False Claims Act Enforcement in the Managed Care Space:

Recent Trends and Proactive Compliance Tips

Thomas Clarkson*
U.S. Attorney's Office
Southern District of Georgia

Scott R. Grubman
Chilivis Cochran Larkins & Bever
Atlanta, GA

*Slides were not prepared by DOJ panelist and his comments reflect his own views and are not intended as an expression of the views of the U.S. Department of Justice or any other entity.

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FCA Brief Overview

FCA Brief Overview

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- Imposes liability for (among other things):

  (A) knowingly presenting, or causing to be presented, **a false or fraudulent claim** for payment or approval;

  (B) knowingly making, using, or causing to be made or used, **a false record or statement** material to a false or fraudulent claim;

  (C) **conspiring** to commit a substantive violation;

  (G) 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.

FCA Brief Overview

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- Violations punishable by:
  - Treble (3x) damages
  - Per-claim penalties between $10,781 and $21,562 (for matters brought prior to 8/1/16, or for conduct prior to 11/2/15, $5,500-$11,000)

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- *Qui Tam* provisions:
  - FCA action can be brought by a private person ("relator") in a *qui tam* action
  - Relator files complaint under seal and serves upon government along with disclosure statement
  - Government has 60 days (with extensions for good cause) to investigate and make **intervention** decision (i.e. whether to take over and litigate case)
    - Typically much longer
    - DOJ policy = 9-12 months
    - In 2011 (last statistics available), avg. seal period was 2 years
  - If government intervenes, relator receives between **15 and 25%** of total recovery
  - If government declines, relator typically can move forward on behalf of government is he/she so chooses. Relator will receive between **25 and 30%**

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- Other ways cases are initiated:
  - Referrals to DOJ from HHS, CMS, or contractors
    - 1-800-MEDICARE
    - ZPIC audits or data analysis
  - DOJ can investigate and bring a direct action for violation of FCA

FCA Brief Overview

- **Important Definitions:**
- "Claim"
  - "[A]ny request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property that" is presented to an officer, employee, or agent of the U.S. or to a contractor.
- "Obligation"
  - "[A]n established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from **the retention of any overpayment**."
- "Material"
  - "[H]aving a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."

FCA Brief Overview

- Intent Standard = "knowing"/ "knowingly"
- "Knowing" and "knowingly"
  - Person has **actual knowledge** of 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;
- Requires **no proof of specific intent to defraud**.

FCA Brief Overview

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- **Reverse False Claims & 60-Day Rule**
  - Must report & refund overpayment within 60 days of **"identification"**
    - "Identification" = quantification
    - FCA definition of knowledge
    - Receipt of overpayment can be completely innocent
  - On 61st day, have avoided an "obligation" & violated FCA
  - 6-month good-faith investigation + 60 days
  - 6-year look-back period
  - *Kane* case

FCA Brief Overview

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- Claims can be false if they are **factually false** or **legally false**:
  - **Factual Falsity Example:** Dr. Smith submits a claim for reimbursement to Medicare. On its face, the claim says, "Dr. Smith saw Patient X on Date Y." If patient X doesn't exist, or if Dr. Smith didn't actually perform the service, then the claim is factually false and the Government can bring a claim against Dr. Smith under the FCA.
  - **Legal Falsity Example:** Dr. Smith submits a claim for reimbursement to Medicare. On its face, the claim says, "Dr. Smith saw Patient X on Date Y." Dr. Smith did actually see and provide care for Patient X on Date Y; however, Patient X was referred to Dr. Smith in exchange for an illegal kickback in violation of the AKS. Government argues that the claim is "legally false" because it wouldn't have reimbursed Dr. Smith if it had known about the illegal kickback scheme.

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- Legal falsity can be **express** or **implied**
  - **Express certification** = provider agreement and/or claim expressly stipulates that compliance with certain laws and regulations is mandatory for participation and/or payment
  - **Implied certification** can be basis for liability when a defendant submitting a claim makes specific representations about the goods or services provided, but fails to disclose non-compliance with material statutory, regulatory, or contractual requirements that make those representations misleading with respect to those goods or services (*Escobar*)

FCA Brief Overview

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- Post-*Escobar*, courts have imposed stringent **materiality** requirement
  - Supreme Court held that FCA is not vehicle to punish "garden-variety breaches of contract or regulatory violations," and fleshed out heightened "demanding" materiality standard.
  - Some courts have said that *Escobar* announced something closer to "outcome dependent" test over "natural tendency" test. EG:
    - ***US ex rel. Dresser v. Qualium Corp.*** (Cali): FCA *qui tam* alleging defendant conducted sleep tests and dispensed DME utilizing unqualified staff at locations not approved by Medicare for such purposes. Court dismissed complaint, holding that although complaint alleged the government would not have paid such claims if it had known of defendant's non-compliance, government failed to explain ***why*** it would not have paid the claims.

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Nuts & Bolts of FCA Investigation

Nuts & Bolts of FCA Investigation

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- **Document Requests**
  - HHS-OIG Subpoenas
  - Civil Investigative Demands
  - State AG (MFCU) subpoenas

Nuts & Bolts of FCA Investigation

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- **Witness Interviews & Testimony**
  - CIDs for oral testimony
  - Interviews of former employees

Nuts & Bolts of FCA Investigation

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- **Other investigative tools**
  - CID interrogatories
  - Data mining

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FCA Enforcement in Managed Care

FCA Enforcement in Managed Care

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- **Common FCA violations in managed care space:**
  - "Cherry-picking" healthy enrollees and "lemon-dropping" undesirable members
  - Falsifying enrollment information to receive higher capitation rates
  - Denying care that is medically necessary
  - Kickbacks
  - Beneficiary inducements

FCA Enforcement in Managed Care

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- **Common FCA violations in managed care space:**
  - Contracting with unlicensed, unqualified, or excluded providers
  - Submitting inflated risk adjustment data in order to receive higher capitated rate
  - Falsely reporting ineligible patients as eligible
  - Retaining overpayments

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- ***Travelers Insurance & United Healthcare*** (2004):
  - Agreed to pay **$10.9M** and **$9.7M,** respectively, for obtaining excessive reimbursements from the government by over-billing for care provided by doctors and hospitals.
  - Government investigation revealed that Travelers kept two set of books: one with actual costs and one with costs reported to the govt.

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- ***Anthem Insurance Companies*** (2005):
  - Anthem agreed to pay **$1.5M** to settle allegations that it overcharged the FEHBP by including profit in the cost of certain services billed to the program and by improperly calculating the amount of drug rebates due to the program.

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- ***Americhoice of Pennsylvania*** (2005):
  - Agreed to pay **$1.6M** to settle allegations that it violated FCA by failing to process or timely process managed Medicaid claims and also reporting inaccurate claims processing data.
  - Such conduct allegedly violate state Medicaid regulations and Americhoice's contract with the state, and reduced capitated Medicaid funds used for patient care below regulatory and contractual threshold, allowing Americhoice to retain more funds than allowed.

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- ***Keystone Mercy Health Plan*** (2006):
  - Agreed to pay **$5M** to settle FCA allegations that it recovered overpayments from Medicaid providers, which it retained past the regulatory and contractual deadlines for remitting the amounts to the state.

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- ***Amerigroup Illinois*** (2008):
  - After adverse jury verdict, Amerigroup agrees to pay **$225M** in FCA settlement. Jury found that Amerigroup violated FCA by receiving capitated payments while discriminating against pregnant women and other high-risk patients by systematically avoiding enrolling such patients, in violation of the MCO agreement.

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- ***CareSource*** (2011):
  - CareSource agreed to pay **$26M** to resolve allegations that it caused Medicaid to make payments for assessments and case managements it failed to provide to children and adults.
  - Allegations included that CareSource submitted false data to state of Ohio so that it appeared it was providing these required services to improperly retain incentives received from Ohio Medicaid and to avoid penalties.

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- ***WellCare Health Plans, Inc.*** (2012):
  - WellCare paid **$137.5M** to resolve FCA allegations that it:
    - Falsely inflated amount it claimed to be spending on medical care in order to avoid returning money to Medicaid and other programs in various statements;
    - Knowingly retained overpayments it had received from Florida Medicaid for infant care;
    - Falsified data that misrepresented the medical conditions of patients and the treatments they received.

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- ***Wellcare Health Plans, Inc.*** (2012):
  - In 2007, a WellCare billing analyst pled guilty to conspiring to defraud Florida's managed Medicaid program. Defendant admitted to reporting improper or inflated expenditures and thereby concealing the fact that WellCare was retaining more than 20% of unspent capitated Medicaid payments, contrary to the contract and regulations.
  - In 2011, several former WellCare executives indicted and convicted. Sentences range from probation to 3 years in prison.

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Building an Effective Compliance Program

Compliance Programs

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- OIG Guidance (Medicare Advantage): Compliance Program Elements:
  - Written Policies & Procedures
    - Standards of conduct
    - Written policies for risk areas
      - Marketing materials and personnel
      - Selective marketing & enrollment
      - Disenrollment
      - Underutilization and quality of care
      - Data collection and submission processes
      - AKS and other inducements
      - Emergency services

Compliance Programs

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- OIG Guidance (Medicare Advantage): Compliance Program Elements:
  - Written Policies & Procedures
    - Retention of records & information systems
    - Compliance as an element of a performance plan
  - Designation of a compliance officer & a compliance committee
  - Conducting effective training & education
    - Formal training programs
    - Informal & ongoing compliance training

Compliance Programs

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- OIG Guidance (Medicare Advantage): Compliance Program Elements:
  - Developing effective lines of communication
    - Hotline or other system for reports of potential misconduct
    - Routine communication/access to compliance officer
  - Auditing and monitoring
    - Marketing/enrollment/disenrollment
    - Underutilization and quality of care
    - Data collection & submission processes
    - AKS & other inducements

Compliance Programs

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- OIG Guidance (Medicare Advantage): Compliance Program Elements:
  - Enforcing standards through well-publicized disciplinary guidelines and policies regarding dealings with ineligible persons
  - Responding to detected offenses, developing corrective action initiatives, and reporting to government authorities

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Questions?

Thomas Clarkson
(912) 201-2601
thomas.clarkson@usdoj.gov

Scott R. Grubman
(404) 262-6505
sgrubman@cclblaw.com