

**Managed Care Fraud:
Enforcement and Compliance
HCCA Compliance Institute**

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Pamela Coyle Brecht, Partner

Pietragallo Gordon Alfano Bosick & Raspanti, LLP

Risk Area: False Data and/or Certifications

- Certifications
- Risk adjustment data
- Encounter data

**Risk Adjustment:
Audit & Enforcement Environment**

- Center for Public Integrity “**Medicare Advantage Money Grab**”
- Letters from Senators Grassley and McCaskill asking federal officials to step up oversight of Medicare Advantage health plans.
- **Government Accountability Office** estimated “**improper payments**” to Medicare Advantage plans at more than **\$12 billion** in 2014.
- HHS subpoenas issued to MAOs
 - DaVita Healthcare (Jan. 2015); requesting Medicare Advantage documentation dating back to January 1, 2008.

**Improper Payments: CMS Estimates Unsupported Diagnoses
Linked to \$1.7 Billion (Nearly 10%) of All Part C Payments**

- MA Organizations received approximately \$170 billion to provide coverage to nearly one-third of all Medicare beneficiaries in 2015.
 - GAO-17-223, MEDICARE ADVANTAGE Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments, <http://gao.gov/assets/690/682145.pdf>
- CMS estimates 9.5% of payments to MAOs are improper because they submit unsupported diagnoses to CMS.
 - OIG Work Plan 2017, page 27, <https://oig.hhs.gov/reports-and-publications/archives/workplan/2017/HHS%20OIG%20Work%20Plan%202017.pdf>

Risk Adjustment Data Validation (RADV) Audits

- 42 C.F.R. § 422.311(a).
- CMS uses RADV audits to test the accuracy of risk adjustment.
- CMS uses the right to retrospectively audit for support of any risk-adjusted payments received by an MAO.
- RADV Audit encompasses review of medical records and clinical documentation that led to the payment.
- MAOs are formally notified of a RADV audit and have a set amount of time to provide the requisite support for the cases selected for audit.
- Risk adjustment evaluations begin with coding assessments but data submission and population health also assessed.

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GAO (2014): CMS Must Ensure Complete & Accurate Encounter Data to Support \$250 Billion in Expected Future Part C Payments

GAO letter to Rep. Levin, Ways and Means, H.R., 7/31/2014

- "...CMS contracts with MA organizations (MAO) to provide covered services to beneficiaries who enroll in one of their plans..."
- April 2014: CMS had 571 contracts with MAOs that served nearly 15.5 million enrollees, approximately 30 % of all Medicare beneficiaries.
- Congressional Budget Office projects that enrollment in MA plans will increase to about 21 million enrollees by 2023. Medicare payments to MAOs expected to grow from \$154 billion (2014) to \$250 billion (2023).
- "...As the MA program expands, setting appropriate payments to MAOs and making Medicare a more prudent purchaser of health care services will remain critical."

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Medicare Part C: Encounter Data

- **2014 GAO report identifies vulnerabilities in oversight of MAOs, notes CMS lacked the following safeguards:**
 - Analysis of encounter data for completeness and accuracy;
 - Medical records review to verify encounter data; and
 - Summaries of encounter data review findings.

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Part C Best Practices: Risk Adjustment

- Establish communications with providers; identify contact personnel for medical record requests or other RADV activities.
- Determine how medical records can and will be supplied to the MAO (i.e., hardcopy or electronic) based upon the technological capabilities of the MAO and the provider.
- Encourage continual education of both plan personnel and providers on the proper maintenance of medical records and coding accuracy and develop communication with providers on the RADV process and the possibility of a RADV audit by the plan or CMS.
- Understand risk adjustment profile.
- Review and determine:
 - Top ten HCC's by volume and intensity; and
 - Top utilizing providers by provider type (physicians, hospitals); and
 - Any claims or record rejections from CMS; and
- Educate providers going forward.

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Risk Area: Kickbacks

- **The Federal Anti-Kickback Statute**, 42 USC § 1320a-7b (b) is a criminal statute that prohibits any person from knowing and willfully, soliciting, receiving, offering or paying remuneration (anything of value) in exchange for referrals for services that are covered by federally insured health care programs (e.g. Medicare and Medicaid). A violation of the AKS is a felony punishable by up to five years in prison and/or fines up to \$25,000.
- Exclusion Risk: Conviction under the AKS results in mandatory exclusion from federal health care programs.
- **The Affordable Care Act** codified and clarified that violations of the Anti-kickback Statute can also result in civil liability under the Federal False Claims Act, 31 USC § 3729-3733 (the "FCA") as well as administrative penalties under the Civil Monetary Penalties Law.
- *Example in MA context:* Florida health plan self-disclosed and agreed to pay over a \$250K fine in connection with allegedly offering "to increase the capitation rates paid to four physicians in exchange for the referral of their patients to [health plan] and . . . increas[ing] the capitation rates of two of the four physicians."

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Risk Area: Medical Loss Ratio

ACA MLR=

$$\frac{\text{Medical care claims} + \text{Quality improvement expenses}}{\text{Premiums} - \text{Federal and state taxes, licensing, and regulatory fees}}$$

- MLR existed long before ACA; was used to evaluate performance of managed care companies.
- Affordable Care Act (ACA)- Created consistent federal standard and modified the calculation.
- Plans that fail to meet the minimum MLR of 85% are required to remit partial payments to HHS
 - ≤ 85% for three consecutive years, suspension of plan enrollment for two years;
 - Less than 85% for five consecutive years, the Secretary to terminates the plan contract.
- Quality improvement expenses include activities that improve patient outcomes, safety, wellness, quality, transparency, or outcomes through enhanced health information technology. Administrative expenses, e.g., insurance broker and agent compensation or fraud prevention activities not included.

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**Risk Area: Medical Loss Ratio (cont'd)
Case Example: WellCare**

- Allegations: WellCare misled Medicaid regulators in Florida and intentionally misstated and improperly attributed certain unallowable expenses in order to manipulate MLRs and avoid a refund to the state and, by extension, improperly inflated earnings.
- Civil and Criminal investigations of alleged Medicare and Medicaid overbilling.
- Outcomes:
 - 2009: DPA and \$80MM (\$40 MM restitution/ \$40MM forfeiture).
 - 2010: Settled shareholder litigation for \$200MM.
 - 2011: Five executives indicted (including former CEO, CFO, General Counsel).
 - 2012: Civil Settlement of FCA allegations for \$137.5MM.
 - 2013: Four executives tried and convicted.
 - 2014: Former CEO sentenced to 36 months in prison.

**Medicare Managed Care
Compliance Best Practices**

1. **Look to Your Certifications and Those Who Sign Them!**
2. **Review Data Submissions and Reports Sent to CMS and Other Government Agencies.**
3. **Consider MCO Obligations to Audit, Investigate and Police Providers.**
4. **Review OIG Reports and Work Plans: identify areas on the radar of enforcement (encounter data reviews, risk adjustment investigations, focus on kickbacks, etc.).**
5. **Take internal reports related to Medicare Managed Care Compliance seriously.**
6. **Self-Report promptly (60-Day Rule).**

Medicaid Managed Care: Risk Areas and Best Practices

January 2017:

OIG's Focus on FWA in the Medicaid Program

- Ann Maxwell, Assistant Inspector General for Evaluation and Inspections, HHS-OIG, testimony before the House Committee on Oversight and Investigations, 1/31/2017
 - “Protecting Medicaid from fraud, waste, and abuse is an urgent priority because of its impact on the health of vulnerable individuals and its fiscal impacts on Federal and State spending.”
 - “As of September 2016, more than **74 million individuals** were enrolled in Medicaid, and the total Medicaid spending for fiscal year (FY) 2016 was **\$574 billion.**” In 2015, **\$230 billion was for Managed Care.**
 - “OIG has consistently identified effective administration and strengthening the program integrity of Medicaid is among the top management challenges facing HHS.”
 - OIG has a unique role in Medicaid program integrity: administer and oversee Federal grants to State Medicaid Fraud Control Units (MFCUs), which investigate and prosecute Medicaid provider fraud.

January 2017:

OIG's Focus on FWA in the Medicaid Program

Testimony of Ann Maxwell, Assistant Inspector General for Evaluation and Inspections, HHS-OIG, 1/31/2017 (cont'd)

- Entities responsible for Medicaid program integrity: OIG, CMS, State Medicaid Agencies, **Managed Care Contractors**.
- **OIG investigations** of Medicaid fraud, 2016
 - 348 criminal actions, 308 civil actions, **\$3 billion recovered**.
- **State MFCU investigations**, 2015
 - 1,889 indictments, **\$744 million recovered**.
- OIG recommendation: "**States should suspend Medicaid payments to providers when there are credible allegations of fraud.**" SSA § 1903(i)(2), as amended, by the ACA § 6402(h)(2).

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Medicaid Managed Care Enforcement

- OIG's focus for 2017 to protecting the Medicaid program from fraud, waste, and abuse, includes:
 - Medicaid MCO Drug Claims: MCO capitation payments should not include claims for reimbursement for drugs not covered by the Medicaid program because there was no rebate payable (i.e., the drug was dispensed beyond the termination date);
 - Health-Care Acquired Conditions: Medicaid MCOs should not be paying providers for inpatient hospital services for treating provider preventable conditions. ACA, 2702, implementing 42 CFR 447.26 (prohibits federal payments for provider preventable conditions).
 - MCO Payments for Services After Beneficiaries' Death: OIG will identify Medicaid managed care payments with dates of service after the beneficiaries' date of death.

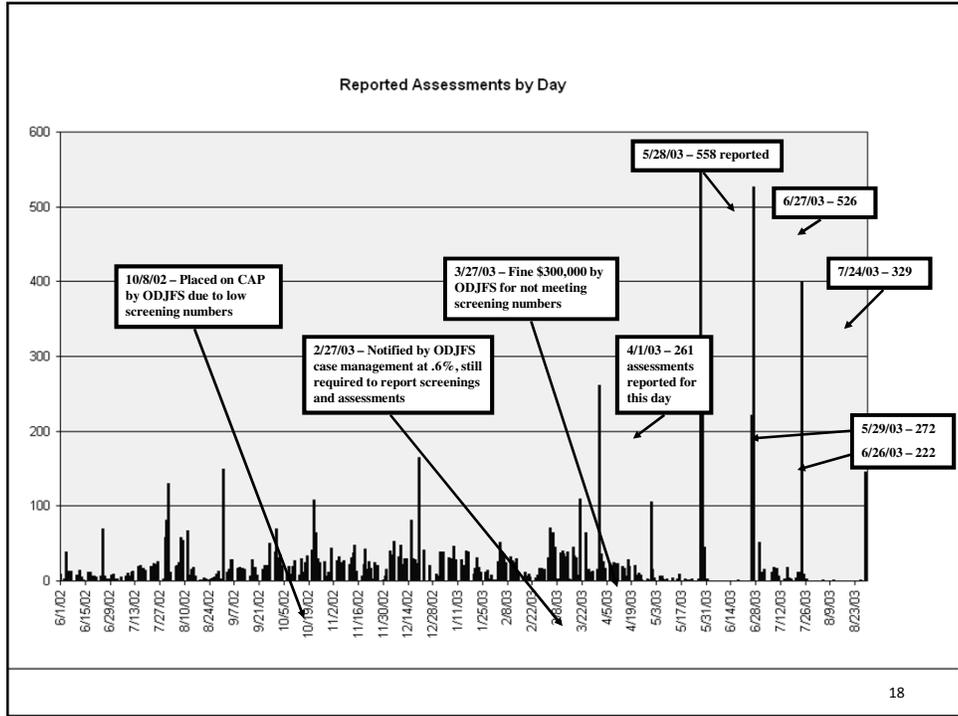
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Fraud Related to Medicaid Waivers

- Section 1115 Waivers: States use funds in ways that do not conform to federal statutory and regulatory requirements.
 - ACA - Section 1115 waivers to allow state Medicaid expansion beyond the flexibility allowed by law.
 - CMS has denied 1115 waivers. I.e., work requirements as a condition of eligibility.
- ACA: In 2015, Federal Medicaid spending grew by 12.6%, and states by 4.9%. The federal increase was driven by newly-eligible enrollees under the ACA who were fully funded by the federal government.
- Section 1915(b) Waivers: Specific type of waiver which permit states to place Medicaid enrollees in managed care plans or long term services and supports (LTSS) for home and community-based services to those who would otherwise be institutionalized.
- Terms of waiver included in MCO provider contracts. For example, the 1915(b) waiver requires that the MCO to “assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring.” The state must also have “a mechanism to identify persons with special health care needs.”
 - Once identified, the MCO must provide care management to these enrollees.

**Medicaid Managed Care Fraud, 1915(b) Waiver
US ex rel Herzog and Rupert v CareSource
 \$26 Million Ability-to-Pay Settlement**

- 1915(b) waiver obtained by the State of Ohio, included identification, specific assessment, and the implementation of care plans for Children with Special Healthcare Needs (CHCN)
- These requirements were memorialized in the MCO provider agreement.
- The relators were MCO nurses who provided critical piece of the puzzle in a complex regulatory and provider agreement-driven program.
- Compliance/Enforcement: Is the MCO Providing All Covered Services?
 - Federal Statutes, regulations, 1915(b) Waiver applications;
 - Managed care contracts between the state agency and the MCO
 - The compliance issue: is the MCO providing the services as required by the waiver and managed care contract?
 - The Agency/Defendant’s Opening Position: What wasn’t provided was “a throw Away Service” (not “material”).



Medicaid Managed Care: The Resolution

- Damages:
 - Getting Over the “Throw Away Service” Argument
 - Difficult to Quantify ≠ 0
 - Thinking Outside the box: What would FFS programs say?
 - Naming the MCO’s Holding Company/Parent
- Other potential state claims:
 - Common Law: Fraud in the inducement:
 - Did you intend to provide required services?
 - Evidence: Inadequate staffing levels
 - Breach of contract: Violations of the Provider Agreement
- Other risks: If tried, and even \$1 in damages, the provider would be excluded under state law.

Medicaid Managed Care – Program Integrity Risks

- Capitated reimbursement
 - Incorrect or inappropriate rate setting
 - Underutilization
- State contracts with MCO, which subcontracts to the providers
 - MCO providing accurate information on contract requirements
 - State has no direct oversight of subcontractors, and inability to detect falsification of information
 - Potential for underutilization
- MCO can capitate providers or use other incentives
 - In appropriate physician incentive plans/ underutilization
- MCO covers only assigned/enrolled beneficiaries
 - Payments to MCO for non-enrolled people
 - Marketing or enrollment fraud
- MCO has select provider networks

**Medicaid Managed Care
Compliance Best Practices**

- Written policies, procedures, and standards of conduct that articulate the organization’s commitment to comply with all applicable Federal and State standards.
- Compliance officer and committee accountable to senior management.
- Effective training and education for compliance officer and other employees.
- Effective lines of communication between compliance officer and organization’s employees.
 - Anonymous must mean that. Don’t discourage use of hotline. Maintain a log of hotline reports, and actually investigate them.
- Internal monitoring and auditing.
 - Detection through claims data analysis, auditing suspicious activities.
- Prompt response and corrective action when offenses are detected.

Questions?