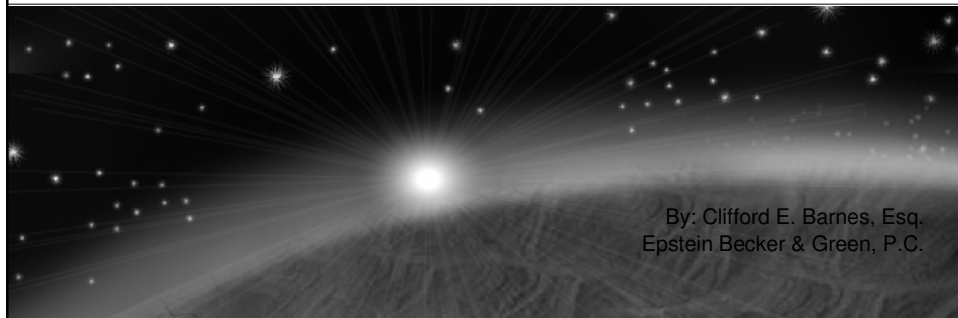


# The New Medicaid Managed Care Compliance Landscape

Health Care Compliance Association  
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## Headlines in News

Medicare, Medicaid Managed Care Gets Scrutiny For Fraud

*Wall Street Journal, March 19, 2008*

Increase in Medicare, Medicaid Managed Care Plans Has Led To “More Complex” Health Care Fraud

*Kaiser Daily Health Policy Report, March 21, 2008*

New Jersey Enacts False Claims Act

*January 13, 2008*



## Agenda

- Current Regulatory Landscape
- Recent Related-Party Challenges to Medicaid Plans
- Effect of Regulatory Landscape on MMCOs
- New Environment for Medicaid Managed Care



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## Current Regulatory Landscape Fraud Waste and Abuse



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## Fraud Waste and Abuse

- Effective 1/1/07, the Deficit Reduction Act (“DRA”) increases the oversight authority over State Medicaid Plans by CMS and OIG.
- The goal of DRA is to eliminate fraud, waste and abuse in Medicaid Program.
- DRA increases investigation and audits by Federal employees, State employees, private contractors with CMS and states.



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## Fraud Waste and Abuse

Deficit Reduction Act changes the Medicaid enforcement environment.

- Encourages enactment of State False Claims Acts.
- Requires Medicaid Managed Care Organizations and related parties that receive more than \$5 million or more annually in Medicaid funds to develop a compliance policy.
- Establishes Medicaid Integrity Program.



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## Current Regulatory Landscape State False Claims



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## State False Claims Act

DRA incentivizes states to enact State False Claims Acts (“FCA”) that meet certain requirements by decreasing the Federal Medicaid Assistance Percentage (“FMAP”) by 10% on amounts recovered under said law. §6031 DRA



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## State False Claims Act

- To be eligible for increased recovery rate, States must request OIGs review of State FCA to determine if it meets federal requirements.
- The following list of States have been reviewed by OIG and found to have met the federal requirements as of February 2009: California, Georgia, Hawaii, Illinois, Indiana, Massachusetts, Nevada, New York, Rhode Island, Tennessee, Texas and Virginia and Wisconsin.
- The following list of States have been reviewed by OIG and found to have **not** met the federal requirements as of February 2009: Florida, Louisiana, Michigan, New Hampshire, New Jersey, New Mexico, and Oklahoma.
- Approximately 34 States have FCAs.



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## State False Claims Act

Most State FCA mirror Federal FCA and stipulate liability for any person who:

- Knowingly presents or causes to be presented...a false fraudulent claim for payment or approval
- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved...



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## State False Claims Act

- Conspires to defraud...by getting a false or fraudulent claim paid or approved by the Government.
- Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property...



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## State False Claims Act

- Under the Federal FCA, “knowing” and “knowingly” means that a person:
  - has actual knowledge of the information
  - acts in deliberate ignorance of the truth or falsity of the information
  - acts in reckless disregard of the truth or falsity of the information
- No proof of specific intent to defraud is required.
- The effect is a standard or know or should know information is false.



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## State False Claims Act

- Some States like New York have made commitments to make fraud and abuse recoveries in specific dollar amounts
- New York has committed to:
  - FY 2008 - \$215 Million
  - FY 2009 - \$322 Million
  - FY 2010 - \$429 Million
  - FY 2011 - \$644 Million
- New York has recovered
  - FY 2008 - \$551 Million



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## State False Claims Act

- Typical Statutory Penalties:
  - Treble damages
  - Civil penalties of \$5,000 - \$10,000 per claim
- Additional Federal False Claims Penalties
  - Program Exclusion
  - Corporate Integrity Agreement
- Extended statutes of limitations (Wisconsin 10 years)



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## State False Claims Act

- Most FCA claims are settled.
- The language in settlement agreement is the most important factor to determine whether the settlement is either deductible as an ordinary and necessary business expense or non deductible as a fine or penalty.
- Even when the settlement payment constitutes a fine or penalty, remedial fines or penalties are deductible.
- Settlement payments are remedial and tax deductible, when designed to compensate the government or another party.
- Settlement payments are punitive and not tax deductible, when designed to punish.



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## Current Regulatory Landscape Mandatory Compliance Policy



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## Mandatory Compliance Policy

DRA requires that any entity that receives \$5 million or more annually from Medicaid must:

- Establish written policies for all employees (including management) and for all contractors and agents explaining State and Federal protections and penalties.



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## Mandatory Compliance Policy

- Provide written policies detailing its policies and procedures for detecting and preventing fraud, waste and abuse including related-party transactions.
- Include in any employee handbook a specific discussion of fraud & abuse laws rights and protection of an employee as a whistleblower and procedures for detecting fraud, waste and abuse.



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## Mandatory Compliance Policy

- When parent corporation and subsidiaries are all integrally involved in furnishing Medicaid items or services, the entire organization is the entity for purposes of determining the \$5 million requirement.
- The MCO or its parent can be the entity.
- If an entity is composed of separate employee handbooks, then the policies must be included in each employee handbook.



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## Mandatory Compliance Policy

- The entity must establish written policies for all employees....of any contractor or agent of the entity.
- To establish written policies, the entity must disseminate the policies to the contractor or agent and make policies available to contractors' or agents' employees involved in performing that work.
- The contractor or agent must abide by policies as to the work the contractor or agent performs for the entity.



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## Mandatory Compliance Policy

If the provider contract's with an MMCO that meets the \$5 million threshold, but the provider itself receives less than \$5 million annually directly from the State Medicaid Agency, then the provider must comply as a contractor of the MMC, regardless of the amount paid by MMCO.



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## Compliance Program Benefits

- An effective compliance program – is a program taken seriously by company and employees – is evidence of operating in good faith and that any alleged impropriety is an outlier of normal business practice and culture.
- Can be the basis of negotiating a monetary settlement that is less than demanded by the government.
- Can also be basis of justifying not imposing non monetary penalties (i.e., audits or Corporate Integrity Agreements).
- Leverage



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## Current Regulatory Landscape New Medicaid Integrity Programs

## Medicaid Integrity Programs

DRA requires CMS to establish and staff a new Medicaid Integrity Program (“MIP”). As part of MIP’s required five-year plan for combating fraud and abuse and ensuring the integrity of the Medicaid Program, CMS must enter into contracts with qualified entities to:

- Perform reviews of providers that furnish items or services.
- Audit claims made under the State Medicaid program including risk contracts.
- Identify overpayments.
- Educate providers and MMCOs regarding payment integrity and quality of care.

## Medicaid Integrity Programs

- The first group of Medicaid audits was set to begin in September 2007.
- According to David Frank, the Director of CMS's Medicaid Integrity Group, MIP audits will go full-steam ahead nationally by Spring 2008.
- Audits will focus on fees-for-service providers in the initial period.
- Audit targets include: Physicians/Practitioners, Home Health/Skilled Nursing, Hospice, Hospital, Nursing Facility/Nursing Homes, Renal Dialysis, DME, Transportation/Ambulance, Labs/x-ray and Pharmacy.



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## Medicaid Integrity Programs

- Director of MIG is former Federal Prosecutor.
- Field Offices: New York, Atlanta, Chicago, Dallas, San Francisco.
- MIG has 100 new federal employees and is funded at \$50-\$75 million per year.
- Expands the data collection effort and coordinates work with States.
- According to CMS Strategic Plan
  - “MIP expects to identify significant overpayments through a carefully crafted audit program”
- State AGs and MCFUs will also conduct audits.



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## Current Regulatory Landscape Certification Requirements



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## Certification by Medicaid Managed Care Organization

*Federal regulation provide that as a condition of receiving payment under the Medicaid Managed Care Program, an MMCO must meet applicable certification and program integrity requirements.\**

\*/ 42C.F.R. §438.602



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## Certification by Medicaid Managed Care Organization

Federal regulations define the type of data that must be certified.

- When State payments to the MMCO are based on data submitted to MMCO, the State must require certification.
- The data that must be certified includes: enrollment data, encounter data, and other information required in contracts proposals and related documents.



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## Certification by Medicaid Managed Care Organization

Federal Regulations require that data from MMCO must be certified by either:

- MMCO's Chief Executive Officer
- MMCO's Chief Financial Officer
- An individual who has delegated authority to sign for the reports directly to the MMCO's CEO or CFO.



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## Certification by Medicaid Managed Care Organization

- The Certification by the CEO, CFO or delegatee must attest based upon the best knowledge, information and belief:
  - To the accuracy, completeness and truthfulness of the data provided
  - To the accuracy, completion and truthfulness of the documents provided
- The MCO must submit the Certification concurrently with the certified data.



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## Current Regulatory Landscape Related-Party Concerns



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## Party-Related Concerns

- CMS issued Guidelines for addressing Fraud and Abuse In Medicaid Managed Care in October 2000.
- Addressing Contracts with related-parties, the Guidelines state:

“Contracts with related parties, such as subsidiaries or other entities owned by persons with a financial interest in the health care plan, may provide an opportunity or diversion of funds without the provision of service, or payment of exorbitant amounts for legitimate services.”



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## Party-Related Concerns

- Federal Regulation provides broad definition of related-parties.
- Effectively any person or entity with a more than 5% interest, (whether equity or debt) or member of non-profit, or a spouse, child or parent of such person.
- Some State Medicaid Managed Care contracts require disclosure of related-party transactions.



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## Recent Related-Party Investigations



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## Recent Related-Party Investigations

On October 24, 2007 federal government executed search warrants for and issued subpoenas on Medicaid Plan regarding:

Related-Party transactions with behavioral health company and reinsurance company.



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## Recent Related-Party Investigations

April 2007, State government has independent accounting firm conduct an audit of MMCO.

December 6, 2007, Attorney General served a Civil Investigative Demand of MMCO requiring production of documents and information.

March 7, 2008 State government filed a complaint against Medicaid Manage Care organization (“MMCO”).



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## Recent Related-Party Investigations

June 5, 2008, the State government amended the complaint against MMCO and added parent entity of the MMCO and the individual owner of the parent or defendants.

- Defendant Owner arranged for excessive fees to be paid to parent company.
- MMCO paid administrative fees to accounting firm, in which the Defendant Owner was a substantial owner, which were not reasonable because they were not limited to actual costs incurred.



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## Recent Related-Party Investigations

- MMCO paid charitable donations which are not expenses related to the administration of the MCO and should not be reported as administrative expenses.
- MMCO did not negotiate health care contracts with its related companies that were at cost or at fair market value.
- MMCO paid related companies amounts that exceeded the amounts paid to unrelated companies for comparable services.



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## Recent Related-Party Investigations

- MMCO received a capitation rate set by the State that was inflated.
- MMCO did not properly disclose its related-party transactions to the State.
- MMCO violated the State False Claims Act.



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## Recent Government Enforcement Activities Involving Medicaid Managed Care Organizations

Plan Name(s)	Enforcement Agency(ies)	Nature of Enforcement Allegations	Outcome/Year
Amerigroup Illinois and Amerigroup Corp.	OIG, DOJ, Illinois Medicaid (qui tam case)	<p>On August 26, 2002, whistleblower litigation filed by former employee alleged that from 2000 to 2003 Amerigroup and its Illinois subsidiary:</p> <ul style="list-style-type: none"> <li>•Followed a policy of not enrolling high-risk individuals, including people with cancer and AIDs, and women in the third trimester of pregnancy;</li> <li>•Falsified its certification that it complied with anti-discrimination statues and policies; and</li> <li>•Submitted 18,130 false claims.</li> </ul>	<p>August 2008 – Amerigroup agreed to pay \$225 million to the U.S. and Illinois to settle their lawsuit. Amerigroup also will pay \$9 million in legal fees and enter into a corporate integrity agreement. The CIA applies to all Amerigroup's managed care plans in all the states in which Amerigroup does business during the term of the CIA.</p>

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## Recent Government Enforcement Activities Involving Medicaid Managed Care Organizations

Plan Name(s)	Enforcement Agency(ies)	Nature of Enforcement Allegations	Outcome/Year
WellCare	DOJ, FBI, OIG, Florida Attorney General Medicaid Fraud Control Unit; Florida Agency for Health Care Administration	<p>An investigation commenced against WellCare for allegedly falsely and fraudulently inflating expenses submitted to AHCA based upon payments to related behavioral health and reinsurance companies in order to reduce the amount it was obligated to pay back to the state under the Medicaid contract.</p>	<p>August 2008 – WellCare agreed to settle for \$32.5 million.</p>

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## Recent Government Enforcement Activities Involving Medicaid Managed Care Organizations

Plan Name(s)	Enforcement Agency(ies)	Nature of Enforcement Allegations	Outcome/Year
Healthfirst	New York Office of the Attorney General, Medicaid Fraud Control Unit	An investigation commenced against Healthfirst, the largest Medicaid managed care organization in New York, for allegedly compensating its marketing representatives based on productivity from 1999-2003, in violation of its Medicaid managed care contracts with the state.	<p>May 2008 – James Boothe, a former executive vice president and chief operating officer of Healthfirst, was charged with first-degree insurance fraud, first-degree scheming to defraud, first-degree offering a false instrument for filing, and first-degree falsifying business records.</p> <p>September 2008 – Healthfirst agreed to settle the investigation for \$35 million.</p>

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## Recent Government Enforcement Activities Involving Medicaid Managed Care Organizations

Plan Name(s)	Enforcement Agency(ies)	Nature of Enforcement Allegations	Outcome/Year
D.C. Chartered Health Plan, Inc.	D.C. Attorney General	On June 5, 2008, the District brought action under the District's FCA against Chartered Health Plan, Inc. (Chartered), the parent corporation of Chartered and the sole shareholder of the parent corporation. The District's complaint alleges the following: illegal related party transactions, and that Chartered paid charitable donations, which expenses were not related to the administration of the MCO and should not have been reported as administrative expenses.	<p>Chartered has entered into settlement discussions and is negotiating a multi-million dollar settlement amount.</p> <p>On October 2008 Chartered agreed to pay multi-million dollar settlement amount.</p>

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## New Environment for Medicaid Managed Care

## New Environment of Medicaid Managed Care

- Increased risks of unexpected losses caused by regulatory actions.
- Failure to have compliance program has more drastic consequences in the new environment.
- Increased expenses to comply.

## How to Respond to New Environment

- Expand reach of compliance program.
- Need to be pro active, not reactive. Audit review risk identification. Assiduously access risk areas.
- Reorient Compliance Program to minimize risk of False Claims Act liability.
- Trust is not an internal control.
- Board involvement.



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## Board Responsibilities in New Environment

- Board has a duty to engage in reasonable efforts to assure that compliance programs are in place and effective.
- Board has a duty to engage in reasonable effort to become aware of signals of system weaknesses.
- Based upon the CIAs in Eli Lilly and Company, effective 1/14/09; and Tenet Healthcare Corp., effective 9/27/06, the board should conduct an effectiveness review of the Compliance Program.
- General Counsel has a duty to advise Board of its monitoring obligations and the structural revisions needed to satisfy them.



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## Board Needs in New Environment

- The Board needs to know:
  - What are the business processes to measure compliance?
  - What are the signals of system failure or adequate monitoring?

## Educate the Board of New Role

- What is the orientation?
- What is the expertise needed?
- What are the reporting relationships?
- What tools are available to the Board?



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