or Provider for the enrollee.

These suspect marketing arrangements implicate multiple fraud and abuse laws, including the Federal Anti-Kickback Statute ("AKS"), Civil Monetary Penalty Laws ("CMPL"), and the False Claims Act ("FCA"):

- The **AKS** makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce, or in return for, the referral of an individual to a person for the furnishing of, or arranging for the furnishing of, any item or service reimbursable under a federal healthcare program.
- The **CMPL** authorizes the OIG to impose penalties, assessments, and program exclusions for fraud and abuse in federal healthcare programs.
- The **FCA** is a federal law that protects the federal government from fraud and abuse by making it illegal to submit a false claim to the government.

Types of Suspect Marketing Arrangements

The OIG identified two types of suspect marketing arrangements:

(1) payments from MA Plans to Providers or their staff to refer patients to specific MA Plans; and

(2) payments from Providers to agents, brokers, or TMOs to refer MA Plan enrollees to the Providers.

Arrangements involving MA Plan compensation to a Provider or their staff could implicate the AKS if the MA Plan offers and pays a Provider or their staff to refer enrollees to a particular MA Plan. Arrangements involving Provider compensation to an agent, broker, or TMO could implicate the AKS if the Provider offers or pays an agent, broker, or TMO to refer enrollees to the Provider for the furnishing or provision of items or services that are reimbursable by a federal healthcare program.

MA Plan Payments to Providers

One compliance risk area involves MA Plans, directly or indirectly, paying remuneration to Providers or their staff in exchange for referring patients to them. **Centers for Medicare & Medicaid Services (CMS)** regulations allow Providers to engage in certain limited marketing or communications-related functions on behalf of an MA Plan.

However, MA Plans are required to ensure that Providers acting on their behalf do not "[a]ccept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization."

MA Plans paying remuneration to Providers or their staff in exchange for referrals or recommendations can result in individuals being enrolled in MA Plans that fail to meet the enrollees' needs. Additionally, an MA Plan may use these payments to Providers or their staff to selectively target individuals for enrollment who are expected to result in increased profits to the MA Plan or, conversely, avoid or discourage enrollment of individuals who are expected to be more costly. Such targeting could constitute discrimination against protected classes of enrollees, such as individuals with disabilities.

MA Plan Payments to Agents and Brokers

Another key compliance risk area involves payments from Providers to agents, brokers and TMOs, such as payments from a Provider to agents and brokers to recommend that Provider to a particular MA enrollee or to refer the enrollee to the Provider.

Agents and brokers who have established relationships with Medicare enrollees may be able to influence those enrollees' Provider selections. The OIG is concerned that agents, brokers, TMOs, and Providers may skew their guidance when providing recommendations regarding Providers or MA Plans based on their improper financial self-interest. The OIG expressed concerns that enrollees were not aware of these financial arrangements and that they may rely on the recommendation of an agent, broker or TMO in making Provider selection decisions that may not best suit their particular needs.

Suspect Marketing Arrangement Characteristics

The OIG developed the list below of suspect characteristics regarding the types of marketing arrangements described above. These characteristics, taken together or separately, could suggest that an arrangement presents a heightened risk of fraud and abuse. This list is illustrative, not exhaustive, and the presence or absence of any one of these factors is not determinative of whether a particular arrangement would be grounds for legal sanctions:

1. MA Payments to Providers or their Staff (Directly or Indirectly Through Agents, Brokers, or TMOs)

- **Payments for Referrals**: Offering or paying a Provider or their staff remuneration (such as bonuses or gift cards) in exchange for referring or recommending patients to a particular MA Plan.
- **Compensation Disguised as Legitimate Payments:** Offering or paying a Provider remuneration that is disguised as payment for legitimate services but is intended to be payment for the Provider's referral of individuals to a particular MA Plan.
- **Compensation for Patient Information**: Offering or paying a Provider or their staff remuneration in exchange for sharing patient information that may be used by the MA Plans to market to potential enrollees.
- **Compensation Based on Health Status**: Offering or paying remuneration to a Provider that is contingent upon or varies based on the demographics or health status of individuals enrolled or referred for enrollment in an MA Plan.
- **Compensation Based on the Volume or Value of Referrals**: Offering or paying remuneration to a Provider that varies based on the number of individuals referred to for enrollment in an MA Plan.

2. Provider Payments to Agents, Brokers, or TMOs

- **Payments for Referrals**: Offering or paying an Agent, Broker, or TMO remuneration (such as bonuses or gift cards) in exchange for referring or recommending patients to a particular MA Plan.
- **Compensation Based on Health Status**: Offering or paying remuneration to an agent, broker, or TMO that is contingent upon or varies based on the demographics or health status of individuals enrolled or referred for enrollment in an MA Plan.
- **Compensation Based on the Volume or Value of Referrals**: Offering or paying remuneration to an agent, broker, or TMO that varies based on the number of individuals referred to for enrollment in an MA Plan.

These practices, alone or in combination, represent potentially abusive practices that could implicate the AKS, CMPL, and/or the FCA.

Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)

On April 4, the Centers for Medicare & Medicaid Services (CMS) released the Contract Year (CY) 2025 Medicare Advantage (MA) and Medicare Part D Policy and Technical Changes final rule ("Final Rule"), which included revisions to the regulations governing how MA organizations and Part D plan sponsors (referred to collectively throughout as "issuers") compensate agents, brokers, and third parties.

The MA Marketing Fraud Alert aligns with the Final Rule relating to MA Plan marketing arrangements with agents, brokers, and TMOs, which will be effective on **January 1, 2025**.

MA Plan Contracts with Agents and Brokers

The Final Rule focuses on payment structures among MA Plans and agents, brokers, and TMOs that may incentivize agents or brokers to prioritize one plan or provider over another regardless of each beneficiary's needs.

- **Compensation:** The Final Rule redefines "compensation" in a manner that establishes the goal of the Final Rule is to ensure that agent and broker compensation reflects only the legitimate activities required of agents and brokers by broadening the scope of the regulatory definition of "compensation," so that it is inclusive of all activities associated with the sales to/enrollment of an individual into an MA Plan.
- **Fixed Fee Agent Broker Compensation:** The Final Rule's new definition of compensation establishes a clear, fixed amount that agents and brokers can be paid regardless of the plan the individual enrolls in. It also closes loopholes historically utilized by MA Plans to pay commissions above compensation caps that create anti-competitive and anti-consumer steering incentives (42 C.F.R. § 422.2274(a) and 423.2274(a).
- **Administrative Payments:** The definition of compensation was amended to include "administrative payments" and set a fixed compensation rate for agents, brokers, and TMOs that reflects the inclusion of such administrative payments 42 C.F.R. § 422.2274(a) and 423.2274(a).
- **Perverse Incentives**: Additionally, the Final Rule generally prohibits contract terms between Medicare Advantage organizations/Part D sponsors and middleman Third-party Marketing Organizations (TMOs), such as field marketing organizations, which may directly or indirectly create an incentive to inhibit an agent or broker's ability to objectively assess and recommend the plan that is best suited to a potential enrollee's needs.

Prohibiting contract terms between issuers and agents and brokers that may create direct or indirect incentives "that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the healthcare needs of a beneficiary." 42 C.F.R. § 422.2274(c)(13) and § 423.2274(c)(13). In the Final Rule, CMS provides the following examples of contract terms that will be impermissible under this prohibition:

- Contract terms that specify renewal or other terms of an MA Plan's contract with an agent broker or TMO contingent upon preferentially higher rates of enrollment;
- Contract terms that make an MA Plan's contract with a TMO or reimbursement rates for marketing activities contingent upon agents and brokers employed by the TMO meeting specified enrollment quotas;
- Contract terms that provide bonuses or additional payments from an MA Plan to a TMO with the explicit or implicit understanding that the money be passed on to agents or brokers based on enrollment volume in plans sponsored by that MA Plan; and
- Contract terms that require a TMO to provide an agent or broker leads or other incentives based on previously enrolling beneficiaries into specific MA Plans for a reason other than what best meets their healthcare needs.

New Requirements for TMOs

The Final Rule codifies the requirement that personal beneficiary data collected by a TMO for marketing or enrolling beneficiaries into an MA plan may only be shared with another TMO when the beneficiary gives prior express written consent. The Final Rule defines **"personal beneficiary data"** to include contact information (e.g., name, address, and phone number) and any other information given by the beneficiary for the purpose of finding an MA Plan, including health information, age, gender, or disability.

Prior express written consent from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject the sharing of their data with each individual TMO.

The Final Rule clarifies, however, that as an exception to this requirement, a TMO transferring a live phone call from a beneficiary to another TMO who can provide real-time assistance (such as an agent or broker) would not require prior express written consent so long as the beneficiary verbally agreed to be transferred during the call.

Compliance Best Practices

Abusive marketing arrangements involving MA Plans, agents, brokers, and Providers may lead to criminal, civil, or administrative liability under other federal laws, including, for example, the OIG's exclusion authority related to kickbacks, the CMPL provision granting the OIG authority to assess civil monetary penalties for MA Plan misconduct, and the FCA.

Recent OIG MA Plan Marketing Enforcement Actions

MCS Advantage

In 2022, the OIG announced that MCS Advantage, an MA Plan, had agreed to pay $4.2 million dollars to resolve FCA allegations regarding a gift card incentive program. The OIG alleged that MCS Advantage submitted, or caused to be submitted, claims for payment to the Medicare Program relating to a gift card incentive program implemented by MCS, which the government alleges resulted in violations of the False Claims Act and the Anti-Kickback Statute.

As a result of the incentive program, MCS distributed 1,703 gift cards to administrative assistants of Providers at an aggregate cost of $42,575 to induce the assistants to refer, recommend, or arrange for enrollment of 1,646 new Medicare beneficiaries to the MCS MA Plan.

Oak Street Health

In 2023, Oak Street Health, a wholly-owned subsidiary of CVS Health, agreed to pay $60 million to resolve allegations that it violated the False Claims Act by paying kickbacks to third-party insurance agents under a Client Awareness Program (the "Program"), in exchange for recruiting Medicare beneficiaries to Oak Street Health's primary care clinics.

Under the Program, third-party insurance agents contacted seniors eligible for or enrolled in Medicare Advantage and delivered marketing messages designed to generate interest in Oak Street Health.

Agents then referred interested seniors to an Oak Street Health employee via a three-way phone call, otherwise known as a "warm transfer," and/or an electronic submission. In exchange, Oak Street Health paid agents typically $200 per beneficiary referred or recommended. The OIG asserted that the payments incentivized agents to base their referrals and recommendations on Oak Street Health's financial motivations rather than the best interests of Medicare beneficiaries.

Compliance Best Practices

- **Providers:** Providers that receive payments from MA Plans or who employ or contract for the services of agents, brokers, or other MA Plan marketers should review their contractual arrangements, employment arrangements, compensation arrangements, and policies and procedures to ensure that such do not exhibit any of the suspect characteristics described in the Special Fraud Alert or that are otherwise prohibited by the Final Rule.
- **Agents, Brokers, and TMOs***:* Agents, brokers, and TMOs who pay or receive payments from Providers or MA Plans for MA Plan marketing services should review their contractual arrangements, employment arrangements, compensation arrangements, and policies and procedures to ensure that such do not exhibit any of the suspect characteristics described in the Special Fraud Alert or that are otherwise prohibited by the Final Rule.
- **MA Plans:** MA Plans that make payments to Providers or who employ or contract for the services of agents, brokers, TMOs, or other MA Plan marketers should review their contractual arrangements, employment arrangements, compensation arrangements, and policies and procedures to ensure that such do not exhibit any of the suspect characteristics described in the Special Fraud Alert or that are otherwise prohibited by the Final Rule.
- **MA Plans, Providers, Agents, Brokers, and TMOs:** MA Plans, Providers, agents, brokers, and TMOs should also consider revising policies and procedures and their compliance programs. They should also ensure that staff are trained on compliance with the new requirements and that their compliance programs implement monitoring and auditing techniques to detect and prevent suspect marketing arrangements and ensure compliance with the Special Fraud Alert and the Final Rule.

Stop, Look, and Listen to Legal Counsel

MA Plans, Providers, agents, brokers, and TMOS should consult knowledgeable healthcare attorneys to review and evaluate any MA Plan marketing arrangements for compliance with the Special Fraud Alert and the Final Rule.

Hinshaw's Health Care law attorneys are available to provide advice and counsel on fraud and abuse matters, including AKS, CMPL, and FCA matters, and can assist healthcare organizations in implementing internal mechanisms to ensure that MA Plan marketing arrangements comply with the Special Fraud Alert and the Final Rule.