

Adjusting the Risk for Medicare Advantage: Recent Enforcement Trends & Litigation Involving Medicare Advantage Risk Adjustment Practices

Brandon J. Moss

Rachel A. Alexander

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Medicare Advantage Organizations & Risk Adjustment

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The Role of MAOs

- Under Medicare Part C, CMS buys insurance for Medicare beneficiaries from private insurers, i.e., Medicare Advantage Organizations (MAOs).
- In 2019, 34% of Medicare beneficiaries received coverage through a MAO.
- The CBO has estimated that by 2029, 47% of Medicare beneficiaries will receive coverage through a MAO.

"A Dozen Facts About Medicare Advantage in 2019," Kaiser Family Foundation. June 6, 2019, accessed Jan. 8, 2020 at <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/>.

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Overview of MAO Payment Basics

- MAOs annually submit a "bid" to CMS, which is the MAO's estimate of the revenue it will require to provide Medicare coverage to enrollees with *average* risk profiles. 42 C.F.R. § 422.254
- The MAO's *bid* is the foundation for the monthly per person amount (i.e., capitation rate) that Medicare pays for each MAO plan enrollee.
- The capitation rate is adjusted based on a number of factors, including the health status of the enrollee, i.e., "risk adjustment." 42 C.F.R. § 422.304

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Risk Adjustment

- CMS uses a blend of claims and encounter data to establish certain Hierarchical Condition Categories (CMS-HCCs) that when applied to the base capitation rate, result in a “risk adjusted” capitation rate.
- Factors used to risk adjust capitation rates include age, gender, disability status, institutional status, and other factors CMS determines to be appropriate, including health status, in order to ensure actuarial equivalence.
42 CFR §422.304(a)(1), (a)(2), and (a)(3)

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Risk Adjustment

- The goal of risk adjustment is to level the actuarial playing field (i.e., adjust for adverse selection) so that MAOs are competing based on the value and quality of their plans, rather than on their ability to avoid enrolling “high risk” enrollees.

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Certification of Payment Data

- As a condition for receiving payment, the MAO organization must certify, “(based on [its] best knowledge, information, and belief) the accuracy, completeness, and truthfulness” of all CMS-requested data, including “specified enrollment information, encounter data, and other information that CMS may specify.” 42 CFR 422.504(l)

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Health Care Fraud Background

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Health Care Fraud: DOJ's Favorite Target

- FY 19 FCA
 - \$3B in recoveries
 - \$2.6B from Health Care sector
 - 633 *qui tams* filed
- DOJ Health Care Fraud Unit
 - 60 prosecutors
 - Strike force model (includes FBI, HHS-OIG, CMS CPI, DEA, IRS, DCIS, USAO, and state/local law enforcement)
 - Charged 309 individuals in 2018 (up 40%)

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Health Care Fraud Enforcement Theories

- Health Care Fraud
- Mail/Wire Fraud
- Conspiracy
- False Statements
- Anti-Kickback Statute
- Stark Laws

Criminal violations can be the predicate for FCA actions

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False Claims Act Basics

- 31 U.S.C. §§ 3729 – 3733.
- Enacted in 1863 in response to Congress' concern that suppliers of goods to the Union Army during the Civil War were defrauding the Army.
- Prohibits a range of false representations that lead to improper receipt of federal money and efforts to improperly avoid an obligation to pay federal money.

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FCA Basics

- **Types of FCA liability:**
 - § 3729(a)(1)(A) – knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval.
 - § 3729(a)(1)(B) – knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.
 - § 3729(a)(1)(G) – “reverse false claim” – 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.
 - § 3729(a)(1)(C) – conspiring to violate the FCA.
 - § 3730(h) – “FCA retaliation claim” – the employee was engaged in protected activity; the employer knew this, and as a result, the employee was discriminated against for lawful efforts in furtherance of an FCA action or to stop a violation.
 - §§ 3729(a)(1)(D), (E), and (F) are rarely invoked.

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FCA Basics

- **Four Elements:**

- Claim or Statement for payment or approval of payment
- The claim or statement is false or fraudulent
- “Knowledge” of the falsehood – actual knowledge, reckless disregard, or deliberate ignorance (§ 3729(b)(1))
- Materiality

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FCA Basics

- **Both the government and citizens have standing to bring an FCA case:**

- Brought by the government
 - The FCA is the federal government’s primary civil litigation tool against fraud.
- Qui Tam
 - Private individuals, known as “whistleblowers” or “relators,” can bring *qui tam* suits on behalf of the government and get a percentage of recovery plus attorneys’ fees.

- **The government can dismiss *qui tam* actions.**

- § 3730(c)(2)(a)

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FCA Basics

- **Heavy Hammer: Treble Damages Plus Statutory Penalties:**

- FCA allows for treble damages, and theories of damages vary widely.
- Penalties:
 - Penalties for each false statement/submission can add up, even when damages are small.
 - Penalties are indexed.
 - 2019 Minimum: Rose from \$11,181 to \$11,463.
 - 2019 Maximum: Rose from \$22,363 to \$22,927.

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FCA Liability & Medicare Advantage

- Plans that do not use accurate, complete, and truthful data to adjust risk could be subject to the False Claims Act.
- Providers submitting inaccurate diagnosis or diagnosis resulting in a different hierarchical condition category will affect data used to adjust risk.
- Plans that do not comply with the “60 Day Overpayment Rule” could be subject to FCA liability:
 - ACA requires that “any overpayment ... be reported and returned [within] 60 days after the date on which the overpayment was identified.” Failure to do so renders the insurer’s initial, but faulty, claim for payment an FCA violation.
 - 2014 Final Rule defined at what point an insurer might be said to have “identified” an overpayment, thus starting the clock:
 - Any code that is inadequately documented in a patient’s medical chart results in an overpayment.
 - An overpayment is “identified” when the MA insurer determines, “or should have determined through the exercise of reasonable diligence,” that it received an overpayment.
 - “Reasonable diligence” means that “at a minimum ... proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments.”
 - But ... *UnitedHealthcare vs. Azar* (D.D.C. 2018).

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FCA Cases Targeting Medicare Advantage

- Upcoding diagnosis cases
- Anti-Kickback cases
- “One-way look” cases
 - False attestation
 - Reverse false claims

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FCA Cases Targeting Risk Adjustment – Upcoding Diagnosis Cases

- *U.S. ex rel. Sewell v. Freedom Health* (M.D. Fla.)
 - Paid \$31.7M in 2017 to resolve allegations it submitted or caused the submission of unsupported diagnosis codes to CMS, resulting in inflated reimbursements.
- *U.S. v. Sutter Health* (N.D. Cal.)
 - Paid \$30M in 2019 to resolve allegations it and its affiliates submitted unsupported diagnosis codes for certain patient encounters of beneficiaries under their care. These unsupported diagnosis scores inflated the risk scores of these beneficiaries, resulting in the MAO plans being overpaid.

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FCA Cases Targeting Risk Adjustment – Anti-Kickback Cases

- *United States ex rel. Nutter v. Khalil* (C.D. Cal. 2019)
 - Beaver Medical Group and of its doctors, Dr. Khalil, agreed to pay over \$5M total to resolve allegations that they reported invalid diagnoses to MA Plans, causing those plans to receive inflated payments.
 - Relator Dr. David Nutter was a former Beaver Medical Group employee.
 - Several MAOs contracted with Beaver to provide health care to Medicare beneficiaries enrolled in their plans; MAOs compensated Beaver with a share of the payments the MAOs received from the beneficiaries (creating a financial incentive for Beaver to submit additional diagnosis codes to the MAOs).

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FCA Cases Targeting Risk Adjustment – One-Way Look Cases

- MA plans and providers face FCA liability for failing to correct (delete) false claims that were previously submitted that the Plan later learns, or in the exercise of reasonable diligence should have learned, were unsupported.
- Early cases targeted providers:
 - *United States v. Lakeshore Med. Clinic, Ltd.*, No. 11-cv-00892 (E.D. Wis. Mar. 28, 2013) (finding reverse false claims where defendant found high rates of “upcoding” during physician audit, but failed to conduct expanded audit or other follow-up).
 - *U.S. ex rel. Kane v. Healthfirst, Inc.*, 11 Civ. 2325 (S.D.N.Y. Aug. 3, 2015) (finding reverse false claims where defendant was provided spreadsheet showing 900 potentially false claims and took no steps to investigate).
- Then, relators and the government targeted plans ...

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FCA Cases Targeting Risk Adjustment – One-Way Look Cases

- *U.S. ex rel. Swoben v. SCAN Health Plans*
 - Relator: James Swoben, former employee of SCAN Health Plan.
 - Initially filed in 2009 against SCAN; subsequently amended to add UnitedHealthcare, WellPoint, Aetna, Health Net, HealthCare Partners, etc.
 - Allegations: The MA organizations conducted one-sided retrospective reviews of diagnosis codes that were designed to only identify appropriate codes that were not previously submitted, not inappropriate codes previously submitted, thus rendering the section 422.504(l) attestations false.

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How Do the Courts View the Arguments?

- *U.S. ex rel. Swoben v. SCAN Health Plans*:
 - 2012 – SCAN paid \$3.82M to settle claims (part of \$320M settlement).
 - 2013 – U.S. declines intervention as to remaining defendants.
 - 2013 – Court dismisses for failure to plead fraud with specificity.
 - Denies Swoben's request to amend.

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How Do the Courts View the Arguments?

- *U.S. ex rel. Swoben v. SCAN Health Plans (aka U.S. ex rel. Swoben v. United Healthcare)*
 - 8/2016 – 9th Circuit revives and remands *U.S. ex rel. Swoben v. United Healthcare*:
 - Issue before court: Whether conducting retrospective medical record reviews designed to identify only diagnoses that would trigger additional payments by CMS, not errors that would result in negative payment adjustments, would cause a certification to be false for purposes of section 422.504(l) and the FCA.
 - Holding: Plan C sponsors can be liable under the FCA if they deliberately “avoid identifying erroneously submitted diagnosis codes that might otherwise have been identified with reasonable diligence.” It can also contravene its annual attestations (and violate the FCA) by deliberately ignoring the red flags that the retrospective chart review results raise as to the validity of the provider-submitted diagnosis codes.

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How Do the Courts View the Arguments?

- *U.S. ex rel. Swoben v. SCAN Health Plans*
 - 11/2016 – Swoben files 4th Amended Complaint.
 - 3/2017 – U.S. intervenes against UnitedHealth defendants.
 - Allegations:
 - Plans were aware of the limited scope of the HealthCare Partners' chart reviews and that awareness rendered the plans' own attestations false.
 - Adds "Reverse FCA" claim.

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How Do the Courts View the Arguments?

- *U.S. ex rel. Swoben v. SCAN Health Plans*

- 10/17 – Court dismisses intervention Complaint:
 - Government failed to allege that CMS would have refused to make risk adjustment payment to United defendants if it had known that the plan was conducting one-way reviews.
 - CMS was aware of the one-way chart reviews and nevertheless continued to pay United and others – i.e., the one-way reviews were not material.
 - The Government's Complaint failed to identify the corporate officers who had signed the Attestations at issue or allege that they knew or should have known that the Attestations were false and that the "classic shotgun pleading" failed to "state clearly how each and every defendant is alleged to have violated" the statute; the Court also provided clear guidelines for amending the Complaint.
 - The Court did not reach the reverse FCA claim, finding that it died when the case was initially dismissed because Swoben failed to appeal that portion of the ruling.
- 10/17 – Government moves to dismiss without prejudice.

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How Do the Courts View the Arguments?

- *U.S. ex rel. Poehling v. UnitedHealth Group, Inc. et al.*

- Initially filed in NY, but moved to California in 2016 in an effort to consolidate it with *Swoben* (judge rejected case).
- Relator: Benjamin Poehling, former UnitedHealth finance employee.
- Allegations:
 - UnitedHealth knowingly obtained inflated risk adjustment payments based on untruthful/inaccurate information about the health status of beneficiaries enrolled in UnitedHealth's MA Plans throughout the country.
 - UnitedHealth conducted a chart review program designed to identify diagnoses not reported by treating physicians that would increase its risk adjustment payments, and ignored information from these reviews showing that hundreds of thousands of diagnoses submitted to Medicare were invalid to avoid repaying Medicare money to which UnitedHealth was not entitled.
- 5/2017 – Government intervened:
 - Three FCA claims plus two common-law claims.
 - Government did NOT assert a reverse FCA claim.

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How Do the Courts View the Arguments?

- *U.S. ex rel. Poehling v. UnitedHealth Group, Inc., et al.*
 - 11/17 – After *Swoben* dismissal, U.S. amended Complaint to include reverse FCA:
 - Allegation: Because UnitedHealth failed to delete invalid diagnoses in RAPS, they failed to return the Medicare overpayments they received based on the invalid diagnosis codes they submitted.
 - 2/18 – Court dismisses claims related to attestations, but allowed reverse FCA allegations regarding failure to return overpayments to continue.
 - “As in [Scan], the government failed to allege that CMS would have refused to make risk adjustment payments if it had known the Attestations were false.”
 - Court found that the materiality of United’s failure to return overpayments was sufficiently plead.

But, while that case progressed ...

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New Defense Arguments

- *UnitedHealthcare Ins. Co. v. Azar* (D.D.C. 2018)
 - The court vacated the Medicare Advantage 60-day repayment rule:
 - Violated the rule of actuarial equivalence.
 - Rule imposed a negligence standard on MA insurers to identify and report overpayments that is inconsistent with the FCA.
 - Rule imposed a “distinctly different and more burdensome definition of ‘identified’ without adequate notice.”
 - The government appealed the decision to the D.C. Circuit and asked the district court judge to partially reconsider the basis of her ruling.

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New Defense Arguments

- *U.S. ex rel. Poehling v. UnitedHealth Group, Inc., et al.*
 - 3/19 – Court denies government’s motion for partial summary judgment:
 - Issue: Was United required by regulation or contract to delete invalid diagnosis codes submitted to CMS for risk adjusted payments that it knew were unsupported by its beneficiaries’ medical records?
 - Relying on *Azar*, the Court declined the rule as a matter of law that UnitedHealthcare was required to delete diagnosis codes it knew to be inaccurate.
 - It could not conclude that the existing regulations unambiguously support the government’s proposed rule.
 - It also ruled that it was not “unambiguously clear” that United was contractually obligated to delete unsupported diagnosis codes.
 - Case remains pending, in discovery.

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Where Does That Leave Us Now?

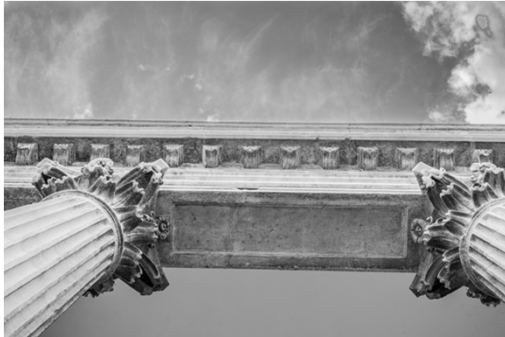
- Despite setbacks, government remains focused on Medicare Advantage.
- The government joined an FCA suit accusing Sutter Health of defrauding Medicare Advantage by exaggerating patient illnesses (*U.S. ex rel. Ormsby v. Sutter Health et al.*):
 - Since then, Sutter Health and its affiliates have moved to dismiss the *Ormsby* case, pointing to *Azar*, and arguing that the government has failed to show that the defendants knowingly overbilled the government or that the defendants’ attestations regarding the accuracy of its billing were actually material to government repayment.
 - The government is challenging the *Azar* court’s conclusion that CMS’ regs had inappropriately deemed as fraud what should have been treated as simple negligence.
- *Swoben* clean-up:
 - The government intervened and settled claims against HealthCare Partners Holdings LLC (d/b/a “DaVita Medical Holdings LLC”) for \$270M.
- Whistleblower Teresa Ross, a former medical billing manager at Group Health Cooperative (GHC), filed a complaint in Oct. 2019 alleging that GHC collected an estimated \$8M from Medicare by manipulating risk scores:
 - Defendants have moved to dismiss and the case is still pending.

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DOJ Policy Pronouncements: Where Are They Going?

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Recent DOJ Policy Pronouncements

- Brand Memo (Justice Manual § 1-20.100)
- “Granston Doctrine” (Justice Manual § 4-4.111)
- “Piling On” Speech (Justice Manual § 1-12.100)
- Individual Accountability & Cooperation
 - Yates Memo & Rosenstein Speech (Justice Manual § 9-28.210)
- Guidelines for Taking Disclosure, Cooperation, and Remediation Into Account for FCA Matters
 - Corporate Compliance Programs (Justice Manual § 9-28.800)

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Concluding Thoughts

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Risk Adjustment Checklist

CMS recommends that MAOs should engage in the following practices:

- Ensure the accuracy and integrity of risk adjustment data submitted to CMS.
- Implement procedures to ensure that diagnoses are from acceptable data sources.
- Submit the required data elements from acceptable data sources according to the coding guidelines.

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Risk Adjustment Checklist

CMS recommends that MAOs should engage in the following practices:

- Submit all required diagnosis codes for each beneficiary and submit unique diagnoses at least once during the risk adjustment data-reporting period, taking care to eliminate duplicate diagnosis clusters.
- Delete diagnosis codes that have been submitted but do not meet risk adjustment submission requirements.

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Risk Adjustment Checklist

CMS recommends that MAOs should engage in the following practices:

- Receive and reconcile CMS Risk Adjustment Reports in a timely manner. Track the submission and deletion of diagnosis codes on an ongoing basis.
- Immediately submit requests for recalculation of risk scores upon discovering inaccurate diagnosis codes that impact the final risk score and payments for a previous payment year.

Medicare Managed Care Manual Chapter 7, § 40 (Role and Responsibility of Plan Sponsors)

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Managing the Risks

- Upcoding Risks
- Anti-Kickback Risks
- Certification Risks

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Questions?



Brandon J. Moss

bmoss@wiley.law
Partner
202.719.7554



Rachel A. Alexander

ralexander@wiley.law
Partner
202.719.7371

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