

## Prohibited Inducements in Medicare and Medicaid Draw Growing Attention

The US Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) continue to rigidly enforce the federal rules that strictly prohibit Medicare and Medicaid providers from giving beneficiaries any sort of goods or services that might be interpreted as "prohibited inducements" to select one provider over another for covered health care services. According to the "Special Advisory Bulletin" issued by the HHS Office of Inspector General, "...a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner or supplier of Medicare or Medicaid payable items or services may be liable for civil monetary penalties (CMPs) of up to \$10,000 for each wrongful act."

HHS has reported that they will interpret

the prohibition to apply to any gift offered or provided to program beneficiaries that has a retail value of more than \$10 individually, or a cumulative value of more than \$50 in a calendar year. "This prohibition has serious implications for the chiropractic practitioner since even the provision of transportation to and from a chiropractic appointment as a courtesy to the Medicare patient becomes a violation of this rule if the value of that transportation exceeds \$10," said ICA Medicare Committee Chair Dr. Michael Hulsebus. "This prohibition applies to both participating and non-participating Medicare providers and all providers, suppliers, etc. in the joint state-federal Medicaid program."

ICA urges extreme caution in this area because of the extreme penalties possible under this rule. Practice promotion incentives that include any discount on examina-

tions, x-rays or any other item of value that exceeds \$10 become a source of potential enforcement action. Likewise, the waiving of co-payments and other fee adjustments may involve a similar liability. This rule applies to both existing, longstanding patients as well as new or possible new patients.

"ICA believes that all DCs must be made aware and/or reminded of this important federal rule in order to help avoid the increasingly aggressive enforcement actions coming out of CMS," Dr. Hulsebus said.

More information on this federal rule, the "**Special Advisory Bulletin: Offering Gifts and other Inducements to Beneficiaries**" published by the HHS Office of Inspector General can be accessed online at: <http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf>

## Medicare Announces Suspension of PFFS Marketing in Response to Deceptive Marketing Practices

On June 15, 2007, The Centers for Medicare and Medicaid Services (CMS) announced that in response to concerns about highly questionable marketing practices, seven health care plan sponsors signed an agreement to suspend voluntarily the marketing of Private-Fee-For-Service (PFFS) plans.

According to the government announcement, "This suspension for a given plan will be lifted only when CMS certifies that the plan has the systems and management controls in place to meet all of the conditions specified in the 2008 Call Letter and the May 25, 2007 guidance issued by CMS. The signatories include: United Healthcare, Humana, Wellcare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee."

"While we note that most health insurance agents are helpful and responsible in describing and explaining choices to beneficiaries, there are a few bad actors that need

to be removed from the system for good," said Leslie V. Norwalk, Esq., Acting Administrator of CMS. "Through a variety of methods, including our 'secret shopper' program that uses trained individuals to attend marketing events and report back on the insurance agents' activities, and the eyes and ears of our thousands of partners throughout the nation, CMS is proactive in protecting beneficiaries from rogue agents. Although the 2,700 agent complaints we logged from December 2006 to April 2007 represent less than one half of one percent of the 1.3 million members enrolled in individual PFFS plans, we can always do better," added Norwalk.

The agreement will continue to apply to individual plans until they have demonstrated to CMS that they have the systems and management controls in place to ensure they can meet all the CMS requirements. Insurance companies signing the agreement will be actively monitored to ensure they do not engage in marketing

while the voluntary suspension is in place. Violations will be subject to a full range of available penalties, which can include suspension of enrollment, suspension of payment for new enrollees, civil-monetary penalties, and termination of the plan's involvement in the Medicare program. The full range of updated conditions will be in effect for all sponsors of PFFS plans beginning October 1, 2007, and violations of those conditions will be subject to the same types of penalties.

"We want to underscore that Corrective Action Plans already in place will remain in effect until full compliance is attained and investigations underway involving fraud or criminal activity will continue to their appropriate conclusion," added Norwalk. "In addition, once marketing resumes, CMS will actively monitor performance. Any violations of the requirements set forth in CMS guidance will be subject to immediate remedial action in accordance with standard procedures."

## Medicare Plans Test of Greater Online Access to Beneficiaries of their Personal Records

Personal information, including claims data, has always been available to Medicare beneficiaries if they request it in writing. Requests for paper copies of billing summaries have been relatively rare. Additional data has also been made available to registered participants through a government website at [www.MyMedicare.com](http://www.MyMedicare.com). Participants in MyMedicare must register and input much of their own data onto the website.

Now, the US Department of Health and Human Services (HHS) is moving to make on-line access to such data easy and routine through a new pilot initiative intended to test

the expansion of data access on-line. "By using emerging technologies and tools, people with Medicare will be better able to manage their health care, resulting in improved quality in the care they receive and ensuring that care is provided more efficiently," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "The steps we are taking today will test whether Medicare's current data will help to populate useful personal health records for Medicare beneficiaries."

The goals of this new initiative, according to HHS, are to assist senior citizens to better track their personal health care ser-

vices and to help beneficiaries and their families monitor their health care needs. Not mentioned in the HHS commentary, however, is the obvious anti-fraud component of such a program, whereby beneficiaries have the means to see from the official record whether the claims filed in their names were accurate. Medicare beneficiaries have always been encouraged to watch the claims filed in their names and report any discrepancies. The cost of the six-month pilot project, described as a test of the feasibility of integrating claims data with other Internet-based tools, is estimated to be \$500,000.