Managed Care: Compliance Issues

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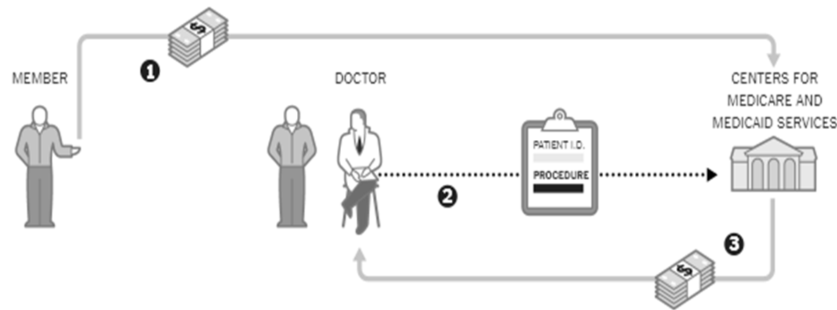
HOT ISSUES

- Medicare Advantage Risk Adjustment
  - Multiple ongoing investigations
  - High profile cases led by DOJ involving UnitedHealth
- AKS in a Risk Adjustment Environment
- Fraudulent Representations re: Networks

Traditional Medicare



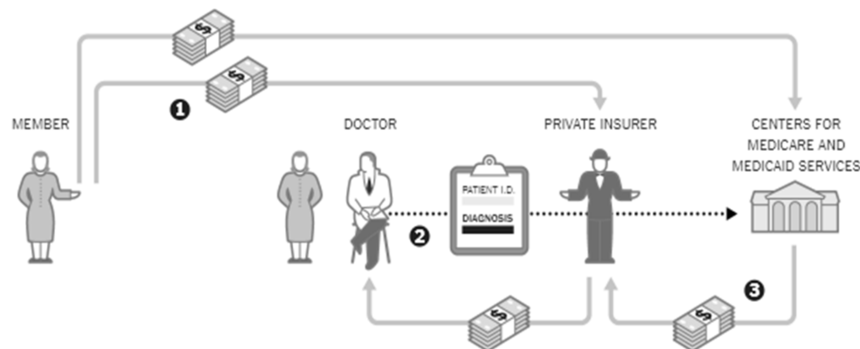
1. Traditional Medicare members pay a monthly premium to the Centers for Medicare and Medicaid Services (C.M.S.), whether or not they visit a doctor. C.M.S. also receives funding from U.S. taxpayers.

2. If members see a doctor, the doctor sends a copy of their medical report to C.M.S., to get paid.

3. C.M.S. pays the doctor. Traditional Medicare compensates doctors according to the procedures they perform — lab tests, scans, operations, etc.

Graphic courtesy of NY Times

Medicare Advantage



1. Medicare Advantage members also pay a monthly premium to C.M.S., and often a separate premium to a private insurance company.

2. If members see a doctor, the doctor sends a copy of the medical report to the private insurer, who then pays the doctor.

3. C.M.S. pays the private insurer a base rate for each member. If the private insurer tells C.M.S. that the member required treatment for certain conditions, C.M.S. pays the insurer more.

Graphic courtesy of NY Times

MA Overview

- What MA plans are

How MA plans are paid

- Bid Process Establishes Plan “base payment” for a member
- Plan bids “revenue requirement” for insuring a medicare beneficiary with a “national average” profile

Risk Adjustment

- Not all members are “average”
- Congressional concern: avoid “cherry picking”
- Risk adjustment process pays plans more or less based on how healthy or sick a member is compared to an average Medicare beneficiary
- E.g.: 1.2 = 20% more costly than average

Risk Adjustment

- Risk score is sum of “coefficients” associated with a member’s demographic and health characteristics
- CMS calibrates model (calculates value of coefficients) based on cost and diagnosis data in its FFS claims database
- MA plan member’s risk score based in part on diagnostic codes submitted by MA plan

Risk Adjustment Claims Submitted to CMS

RAPS submissions to CMS seek payment based on the assertion that a given member:

- Has the given diagnosis; and
- The diagnosis was treated or affected treatment:
  - ✓ By a qualified provider;
  - ✓ During the relevant treatment year;
  - ✓ In a face-to-face visit.

Upcoding Diagnoses to Increase Risk Adjustment Scores

- Medicare pays private insurance companies a monthly fee (capitation rate) to provide care for Medicare beneficiaries.
- Medicare pays a higher capitation rate if the plans' members have certain diseases, such as cancer, diabetes, heart disease or an acute stroke, that are known to be very expensive to treat. These extra payments are known as "risk adjustment" or "risk scoring" payments.
- It can be a violation of the False Claims Act to claim beneficiaries are sicker than they actually are.
- Example:
  - ✓ Claiming patients were treated for chronic kidney disease, major depression or malnutrition when they did not actually have those diseases.

Upcoding Diagnoses to Increase Risk Adjustment Scores

- U.S. ex rel. Sewell v. Freedom Health (M.D. Fla.)
- U.S. v. Janke (S.D. Fla.)
- Submitting unsupported diagnosis codes to inflate risk adjustment payments
- $32 million (Sewell) & $22 million (Janke) settlements

One-Way Look Cases

MA Plans face FCA liability for failing to correct (delete) false claims that were previously submitted that the Plan later learns, or in the exercise of reasonable diligence should have learned, were unsupported.

Early cases:

United States v. Lakeshore Med. Clinic, Ltd., 11 Civ. 00892 (E.D. Wis. Mar. 28, 2013)

Finding reverse false claims where defendant found high rates of "upcoding" during physician audit, but failed to conduct expanded audit or other follow up.

U.S. ex rel. Kane v. Healthfirst, Inc., 11 Civ. 2325 (S.D.N.Y. Aug. 3, 2015)

Finding reverse false claims where defendant was provided spreadsheet showing 900 potentially false claims and took no steps to investigate.

One-Way Look Cases

More recent cases

- U.S. ex rel. Swoben v. SCAN, (C.D. Cal.) - $3.8 million settlement
- Current environment: uncertainties and ambiguities

One-Way Look Cases

U.S. ex rel. Swoben v. UnitedHealth (C.D. Cal.)

- Allegations
- Motion to Dismiss
- Ruling

U.S. ex rel. Poehling v. UnitedHealth (C.D. Cal)

- Allegations
- Motion to Dismiss (Falsity)
- Ruling

Risk Adjustment: MA Plan Perspective

- UnitedHealth APA lawsuit
- Actuarial Equivalence and related statutory requirements
- CMS risk adjustment model and importance of CMS's own errors
- RADV FFS adjuster
- Coding Intensity Adjuster

Analysis of Early RA Cases

- Early cases: lessons?

Other Managed Care Issues - Anti-Kickback Statute

- Statute precludes payment of any "remuneration" with the intent to induce federally-insured patient referrals
- In managed care arena, plans argue that they must pay providers to induce them to join the network
- Argument: AKS applies differently, or not at all

Other Managed Care Issues - False Representation of Network

- In order for plans to qualify must demonstrate sufficient provider network
- Providers must be qualified and sufficiently wide geographic area

Materiality Post-Escobar

- *Universal Health Services, Inc. v. United States ex rel. Escobar,* 136 S. Ct. 1989 (June 16, 2016)
  - Background: Courts had developed various "pigeon holes" for FCA liability
    - Substandard goods or services
    - Express false certification
    - Implied false certification
    - Legally false claims
    - Factually false claims
    - Others
  - *Escobar* was health care matter where provider used unlicensed and unsupervised staff to provide mental health services, contrary to regulation
  - Relied on theory of "implied false certification"

Materiality Post-Escobar

- Current favored defense: *Escobar* creates a mandatory two-part test for ***any*** implied certification claim
- *Escobar* held that implied certification can be maintained "***at least*** where two conditions are satisfied":
  - "first, the claim does not merely request payment, but also makes specific representations about the goods or services provided;"
  - "and second, the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths." (at 2001, emphasis added)

- The Government and Relators argue that it is simply illustrative, not mandatory

Materiality Post Escobar

- Second aspect of Escobar holding: "Strict enforcement" of FCA's Materiality Standard
- Rigorous and demanding
- Under any definition, looks to "actual" or "likely" impact on recipient of alleged false claim or statement
- Government payment practice "very strong evidence" not material

Post Escobar Case

- Number of Courts have read Escobar to mean that plaintiff must plead (and ultimately prove) that agency would not have paid had it known the truth
  - Coyne v. Amgen (Second Circuit)
  - U.S. ex rel Petratos v. Genentech (Third Circuit)
  - Growing number of district court cases

Escobar Materiality and MA Implications

- Swoben decision
- Poehling decisionb

Implications For Compliance

- Scope and existence of duty to validate provider submitted diagnostic codes
- If such duty exists at all, how deal with CMS errors?
- CMS lack of clarity; potential APA ruling impact
- MA plans perspective: FCA not the right way to clarify let alone create duties