HCCA’S 2014 MANAGED CARE COMPLIANCE CONFERENCE
Session 401 Panel Discussion
Managed Care Compliance: RAC, RADV, False Claims Act, and OIG and CMS Initiatives
10:30 am – 12:00 pm, February 11, 2014
Westin Kierland Resort & Spa
Scottsdale, Arizona

Health Care Fraud and Abuse
A High Priority

Managed Care Compliance Conference
Tuesday, February 11, 2014, 10:30 a.m. to 12:00 p.m.

401 Managed Care Compliance:
RAC, RADV, False Claims Act and OIG CMS Initiatives
Medicare/Medicaid Track

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The False Claims Act
Why is it so scary?

“In looking for people to hire, you look for three qualities: integrity, intelligence, and energy.

And if they don't have the first, the other two will kill you.”
— Warren Buffet

False Claims Act Damages

• **Compensatory Damages: False Certification**
  Case: Measured by the amount of money paid out by reason of the False Claim over and above what it would have paid if the claims had been truthful. *United States v. Rogan*, 459 F. Supp. 2d 692 (N.D. Ill. 2006).
False Claims Act Damages

- **Treble Damages:** Compensatory Damages may be doubled or tripled. 31 U.S.C. § 3729(a).

False Claims Act Damages

- **Civil Penalties:** Any person who violates § 3729(a)(1) through (a)(7) of the Act is liable (in addition to damages) for a civil penalty between a minimum of $5,500 and a maximum of $11,000. 31 U.S.C. § 3729(a), 28 C.F.R. § 85.3(a)(2009).

False Claims Act Damages

False Claims Act Damages

- **Note:** In health care, False Claims Act is particularly dangerous where there is a high number of low value dollar claims.
- **Exclusions:** Individual or Organization may be subject to permissive or mandatory exclusion. 42 U.S.C. § 1320(a)1 – 7a. Exclusion is a death sentence to a healthcare executive or organization.

Criminal Actions can be brought for violations of False Claims Act.

False Claims Act Fiscal Year 2013 Results

- $5.8 Billion Dollars Recovered
- 3,214 Individuals and Entities excluded from participation in Federal health Care Programs.
  - 960 Criminal Actions Instituted
  - 472 Civil Actions Commenced

**Source:** HHS Office of Inspector General – Semi-Annual Report to Congress Fall 2013.
False Claims Act Fiscal Year 2013 Results

<table>
<thead>
<tr>
<th>Example</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Compensatory Damages (Jury Verdict)</td>
<td>$48 Million</td>
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<tr>
<td>Triple Damages</td>
<td>$144 Million</td>
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<tr>
<td>Civil Penalty (18,130 False Claims x $10,500 per Civil Penalty)</td>
<td>$190,365,000</td>
</tr>
<tr>
<td>Total Verdict</td>
<td>$334,465,000</td>
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Lying to Federal Agents or the Federal Government
Lauren C. Stevens, Esq.


Lying to Federal Agents 18 US.C. § 1001.

Knock & Talk
ChiefExecutive.Net

January 5, 2014
New World Law Enforcement & MAO

Coordinated Anti-Fraud Program
Payors & Law Enforcement
DOJ & HHS Coordinated
Anti-Fraud Program
Joint Task Force

New World Law Enforcement & MAO

Schemes Investigated: Upcoding –
Doctor/Hospital bills for code or procedure not performed. Paid for a more complex version of simpler procedure they did perform.

New World – Risk Adjustment

MAO paid for member health status. The sicker the member, the higher the reimbursement.

MAO Diagnosis.
Government claims diagnosis treating physician diagnosis.
New World – Risk Adjustment

Now victim of crimes becomes alleged perpetrator of the crime. Because MAO is submitting member’s risk adjustment multiplier.

Diagnostic Code

Diagnosis Code must be documented in the medical record. Diagnosis Code must stem from a face-to-face encounter between physician and the patient during the year.

Certification
America’s Health Choice Medical Plan
Medicare Advantage Organization
Medical Resources
Vero Beach, Florida

Alleged to have falsely increased severity of beneficiary diagnosis to obtain higher Medicare payments.

Risk Adjustment Data Accuracy

Annual Attestation
• MA plans must certify that risk adjustment data is accurate, complete and truthful (based on best knowledge, information, and belief) (42 C.F.R. § 422.504(l))
• Creates a duty to, at a minimum, “put in place an information collection and reporting system reasonably designed to yield accurate information,” including ordinarily conducting “sample audits and spot checks … to verify whether [the system] is yielding accurate information” (64 F.R. 61893, 61900 (November 15, 1999))
Scan alleged to have improperly billed diagnostic codes to CMS that led to higher risk adjustment scores and therefore, higher monthly capitation rates to Scan. Scan used outside companies to review the medical charts for patients with the hope of finding additional diagnostic codes to report. Scan substituted the judgment of treating physicians for that of an outside consultant. Scan never told CMS that the original diagnosis code might need to be deleted.
Overpayment Collection Leading to False Claims Act Liability

On January 6, 2014, CMS issued a proposed rule that would strengthen efforts to collect Medicare overpayments from MA Plans and Part D Sponsors, as well as allow CMS to collect information directly from organizations that contract with Medicare Advantage Plans and Part D Sponsors.

The proposed rule would implement Section 6402 of the Affordable Care Act, which requires Medicaid Advantage Plans and Part D Sponsors to report and return any Medicare overpayment they receive within 60 days of identifying the overpayment. In addition, the CMS proposed rule would require Medicare Advantage Plans and Part D sponsors to identify any overpayment received within the six most recent completed payment years.

Failure to return an overpayment would trigger an obligation on the False Claims Act.

The Statute of Limitations for FCA is six years from the date of the offense.
OIG FY 103 Work Plan

- Review diagnoses submitted to CMS for compliance with federal rules
- Ensure documentation supports diagnoses submitted to CMS
- Determine if CMS properly adjusted payments to MA plans based on the results of its CY 2007 data validation reviews (see recent reports on RADV audits of MA plans)

FALSE CLAIMS ACT: NEW RISKS FOR QUALIFIED HEALTH PLANS OFFERED THROUGH THE EXCHANGE (“QHPs”)

   a. FCA will be used as a key health care fraud enforcement tool for Exchange related activities. See Letter dated October 30, 2013 from HHS Secretary Kathleen Sebelius to Representative Jim McDermott.
   b. The Patient Protection and Affordable Care Act (“ACA”) makes it clear that payments made by, through, or in connection with the Exchange are subject to the FCA if such payments include any federal funds. 42 U.S.C. § 18033(a)(6)(A).
   c. A QHP will accept payments for advance premium tax credits, advance cost-sharing reductions, and risk corridor, risk adjustment, and reinsurance payments and charges. These are considered federal funds.

d. ACA also provides that compliance with the requirements of the ACA concerning the eligibility for a health insurance issuer to participate in the Marketplace is a material condition of when an issuer is entitled to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Marketplace. 42 U.S.C. § 18033(a)(6)(B).

i. This provision gives the government broad authority to impose FCA violations against a QHP. An issuer’s failure to follow the complex Exchange rules or comply with the various reporting requirements can be considered an FCA violation.

ii. In establishing that a QHP’s compliance with the ACA is a material condition for payment, a QHP will not likely be successful in asserting a false certification defense.

2. FCA Risks for QHPs

a. Overall Complexity – Health plans must meet many complex requirements to become and remain certified as a QHP.

b. Attestations Signed by QHPs as Part of QHP Application—Any failure to comply with the attestations or commitments that QHPs made as part of the application/certification process can become the basis for FCA liability; creates a simplified platform upon which the government or a qui tam relator can build an FCA case.

c. Risk of Submitting Incorrect Data Submitted to Receive Payments Under the ACA

i. Risk Adjustment Program:

1. Permanent program to discourage adverse selection. Applies to non-grandfathered QHPs in the small group and individual markets. Provides payments to health insurance issuers that disproportionately attract higher-risk populations (individuals with chronic conditions). There will be a transfer of funds from plan with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection.

2. Data will need to be provided to establish individual risk scores. Ensure accuracy of data. Manipulation concerns: upcoding for conditions where premium transfers will be made between plans within a given market based upon a member’s demographic and diagnostic risk score. Much of the data created by the plan will be dependent on data generated by providers.
2. FCA Risks for QHPs

ii. Reinsurance Program:
1. Temporary, transitional program intended to help stabilize premiums for coverage in the individual market during the first 3 years of Exchange operation when individuals with higher-cost medical needs gain insurance coverage.
2. Data will be provided that will establish reinsurance fees that plans must pay and reinsurance payments that HHS will pay plans.
3. When requesting reinsurance subsidies, claims must be documented and priced correctly.

iii. Risk Corridor Program:
1. A temporary program that will apply to QHPs in the individual and small group markets during the first 3 years of Exchange operation to protect against uncertainty in rate setting.
2. Data submitted will then be used to determine risk corridor payments to plans.
3. Complex calculations will be required at the product level. New process for many plans.

iv. Risk of submitting incorrect data required of QHP, such as transparency data:
1. Claims payment policies and practices;
2. Claims denial data;
3. Financial disclosures;
4. Enrollment and disenrollment data;
5. Rating practices;
6. Data on cost-sharing and payment with respect to any out-of-network coverage; and
7. Information on enrollee rights.
Proactive Ways to Foster an Effective Compliance Program and Preventative Compliance Action

1. Board
2. CEO
3. Honesty
4. Integrity
5. Execute on Basics
6. Strong Audit Process
7. Strong Attestation Review Process
8. Sears Case
9. Morgan Stanley Case

Laws Impacting Medicare Advantage Plans

- Health Care Fraud (18 U.S.C. 1347)
- Theft or Embezzlement in Connection with Health Care (18 U.S.C. 669)
- False Statements relating to Health Care Matters (18 U.S.C. 1035)
- Obstruction of Criminal Investigations of Health Care Offenses (18 U.S.C. 1518)
- Mail and Wire Fraud (18 U.S.C. 1341 and 1343)
- Criminal Penalties for Acts involving Federal Health Care Programs (42 U.S.C. 1320a-7b)
Laws Impacting Medicare Advantage Plans

- The Criminal False Claims Act (18 U.S.C. 287)
- The Civil False Claims Act (31 U.S.C. 3729-3733)
- Civil Monetary Penalties Law (42 U.S.C. 1320a-7a)
- Limitations on Certain Physician Referrals (Stark Law (42 U.S.C. 1395nn))
- Exclusion of Certain Individuals and Entities from Participation in Medicare and other Federal Health Care Programs (42 U.S.C. 1320a-7)

Sources of Liability

- Anti-kickback Statute. 42 U.S.C. §1320a-7b(b)
- Stark law. 42 U.S.C. §1395nn
- Civil Money Penalties. 42 U.S.C. §1320a-7a
- Civil False Claims Act. 31 U.S.C. §3729-3733
- Criminal penalties for making or causing to be made false statements or representations. 42 U.S.C. §1320a-7b(a)
- Violation of assignment terms. 42 U.S.C. §1320a-7b(e)

Sources of Liability

- Theft of embezzlement in connection with health care fraud. 18 U.S.C. § 669
- False statements in connection with delivery of or payment of health care benefits 18 U.S.C. §1035
- Statements or injuries generally 18 U.S.C. §1001
- Conspiracy to defraud government 18 U.S.C. § 286
- Health Insurance Portability and Accountability Act (HIPAA) 42 USC § 1320d-1320d(8)
Sources of Liability

- Theft of public money 18 U.S.C. § 641
- Theft and bribery from federal program 18 U.S.C. § 666
- Mail and wire fraud 18 U.S.C. §1341, 1341
- Conspiracy 18 U.S.C. § 371
- Injunction in health care fraud offenses. 18 U.S.C. § 1345
- Program fraud civil remedies act 31 U.S.C. § 3801

Sources of Liability

- Medicaid fraud
- Prohibition on payment for physician referrals
- Illegal remuneration
- Civil monetary penalty
- Criminal penalties
- Patient’s freedom of choice 42 U.S.C. § 1395a

False Claims Act
31 U.S.C. § 3729-3733

Civil Action
Knowingly standard

- Actual knowledge of the information;
- Acting in deliberate ignorance of the truth or falsity of the information; or
- Acting in reckless disregard of the truth or falsity of the information
- Innocent mistake or mere negligence is not sufficient to establish a false claim.
Civil False Claims Act

Qui Tam Action

“Qui Tam” comes from Latin phrase “qui tam pro domino rege quam pro si ipso in hac parte sequiter” which means “who sues on behalf of the King as well as for himself”.

- Any person may bring an action under the False Claims Act ("FCA").
- Party bringing action known as “relator” or “whistleblower”.
- Relator must provide the government with a copy of the complaint and substantially all material evidence and information the person possesses.
- The complaint is sealed for at least sixty days to allow the government time to determine whether it will join as a plaintiff in the suit.
- Only the government can intervene in a FCA suit.

Civil False Claims Act

Qui Tam Action

- If a whistleblower prevails entitled to:
  - Reasonable and necessary attorneys fees;
  - At least 15% but no more than 25% of the proceeds of the judgment or settlement for originating the Qui Tam complaint; if the government does not join, the whistleblower will receive between 25% and 30% of the total recovery;
  - Post Judgment interest at the maximum legal rate; and
  - Any further relief the Court may impose
  - Statute of limitations not more than 6 years from violation or no more than 3 years from date when facts material to action are known or reasonably should have been known but in no event more than 10 years after the date of the violation
  - No retaliation against whistleblower

Civil False Claims Act

Qui Tam Action

- Frivolous suit – defendant entitled to attorneys fees and costs

- Civil penalties include a fine or not less than $5,500 and not more than $11,000 for each false claim adjusted, plus treble damages
Relief From Retaliation

- Employee, Contractor, or agent is entitled to relief from retaliation to make them whole if discharged, demoted, suspended, threatened, harassed, or in any manner discriminated against in terms of employment because of lawful actions they conduct to stop violations of this law.

- Relief can include reinstatement, 2 times amount of back pay, interest on back pay and any special damages as result of the discrimination and litigation costs and reasonable attorney fees.

False Claims Act
18 U.S.C. § 287

Criminal
Actual knowledge of intentional act

§ 3.02 Federal Offenses
Whoever makes or presents to any person or officer in the civil, military or naval service of the United States, or to any department or agency thereof, any claim upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious or fraudulent, shall be imprisoned not more than five years or shall be subject to a fine or both.

False Claims Act
18 U.S.C. § 287 (con’t)

Criminal
Actual knowledge of intentional act

(1) Making or presenting a claim that is false, fictitious or fraudulent;
(2) To a department or agency of the United States;
(3) Knowing that it is false, fictitious or fraudulent.

- Beyond a reasonable doubt standard
- Criminal penalties include a fine of not more than $25,000 or imprisonment of not more than five years.
**Anti-Kickback**

Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)). Prohibits one from knowingly and willfully soliciting, receiving, offering, or paying any remuneration directly or indirectly, in cash or in kind, in exchange for Medicare and/or Medicaid referral. Penalties include a fine of not more than $25,000 or imprisonment for five years or both.

**Stark**

Stark Law (42 U.S.C. § 1395nn). Prohibits a physician with a financial relationship in or with an entity from referring patients to that entity for designated health services and prohibits the entity from submitting a bill for those services. Penalties include civil monetary penalties of up to $15,000 for each service and may include exclusion for the Medicare/Medicaid programs.

**Designated Health Services**

1. Clinical laboratory services
2. Physical therapy services
3. Occupational therapy services
4. Outpatient speech-language pathology services
5. Radiology and certain other imaging services
6. Radiation therapy services and supplies
7. Durable medical equipment and supplies
8. Parenteral and enteral nutrients, equipment, and supplies
9. Prosthetics, orthotics, and prosthetic devices and supplies
10. Home health services
11. Outpatient prescription drugs
12. Inpatient and outpatient hospital services
### Civil Money Penalties

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<th>Section 1903(m)(5)(A)(vi)</th>
<th>Section 1857(f)</th>
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### Intermediate Sanctions

42 C.F.R. 422.750

- Civil monetary penalties
- Suspension of enrollment of Medicare beneficiaries
- Suspension of marketing activities

Enrollment, payment and marketing sanctions continue in effect until CMS is satisfied that the deficiency on which the determination was based has been connected and is not likely to recur.
Intermediate Sanctions (con’t)

Basis for imposing sanctions
42 C.F.R. 422.752

• Fails to substantially provide medically necessary services and that failure adversely affects enrollee
• Expels or refuses to reenroll a beneficiary in violation of Medicare Part C
• Engages in any practice that could reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future services
• Misrepresents or falsifies information that it furnishes
  — to CMS or
  — to an individual or any other entity

Intermediate Sanctions (con’t)

• Fails to comply with requirements of 42 CFR 422.206 which prohibits interference with practitioner’s advice to enrollees
• Employment or contracts with an excluded individual or entity for the provision of
  — health care
  — utilization review
  — medical social work
  — administrative services

Compliance Program
Guidance for Medicare Advantage Plans
Benefits

• Improved communication with and satisfaction of enrollees
• Effective internal controls
• Quick and accurate reaction to employee and operational compliance concerns and capability to target resources to respond
• Commitment to honest and responsible conduct
• Regulate yourself before the government regulates you
• Prevention, Prevention, Prevention
• Continuous monitoring of your business practices and quality of care and billing issues
• Identify problems and correct them before the government finds a problem and penalizes MA

Benefits

• Centralized source of health care regulatory material
• Improvement to MA financial and operational structure


The manual directs that “an organization shall”

1. Exercise due diligence to prevent and detect criminal conduct, and
2. Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

The Federal Sentencing Guidelines look to the traditional Seven (7) Elements of an Effective Compliance and Ethics Program.
Garth Peterson, former Managing Director in the Morgan Stanley Real Estate Group’s Shanghai Office conspired with two (2) others, including a Chinese government official, to misappropriate a multimillion dollar interest in a Shanghai apartment building being sold by a Morgan Stanley fund. Mr. Peterson was sentenced to nine (9) months in prison followed by a three (3) year supervised release. Morgan Stanley was not charged in the case because it did the following:

- Maintained strong internal controls;
- Frequent training on internal policies;
- Written Compliance Certifications;
- Frequent Foreign Corrupt Practices Act ("FCPA") related compliance reminders;
- Continuous monitoring; and
- Conducted extensive due diligence.

Morgan Stanley was able to point to:

- Historical evidence of a strong FCPA Compliance program;
- Global internal controls identified the FCPA issues;
- Management took prompt and effective action;
- Implementation of an enhanced compliance program; and
- Thorough investigation and cooperation with law enforcement authorities.
Finally, the structure of the Morgan Stanley program included:

- Board and Senior Management oversight;
- Standards and Procedures;
- Screening,
- Monitoring and auditing;
- Promotion and enforcement; and
- Responding to violations.

Medicare Managed Care Manual, Chapter 21

- Basic Requirement
  - Medicare Advantage Organizations are “required to adopt and implement an effective compliance program, which must include measures to prevent, detect and correct Part C or D program noncompliance as well as FWA.” See Section 30, Ch. 21 of the MMCM.
  - Sponsors are also required to perform audits of their FWA risk areas. See Section 50.6.2, Ch. 21 of the MMCM.

Medicare Managed Care Manual, Chapter 21

- 7 Elements of an Effective Compliance Program (Section 50)
  - Written Policies, Procedures, and Standards of Conduct
  - Compliance Officer, Compliance Committee and High Level Oversight
  - Effective Training and Education
  - Effective Lines of Communication
  - Well Publicized Disciplinary Standards
  - Effective System for Routine Monitoring and Identification of Compliance Risks
  - Procedure and System for Prompt Response to Compliance Issues
Medicare Managed Care Manual, Chapter 21

• Definitions
  • Fraud:
    - "knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347."
  • Waste:
    - "the unnecessary overutilization of services, or other practices that, directly or indirectly, results in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources."
  • Abuse:
    - "actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services where there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between 'fraud' and 'abuse' depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors."

PDP Compliance Guidance

Medicare Prescription Drug Benefit Manual

Chapter 9 tracks MMCM Chapter 21

Continual Interaction
Hot Compliance Risk Area

Employee Screening
Background Checks
OIG Exclusion List

Employee Screening
• Licensure-Primary Sources
• Credentials and Training
• National Practitioner Data Bank (NPDB), if applicable
• Past abuse, neglect or mistreatment

Background Checks
• Criminal
• Conflicts Checks
OIG Exclusion List

- OIG Website – http://oig.hhs.gov/fraud/exclusions.asp
- Never been excluded or otherwise precluded from eligibility for participation in any federal program, including, but not limited to, the Medicare and/or Medicaid programs or eligibility to hold any position or render any services for which Employee’s compensation is paid with federal funds.

Mandatory Reporting

- HIPAA IT or Privacy Breach of Unsecured PHI
- Report to Compliance Officer immediately any suspected breach for investigation and risk assessment
- May require notification
- Applicable to both MA and Business Associates

Responding to Compliance Issues

- Investigation
- Recommendation
- Corrective Action and follow up, if necessary
- Corrective Action may include appropriate Disciplinary Action, Remediation or Repayment
- Failure to remit an overpayment within 60 days of identification (which may require investigation first) may rise to the level of false claim
Specific Risk Areas

• Improper inducements, kickbacks and self-referrals
• The election process
• Benefits and beneficiary protection
• Quality assessment and performance improvement
• Cost sharing
• Solvency, licensure and other State regulatory issues
• Claims processing
• Appeals and grievance procedures
• HIPAA compliance
• Employee screening, background checks, OIG exclusion list

High Risk Areas

• Marketing materials and personnel
• Selective marketing and enrollment
• Disenrollment
• Underutilization and quality of care
• Data collection and submission processes
• Anti-kickback and other inducements
• Emergency Services
• Prescription Drug Benefits
• Breach of unsecured PHI
• Offshore attestation for FDR Entities

Risk Areas
False Certification or Attestation

The Health Plan is alleged to have made a false Certification or Attestation of bid facts, of statutory or regulatory compliance, or of the existence or nonexistence of certain conditions which are alleged to be a prerequisite to the Government’s payment. Two (2) issues to be considered are:

1. Whether the alleged false statement is the cause of the government providing the benefit; and
2. Whether the alleged false statement caused the government’s payment or loss.
The Process to ensure true Certifications or Attestations:

- Undertake a verifiable Due Diligence process to assure the facts submitted are true;
- Have originators of the data sign Certifications up to the ultimate person signing the bid or Certification that the factual information is true;
- Maintain all relevant factual data underlining the Certification; and
- Have one (1) Independent objective review of the Certified fact prior to submission.

Such a process shows thoughtful, objective review of important factual information underlining the Certification which can be reviewed at a later date should an issue arise.

RAC JURISDICTION OVER PART C & D

The Affordable Care Act (ACA) § 6411(b) added Section 1893(h)(9) of the Social Security Act expanding RAC audits to include Medicare Advantage (Part C) and Prescription Drug Plan (Part D) programs.

WHO ARE THOSE GUYS

DPOA is tasked with implementation and oversight of the Part D RAC Program.

ACLR Strategic Business Solutions is tasked with performing Part D RAC audits.

http://aclrsbs.com
WHAT ARE THEY AUDITING

• Identify underpayments and overpayments and recoup overpayments
  — Ensure that each MA plan under Part C and Prescription Drug Plan under Part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan.
  — Examine claims for reinsurance payments to determine whether Prescription Drug Plans submitting such claims incurred costs in excess of the costs allowed.
  — Review estimates submitted by Prescription Drug Plans with respect to the enrollment of high-cost beneficiaries and compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.
• Refer Fraud and Abuse concerns to Medicare Drug Integrity Contractor (MEDIC).

AUDITS

• Conducted in three phases:
  — Pre-Audit: CMS determines audit criteria and scope to conduct audits of previous Medicare Part D payments.
  — Audit: The Part D RAC conducts payment analysis at the contract ID and plan ID level. The Part D plan sponsor will be notified of the RAC’s findings, including the impact of the overpayment. The impact calculation is a combination of the reinsurance and low-income cost-sharing amounts.
  — Post-Audit: Identified overpayments are collected from the Part D plan sponsor. If a Part D plan sponsor feels the RAC findings are in error, this is also the phase in which a sponsor is provided opportunity to appeal.

AUDITS

• CMS determines the audit year and audit issues and the criteria on which RAC auditor will use to audit.
• CMS requires the RAC to review all contracts that fall within a specific year.
AUDIT ISSUES IDENTIFIED

• Prescription Drug Event (PDE) records associated with excluded providers
• Direct and Indirect Remuneration (DIR)
• Duplicate PDEs

HOW FAR BACK DO THEY GO

2007 contract year

What Do They Review

• Performed Excluded Provider Audit Review for 2007
• Has initiated Excluded Provider Audit Review for plan years 2008-2009
• Conducts Part D Prescription Drug Events (PDE) on post pay basis
• Ensures that MA has implemented an effective anti fraud plan
• Examines claims for reimbursement to determine whether PDPs are submitting claims in excess of costs allowed
• Reviews estimates submitted by PDPs with respect to enrollment of high cost beneficiaries comparing them to actual enrollment
HOW DOES RAC IDENTIFY OVERPAYMENTS AND UNDERPAYMENTS

- Payment analysis and create impact calculations based on PDE data provided by CMS
- RAC may send request for additional information to Part D plan sponsor
- Impact of Part D RAC identified overpayments is determined by calculating the effect of the overpayment or reinsurance and low income cost sharing amounts
Reconciliation performed and Notice of Improper Payment (NIP) issued

APPEALS

- Part D Plan Sponsor only gets 2 levels of appeal
  Redetermination – within 30 calendar days
  Reconsideration – within 15 calendar days

RAC DATA VALIDATION CONTRACTOR

Livanta is the data validation contractor
- will confirm RACs improper payment findings
- measure RACs accuracy rate

http://www.livanta.com
CMS Guidance

9/28/10 Letter to Plan Sponsors
Marketing sales
Enrollment
educational event requirements

CMS must review marketing materials in accordance with 30.5, 30.5.1, 120.4 of the Medicare Marketing Guidelines (MMG) as amended 2012
Website must be consistent with approved marketing materials
Materials must be submitted directly by Plan Sponsor

CMS Guidance (con’t)

Enrollment
CMS Online Enrollment Center
Plan Sponsor Website

Educational Events
Public venue
Hosted by Plan sponsor or Third Party

Appointments are not educational events

GAO Report

• CMS requires MA Part D Plans to perform retrospective drug utilization review (DUR) analysis to identify prior inappropriate or unnecessary medication use and provide education such as alert letters to prescribers
• Analyze prescription claims data for doctor shopping and excessive use of highly abused drugs
• MA has weak DUR (CMS audit hot button)
• Of the 170,000 beneficiaries studied who received prescriptions of frequently abused drugs from 5 or more practitioners 71% (120,000) were eligible for Part D benefits based on disability and 72% of those (122,000) received Medicare low income cost sharing subsidy
GAO Report to Congress
January 2013 GAO-13-206

• Substantial Excess Payments Underscore need for CMS to Improve Accuracy of Risk Score Adjustments
  – Coding Differences on risk scores from 2010-2013 was greater than CMS risk score adjustment of 3.4% resulting in excess payments to MA plans of $3.2 billion.

OIG Semi-Annual Report Fall 2013

• Part C Overpayments
  Risk score calculation errors and overpayments
• Part D Investment Income
• Part D Questionable Billing Patterns for high prescribing physicians
• Part D Unauthorized Prescribers
• Part D Dual Eligibles-Mandatory Review

OIG Work Plan 2013

The U.S. Department of Health and Human Services, Office of Inspector General General Work Plan for Fiscal Year 2013 summarized new and on-going reviews and activities that OIG plans to pursue to HHS Programs and Operations during the next Fiscal Year and beyond.
OIG Work Plan 2013 (con’t)

Medicare encompasses Pages One (1) through Fifty (50) of the Work Plan and includes such topics as:

Medicare Part C Focus
- Special Needs Plans – CMS Oversight of Enrollment and Special Needs Plans
- Provision of Services – Compliance With Medicare Requirements
- Beneficiary Appeals – Beneficiary Requests for Reconsideration of Denied Services
- MA Organization Bid Proposals – CMS Oversight of Data Quality and Accuracy
- Duplicate Payments – Cost-Based Health Maintenance Organization Plans Paid Under Capitation Agreements and Fee for Service
- Encounter Data – CMS Oversight of Data Integrity (New)

OIG Work Plan 2013 (con’t)

- Risk Adjustment Data – Sufficiency of Documentation Supporting Diagnoses
- Risk Adjustment Data – Accuracy of Payment Adjustments
- Risk-Adjusted Payments – Medicare Advantage Organizations that Offer Prescription Drug Plans
- Cost Reports – Accuracy of Expenditures Claimed by Health Care Prepayment Plans
- Reporting Requirements – CMS Quality Oversight of MA Organization Reporting

CY2013 Annual Election Period Marketing Surveillance Summary Report

- The Centers for Medicare & Medicaid Services (CMS) oversees Medicare Advantage Organizations (MAOs), Medicare Advantage-Prescription Drug Plans (MA-PDs), and Prescription Drug Plans (PDPs) that have contracted with CMS to offer Medicare coverage
- Plan sponsors must ensure that their marketing representatives and agents/brokers comply with CMS marketing requirements and guidelines
- CMS has been directly monitoring plan compliance in this area for the past seven years
Through its market surveillance program, CMS strives to:
- Identify areas of non-compliance that may result in corrective actions and/or penalties to the plan sponsor
- Analyze trends across MAOs, MA-PDs, and PDPs with respect to marketing practices
- Ensure that compliance penalties and outreach efforts are targeted and prioritized appropriately and that plan sponsors are responding effectively; and
- Ensure that only appropriate advertisements are being published across the country.

Currently, market surveillance efforts include three oversight activities:
- Public Event Secret Shopping (secret shopping)
- Unreported Marketing Events (clipper service review)
- Surveillance Marketing Allegation Response Team (SMART) activities

Secret Shopping -
Secret shopping is undercover surveillance of formal public MA and Part C plan marketing events.

Deficiencies include:
- Special Needs Plan (SNP) Information
- Drug Coverage
- Event Did Not Take Place
- Miscellaneous Deficiencies
- Absolute Marketing Statements
Secret Shopping (con’t)
• Contact Information
• Inappropriate Statements/Inaccurate Statements/Scare Tactics
• Food/Gifts
• PFFS Information
• Sign in Sheets

The following are deficiencies in new categories reviewed:
– Star Rating (Plan Rating)
– Multi-language insert
– Ad hoc deficiencies

Report Date: October 24, 2013

Social Media/Social Network Surveillance

Twitter

Facebook

You Tube
Responding Appropriately to Government Inquiries and Possible Enforcement

• Where there is potential liability, coordination between legal and compliance departments is important
  — Coordination allows appropriate application of attorney-client and work product privileges
  — Helps assure application of appropriate legal standards, and promotes coordinated compliance

Responding Appropriately to Government Inquiries and Possible Enforcement

• Inquiries from enforcement agencies are different from CMS inquiries
  — Enforcement agency inquiries signal an investigation and should be handled by or in coordination with counsel
• Critical components of communications with government
  — Communications should be accurate, complete, and not misleading
  — Future relationship and credibility are key
  — CMS is a primary customer, so maintaining the relationship is critical
  — Test: If full facts were revealed, how would your communication to the government appear?

Responding Appropriately to Government Inquiries and Possible Enforcement

• Strategic disclosures to government can help manage risks of possible enforcement actions
  — Factual disclosures may be needed to assure that certifications are accurate
  — Helps establish that the organization reasonably and responsibly addressed problems
  — Sets up possible defenses to enforcement actions
Responding Appropriately to Government Inquiries and Possible Enforcement

• Key steps to assure communications to government are accurate
  – Don’t get ahead of what you know
  – Confine the scope of representations -- avoid broad and sweeping pronouncements
  – Don’t represent that a problem was inadvertent, unless investigation reveals that to be true

Responding Appropriately to Government Inquiries and Possible Enforcement

• Responses to government inquiries should be tightly managed
  – Communications should flow through designated individuals
  – Employees should be advised they are not authorized to respond to government requests for documents without coordinating with compliance/legal department
  – Employees should receive guidance for responding to government search warrants, subpoenas, and interviews

Recent FCA Cases

• US v. Janke, 09 CV-14044 (S.D. Fla.)
  – Filed by Main Justice in Feb. 2009 against owners of health plan and jointly-owned, capitated provider group
  – Settled in November 2010 for $22.6 million (CMS had estimated overpayments for one year of $28.5 million)
  – CMS had conducted an audit showing 61% of HCCs could not be supported
Recent FCA Cases

• US v. Janke, 09 CV-14044 (S.D. Fla.)
  - US alleged defendants:
    • Failed to review claims for erroneous data before submission
    • Failed to delete diagnoses found to be erroneous
    • Used of software system incapable of submitting deletes
    • Conducted data sweeps of patient files to submit additional diagnoses, created new encounters, sent encounters to treating physicians, and submitted data to CMS even if treating physicians refused to sign encounters
    • Received independent confirmation that they had submitted unsupported diagnoses

Recent FCA Cases

• US ex rel. Swoben v. Scan Health Plan, CV-09-5013 (C.D. Cal.)
  - Relator alleged violations with respect to both Medicare and Medicaid programs.
  - Settled for $324 million
  - Vast majority of settlement related to Medicaid programs (just over 1% of settlement amount attributed to Medicare)
  - Medicare Advantage allegations:
    • Scan conducted retrospective blind reviews of medical records to determine supported diagnoses
    • Scan submitted to CMS as corrections codes that reviewers had identified that had not been previously submitted
    • Scan failed to inform CMS of codes that reviewers had not found but had been previously submitted

Recent FCA Cases

  - Relator alleges that plan violated the FCA by submitting bids in 2007 and 2008 that violated the margin requirements of the Bid Pricing Tool Instructions for general enrollment and EGWP plans
  - DOJ declined to intervene
  - District Court denied plan’s motion to dismiss (December 2012)
    • Open factual question whether bid margins were within range
    • Cannot decide government knowledge defense at this stage
Enforcement Actions

Wellcare Ariz. 9/22/11
Failure to provide accurate enrollment information in Evidence of Coverage (EOC) for Contract Year (CY) 2011
CMP $20,000

The Regence Group 2/22/11
Failure to provide accurate enrollment information in Annual Notice of Change Documents for Contract Year 2011
CMP $100,000

Enforcement Actions (con’t)

Geisinger 2/22/11
Failure to provide accurate enrollment information in EOC documents for CY 2011
CMP $20,000

Coventry 2/22/11
Failure to provide accurate enrollment information in ANOC documents for CY 2011
CMP $20,000

Enforcement Actions (con’t)

Blue Cross of Idaho Health Services, Inc. 9/22/11
Failure to provide accurate enrollment information in EOC for CY 2011
CMP $20,000

Universal American Corp. 8/5/11
Suspension of marketing and enrollment activities effective 12/5/10
• Pattern of prohibited marketing practices targeted to highly vulnerable population
• Plan of correction attestation
• Sanction accepted valuation
• Lifting of sanctions
Enforcement Actions (con’t)

HealthNet, Inc. 11/19/10
Suspension of enrollment of Medicare beneficiaries and of marketing activities
• Serious threat to health and safety of Medicare beneficiaries
• Related primarily to protected prescription drug classes

Aetna Life 4/5/10
Suspension of marketing and enrollment
• Failure to effect meaningful transition from open formulary to new closed formulary
• Website inaccuracies as to formulary
• Beneficiary medication access issues

Citrus Health Care 12/16/08
Suspension of marketing and enrollment
• Subject of 2 focused audits in 2008
• Pattern of widespread deficiencies in its administration and operations
• Enrollment and disenrollment issues
• Claims determination issues
• Credentialing issues

Wellpoint 1/12/09
Intermediate sanctions
• Serious threat
• Suspension of enrollment
• Suspension of marketing activities
• Longstanding and persistent failure
  –enrollment
  –administration of low income subsidy benefit
  –charging of enrollee premiums
  –marketing
  –appeals and grievances
  –prompt payment of claims
Panelists

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