

## Fraud and Abuse in Managed Care

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### Overview

- Managed Care Plans are at the unique intersection of Healthcare Fraud and Abuse
- Two Broad Categories:
  - Fraud Against the Plan
  - Fraud by the Plan



## Fraud Against the Plan – Overview

- Healthcare Fraud has a significant effect on Managed Care plans:
  - In FY 2015 DOJ reported that \$3.3 billion was recovered by the government related to healthcare fraud judgments and settlements
  - Since 2007, Tennessee (all managed Medicaid) has recovered over \$150 million in healthcare fraud judgments and settlements on behalf of TennCare
  - The Centers for Medicare and Medicaid Services estimated over \$65 billion in overpayments in 2011
- Fraud affects both Government and Private Beneficiaries

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## Fraud Against the Plan – Overview

- Fraud can take all forms and arise from both providers and beneficiaries
- Common provider issues:
  - Up-coding
  - Double Billing
  - Overutilization/Overtreatment
  - Retention of overpayments by providers
    - Potential applicability of 60-Day Rule

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## Fraud Against the Plan – Examples

- Common beneficiary issues:
  - Overutilization
    - Multiple scripts/diversion particularly in pain management context
  - Ineligible and Unauthorized beneficiaries
  - Specific issues related to Self-Funded and Commercial Plans
  - Issues related to tracking, communication and continuity of care

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## Fraud Against the Plan – Required Prevention

- Managed care plans are required under statute to implement a compliance plan to guard against fraud. See 42 C.F.R. § 438.608. The plan must include seven elements:
  1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards
  2. The designation of a compliance officer and a compliance committee that are accountable to senior management

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## Fraud Against the Plan – Required Prevention

*(continued)*

3. Effective training and education for the compliance officer and the organization's employees
4. Effective lines of communication between the compliance officer and the organization's employees
5. Enforcement of standards through well-publicized disciplinary guidelines
6. Provision for internal monitoring and auditing
7. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

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## Fraud Against the Plan – Required Prevention

*(continued)*

- 42 C.F.R. §422.503 – Compliance Requirements to downstream entities
  - “MA organization must require all of its first tier, downstream, and related entities to take the CMS training and accept the certificate of completion of the CMS training as satisfaction of this requirement.”
- Required Reporting Requirements of Fraud and Suspected Fraud

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## Fraud Against the Plan – Investigation and Prevention

- Data Mining and Data Analysis
- Provider Relations
  - Onsite Audits and Walkthroughs
  - How often and what providers?
- Pay attention to common fraud schemes
  - DOJ/OIG Press Releases, convictions, lawsuits
  - Healthcare Fraud Working Groups
  - OIG Workplan
  - Industry Groups – *e.g.*, NHCAA

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## Fraud Against the Plan – Coordination with the Government

- State Medicaid agencies now required to suspend payments upon an investigation of a credible allegation of fraud, absent a “good cause” – such as preserving beneficiary access or not alerting suspected parties of ongoing investigations.
  - “Credible Allegations” may include compliance hotline complaints, claims of data mining, patterns identified through internal and external audits, FCA claims, or law enforcement investigations
- Requires significant coordination between Medicaid agencies and MCO Plans
- Same authority granted to Medicare - 42 CFR 405.371

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## Fraud Against the Plan – Relationship with the Government

- When to report?
  - Is there fraud or is fraud suspected?
  - Patient safety concerns?
  - Contractual ramifications?
- Everyday plan administration communications vs. specific communications related to fraud and abuse issue
  - Consistency of communication
  - When should a lawyer be involved?

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## Special Considerations Related to Managed Care: Damages

- Capitated Damages:
  - MCOs are paid on a capitated basis – which creates an intrinsic motivation to reduce medical expenditures and a buffer against unnecessary health care services.
- *U.S. ex rel. Zemlenyi v. Group Health Cooperative*, 2:09-cv-00603 (W.D. Wash. 2011):
  - Court granted motion to dismiss, finding “[t]he scheme alleged is difficult to construe as a violation of the FCA upon a consideration of the capitated payment system, in which a health care provider is paid a contracted or fixed rate per patient regardless of the number or type of services provided to the enrolled member. Under such a system, it cannot be said that false claims are being made, since payments remain the same regardless of whether a surgery is performed or not.”

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## Fraud by the Plan

- Fraud and Abuse Risks against Managed Care Programs Relate to Government Healthcare Programs, including:
  - Medicare Managed Care (Part C)
  - Medicaid
  - Other Federal Health Care Programs such as FEHB
- Risks from:
  - False Claims Act
  - State False Claims Act
  - Civil Monetary Penalties
  - Anti-Kickback Statute

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## Fraud by the Plan

- Claims Submissions and Billing:
  - Manipulation of risk adjustment data
  - Retention of overpayments
  - Traditional fraud schemes such as billing for services not rendered in non-risk adjusted Medicaid plans
- Marketing and Enrollment Fraud
  - Inducement of Beneficiaries
  - Enrollment of ineligible/non-existing beneficiaries
  - Cherry-picking beneficiaries
  - Violations of Anti-Kickback Statute/Stark

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## Fraud by the Plan

- Underutilization:
  - Delayed first contact and/or assignment of primary care physician
  - Discouragement of treatment and denial of medically necessary treatment
  - Unreasonable prior authorization requirements
- Procurement of Government MCO Contract
  - Falsification Contractual Requirements, including credentials, financial solvency, provider network, and subcontract or subcontractor
  - Bid-rigging, Collusion, Illegal Tying Agreement

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## Fraud by the Plan – Operative Statutes

- False Claims Act 31 U.S.C. § 3729 *et seq.*:
  - Prohibits the knowing submission of “False Claims” in the United States
  - Claims can be rendered “false” by failure to comply with certain laws, rules and regulations
  - “Knowing” also means deliberate ignorance and reckless disregard
  - Allows for treble damages and penalties of between \$5,500 and \$11,000 per claim
  - Reverse False Claim provision, 31 U.S. C. 3729(a)(1)(G)
    - See 42 C.F.R. §422.326 Reporting and returning of overpayments

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## Fraud by the Plan – Operative Statutes

- Civil Monetary Penalties Law 42 U.S.C. 1320a-7a
  - Prohibits a broad range of conduct
  - Provides for various damages, including civil money penalty of not more than \$10,000 for each item or service improperly provided or ordered
  - Importantly to MCOs, prohibits certain remuneration to beneficiaries
  - CMP Law and HHS-OIG Guidance relates to providers, but OIG takes the position that CMP also applies to MCOs

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## Fraud by the Plan – Operative Statutes

- Anti Kickback Statute, 42 U.S.C. 1320a-7b:
  - Criminal statute that prohibits the exchange or offer to exchange of **anything of value**, in an effort to induce or reward the referral of federal health care program business.
  - Broadly drafted and establishes penalties for individuals and entities on both sides of the prohibited transaction
  - Conviction for a single violation under the Anti-Kickback Statute may result in a fine of up to \$25,000 and imprisonment for up to five years. Violations can also serve as a predicate of a FCA action

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## Fraud by Reporting the Plan – Claims Submission and Data

- False documentation/coding of conditions not actually treated
- Up-coding diagnosis to make patients appear sicker and affect RADV
- Billing for services not rendered and traditional up-coding in non-risk adjusted Medicaid plans
- Focus of enforcement and investigation efforts
- Government Accountability Committee – tasked to conduct extensive audits of billing mistakes and overcharges to curb the estimated billions of dollars that such errors and overcharges cost taxpayers each year.
  - **History of Overpayments:** Audits of six plans found that overpayments resulted in a loss of \$650 million in 2007 alone.
  - **Recommendation:** “CMS should establish specific plans for using MA encounter data and thoroughly assess data completeness and accuracy before using the data to risk adjust payments or for other purposes.” GAO Report, July 2014.

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## Fraud by Reporting the Plan – Claims Submission and Data

- Plan must certify that risk adjustment data is accurate, complete and truthful (42 C.F.R. § 422.504(l))
  - Duty to “put in place an information collection and reporting system reasonably designed to yield accurate information,” including conducting “sample audits and spot checks . . . to verify whether [the system] is yielding accurate information
- Certification can trigger FCA liability

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## Fraud by Reporting the Plan – Claims Submission and Data

- Recent Case developments:
  - *U.S. ex rel Valdez v. Aveta*
  - *U.S. ex rel Graves v. Plaza Medical (Humana)*
  - *WellCare*

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## Fraud by the Plan – Beneficiary Enrollment

- Cherry Picking Beneficiaries
  - Deliberately avoiding more costly beneficiaries in a capitated plan
- *U.S. ex rel. Tyson v. Amerigroup Illinois, Inc.*, 2006 WL 4586279 (Sept. 13, 2006):
  - Allegations that MCO “trained its marketing representatives to avoid pregnant women and people who were ill.”

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## Fraud by the Plan – Beneficiary Inducement

- HHS-OIG: offering inducements to influence beneficiary choice of provider raises quality & cost concerns
  - Nominal gifts OK – value under \$10, no more than \$50 in aggregate per year
  - Five exceptions where a beneficiary inducement may exceed the nominal amounts
  - Cannot be used in pre-enrollment advertising
  - Cannot incentivize the enrollment of others in the Plan
  - Cannot be used to “steer” beneficiaries to particular providers, practitioners or suppliers

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## Fraud by the Plan – Provider/Payor Relationships

- Clinical Programs, including Physician Incentive Compensation Programs designed to incentivize under or over-treatment or other improper activities
- Eligible Managed Care Organization Safe Harbor (42 CFR 1001.952(t))
  - 1. Signed agreement, longer than 1 year, specifies the items and services covered under the agreement
  - 2. No tie in to, or inducement related to, services reimbursed under fee for service or cost-based plan
  - 3. No cost-shifting that results in increased payment from a federal health care program

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## Fraud by the Plan – Provider/Payor Relationships

- Medicare and Medicaid plans may institute Physician Incentive Programs as long as:
  - Do not create incentives to limit medically necessary services
  - Creates “substantial financial risk” for the physician (either fees at risk or significant bonus amounts)
- MCO should structure programs following OIG Advisory Opinion No. 08-16

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## Fraud by the Plan – Underutilization

- Repeated or systematic failure to provide members with medically necessary health care in a timely manner
- *U.S. ex rel. Rupert v. Caresource Management Group, Co., et al.*, 2:06 CV 961 (S.D. Oh. 2011)
  - FCA settlement for \$26 million resolving allegations that Defendants knowingly failed to provide required screening, assessment, case management services, data submissions, data reconciliations, and other case management-related requirements for child enrollees with special health care needs and for adults. And Defendants submitted false data to the State of Ohio so that it appeared they were providing these required services, thereby allowing Defendants to fraudulently retain the incentive portion of the capitation payments, and avoid penalties.

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## Looking Ahead – 2016 and beyond...

- Fraud against the Plan:
  - Data mining/data analysis
  - Integration with DOJ/Govt Payors
  - Overpayments and how to handle
- Fraud by the Plan:
  - RADV and other data reporting
  - Overpayments and how to handle
  - Increased *qui tam* activity

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## So what should you do?

- Culture of Compliance
  - Compliance Program
  - Effective Communication
- Be aware of the unique position of MC Plans
- Stay up to date on recent fraud and abuse developments
- Consider involving in-house counsel early on for internal discussions

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## Questions?



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