Managed Care Enforcement and Compliance

November 5, 2023

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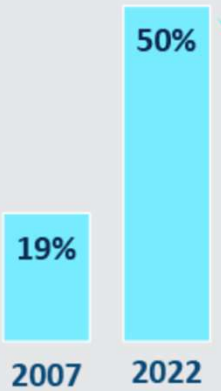
1

By the Numbers



50% Medicare enrollees received care through Medicare Advantage in 2022.

81% of current Medicaid enrollees receive at least one component of care through managed care.

$403B in Government spending on Medicare Advantage in 2022 (50% of all Medicare funds).

$254B Federal match for Medicaid managed care in 2021.

Managed Care Featured Topic
OIG.HHS.GOV

2

Priority Area

HHS-OIG Strategic Plan

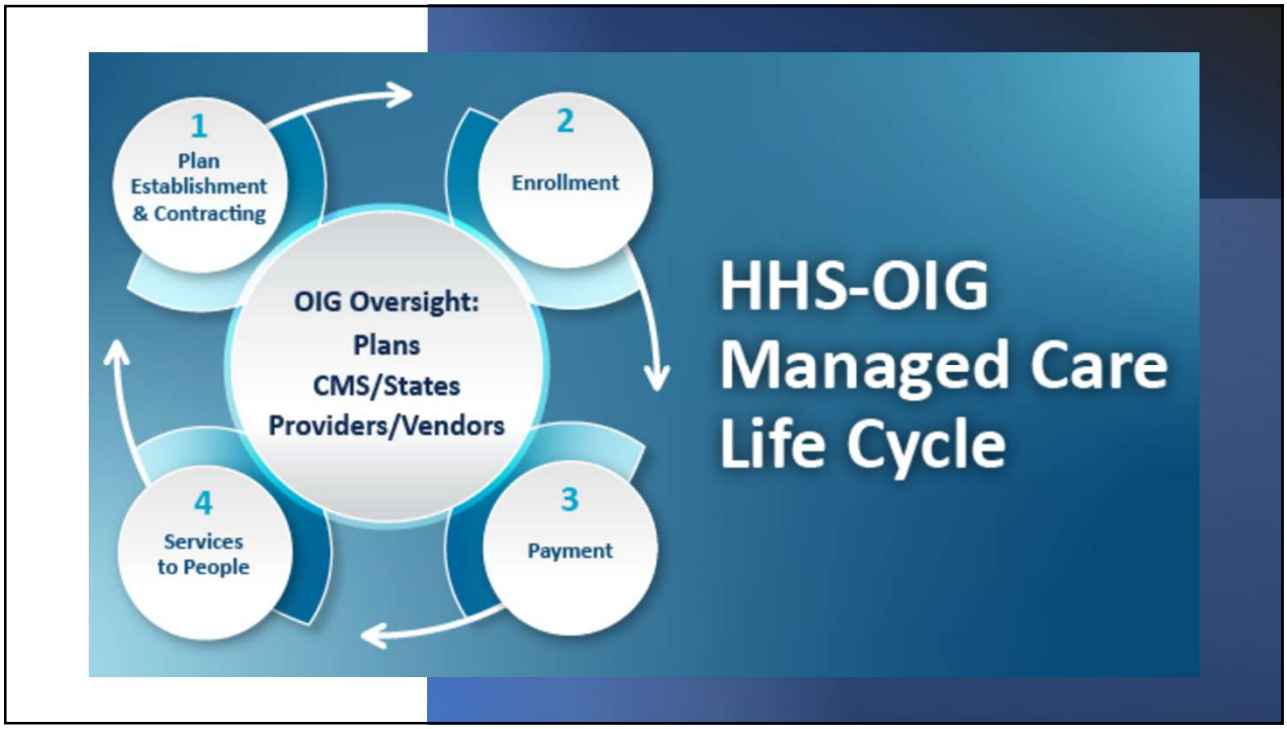
Oversight of Managed Care For Medicare and Medicaid

3

Goals of Strategic Plan

1. Promote access to care for people enrolled in managed care
2. Provide comprehensive financial oversight
3. Promote data accuracy and encourage data-driven decisions

4



5

Goal #1: Promote Access

Cross-program behavioral health study

- Examining the ratio of providers to enrollees, ability of providers to accept new patients and schedule appointments, and network adequacy.

OIG examined prior authorization requests in Medicare Advantage

- In 13% of cases, plans denied services that met Medicare coverage rules.
- Certain Medicaid MCOs denied 1 out of every 8 requests for the prior authorization of services
- States had limited oversight of MCO prior authorization denials.

6

Goal #2: Comprehensive Financial Oversight

- Risk Adjustment Audits and Evaluations (Part C)
- Medical Loss Ratio Reporting (Medicaid)

7

Goal #3: Promote data accuracy and encourage data-driven decisions

Encounter Data (Part C)	T-MSIS Data (Medicaid Managed Care)
• Lacking provider identifiers	• Incomplete and inaccurate data

8

Recent Enforcement in Part C

- The Cigna Group settlements in September 2023
  - False Claims Act
  - Medicare Advantage Risk Adjustment
  - 5-year CIA

9

OIG's Compliance Guidance

Updating and improving existing Compliance Program Guidance

Developing new CPGs specific to health care industry segments/entities

Medicare Advantage CPG expected in 2024

10

11

Managed Care Enforcement & Compliance

HCCA Healthcare Enforcement Compliance Conference

November 5, 2023

Dan Meron, Partner, Latham & Watkins

Teresa Mason, Epstein Becker & Green

12

Agenda

- Medicare Advantage – Brief Overview
- OIG Enforcement
- Recent DOJ Qui Tams / Settlements
- Compliance Considerations

13

Medicare Advantage Overview

Medicare Advantage

- Created to improve care coordination, reduce costs and maintain quality of care by engaging the private sector
- Initial concerns – cherry picking and withholding services
- Payment methodology - prospective capitated payment model, development of risk adjustment model.

Risk Adjustment

- CMS pays plans based on calculation (risk score) – takes into account certain demographics (age / sex(and health status of plan members
- Health status = diagnosis codes
- Some, not all, diagnosis codes map to a Hierarchical Condition Category (HCC)
- HCCs assigned a value (co-efficient) which contributes to a risk score

14

Medicare Advantage Regulatory Landscape

CMS Guidance in Risk Adjustment

- 2008 Participant Guide and Medicare Managed Care, Chapter 7: Risk Adjustment
- 2020 Contract Level Risk Adjustment Data Validation, Medical Record Review Guidance

Diagnosis Submission Guidelines

- Face-to-face encounter with an acceptable provider, at an acceptable site of service in the year of service
- Report all current conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management
- Apply ICD-10 guidelines and development of industry standards (MEAT, TAMPER)

15

Medicare Advantage Enforcement Players

Center for Medicare & Medicaid Services (CMS)	Office of Inspector General (OIG)	Department of Justice (DOJ) / Qui Tam Bar
• Program Audits • Financial Audits • Risk Adjustment Data Validation Audits (RADV)	• Targeted & contract wide audits and investigations • Corporate integrity agreements	• Active investigations and settlements

16

Medicare Advantage Enforcement Tools

False Claims Act

- Makes it illegal to cause a false claim for payment by a federal payor (Medicare or Medicaid)
- Knowingly submit, cause to be submitted, retention of an overpayment (reverse false claims)

Medicare Part C Overpayment Rule

- MAO must disclose any funds that an MAO has received or retained to which the MAO is not entitled to
- 60 day clock once organization has identified an overpayment or potential FCA implications
- "Identification" of an overpayment definition in flux

17

Recent FCA Cases and Settlements

Implications for Compliance

18

United States ex rel. Poehling v. UnitedHealthcare (C.D. Cal)

- Intervened case
- Central allegation: United did "blinded" chart reviews and allegedly failed to delete provider-submitted codes it "knew" were unsupported
- Source of obligation?
  - Implications for compliance officers

19

Cigna "Chart Review" Settlement (DOJ; EDPA)

- Pre-Complaint Settlement
- Settled Allegation:
  - "[1] Cigna retained professional coders to conduct retrospective reviews …to identify all risk-adjusting conditions that the charts supported" and submitted those codes to CMS for payment"
  - [2] "However, Cigna's chart reviews also did not substantiate some diagnosis codes reported by healthcare providers."
  - [3] "In other words, healthcare providers had reported diagnosis codes …that Cigna's coders did not find"….
  - [4] "But Cigna did not investigate or withdraw the unsubstantiated, invalid diagnoses"

20

Cigna "Chart Review" Settlement (DOJ; EDPA)

- Fluctuating allegations re "knowledge"
  - Did not substantiate
  - Did not find
  - Did not investigate
- Obligation:
  - "false certifications that its data was 'accurate, complete and truthful"
  - What is the level of accuracy given this type of data?

21

U.S. ex rel. Ross v. Independent Health (DOJ; WDNY)

- Allegations:
  - Addenda
    - Post 90 day "rule"
    - What is existence and source of the rule?
    - Conditions beneficiaries factually do not have
- Coding Policies

22

U.S. ex rel. Ross v. Independent Health (DOJ; WDNY)

- Areas of dispute:
  - Must the chart document "treatment" when coding chronic conditions for risk adjustment purposes
    - Applicability of procedure coding criteria to risk adjustment diagnosis coding
  - Meaning of "care or treatment" in ICD Guidelines

23

U.S. ex rel. Ross v. Independent Health (DOJ; WDNY)

- What type of documentation suffices?
  - Problem lists
  - Medical Record Addenda
  - "Status" and "History" conditions – e.g. "old MI"

24

U.S. ex rel. Ross v. Independent Health (DOJ; WDNY)

- Lack of formal regulations addressing the specific issues
- Guidelines broad and ambiguous
- CMS's own guidance to RADV coders conflicts with many DOJ enforcement theories
- Enforcement Theories based on coding for E/M purposes conflicting with Risk Adjustment coding certification training

25

Cigna – Morbid Obesity Settlement (DOJ; EPDA)

- "Clinical Accuracy"
- Settled conduct:
  - "Cigna knowingly submitted and/or failed to delete inaccurate and untruthful diagnosis codes for morbid obesity"
  - "Individuals with a BMI below 35 cannot properly be diagnosed with morbid obesity."

26

Cigna – Home Visits Settlement (SDNY, TN)

- "Admitted conduct" included:
  - Home visit practitioners "in many cases were not permitted by Cigna to provide treatment or write prescriptions
  - According to Cigna criteria, many of the conditions requires lab testing, imaging or other diagnostic testing to diagnose but the providers lacked the equipment to do so
  - Many of the conditions were not reported to CMS by Cigna from any other encounter that year
  - Many of the conditions diagnosed in the home visits were not documented with clinical information corroborating the diagnosis

27

Compliance Considerations

28

MA Compliance Considerations

- Cigna enters into Corporate Integrity Agreement
  - Term of 5 years
  - Requirements
    - Compliance officer, compliance committee, policies and procedures, training, etc.
    - Reportable events: significant overpayment, probable violations of the law
    - Implementation and Annual Reports
    - Engagement of an IRO for annual auditing
      - Focused on chart reviews and in home assessment members
      - Return of overpayment

29

DOJ MA Enforcement Focus


Retrospective Chart Reviews


In Home Assessments


Prospective Engagement of Providers


Coding Methodologies / Education


Auditing & Monitoring


Compliance Oversight

30

MA Compliance Considerations

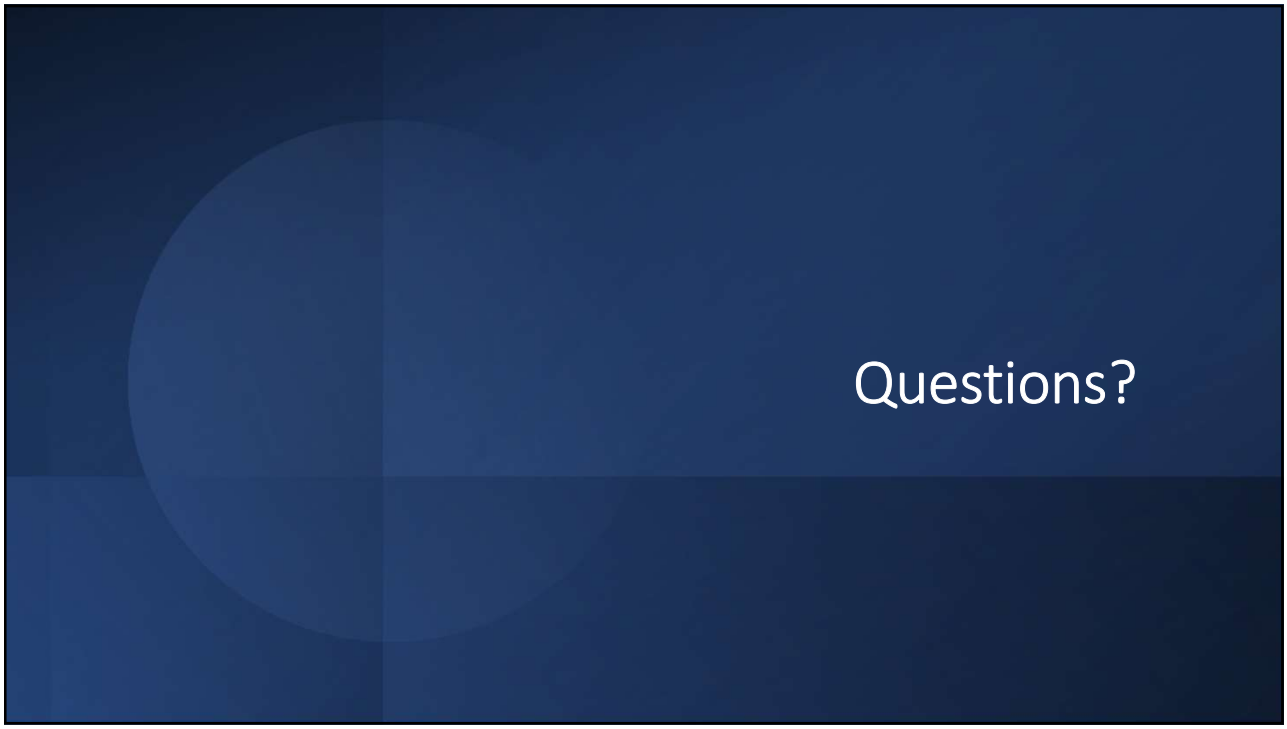
- Stay abreast of the evolving enforcement landscape
- Review program activities with backdrop of current agency focus and enforcement landscape in mind
- Establish compliance oversight of operational RA activities (e.g., compliance officer, compliance sub-committee)
- Develop and establish RA specific policies and procedures

31

MA Compliance Considerations

- Improve oversight activities
  - Plan initiated activities (retro, IHAs, prospectives)
  - Vendor / provider relations
- Engage with and educate providers
- Review auditing / monitoring processes
- Promote collaboration between key personnel whose departments touch RA - quality, data analytics, data integrity, provider relations, etc.

32



33