Developments in Government Managed Care Fraud Enforcement

2021 AHLA Fraud and Compliance Forum

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Notes:

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Background on Managed Care Programs with Risk Adjustment

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Background on Managed Care Programs with Risk Adjustment

- Medicare and Medicaid contract with commercial entities to provide a covered benefit for a **per member, per month (PMPM)** fee
- When these amounts are risk adjusted, the PMPM varies depending upon the expected health status of the member (i.e. risk score)

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Background on Managed Care Programs with Risk Adjustment – Data Submission Process

- Provider
  - Encounter with member
  - Documents member visit in medical record
  - Diagnosis codes are assigned
  - Submits claims or encounter data to MA plan
- MA Plan
  - Processes and filters claims and encounter data from providers
  - Submits risk adjustment data to CMS via RAPS and EDPS
- CMS
  - Processes data for risk adjustment factor calculation and payment
  - Returns data to MA plans with accepted or error code status

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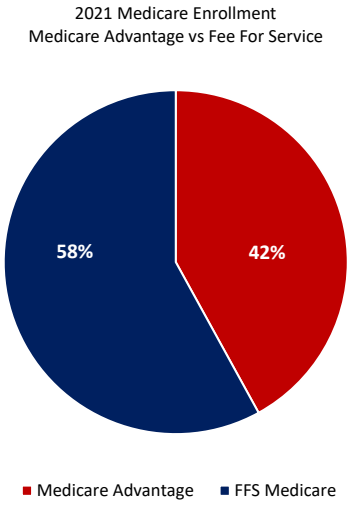
Background on Managed Care Programs with Risk Adjustment

- The health care world is changing.
- A significant number of beneficiaries are covered by managed care programs and the trend continues upwards
- MA enrollees account for $343 billion (46%) of total Medicare spending (net of premiums) in 2021



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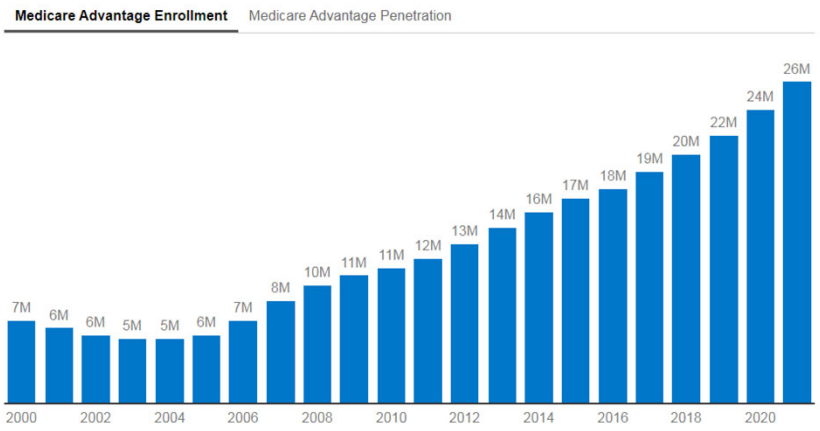
Medicare Advantage Enrollment Trends

Figure 1

Total Medicare Advantage Enrollment, 2000-2021



Source: Kaiser Family Foundation

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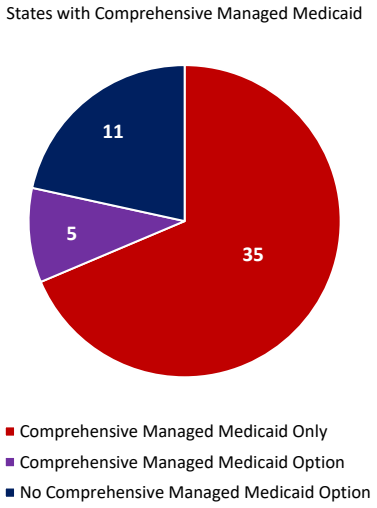
Background on Managed Care Programs with Risk Adjustment

- 70% of Medicaid enrollees are in comprehensive Managed Care programs
- 35 States and the District of Columbia offer only comprehensive Medicaid Managed Care
- 5 States offer it as an option



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Background on Managed Care Programs with Risk Adjustment

<u>Other Factors Impacting Reimbursement</u>

- *Medical Loss Ratio (MLR) Requirements*
- *Risk Corridors*
- *More Complex Bidding*

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Market Factors - Significant Financial Risk

- Uncertain reimbursement
- Increased pressure on cost management
- Financial Risk and Operational Responsibilities Further Delegated
- More complex arrangements and interaction between plans and providers

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Market Factors - Involvement of Third Party Vendors

- Coding
- Chart Review
- Data Submissions and Filtering
- Patient Outreach and Assessment
- Bid Submission
- Platforms and EHR

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Other Key Considerations

Regulatory Uncertainty

- Questions regarding Medicare Advantage raised by recent rulings and enforcement actions
- Managed Medicaid still maturing and appears to have increased regulatory and enforcement focus
- Regulations and Enforcement may not be fully aligned

Enforcement Environment

- Medicare Advantage fraud remains a key enforcement priority

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Other Key Considerations

Business environment

- Medicare Advantage still robust business model
  - Attracts new entrants, including many health systems and smaller entities less familiar with risk adjustment and Medicare Advantage compliance requirements and costs
- Managed Medicaid
  - Programs vary state by state
- Continued influx of third parties and vendors to support risk adjustment programs
  - Contracting, delegation and compliance program uncertainty
  - Continued need for appropriate oversight

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Case Law Update

Recent Developments – Part 1

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Key Matters that are Public

Approximately 20 Known Public Qui Tam Medicare Advantage-related matters since 2009

Since 2018 over $370M in related settlements announced:

- Includes the two largest Medicare Advantage settlements
  - $270M Health Care Partners (2018)
  - $90M Sutter (2021)
- Other settlements include providers and MAOs:
  - $5M Beaver Medical (2019)
  - $6.3M GHC (2020)
  - $2.25M Keystone (2020)

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Evolution of Matters Over Time

Factual Allegations:
- Use of addenda
- Chart reviews (one-way, two-way)
- Submissions/non-deletions (critical fact: knowing or negligent)
- Oversight of provider data
- Non-compliance with coding guidelines
- In home assessments and other efforts to capture additional diagnoses
- Kickbacks
- Medically unnecessary tests/visits

Scope of Defendants:
- MAOs
- Providers
- Third Parties

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Select Enforcement Activity

Swoben, No. 09-05013 (C.D. Cal.) (unsealed *qui tam*, 9th Circuit revived on appeal, dismissal of DOJ complaint-in-intervention)

- 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)
- DOJ Complaint-in-Intervention dismissed; DOJ elected not to amend

Silingo, No. 13-01348 (C.D. Cal.) (unsealed *qui tam*, DOJ declined, dismissal reversed on appeal, case settled)

- In-home assessment vendor allegedly submitted false diagnoses to health plan defendants
- Plan defendants allegedly submitted those diagnoses to CMS without adequate vendor oversight

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Notes:

Select Enforcement Activity (cont.)

Poehling, No. 11-0258 (C.D. Cal.) (unsealed *qui tam*, DOJ intervention, case proceeding, trial scheduled for 2/21/2023)

- Health plan allegedly manipulated risk scores, by, among other things, performing "one-way" chart reviews and failing to delete specific codes determined to be inaccurate via temporary "two-way" chart review process
- Attestation-based claims dismissed; MTD reverse FCA-based claims denied; DOJ's partial summary judgment motion was denied in March 2019

Ormsby, 15-CV-01062-JD (N.D. Cal.) (civil *qui tam*, DOJ intervened, case settled)

- Defendants, Sutter Health and Palo Alto Medical Foundation, allegedly knowingly submitted unsupported diagnosis codes to the MAOs with which they contracted
- DOJ intervention in December 2018
- Court denied defendants' motions to dismiss, rejecting defenses regarding actuarial equivalence and knowledge
- $90M Settlement announced in August

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2020: Enforcement Activity

2020 Settlements:

Kaiser Foundation Health Plan of Washington $6.3 million settlement with DOJ to resolve allegations that it submitted inflated and invalid diagnoses codes for MA beneficiaries, by knowingly allowing a third-party vendor to routinely "upcode" claims (Nov. 2020)

Independence Blue Cross (IBC) agreed to pay $2.25 million to resolve allegations that it incorrectly calculated actual prior costs in the financial bids it submitted, resulting in inflated reimbursement to IBC (Sept. 2020)

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2020: Enforcement Activity

Pending Litigation:

U.S. v. Anthem, Inc. March 2020 FCA action related to Anthem's alleged failure to delete inaccurate diagnosis codes submitted to CMS for risk adjustment purposes, effectuated in part through one-way chart review. Anthem's motion to dismiss is pending

U.S. ex rel. Cutler v. Cigna Corp. Unsealed FCA q*ui tam* in which relator alleges Cigna-HealthSpring inappropriately captured diagnoses not supported in the underlying medical record by encouraging nurses to diagnose beneficiaries with exaggerated medical problems, promoted falsification of diagnoses, and reported health conditions not supported by medical documentation or reliable clinical information.

- DOJ declined in part to intervene. Case recently reassigned to SDNY. Case proceeding.

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2021: Notable New Cases

U.S. v. Kaiser Permanente

- On July 30, 2021, the government intervened on six separate *qui tam* complaints against Kaiser, which were originally filed between 2013 – 2021. One complaint remains unsealed.
- The government intends to intervene only on those allegations relating to the submission of false claims for "risk-adjustment payments based on diagnoses improperly added via addenda under Medicare Part C from the years 2009 until present."
- Allegations include, among other things, that Kaiser failed to audit potential coding concerns, remediate as required and appropriately submit data corrections. Failure to look back at past data submissions.
- The government's consolidated complaint in intervention will be filed in the next 90 days.

UnitedHealthcare Insurance Co. et al. v. Becerra et al. ("UnitedHealthcare"), case number 18-5326 (D.C. Circuit 2021)

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RADV Audits

Recent Developments

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CMS RADV Audits

- CMS periodically conducts Risk Adjustment Data Validation ("RADV") audits of selected Medicare Advantage contracts "to ensure risk adjusted payment integrity and accuracy," 42 C.F.R. § 422.311(a)
- RADV Audit encompasses review of medical records and clinical documentation
- Initial 2008 PY audits were not extrapolated. Uncertainty regarding whether and how 2011 – 2014 PY audits would be extrapolated
- COVID Suspension: In March of 2020 CMS announced it was suspending audit activities related to the payment year 2015 and won't initiate any additional contract-level audits until after the public health emergency is over. Payment year 2014 medical record submissions and review of records were not suspended.

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Compliance basics

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Compliance Guidance and Frequently Cited Documents

- U.S.S.C. §8B2.1: Effective Compliance and Ethics Program (7 Fundamental Elements)
  1. Written policies and procedures
  2. Compliance professionals
  3. Effective training
  4. Effective communication
  5. Internal monitoring
  6. Enforcement of standards
  7. Prompt response
- February 8, 2017 – DOJ's Fraud Section issued "Evaluation of Corporate Compliance Programs"
- Medicare Managed Care Manual
- Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide
- Risk Adjustment 101 Participant Guide
- Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance

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Compliance Guidelines

Medicare Managed Care Manual. Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual. Chapter 9 - Compliance Program (2012).

- Monthly checks for excluded individuals among employees and first-tier, downstream, and related entities.
- Processes to identify, deny, prevent payment of claims from excluded providers at point of sale.
- Requires disclosure by employees and first tier, downstream or related entities of new exclusions.
- Establish SIU unit or perform SIU functions through compliance.

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Plan Duty to Investigate Providers

Medicare Advantage

- Sponsors are required to investigate potential FWA [Fraud, Waste, Abuse] activity to make a determination whether potential FWA has occurred.
- Sponsors must conclude investigations of potential FWA within a reasonable time period after the activity is discovered."
  - CMS Medicare Managed Care Manual
- OIG Work Plan

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Compliance Guidance for Managed Care

DOJ will evaluate adequacy of compliance program and oversight

HHS-OIG Guidance (Civil)

- "Employees, managers and the Government will focus on the **words and actions (including decisions made on resources devoted to compliance)** of an organization's leadership as a measure of the organization's commitment to compliance."
- "The use of **audits or other risk evaluation techniques** to monitor compliance and assist in the reduction of identified problem areas."

DOJ Criminal Division Guidance

- "How have senior leaders, through their **words and actions**, encouraged or discouraged the type of misconduct in question? What concrete actions have they taken to **demonstrate leadership in the company's compliance and remediation efforts**?"
- "What types of **audits** would have identified issues relevant to the misconduct? Did those audits occur and what were the findings? …. How often has the company updated its **risk assessments** and reviewed its compliance policies, procedures, and practices?"

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Appendix A: Public Lawsuits

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Notes:

Lawsuits that are Public

Medicare Advantage

- Dozens of publicly-known Medicare Advantage-related actions
  - Most in California and Florida Jurisdictions
  - Defendants Typically Medicare Advantage Organizations but also included providers in a handful of instances (Janke, Baez)
  - Allegations include alleged submission of false diagnoses but other non-submissions issues are prominent
- Allegations (evolve over time):
  - Submissions/non-deletions
  - Oversight of provider data
  - In home assessments
  - Two-way chart review

Profile of Defendants

- MAOs – Direct contract with CMS
- Medical Providers – First Tier Entities, begin to take on risk
- Service Providers (e.g. in home assessments, chart reviewers, submitters) – increased use by MAOs and providers

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Lawsuits that are Public

- *Baez v. Thompson* (Submission of diagnoses by provider)
- *United States v. Janke* (Submission of diagnoses by plan)
- *United States ex rel. Swoben v. SCAN Health Plan* (Duals; first of two Swoben matters)
- *United States and State of Florida ex rel. Sewell v. Freedom Health* (Submissions)
- *United States ex rel. Poehling v. UnitedHealth Group* (Submissions; Two-way Chart Review)
- *United States ex rel. Conte v. Blue Cross Blue Shield of South Carolina* (Submissions; improper filtering)
- *United States ex rel. Silingo v. Mobile Med. Examination Servs.* (Home visits)
- *United States ex rel. Ramsey-Ledesma v. Censeo Health* (Home visits)
- *United States ex rel. Ormsby v. Sutter Health* (Known unsupported codes without deletions; pre-population)
- *United States ex. rel. Rasmussen v. Essence Grp. Holdings Corp.* (data mining)
- *United States ex. rel. Cutler v. Cigna Corp.* (data mining and one-sided chart reviews)
- *United States v. Anthem* (vendor chart reviews)
- Osinek v. Kaiser Permanente (Filed under seal in 2013; government intervened and made public in 2021) (data mining and use of addenda)

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Appendix B: Smaller Enforcement Actions

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Smaller Enforcement Actions

Regulatory and enforcement activity by CMS provides additional directional perspective

CMS Part C and Part D Enforcement Actions

- Part C Enforcement actions tend to focus on beneficiary impacts
- Organizational Determinations, Appeals and Grievances
- Marketing Violations
- Terminations are infrequent - civil monetary penalties or suspension of enrollment and marketing most common

Most enforcement actions encompass both Part C and Part D activities by plan – smaller subset relate to only Part C or Part D

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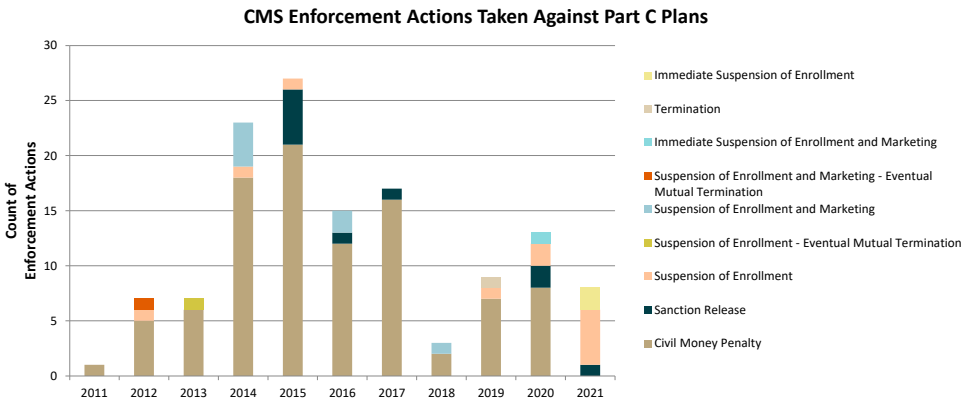
Enforcement Actions



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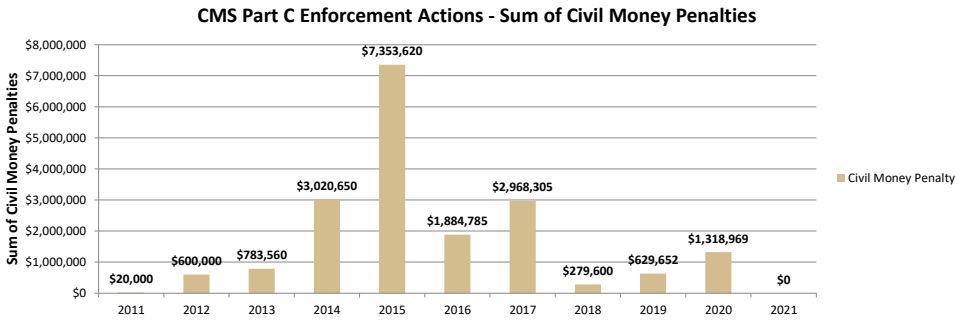
Enforcement Actions - Penalties



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Notes:

Smaller Enforcement Actions

- Most smaller enforcement actions continue to include both Part C and Part D components
- Notably, no Civil Monetary Penalties thus far in 2021
  - All actions involved suspension of enrollment

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QUESTIONS?

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