

HCCA's Managed Care
Compliance Conference

New Enforcement Era for MA and Part D

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Agenda

- Federal Enforcement Landscape for MA and Part D
- Recent Investigations and Settlements involving Managed Care
- New Enforcement Tools under Health Reform
- Next Steps for MA and Part D Plans

*Federal Enforcement Landscape for
MA and Part D Plans*

Federal Enforcement Landscape

- Health care fraud remains one of Obama Administration's top enforcement priorities
 - \$1.9 billion in 2011 budget for HHS Fraud Fighting activities
- DOJ-HHS joint fraud fighting activities
 - HEAT, HCFAC, Medicare Fraud Strike Force Teams
 - \$4 billion recovered in FY 2010 from government health fraud activities
 - Highest annual amount ever
- \$2.5 billion recovered in FY 2010 from civil False Claims Act (FCA) cases
 - Highest in DOJ history

Federal Enforcement Landscape

- What is different about today about the federal health care fraud enforcement landscape?
 - More health fraud enforcement agents
 - Better trained agents
 - Better inter-agency coordination
 - More access to data
 - Increased range of enforcement tools under Health Reform
 - Agency structures modified to better support enforcement goals
 - Focus on public and provider outreach about fraud

*Recent Investigations and Settlements
involving Managed Care*

Recent Investigations/Settlements Involving Managed Care

- Growing list of federal government fraud enforcement involving managed care
- Wellcare “raid” and settlement involving Medicaid fraud allegations
 - Qui tam investigation brought by plan’s former financial analyst
 - Allegations based on “false claims” and “reverse false claims” include:
 - payments to providers through one account for expenses incurred by another account
 - “swapping across years” payments to providers – paying inflated amounts to providers in current year with intention to recapture payments in later years
 - claiming “inflated” reinsurance premiums paid to wholly-owned subsidiary
 - overstating number of enrollees
 - Plan agreed to pay \$137.5 million to the U.S. Department of Justice and other federal agencies
 - Whistleblower claimed fraud was worth \$400-\$600 million, leading to potential treble damages of over \$1 billion
 - Plan also paid \$80 million to settle criminal suit

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Recent Investigations/Settlements Involving Managed Care

- America’s Health Choice Medical Plans (Nov. 2010)
 - First FCA settlement involving a MA plan
 - \$22.6 million paid by Medical Resources LLC, the primary provider group to the MA plan
 - Allegations are that plan submitted false diagnosis codes to the government
 - CMS previously terminated plan’s contract in 2007 based on substandard care, provider shortages, delays in referrals for care

America's Health Choice Medical Plans (cont)

- Complaint:
 - “The defendants knowingly failed to review claims for erroneous data before submitting them for payment to CMS. Their practice was to knowingly submit as many diagnosis codes as possible without regard to their truthfulness and let CMS attempt to catch any inaccuracies.” Complaint ¶ 25.
 - Defendants used system that could submit diagnosis codes to CMS, but was not able to delete diagnosis codes later found to be erroneous. Complaint ¶ 26.
 - Defendants allegedly conducted “data sweeps” by hiring unlicensed physicians to review medical records for evidence of diagnosis codes from prior period to submit to CMS; submitted codes to CMS even though physicians refused to sign new encounter forms created by the outside reviewers. Complaint ¶ 30.
 - “Team members,” an outside consultant and two potential buyers all identified and reported these issues to the plan's owners on separate occasions. Complaint ¶ 30-35.

America's Health Choice Medical Plans (cont)

- Lessons for the industry:
 - Strengthen internal processes for supporting HCC assignment
 - Improve auditing in this area
 - Establish process for prompt correction of submitted codes where necessary
 - Assign responsibility for this area within the company
 - Assess the plan's documentation requirements
 - Engage outside reviewers with proper credentials to conduct legitimate process; what is the review/approval process for such engagement?
 - Update/create specific p&p's to govern in this area

Recent Investigations/Settlements Involving Managed Care

- Care Source (Feb. 2011)
 - 4th largest Medicaid MCO
 - \$26 million to settle FCA case
 - Allegations are that plan failed to provide required screenings, assessment and case management to child enrollees with special needs and adults
 - FCA case brought by 2 former employees

CareSource (cont)

- Lessons for the industry:
 - Improve auditing of key operational areas
 - Ensure culture of compliance
 - Confirm effective process for internal reporting
 - Evaluate exit interview process for terminating employees

Recent CMS Enforcement Actions

- Enrollment Suspensions 2010
 - Areas cited include:
 - involuntary disenrollments
 - enrollment applications
 - creditable coverage
 - Improper oversight of sales agents
 - Issues identified during follow-up site visit and/or via CTM
- Financial Penalties for Failure to Issue Timely ANOCs/EOCs

Recent CMS Enforcement Actions

- Lessons for the industry:
 - Repeat violations lead to tougher sanctions
 - Confirm CAPs are completed on time
 - Member complaints need to be taken seriously and reviewed for trends
 - Even where financial penalties are low, reputational damage may be higher
 - Stay off the agency's "radar" screen

New Enforcement Tools under Health Reform

Health Reform: Integrated Data Repository

- Integrated Data Repository
 - CMS to aggregate claims and payment data for Medicare Parts A, B, C & D and other government programs
 - Inter-agency agreements between CMS and VA, DOD, SSA, Indian Health
 - Purpose: Identify fraud, waste and abuse
 - OIG and DOJ will have access to claims and payment data
- Considerations for Plans:
 - More opportunity for government “data mining”
 - Better informed government enforcement agencies prosecuting enforcement actions
 - Plans may want to assess effectiveness of their current compliance program activities on data integrity

Health Reform: Return of Overpayments

- Overpayments must be reported / returned within 60 days after being “identified”
 - “Overpayment” means any funds that a person receives or retains under Title XVIII or Title XIX to which the person, after applicable reconciliation, is not entitled
 - “Persons” subject to overpayment return obligations specifically includes a provider of services, supplier, Medicaid managed care organization MA organization, or PDP sponsor
 - Explanation must accompany refunds
 - Overpayments not timely returned become “obligations” under Federal False Claims Act (FCA)
- CMPs for knowingly failing to return/report overpayments
 - Penalty: \$10,000 for each item or service and an assessment of not more than 3 times the amount claimed

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Health Reform: Return of Overpayments

- Considerations for Plans:
 - Assess adequacy of plan’s process for identifying and returning overpayments to federal government
 - Review plan’s processes for responding to FDR-initiated notices of overpayments
 - Review plan’s processes for auditing payments to FDRs to identify overpayments
 - Assess plan’s contract rights in agreements with FDRs re: overpayment returns, offset, recoupment, etc.

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Health Reform: False Statements in Applications

- **OIG can exclude individuals/entities that knowingly make or cause “false statement, omission or misrepresentation” of “material fact” in any “application, agreement, bid or contract to participate”**
 - Includes MA plans, Part D plans and Medicaid managed care plans
 - Also applies to providers/suppliers to such plans
- **Enhanced CMS civil monetary penalties for violations**
 - **Penalty: \$50,000 for each false statement plus assessment of not more than 3 times the total amount claimed**

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Health Reform: False Statements in Applications

- **Considerations for Plans:**
 - Assess plan’s data integrity procedures for bids, applications, etc.
 - Include review of plan’s process for creating supporting documentation
 - Incorporate bids, applications etc. into company compliance program
 - Who creates the documents?
 - Who signs off on the data?
 - Where are they kept?
- **Move beyond tracking of due dates**
only

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Health Reform: New CMS Intermediate Sanctions

- Penalties for persons who:
 - Enroll beneficiaries without consent
 - Transfer an individual from one plan to another without prior consent for purpose of earning a commission
 - Fail to comply with marketing approval requirements
 - Engage in prohibited marketing activities
- Penalties also apply person that *employs or contracts with* a person who engages in conduct subject to sanctions

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Health Reform: New CMS Intermediate Sanctions

- Considerations for Plans:
 - Assess compliance program protocols for enrollment and marketing compliance
 - Review adequacy of plan's oversight of agents and brokers
 - Ensure p&p's are up-to-date, publicized, training etc.

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Health Reform: RAC Audit Expansion

- Expansion of the Recovery Audit Contractor (RAC) Program to Medicare Parts C and D
 - No later than December 31, 2010
- Expansion of RACs responsibilities to:
 - Ensure MA plans under Part C have an anti-fraud plan in effect and to review the effectiveness of each such plan
 - Ensure prescription drug plans under Part D have an anti-fraud plan in effect and to review the effectiveness of each such plan
 - Examine claims for reinsurance payments for prescription drug plans
 - Review estimates and actual enrollment of high cost beneficiaries in prescription drug plans

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Health Reform: RAC Audit Expansion

- Considerations for Plans:
 - Conduct your own review of “anti-fraud plan effectiveness”
 - Review of reinsurance payments for prescription drug plans
 - Review of estimates and actual enrollment of high cost beneficiaries in prescription drug plans
 - Review FDR contracts provisions on audit and recoupment rights for overpayments

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Health Reform: Amendments to Federal Healthcare Fraud Statute

- HIPAA Crime of Health Care Fraud prohibits knowingly and willfully:
 - Executing or attempting to execute a “scheme or artifice” to defraud any health care benefit program
 - Applies to any public or private plan or contract under which any medical benefit, item, or service is provided to any individual
 - Includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.
- Health Reform modified the “intent” standard under HIPAA
 - a person need not have actual knowledge or specific intent to commit a violation

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Potential Personal Exposure?

- In late 1990s, Christi Sulzbach was Tenet Healthcare's designated corporate integrity officer
 - Company had settled government fraud charges in 1994
 - Under settlement and CIA, Sulzbach submitted sworn declarations in 1997 and 1998 attesting to Tenet's compliance with legal standards for federal health care funding, e.g., Stark Law
- Government brought FCA action against Sulzbach in 2006
 - In connection with government receiving privileged documents in \$920 million settlement
 - Crime-fraud exception
 - Prior legal advice from outside counsel
- In 2010, courts dismissed the case based on statute of limitations

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Board of Directors Responsibility for Compliance

- Increasing government focus on requiring Boards /Senior management to certify compliance program effectiveness
 - Specific requirement in recent CIAs
 - State mandated compliance programs require senior official certification (e.g., NY)
 - CMS requires plan's response to deficiencies to include certification
- Suggested resources for Boards of health care companies:
 - *Corporate Responsibility and Corporate Compliance* (OIG-AHLA 2003)
 - *An Integrated Approach to Corporate Compliance* (OIG-AHLA 2004)

AHIP Report on Insurer Anti Fraud Activities (Jan. 2011)

- Estimated savings from industry anti-fraud activities was \$3/enrollee (2008 data)
 - \$300 million for large companies
 - \$10 million for medium companies
 - \$5 million for small companies
- Consumer fraud is area of increasing concern
- Fraud is being referred to law enforcement and regulatory agencies
- Open questions include:
 - Unnecessary services
 - Misrepresenting non covered treatments
 - Falsifying patient diagnosis
 - Billing patients for services already paid for
 - Kickbacks
 - Sales of unnecessary DME

Key FERA Amendments to FCA

- FERA amended the FCA definition of “claim” to include requests for money or property submitted to
 - an officer, employee or agent of the United States, or
 - a contractor, grantee or other recipient “**if the money or property is spent or used on the Government’s behalf**” or “**to advance a Government program or interest**” and the Government has provided any portion of the money or property to, or will reimburse, the contractor, grantee or recipient for such money or property

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Key FERA Amendments to FCA

- FERA also modified the “reverse false claims” provisions of the FCA
 - Adds liability for “knowingly and improperly avoiding or decreasing” an “obligation” to pay or transit money or property to the Government
 - Obligation includes “**retention of any overpayment**”

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Penalties for FCA Violations

- Penalties for FCA violations include:
 - Civil monetary penalties from \$5,000 to \$10,000 per claim (as such amounts may be adjusted)
 - “Treble” damages, e.g., up to 3 times the amounts of damages sustained by the Government
- Violators also can be held responsible for repayment of the Government’s costs of the civil action brought to recover penalties or damages

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A Quick Note about Qui Tam Litigation

- *Qui tam* relators also have standing to file FCA cases in the name of the U.S. Government
 - The *qui tam* complaint is filed under seal
 - The Government decides whether to “intervene” in the case
 - If the Government intervenes, it takes primary responsibility for prosecuting the action – it can dismiss or settle the case notwithstanding objections from the relator
 - If the Government declines to intervene, the relator has the right to pursue the case on an individual basis
- If the Government intervenes, the relator receives 15-25% of the proceeds of the action or settlement
 - If the Government declines to intervene but the relator proceeds with the case, the relator is entitled to 25%-30% of the proceeds or settlement, plus reimbursement of reasonable expenses

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Potential Implications For Plans ??

- More government enforcement actions
 - More potential for financial penalties
 - Agencies may have access to more/better data
- Increased likelihood of whistleblower complaints
- Increased government auditing of plans and providers, other business partners
- More plan interactions with CMS, OIG and DOJ

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Next Steps for Plans

- Other policies that also may need to be reviewed and updated
 - “Knock at the door” policy
 - Records management policy
 - Disciplinary actions policy
 - Exit interview protocols for departing employees
 - CMS “chron” file protocols
- Internal and external monitoring and auditing activities need to be reviewed and strengthened
- Training programs may need to be modified
 - Including FDRs

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Next steps for Plans (cont.)

- “Inter-company” compliance programs may need to be restructured
 - How does the Plan find out about potential compliance issues downstream before a *qui tam* complaint is filed?
 - What rights does the Plan have to investigate issues and impose corrective actions on downstream entities?
 - What is the relationship between the Plan’s CCO and the CCO for key FDRs, such as the PBM?

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