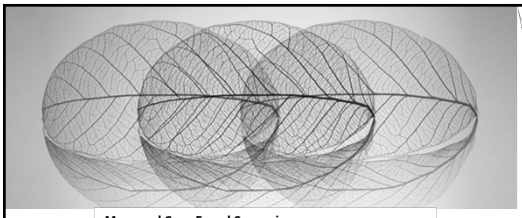

Managed Care Fraud Scenario:
The Impact of the Compliance Program in Litigation

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Overview

- Managed Care Fraud: Against the Plan / By the Plan
- Requirement of a Compliance Program within a Managed Care Structure
- Allegations in Recent Claim filed in the District Court of Puerto Rico
- Basis of the Claim under the False Claims Act
- Relator or not Relator? –Ethical Duties
- The Impact of the Compliance Program Under the Specific Scenario

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Managed Care Fraud: Against the Plan / By the Plan

Managed Care Plans are at the unique intersection of Healthcare Fraud and Abuse in two broad categories:

FRAUD AGAINST THE PLAN	FRAUD BY THE PLAN
* Up-coding * Double Billing * Overutilization/Overtreatment * Retention of overpayments by providers (with Potential applicability of 60-Day Rule)	* Manipulation of risk adjustment data * Retention of overpayments * Inducement of Beneficiaries * Enrollment of ineligible/non-existing beneficiaries * Cherry-picking beneficiaries

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Requirement of a Compliance Program within a Managed Care Organization

- 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 the Seven Elements:

1. Exercise Effective Compliance and Ethics Oversight
2. Establish Effective Policies, Procedures and Controls
3. Train and Educate Employees on Compliance and Ethics
4. Establish Effective Lines of Communication
5. Ensure Consistent Enforcement and Discipline of Violations
6. Monitor and Audit Compliance and Ethics Programs for Effectiveness
7. Appropriate Response to Incidents and Corrective Actions

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Allegations in Recent Claim filed in the District Court of Puerto Rico.

RODRIGUEZ-FALCIANI v. TRIPLE S, 18-1065 (DRD)

THIS IS NOT A *QUI TAM* ACTION; IT IS BASED ON RETALIATORY TERMINATION OF EMPLOYMENT

1. Plaintiff (a licensed attorney) was the Director of TSS's Audit and Investigation Unit at the time she was terminated from her employment in March 2017.
2. She alleges that she was terminated "*as a result of her participation in an investigation of suspicious practices by certain laboratories and physicians in Puerto Rico, in which they charged for genetic testing services which were not medically indicated, for people insured by Triple S, including those for whom federal funds were disbursed.*"
3. Defendant TSS denies such claims, and alleges other reasons for termination including: not following protocols for provider cancellation, lack of documentation to support investigations, bypassing chain of command and breaching confidentiality.

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Allegations: Fraud Against the Plan

1. Plaintiff was involved in the investigation of TSS's contractual disputes concerning the billing of genetic tests by specific providers.
   - *Alleged scheme: "runners and sales representatives from at least two laboratories based in the United States would approach patients at physicians' offices, including those insured by Triple-S, offering them a "free" test, which would not involve the payment of a deductible, since the cost would be assumed by Triple-S.*
   - *"These individuals would deliver the saliva samples from patients in the offices of the physicians to four laboratories in Puerto Rico which were Triple-S contracted providers.*
   - *The four laboratories would send the samples to laboratories based in the continental United States.*
   - *The laboratories in Puerto Rico would then bill Triple-S for the procedure, although their only role was to send the samples to the State-side laboratories".*

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Allegations: Fraud Against the Plan

1. Allegedly Triple S paid millions of dollars to the providers for these services.
2. Plaintiff investigated and allegedly reported the incident to federal authorities. It is not clear from the allegations, but it can be surmised that she did both on behalf of Triple S.
3. Triple S filed civil claims against the providers.
4. As alleged, a confidential agreement with a specific provider required ongoing monitoring and auditing of HRP's compliance with certain requirements, including but not limited to training of employees on Fraud Waste and Abuse.
5. Allegedly, the provider did not comply with these requirements and consequently Triple S was to cancel the contract with the provider.
6. Allegedly, in response to a letter sent by the provider's attorney requesting that the plaintiff be removed from the corrective action implementation, plaintiff Rodriguez was terminated from her employment.
7. Triple S and the provider categorically denies all allegations and Triple S counter-claims for breach of confidentiality.

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Basis of the Claim under the False Claims Act

The FCA provides protection against discharge, demotion, suspension, threats, harassment, or other discrimination in the terms and conditions of employment resulting from lawful acts under the Act. 31 U.S.C. § 3730(h)

REMEDY	STATUTE OF LIMITATION
• Reinstatement with the same seniority status • 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination • Litigation costs and reasonable attorneys' fees	• 3 years after the date when the retaliation occurred • Action under this subsection may be brought in the appropriate district court of the United States

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Basis of the Claim under the False Claims Act

***PRIMA FACIE* CASE:**

1. Protected Conduct
   - The relator must show that his or her conduct was protected under the Act
2. Knowledge
   - the employer knew about the relator's conduct and
3. Retaliatory Behavior
   - the employer engaged in retaliatory behavior because of such conduct

> "'**[P]rotected conduct**' [includes] 'activities that reasonably could lead to an FCA [suit], in other words, investigations, inquiries, testimonies or other activities that concern the employer's knowing submission of false or fraudulent claims for payment to the government."
>
> *United States ex rel. Nowak v. Medtronic*, 806 F. Supp.2d 310, 339 (D. Mass. 2011)

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Relator or not Relator? –Ethical Duties

BASIC PREMISE: Both a Compliance Officer (whether attorney or not) and an in-house counsel can be relators under the False Claims Act.

THE QUESTION: What information can such relators use to establish the case and when can such relators disclose.

HCCA Code of Ethics: R.1.4; R.2.6 and R.3.2. Disclose to highest authority; resign; maintain confidentiality unless to prevent a crime or required by law.

ABA Model Rules of Professional Conduct: Rule 1.6 (Maintain confidence); R. 1.13 (organization as a client).

See also Sarbanes-Oxley Act Of 2002 Sec. 307.

TAKEAWAY: - *Relators who are also attorneys should make every effort to base an FCA complaint on nonconfidential information if the alleged fraud is not ongoing. In contrast, a retaliation claim under the FCA may rely on confidential information pursuant to Rule 1.6, but state retaliation law varies with respect to former in-house counsel standing to sue.*

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The Impact of the Compliance Program Under the Specific Scenario

Element I. Oversight

a. The complexity of the organizational structure of the Compliance Program (Fraud Unit);

b. The hierarchy and reporting responsibilities will also be scrutinized (communications between in house counsel and chief compliance officer);

c. The sufficiency of oversight on provider activity (timing of identified improper billing and/or overpayments).

Element II. Policies and Procedures

a. Were policies and procedures in place that would guide the investigation / was it followed?

b. If the basis for termination was that the plaintiff did not follow proper procedure for provider cancellation, were those procedures pre-established?

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The Impact of the Compliance Program Under the Specific Scenario

Element III. Training and Education

a. Was there a specific protocol pre-established for the Fraud Unit that required specific training?

b. What was the training required from the providers prior to the allegations?

Element IV. Effective Lines of Communications

a. How was the overpayment identified? Hotline? / Audit?

b. What was the communication protocol with the provider once the misconduct was identified? What was the communication protocol afterwards?

c. Was the communication protocol followed? With the Provider? With the federal authorities? (Interaction with the Legal / Compliance Departments).

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The Impact of the Compliance Program Under the Specific Scenario

Element V. Consistent Enforcement and Discipline of Violations

a. Was there a specific protocol pre-established by the Fraud Unit that required specific enforcement?

b. Did the plaintiff follow such protocols?

c. Were these protocols not applied consistently with the co-defendant provider?

d. Does this has to do with the reason for termination?

Element VI. Monitoring and Auditing

a. How was the overpayment identified? Hotline? / Audit?

b. Was effective monitoring previously implemented? Will this be a reason for termination?

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The Impact of the Compliance Program Under the Specific Scenario

Element VII. Appropriate Response to Incidents and Corrective Actions

a. Perhaps the most important factor in this litigation.

b. Did the settlement agreement with the provider contain requirements truly similar to a CIA? **Is this the standard required from MCOs?**

c. Was the MCO's response appropriate? Did the representative of the MCO (plaintiff) proceed accordingly?

d. Was there special consideration by the MCO in the case of the co-defendant provider?

TAKEAWAY: The strength of the Compliance Program will serve as a mechanism for offense or defense in litigation, be it *qui tam* or of a retaliatory allegation nature.

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THANKS!

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Jorge Pérez-Casellas is a Senior Director at Ankura with experience in healthcare regulatory matters. He provides compliance and privacy advisory services as well as interim compliance support services. He recently completed a tenure as Interim Chief Compliance Officer at Presence Health, Chicago, and currently serves as consultant for various clients including third party billing companies, health systems and private practitioners.

Jorge completed the LLM degree in healthcare law with a compliance concentration at Loyola University Chicago School of Law. His thesis focused on the federal government's use of extrapolation methodologies to enforce penalties under the False Claims Act. Jorge is experienced in policy development and interpretation, an expert in Stark Law and the Anti-Kickback Statute, as well as analytical solutions to system-wide compliance glitches, and the implementation of tailored compliance programs.

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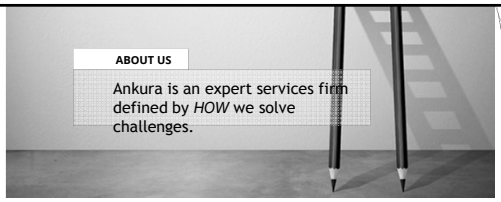

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