wiley

The Risks of Risk Adjustment Reviews:

Enforcement Trends & Litigation Involving Medicare Advantage Risk Adjustment Practices

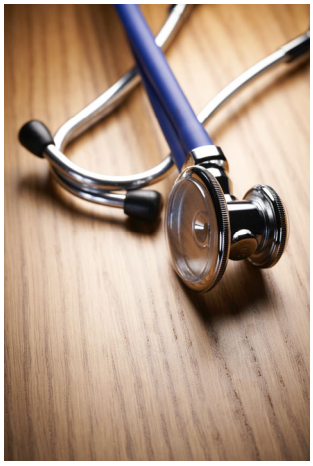
Brandon J. Moss

Rachel A. Alexander

This presentation is accompanied by oral explanation and should not be relied upon for legal advice.

1

wiley.law



Medicare Advantage Organizations & Risk Adjustment

2

wiley.law

The Role of MAOs

- Under Medicare Part C, CMS buys insurance for Medicare beneficiaries from private insurers, i.e., Medicare Advantage Organizations (MAOs).
- In 2020, 36% of Medicare beneficiaries received coverage through a MAO.
- The CBO has estimated that by 2030, 51% of Medicare beneficiaries will receive coverage through a MAO.

"A Dozen Facts About Medicare Advantage in 2020," Kaiser Family Foundation. April 22, 2020, accessed Dec. 28, 2020 at https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/.

wiley.law

Overview of MAO Payment Basics

- MAOs annually submit a "bid" to CMS, which is the MAO's estimate of the revenue it will require to provide Medicare coverage to enrollees with *average* risk profiles. 42 C.F.R. § 422.254
- The MAO's bid is the foundation for the monthly per person amount (i.e., capitation rate) that Medicare pays for each MAO plan enrollee.
- The capitation rate is adjusted based on a number of factors, including the health status of the enrollee, i.e., "risk adjustment." 42 C.F.R. § 422.304
  - Factors used to risk adjust capitation rates include age, gender, disability status, institutional status, and other factors CMS determines to be appropriate, including health status, in order to ensure actuarial equivalence. 42 CFR §422.308(c)

wiley.law

Risk Adjustment

- CMS uses a blend of claims and encounter data to gather data related to the enrollees' health status. This data is then used to establish certain Hierarchical Condition Categories (CMS-HCCs) that when applied to the base capitation rate, result in a "risk adjusted" capitation rate.
  - In response to COVID-19 impacts on claims and encounter data, CMS announced that MAO's would be able to submit diagnosis data from certain qualifying telehealth visits for purposes of risk adjustment calculations. See, Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQs April 27, 2020 (Updated on August 3, 2020)

wiley.law

Certification of Risk Adjustment Data

- The goal of risk adjustment is to level the actuarial playing field (i.e., adjust for adverse selection) so that MAOs are competing based on the value and quality of their plans, rather than on their ability to avoid enrolling "high risk" enrollees.
  - The integrity and accuracy of the data that factors into the risk adjustments is an important factor to achieving that level playing field.
- As a condition for receiving payment, the MAO organization must certify, "(based on [its] best knowledge, information, and belief) the accuracy, completeness, and truthfulness" of all CMS-requested data, including "specified enrollment information, encounter data, and other information that CMS may specify." 42 CFR 422.504(l)

Health Care Fraud Background

7

Health Care Fraud: DOJ's Favorite Target

- FY 19 FCA
  - $3B in recoveries
    - $2.6B from Health Care sector
  - 633 *qui tams* filed
- DOJ opened 1,112 new civil health care fraud investigations in FY 19
- DOJ opened 1,060 new criminal health care fraud investigations in FY 19
- DOJ Health Care Fraud Unit
  - 60 prosecutors
  - Strike force model (includes FBI, HHS-OIG, CMS CPI, DEA, IRS, DCIS, USAO, and state/local law enforcement)
    - 2020 DOJ Fraud Section's Health Care Fraud Unit operated 15 Health Care Fraud and Prescription Opioid Strike Forces in 24 federal judicial districts across the United States
  - Charged 344 individuals in 2019 (associated with $4.1B in alleged losses)
    - 158 medical professionals (66 for illegal opioid prescriptions)

8

wiley.law

Health Care Fraud Enforcement Theories

- Health Care Fraud
- Mail/Wire Fraud
- Conspiracy
- False Statements
- Anti-Kickback Statute
- Stark Laws

Criminal violations can be the predicate for FCA actions

wiley.law

False Claims Act Basics

- 31 U.S.C. §§ 3729 – 3733.
- Enacted in 1863 in response to Congress' concern that suppliers of goods to the Union Army during the Civil War were defrauding the Army.
- Prohibits a range of false representations that lead to improper receipt of federal money and efforts to improperly avoid an obligation to pay federal money.

wiley.law

FCA Basics

- **Types of FCA liability:**
  - § 3729(a)(1)(A) – knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval.
  - § 3729(a)(1)(B) – knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.
  - § 3729(a)(1)(G) – "reverse false claim" – knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government.
  - § 3729(a)(1)(C) – conspiring to violate the FCA.
  - § 3730(h) – "FCA retaliation claim" – the employee was engaged in protected activity; the employer knew this, and as a result, the employee was discriminated against for lawful efforts in furtherance of an FCA action or to stop a violation.
  - §§ 3729(a)(1)(D), (E), and (F) are rarely invoked.

11

wiley.law

FCA Basics

- **Four Elements:**
  - Claim or Statement for payment or approval of payment
  - The Claim or Statement is false or fraudulent
  - "Knowledge" of the falsehood – actual knowledge, reckless disregard, or deliberate ignorance (§ 3729(b)(1))
  - Materiality

12

wiley.law

FCA Basics

- **Both the government and citizens have standing to bring an FCA case:**
  - Brought by the government
    - The FCA is the federal government's primary civil litigation tool against fraud.
  - *Qui Tam*
    - Private individuals, known as "whistleblowers" or "relators," can bring *qui tam* suits on behalf of the government and get a percentage of recovery plus attorneys' fees.
- **The government can dismiss *qui tam* actions.**
  - § 3730(c)(2)(a)

wiley.law

FCA Basics

- **Heavy Hammer: Treble Damages Plus Statutory Penalties:**
  - FCA allows for treble damages, and theories of damages vary widely.
  - Penalties:
    - Penalties for each false statement/submission can add up, even when damages are small.
    - Penalties are indexed.
    - 2020 Minimum: $11,665.
    - 2020 Maximum: $23,331.

wiley.law

FCA Liability & Medicare Advantage

"**Medicare Part C is an area where you can expect to see enforcement efforts in the years to come**. As you may know, almost a third of Medicare beneficiaries opt out of traditional fee for service Medicare under Parts A & B, and enroll in private Medicare Advantage Organization (or "MAOs") plans instead. In 2019, payments to MAOs totaled about $250 billion. **We've had several major False Claims Act resolutions in this area in the past few years, and we expect more to come.**"

- Ethan P. Davis, Principal Deputy Assistant Attorney General (6/26/20)

wiley.law

FCA Cases Targeting Medicare Advantage

- Common theories of liability in risk adjustment cases:
  - Blatant upcoding to increase risk scores
  - Incremental upcoding and manipulation of patient records
  - Failure to correct or identify inappropriate codes
  - Anti-kickback statute violations
- Cases brought by relators or the government
  - Relators: MAO/Plan, provider and vendor employees (doctors, nurses, auditors, compliance officers, etc.)
  - Intervention rate is higher than average

wiley.law

FCA Liability & Failure to Act Cases

- "Failure to Act" cases are currently the most contested because, amongst other reasons, they implicate the largest dollar figures.
  - MA plans and providers 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.
- Key points for litigation:
  - Do MAOs have a refund obligation?
    - ACA requires that "any overpayment ... be reported and returned [within] 60 days after the date on which the overpayment was identified." Failure to do so renders the insurer's initial, but faulty, claim for payment an FCA violation.
    - What is an overpayment and when is it identified?
      - 2014 Final
      - But ... *UnitedHealthcare vs. Azar* (D.D.C. 2018)
  - Are annual certifications "material?"
  - Is sub-regulatory guidance legally enforceable?

wiley.law

Key Cases

- *U.S. ex rel. Swoben v. SCAN Health Plans*
  - Relator: James Swoben, former employee of SCAN Health Plan.
  - Initially filed in 2009 against SCAN; subsequently amended to add UnitedHealthcare, WellPoint, Aetna, Health Net, HealthCare Partners, etc.
  - Allegations: The MA organizations conducted one-sided retrospective reviews of diagnosis codes that were designed to only identify appropriate codes that were not previously submitted, not inappropriate codes previously submitted, thus rendering the section 422.504(l) attestations false.
  - 2012 – SCAN paid $3.82M to settle claims (part of $320M settlement).
  - 2013 – U.S. declines intervention as to remaining defendants.
  - 2013 – Court dismisses for failure to plead fraud with specificity; Relator appeals.

wiley.law

Key Cases

- *U.S. ex rel. Poehling v. UnitedHealth Group, Inc. et al.*
  - Initially filed in NY, but moved to California in 2016 in an effort to consolidate it with *Swoben* (judge rejected case).
  - Relator: Benjamin Poehling, former UnitedHealth finance employee.
  - Allegations:
    - UnitedHealth knowingly obtained inflated risk adjustment payments based on untruthful/inaccurate information about the health status of beneficiaries enrolled in UnitedHealth's MA Plans throughout the country.
    - UnitedHealth conducted a chart review program designed to identify diagnoses not reported by treating physicians that would increase its risk adjustment payments, and ignored information from these reviews showing that hundreds of thousands of diagnoses submitted to Medicare were invalid to avoid repaying Medicare money to which UnitedHealth was not entitled.

wiley.law

Key Cases

- *U.S. ex rel. Swoben v. SCAN Health Plans* (*aka U.S. ex rel. Swoben v. United Healthcare*)
  - 8/2016 – 9th Circuit revives and remands *U.S. ex rel. Swoben v. United Healthcare:*
    - Issue before court: Whether conducting retrospective medical record reviews designed to identify only diagnoses that would trigger additional payments by CMS, not errors that would result in negative payment adjustments, would cause a certification to be false for purposes of section 422.504(l) and the FCA.
    - Holding: Plan C sponsors can be liable under the FCA if they deliberately "avoid identifying erroneously submitted diagnosis codes that might otherwise have been identified with reasonable diligence." It can also contravene its annual attestations (and violate the FCA) by deliberately ignoring the red flags that the retrospective chart review results raise as to the validity of the provider-submitted diagnosis codes.

wiley.law

Key Cases

- *U.S. ex rel. Swoben v. SCAN Health Plans*
  - 11/2016 – Swoben files 4th Amended Complaint.
  - 3/2017 – U.S. intervenes against UnitedHealth defendants.
    - Allegations:
      - Plans were aware of the limited scope of the HealthCare Partners' chart reviews and that awareness rendered the plans' own attestations false.
      - Adds "Reverse FCA" claim.
- *U.S. ex rel. Poehling v. United Health*
  - 5/2017 – Government intervened:
    - Three FCA claims plus two common-law claims.
    - Government did NOT assert a reverse FCA claim.

wiley.law

Key Cases

- *U.S. ex rel. Swoben v. SCAN Health Plans*
  - 10/17 – Court dismisses intervention Complaint:
    - Government failed to allege that CMS would have refused to make risk adjustment payment to United defendants if it had known that the plan was conducting one-way reviews.
      - CMS was aware of the one-way chart reviews and nevertheless continued to pay United and others – i.e., the one-way reviews were not material.
      - The government's Complaint failed to identify the corporate officers who had signed the Attestations at issue or allege that they knew or should have known that the Attestations were false and that the "classic shotgun pleading" failed to "state clearly how each and every defendant is alleged to have violated" the statute; the Court also provided clear guidelines for amending the Complaint.
      - The Court did not reach the reverse FCA claim, finding that it died when the case was initially dismissed because Swoben failed to appeal that portion of the ruling.
  - 10/17 – Government moves to dismiss without prejudice.

wiley.law

Key Cases

- *U.S. ex rel. Poehling v. UnitedHealth Group, Inc., et al.*
  - 11/17 – After *Swoben* dismissal, U.S. amended Complaint to include reverse FCA:
    - Allegation: Because UnitedHealth failed to delete invalid diagnoses in RAPS, they failed to return the Medicare overpayments.
  - 2/18 – Court dismisses claims related to attestations, but allowed reverse FCA allegations regarding failure to return overpayments to continue.
    - "As in [Scan], the government failed to allege that CMS would have refused to make risk adjustment payments if it had known the Attestations were false."
    - Court found that the materiality of United's failure to return overpayments was sufficiently plead.

But, while that case progressed ...

wiley.law

Key Cases

- *UnitedHealthcare Ins. Co. v. Azar* (D.D.C. 2018)
  - The court vacated the Medicare Advantage 60-day repayment rule:
    - Violated the rule of actuarial equivalence.
    - Rule imposed a negligence standard on MA insurers to identify and report overpayments that is inconsistent with the FCA.
    - Rule imposed a "distinctly different and more burdensome definition of 'identified' without adequate notice."
  - The government appealed the decision to the D.C. Circuit, which heard oral arguments in late 2020

wiley.law

New Defense Arguments

- *U.S. ex rel. Poehling v. UnitedHealth Group, Inc., et al.*
  - 3/19 – Court denies government's motion for partial summary judgment:
    - Issue: Was United required by regulation or contract to delete invalid diagnosis codes submitted to CMS for risk adjusted payments that it knew were unsupported by its beneficiaries' medical records?
    - Relying on *Azar*, the Court declined the rule as a matter of law that UnitedHealthcare was required to delete diagnosis codes it knew to be inaccurate.
      - It could not conclude that the existing regulations unambiguously support the government's proposed rule.
      - It also ruled that it was not "unambiguously clear" that United was contractually obligated to delete unsupported diagnosis codes.
  - Case remains pending, in discovery.

wiley.law

Where Does That Leave Us Now?

- Despite setbacks, government has remained focused on Medicare Advantage...
  - And the tide may be turning in its favor
- *U.S. ex rel. Ormsby v. Sutter Health et al.*
  - 3/15 – Relator (former coding manager) files complaint
  - 3/18 – Government files complaint in intervention
  - 6/18 – Defense files motion to dismiss pointing to Azar, and arguing that the government has failed to show that the defendants knowingly overbilled the government or that the defendants' attestations regarding the accuracy of its billing were actually material to government repayment.
  - 5/20 – Court rejects motion to dismiss
    - 100 page opinion

wiley.law

Where Does That Leave Us Now?

- *U.S. v. Anthem*
  - 3/20 – U.S. files complaint against Anthem alleging one-sided retrospective reviews
  - 9/20 – Defense files motion to dismiss, transfer and strike
- *U.S. ex rel. Ross v. Group Health et al. (W.D.N.Y.)*
  - 4/12 – Relator (former medical billing manager) files complaint
  - 7/19 – Complaint unsealed without intervention
  - 10/19 – Defense files motion to dismiss on grounds that the Relator can't rely on sub-regulatory guidance (the Participant Training Guide) to support an FCA claim
  - 1/20 – U.S. intervenes as to certain defendants; GHC files notice of settlement in principle
  - 11/20 – GHC settles with government for $6.4M

wiley.law

DOJ Policy Pronouncements: Where Are They Going?

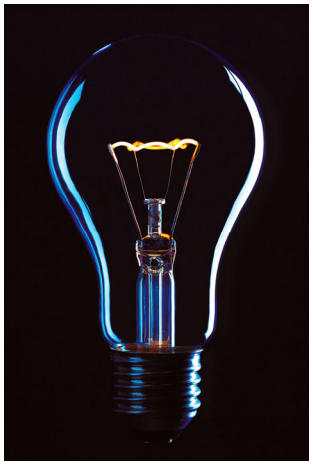
wiley.law

Recent DOJ Policy Pronouncements

- Brand Memo (Justice Manual § 1-20.100)
- "Granston Doctrine" (Justice Manual § 4-4.111)
- "Piling On" Speech (Justice Manual § 1-12.100)
- Individual Accountability & Cooperation
  - Yates Memo & Rosenstein Speech (Justice Manual § 9-28.210)
- Guidelines for Taking Disclosure, Cooperation, and Remediation Into Account for FCA Matters
  - Corporate Compliance Programs (Justice Manual § 9-28.800)

29

wiley.law



Concluding Thoughts

30

wiley.law

Risk Adjustment Checklist

CMS recommends that MAOs should engage in the following practices:

- Ensure the accuracy and integrity of risk adjustment data submitted to CMS.
- Implement procedures to ensure that diagnoses are from acceptable data sources.
- Submit the required data elements from acceptable data sources according to the coding guidelines.

31

wiley.law

Risk Adjustment Checklist

CMS recommends that MAOs should engage in the following practices:

- Submit all required diagnosis codes for each beneficiary and submit unique diagnoses at least once during the risk adjustment data-reporting period, taking care to eliminate duplicate diagnosis clusters.
- Delete diagnosis codes that have been submitted but do not meet risk adjustment submission requirements.

32

wiley.law

Risk Adjustment Checklist

CMS recommends that MAOs should engage in the following practices:

- Receive and reconcile CMS Risk Adjustment Reports in a timely manner.
- Track the submission and deletion of diagnosis codes on an ongoing basis.
- Immediately submit requests for recalculation of risk scores upon discovering inaccurate diagnosis codes that impact the final risk score and payments for a previous payment year.

Medicare Managed Care Manual Chapter 7, § 40 (Role and Responsibility of Plan Sponsors)

wiley.law

Managing the Risks

- Upcoding Risks
- Kickback Risks
- Certification Risks

wiley

Questions?

Brandon J. Moss
bmoss@wiley.law
Partner
202.719.7554

Rachel A. Alexander
ralexander@wiley.law
Partner
202.719.7371

35