



**HCCA**  
**Healthcare Enforcement Compliance Institute**

**Managed Care Fraud Enforcement & Compliance: Industry Trends and Key Topics**  
**Washington, D.C.**  
**Sunday, October 25, 2015**  
**3:30 p.m. – 5:00 p.m.**



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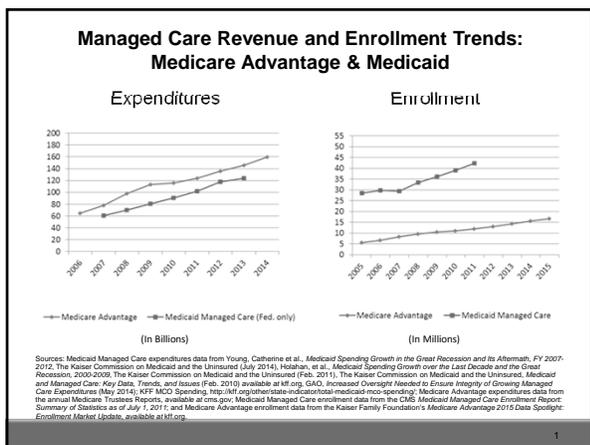
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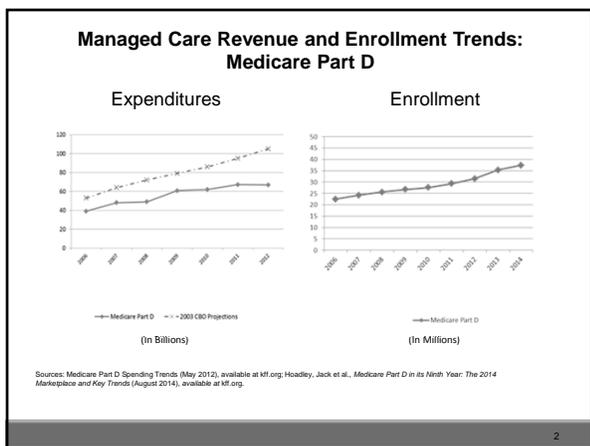
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**Managed Care Revenue and Enrollment Trends:  
Affordable Care Act**

**Insurance Exchanges (10.2 million enrollees in 2015)**

- State exchanges
- Federal exchange

**Medicaid Expansion (11.2 million expansion enrollees in 2015)**

- Medicaid expanded to include individuals under 65 with income below 133% of the federal poverty level
- 28 states and D.C. implemented the Medicaid expansion as of 2015
- Additional Medicaid expansion anticipated in light of the Supreme Court's decision in *King v. Burwell*

Sources: March Effectuated Enrollment Consistent with Department's 2015 Goal, HHS News Release, June 2, 2015; Vikki Wachino, Approximately 11.2 Million Additional Individuals Enrolled in Medicaid as of January 2015, HHS Blog (March 20, 2015).

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**Regulatory Trends: Medicare Managed Care Manual**

**Compliance Program Standards**

- Seven Elements of an Effective Compliance Program (e.g., policies and procedures, training, disciplinary standards, hotlines)
- "Sponsors must ... implement ... a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements."
- "An effective program to control [Fraud, Waste and Abuse (FWA)] includes policies and procedures to identify and address FWA at both the sponsor and [First Tier, Downstream or Related Entity (FDR)] levels ...."

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**Regulatory Trends: Key Certifications**

**Medicare Advantage Annual Attestation, 42 C.F.R. § 422.504(l)**

- MA organization must certify that risk adjustment data is accurate, complete and truthful (based on best knowledge, information, and belief)

**Medicare Advantage Overpayment Attestation, 42 C.F.R. § 422.504(l)(5)**

- MA plans "must certify (based on best knowledge, information, and belief)" that the information the MA plan submits to CMS for purposes of reporting and returning overpayments is "accurate, complete and truthful"

**New York State Model Managed Care Contract**

- "Covered services provided by the Contractor under this Contract shall comply with all standards of the New York State Medicaid Plan established pursuant to [state law]."

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**Medicare Advantage in the Cross-Hairs:  
Senator Grassley Calling for Crackdown**

- **May 19, 2015 :**
- **Senator Grassley** wrote letters to Attorney General Loretta Lynch and acting CMS Administrator Andrew Slavitt, asking to tighten scrutiny of Medicare Advantage health plans suspected of overcharging government
- In the letters, Senator Grassley cited CMS investigation which found the agency made more than \$70 billion in "improper" payments to Medicare Advantage plans between 2008 and 2013

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**Senator Grassley Letter (cont.)**

- Grassley additionally referenced Center for Public Integrity reports on "an increasing number" of whistleblower lawsuits targeting Medicare Advantage
- Asked both Justice and CMS to tell him how many risk score fraud investigations had been conducted over the last five years and their outcomes
- "Safeguards become all the more important as Advantage adds more patients and billions of dollars of hard-earned taxpayer money is at stake[.]"

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**Recent Enforcement/Qui Tam Cases: Risk Adjustment**

*Provider Generated Submissions*

- *Graves*, No. 10-23382 (S.D. Fla.) (unsealed *qui tam* , DOJ non-intervention, case proceeding)
  - Network provider allegedly submitted inaccurate diagnoses, and health plan submitted data with allegedly inadequate compliance oversight
- *Thompson*, No. 15-80012 (S.D. Fla.) (criminal indictment)
  - Network provider allegedly submitted false diagnoses to health plan
  - DOJ indicted provider in February 2015, trial scheduled for September 2015
- *Janke*, No. 09-14044 (S.D. Fla.) (FCA settlement)
  - Defendants allegedly submitted codes for MA reimbursement that were not supported and failed to look for erroneous diagnoses or delete codes upon learning that they were inaccurate
  - \$22.6M settlement in November 2010

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**Recent Enforcement/Qui Tam Cases:  
Risk Adjustment (cont.)**

**Chart Reviews**

- *Swoben*, No. 09-05013 (C.D. Cal.) (unsealed *qui tam*, DOJ declined, pending appeal of dismissal)
  - Network provider of SCAN and other health plans allegedly inflated risk scores through retrospective chart reviews
  - \$320M settlement with SCAN in August 2012 (with \$4M related to MA allegations); allegations against other defendants dismissed, which Relator has appealed

**In-Home Assessments**

- *Silingo*, No. 13-01348 (C.D. Cal.) (unsealed *qui tam*, DOJ declined, MTD pending)
  - In-home assessment vendor allegedly submitted false diagnoses to health plan defendants
  - Plan defendants allegedly submitted those diagnoses to CMS without adequate vendor oversight
  - Compliance officer, alleged that MedXM coders advised the company's contracted medical examiners to perform exams to alter patients' medical records to make patients appear sicker to increase Medicare payments to the health plans;

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**Recent Enforcement/Qui Tam Cases:  
Risk Adjustment (cont.)**

- Suit alleges MA plans Molina (CA), WellPoint (Anthem BCBS), HealthNet of California, Alameda Alliance for Health "turned a blind eye:"
- Allegations include: In December of 2012 approx. 750 Molina patients had "identical vital statistics for age, weight, sex height, blood pressure and heart rate" as well as similar medical findings, all done by the same doctor!
- *Ramsey-Ledesma*, No. 14-00118 (N.D. Tex.) (recently unsealed *qui tam*, DOJ declined)
  - Similar to *Silingo*, but related to a different vendor

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**Recent Enforcement/Qui Tam Cases:  
Risk Adjustment (cont.)**

**Filter Logic**

- *Conte*, No. 13-02251 (D. S.C.) (unsealed *qui tam*, DOJ declined, case proceeding)
  - BCBS South Carolina's filtering process allegedly sent risk adjustment data to CMS that was not eligible under CMS guidance, resulting in inflated premiums

**Other Risk Adjustment Issues**

- *Valdez*, No. 15-01140 (D. P.R.) (unsealed *qui tam*, DOJ non-intervention, case proceeding)
  - Health plan allegedly manipulated its risk scores by, among other things, entering into risk-sharing arrangements with network providers and setting risk-adjustment focused performance goals for its employees
- *Poffinbarger*, No. 11-00993 (W.D. Mich.) (employment/retaliation issues, case settled with no admission of fault)
  - While the plaintiff did not bring a *qui tam*, she claimed that she was fired after refusing to follow instructions to focus only on adding additional codes and to ignore deletions of unsupported codes

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### Recent Enforcement/Qui Tam Cases: Other Topics

#### Provider Payments

- *Wilkins*, No. 08-03425 (D. N.J.) (unsealed *qui tam*, DOJ declined, dismissed after settlement)
  - Health plan allegedly provided kickbacks to clinics to induce the transfer of patients to its MA plan
- *Osheroff*, No. 10-24486 (S.D. Fla.) (unsealed *qui tam*, DOJ declined, dismissed with prejudice, affirmed on appeal)
  - Allegations against clinics and a health plan based on the clinics supposedly providing illegal incentives, such as transportation and food, to patients

#### Bidding Instructions

- *McGowan*, No. 09-05984 (N.D. Cal.) (unsealed *qui tam*, DOJ declined, settled)
  - Health plan allegedly falsely certified compliance with MA bidding instructions

#### Network Adequacy

- *Mouw*, No. 12-08051 (C.D. Cal) (recently unsealed *qui tam*, DOJ declined)
  - Health plan allegedly had inadequate network access under CMS regulations

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### Civil False Claims Act

#### Elements

- Prohibits knowingly presenting a false claim or knowingly making a false record or statement material to a false claim
- “Knowingly” includes acting in reckless disregard or deliberate ignorance of the truth or falsity of the information

#### Damages, Penalties and Whistleblowers

- Government may recover treble damages
- Civil penalties of up to \$11,000 per claim
- *Qui tam* provisions allow individuals (e.g., employees, contractors, providers) to sue and share in ultimate recovery

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### Civil False Claims Act: 60-Day Overpayment Rule

#### Background

- The Affordable Care Act requires that overpayments be reported and repaid within 60 days after identification.
- Effective January 1, 2015, identified “overpayments” must be “reported” and “returned” within 60-days, or they may become “obligations” under the False Claims Act (42 C.F.R. § 422.326).

#### CMS Operational Guidance

- “Reporting” satisfied by requesting a Remedy Ticket (for each contract and payment year)
- “Returning” satisfied by submitting data corrections
- “Risk Adjustment Data” vs. “Other”
- No appeals process
- 6-year look-back period

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**Civil False Claims Act: 60-Day Overpayment Rule (cont.)**

**Investigative Steps**

- CMS Guidance requires that MA plans must take affirmative investigative steps related to potential "overpayments":
  - Overpayments can include data inaccuracies that MA plans *"should have determined through the exercise of reasonable diligence"*
  - Reasonable diligence includes *"proactive compliance activities"* and *"investigation . . . in response to credible information of an overpayment"*
  - Example from Proposed Overpayment Guidance for Parts A & B: Compliance hotline complaints create an obligation to timely investigate
- DOJ Position: "an entity 'has identified an overpayment' when it 'has determined, or *should have determined through the exercise of reasonable diligence*, that [it] has received an overpayment ..."  
*United States ex rel. Kane v. Healthfirst, Inc.* (emphasis added).

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**Civil False Claims Act: 60-Day Overpayment Rule (cont.)**

**Congressman Howard Berman:**

- "Liability for all non-disclosed overpayments of the same type also should be imposed once an organization or other person is on notice that it has been employing a practice that has led to multiple instances of overpayment. For example, *if a corporation learns after-the-fact that it has been violating a billing rule or a contract requirement in its billing, and it nonetheless fails to comply with a legal obligation to disclose the resulting overpayments, this amendment renders the corporation liable under the Act for all overpayments resulting from the violation of the billing rule or contract requirement, even those not specifically identified or quantified.*"

Source: 155 Congressional Record E1235 (Monday, May 18, 2009) (emphasis added).

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**Civil False Claims Act: Special Considerations**

**Federal Rule of Civil Procedure 9(b) - Pleading with Particularity**

- Risk adjustment submissions - tracing the allegedly false claim
- Identifying claim for payment
- Plan/provider knowledge of allegedly false claim may be pled generally

**Damages?**

- RADV audits and Fee-for-Service Adjuster
- Critical actuarial principals underlying Part C

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**Recent Enforcement/Qui Tam Cases:  
WellCare Civil & Criminal Cases**

**Background**

- WellCare was required under Florida law to spend 80 percent of the capitation paid to it, as a managed care plan, on "the provision of behavioral health care services." If it spent less than 80 percent of the capitation on such services, WellCare was required to return the difference to the State.
- WellCare was alleged to have made false and fraudulent statements regarding its expenditures, in part by mischaracterizing payments to a subsidiary, in order to conceal and retain those overpayments.

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**Recent Enforcement/Qui Tam Cases:  
WellCare Civil & Criminal Cases (cont.)**

**Whistleblower**

- Health plan data analyst filed FCA complaint in June 2006.
- Met with the FBI in August 2006 and then wore a camera/recorder (he recorded 650 hours of conversation over 18 months).
- Tapes included the so-called "Golden Meeting":
  - "We've danced around this, and we send 'em a check every year . . . [w]e never have formally been asked to justify, or we've never been audited for this."
    - Defendant and former VP of a wholly-owned subsidiary of WellCare
  - "Every year we've fed the gods. We've paid them a little money to keep them happy. We've paid them a million bucks a year, or whatever," and "[f]or WellCare provided encounter data prices, 'we're gonna show a 50% loss ratio.'"
    - Defendant and former WellCare VP of medical economics

Quotations from Bloomberg News story November 20, 2012 "Fraud Trial for WellCare Ex-CEO Shows Medicaid Abuse."

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**Recent Enforcement/Qui Tam Cases:  
WellCare Civil & Criminal Cases (cont.)**

**Settlements**

- \$40 million in restitution, \$40 million forfeiture, outside monitor all under a 2009 deferred prosecution agreement
- \$137.5 million FCA settlement (with the whistleblower receiving \$20.7 million)
- \$200 million shareholder settlement
- \$10 million SEC settlement

**Sentences**

- Three executives sentenced to prison (former CEO, VP and CFO)
- Trial of general counsel pending
- More individuals on the DOJ radar

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**Compliance Best Practices**

1. **Look to Your Certifications and Those Who Sign Them!**
2. **Review Data Submissions and Reports Delivered to Medicare and Other Governmental Authorities.**
3. **Consider Obligations to Investigate and Police Providers.**
4. **Examine Key Risk Areas.**

*For example ...*

- Risk Adjustment
- Kickbacks
- Medical Loss Ratio
- HEDIS/STAR Ratings and Quality

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**Medicare Part C – Hot Buttons**

- No. 1: Risk Adjustment Fraud (Comparable to alleging "Upcoding" for diagnoses);
- No. 2: Kickbacks
- No. 3: Medical Loss Ratio
- No. 4: HEDIS/Star Ratings and Quality (Data Fraud)

- Other Topics
  - Provider Payments
  - Bidding Instructions
  - Network Adequacy

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**Risk Area No. 1: Risk Adjustment**

**Background**

- Medicare Advantage ("MA") Part C Plans are paid a capitated rate based primarily on the health status of the beneficiary. In recognition of the "risk" MA Plans take by agreeing to cover beneficiaries for a capitated rate, CMS makes a "risk adjustment." Risk adjustment is based on demographic factors and health risk.
- MA Plans receive an increased premium for beneficiaries receiving healthcare for conditions associated with higher costs.
- Under Medicare Advantage, diagnoses submitted for payment must be documented in a medical record that was based on a face-to-face encounter between a patient and a qualifying healthcare provider.
- Risk adjustment fraud: The typical allegation is that MA Plans report a provider's diagnoses that members do not have, were not treated for, or that is unsupported in the medical record.

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**Risk Area No. 1: Risk Adjustment (cont.)**

**RADV Audits**

- Extrapolation and Fee-for-Service Adjuster
- Contract vs. National (see HHS FY 2014 Financial Report citing 2.9% "net" improper payment rate -- \$4.0B)
- Other RADV audit protocol changes

**Beyond the MA Program**

- The ACA expands risk adjustment to the commercial insurance market
- State Medicaid managed care programs

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**Risk Area No. 2: Kickbacks**

**Elements**

- Offer, pay, solicit, or receive
- Remuneration
- Intent (knowingly and willfully)
- Induce
- Referral or recommendation
- Item or service reimbursable by a Federal Health Care Program

**Affordable Care Act**

- "[A] person need not have actual knowledge . . . or specific intent to commit a violation . . . [of the Anti-Kickback Statute]." ACA § 6401(f)
- "[A] claim that includes items or services resulting from a violation of [the Anti-Kickback Statute] constitutes a false or fraudulent claim for purposes of [the False Claims Act]." ACA § 6401(f)

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**Risk Area No. 2: Kickbacks (cont.)**

**Kickbacks on the ACA Exchanges**

**Sebelius's October 2013 Letter**

- HHS "does not consider [policies offered through state and federal exchanges under] the Affordable Care Act to be federal health care programs."

**November 2013 and February 2014 CMS Memoranda**

- "It has been suggested that hospitals . . . and other commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces . . . HHS discourages this practice and encourages issuers to reject such third-party payments."
- This "does not apply to payments for premiums and cost sharing made on behalf of QHP enrollees by . . . state and federal government programs or grantees (such as the Ryan White HIV/AIDS Program). QHP issuers and Marketplaces are encouraged to accept such payments."

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### Risk Area No. 2: Kickbacks (cont.)

**Interim Final Rule (79 Fed. Reg. 15240, 15242 (Mar. 19, 2014))**

- QHPs "must accept third-party premium and cost-sharing payments from ... government programs .... [However] we remain concerned that third- party payments of premium and cost sharing ... could skew the insurance risk pool .... We continue to discourage such third-party payments ... and we encourage QHPs and SADPs to reject these payments."

**Select Reactions**

- Senator Grassley:** "I am alarmed at indications that the Administration may try to exempt [ACA] from certain federal anti-fraud provisions ... Congress' intent to treat kickbacks under [ACA] as False Claims Act violations is clear. It cannot lawfully be nullified by the stroke of a pen through an administrative exemption." November 2013 letter to Sebelius; see also February 2014 letter to Sebelius.
- AHIP:** "It is a conflict of interest for hospitals and drug companies to pay patients' premiums and cost-sharing for the sole purpose of increasing utilization of their services and products ..." Louise Radnofsky, *Insurers Fight Hospitals' Paying Premiums*, Wall St. J. (Dec. 16, 2013).

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### Risk Area No. 2: Kickbacks (cont.)

**Provider Contracting**

- Anti-kickback safe harbor
- Fair market value
- Exclusivity
- Other payments

**Marketing Efforts**

- Co-marketing
- Provider involvement in enrollment

**OIG Oversight**

- Example:** 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 No. 3: Medical Loss Ratio

ACA MLR=

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

**The Affordable Care Act**

- Beginning in 2014, MA plans that fail to meet the minimum MLR of 85% will be required to remit partial payments to the Secretary of Health and Human Services.
- If the MLR is less than 85% for three consecutive years, the Secretary will suspend plan enrollment for two years; and if the medical loss ratio is less than 85% for five consecutive years, the Secretary will terminate the plan contract.
- Quality improvement expenses:
  - Included:** Activities that, for example, improve (i) patient outcomes, safety, or wellness, or (ii) quality, transparency, or outcomes through enhanced health information technology
  - Excluded:** Administrative expenses, such as insurance broker and agent compensation or fraud prevention activities

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**Risk Area No. 3: Medical Loss Ratio (cont.)**

▪ **Classifying Expenses**

- Administrative expenses
- Activities that improve health care quality
- Anti-fraud efforts

▪ **Cases**

- *MRI Scan Center, LLC v. Nat'l Imaging Assocs., Inc.*
  - Filed January 2013.
  - Alleges manipulation of Explanation of Benefits and Remittance Advices to avoid paying MLR rebates under ACA.
  - Case dismissed for failure to state a claim (May 2013)

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**Risk Area No. 4: HEDIS/STAR Ratings and Quality**

**Background**

- STAR ratings based on HEDIS, CAHPS, HOS and administrative data
- STAR ratings impact bonus payments and bid rebates
- CMS policy to reduce an MA contract's STAR measure rating to 1 star if it is identified that is based on "biased or erroneous data." CMS Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Final Call Letter.
  - Includes "cases where CMS finds mishandling of data, inappropriate processing, or implementation of incorrect practices by the organization/sponsor have resulted in biased or erroneous data."
  - CMS has stated its interest in developing additional steps to protect data integrity.
  - CMS has considered alternatives to a 1-star reduction in prior years, but has not implemented a different approach.

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**Risk Area No. 4: HEDIS/STAR Ratings and Quality (cont.)**

▪ **Data Accuracy**

- Monitoring/auditing data underlying STARS and HEDIS submissions

▪ **Relationships with Vendors and Providers**

- Provider credentials
- Accurate diagnosing
- Diagnosing limitations in certain settings (e.g., in-home assessments)
- Follow-up care & coordination with clinical programs
- Compensation

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