crowell moring

Health Care Industry Emerging Legal Issues Webinar Series

Medicare Advantage Risk Adjustment Payment Issues: Latest Developments, Risk Areas, & Mitigation Strategies

Christine Clements
Scott Douglas
David O'Brien

July 23, 2015

The webinar will begin shortly, please stand by. The materials and a recording will be sent to you after the event.

Agenda

- What's New – Why the Spotlight on Risk Adjustment?
- View from the Hill
- Risk Adjustment and the FCA
- Risk Mitigation Considerations

What's New in Risk Adjustment

- Congressional Letters
  - Sen. Chuck Grassley (R-IA) requested information from CMS and DOJ on steps taken to ensure insurance companies are not fraudulently altering risk scores and investigations into "risk score fraud"
  - Sen. Claire McCaskill (D-MO) requested briefing by CMS before June 12, 2015, "about what CMS is doing to address the issue of inflated risk scores"

What's Behind the Letters?

- The Center for Public Integrity's April 23, 2015, article on whistleblower lawsuits involving risk adjustment cited by both Grassley and McCaskill
- GAO report on payment accuracy in Medicare Advantage

The Congressional Environment

- Medicare Advantage enjoys broad, bipartisan support on the Hill
- Appeals uniquely to both GOP and Dems
- Funded properly, it works
- Aligned with broader health care policy goals
- Challenge is in not attempting to squeeze excessive savings from the program
- A few ongoing concerns

Congressional/Agency Correspondence

Congressional inquiries occur every day and range from routine to critical

- Reacting to agency action/inaction
- Constituent Issues
- Public/Press
- Developments in the Courts

Be mindful of issues with converging motivations

What is the Likely Agency Response?

CMS

- Concerned but Ever Vigilant
- Always Open to Considering Improvements
- Balance between transparency and protecting sensitive business information

DOJ

- Ongoing Investigation – Stay Tuned

What Should Plans be Doing?

- Know that hearings are always possible
- Monitor opponents/critics
- Provide as much information as possible
- Don’t allow yourself to be criticized for issues inherent in the program
- Work to develop an industry consensus on how to deal with outliers
- Don’t hesitate to point out deficiencies in current audit procedures

Elements of the FCA

- Principal Causes of Action
  - "Any person who . . . knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A)
  - "Any person who . . . knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(B)
- Other Commonly-used Causes of Action
  - Conspiracy to defraud by getting a false claim paid ((a)(1)(C))
  - "Reverse" false claims ((a)(1)(G))

FCA Liability: Four Elements of a False Claim

- The Contractor submits (or *causes* to be submitted) a **"claim"** for payment; and
- The Contractor's claim is **false or fraudulent**; and
- The Contractor **knew** that the claim was false or fraudulent; and
- The falsehood was **material** to the decision to pay the claim—*i.e.*, it was "capable of influencing" the payment

Materiality

- To be material, a falsity must either:
  1. have a "**natural tendency to influence,**" OR
  2. be "**capable of influencing,**" the payment or receipt of money or property
- Examples:
  - The *Government relied upon* the false information in deciding to pay the claim; or
  - The falsity had the *potential to influence* the Government's payment decision

Claim Definition

- **Claim**: FCA defines a **"claim"** as any request or demand for money or property that is:
  - Presented to an **officer or employee** of the United States,

    OR

  - Made to a **contractor, grantee or other recipient**, if government provided funds are used to pay for or reimburse the claim to the contractor, grantee or other recipient (e.g., a subcontractor submits an invoice to a prime contractor that holds a federal contract)

Claim Definition

- **Claim**: Encompasses virtually all demands or requests for money that are made to a Government agent, a contractor or a grantee, provided that the Government has provided some portion of the money sought
  - Any action by the Contractor that has the **purpose and effect** of causing the Government or a recipient of Government funds to pay out money it is not obligated to pay, or any action that **knowingly deprives** the Government of money it is lawfully due
  - Each separate submission that seeks payment from the Government or a recipient of Government funds is a claim for purposes of the FCA, even if each submission is under the same contract

Claims in the Risk Adjustment Context

- Article IV of standard CMS/MAO contract makes it "a condition of payment" that CEO or delegate "must request payment under the contract on [attestation] forms attached hereto"

Claims in Risk Adjustment Context

- Contract Attachment B---"the MA Organization ***hereby requests payment***, and in doing so makes the following attestation concerning CMS payments"
- Includes and acknowledgment "that the information described below [risk adjustment data] ***directly affects the calculation of CMS payments*** to the MA Organization", and that
- Misrepresentations to CMS may result in Federal civil and/or criminal action

Scienter and Falsity in Risk Adjustment Context

- "Based on best knowledge, information and belief . . . all information submitted to CMS in this report is accurate, complete, and truthful."
- This necessarily requires some verification of the ICD-9 codes submitted by the providers
- Hard to say how much

Scienter and Falsity in Risk Adjustment Context

- ICD-9 codes not supported by the requisite medical records would be considered false
- Also false, if the ICD-9 code was not based on a face to face encounter as required
- But the ICD-9 codes need only be adequately documented by one provider even if the charts of other providers do not document them

Potential Liability Under 3 FCA prongs

- Under the "condition of payment" attestation forms the MAO "requests payment", the definition of an FCA claim, and if it's false, 31 U.S.C. section 3729(a)(1)(A) is violated
- If the risk adjustment data is unsupported or false, 3729(a)(1)(B) is violated
- If the MAO knows that the risk adjustment data upon which it's been paid is false and fails to refund it, the reverse false claims section 3729(a)(1)(G) is violated

Examples of FCA Risk Adjustment Suits

The Unites States itself (not a qui tam) sued the Jankes for violations of the FCA because:

- The MAO they owned improperly "assigned" ICD-9 codes that weren't supported by the medical records
- The MAO failed to delete erroneous diagnosis clusters
- The MAO created new encounter forms that were not signed by the treating physicians
- DOJ also alleged that the MAO's risk scores were higher by significant percentages than Florida and national MAOs

Example 2

- A doctor sued an MAO and the doctor who bought her practice in an FCA qui tam action in Florida alleging that the risk adjustment data that the MAO submitted to CMS was not supported by the medical records and that the MAO knew this
- Relator alleged that she reviewed some of the medical records and failed to find support for the diagnoses
- Relator alleged that the incidence of certain diagnoses increased dramatically when another doctor bought her practice
- She alleged that because of this anomalous increase the MAO knew or should of known that the new doctor was manipulating the risk adjustment data

Example 2 (cont'd)

- The MAO was successful in moving to dismiss the first complaint on the grounds that relator had not adequately pled that actual false claims had been submitted to CMS
- Courts require that relators allege specifically that the fraudulent scheme at issue leads to the submission of false claims
- The 4th Circuit has held that when a defendant's actions, as alleged and as reasonably inferred from the allegations, *could* have led, but *need not necessarily* have led, to the submission of false claims, a relator must allege with particularity that specific false claims actually were presented to the government for payment
- The MAO also argued that neither it nor other MAOs receive or review medical records underlying the ICD-9 codes as a matter of course and the relator made no allegation that CMS required plans to do so

Risk Mitigation Considerations

- Internal Controls
  - "[W]e have always expected that MA organization[s] … implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." 79 Fed. Reg. 29844, 29923 (May 23, 2014)
  - What are appropriate payment evaluation procedures?
  - Does an *expectation* give risk to a legal obligation and liability for not meeting that expectation?

Risk Mitigation Considerations (cont'd)

- Overpayment Rule, 42 C.F.R. § 422.326
  - Codifies ACA requirement that MAOs report and return identified Medicare overpayments.
  - What's an overpayment in the risk adjustment context?
  - What is the relationship between an "overpayment" and the Fee-for-Service Adjuster that CMS still has not proposed?

Risk Mitigation Considerations (cont'd)

- Vendors
  - Appropriately qualified, licensed, and supervised staff
  - Tie compensation arrangement to activities that further payment accuracy
  - Monitoring
    - Audits
    - Member satisfaction surveys
    - Other

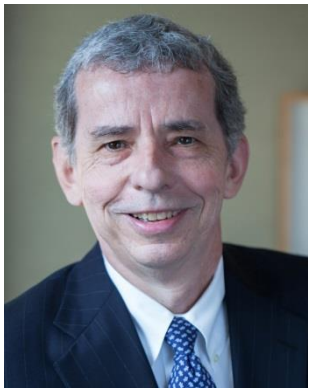
Risk Mitigation Considerations (cont'd)

- CMS best practices for in-home assessments:
  - Performed by physicians, or qualified non-physician practitioners
  - Include all components of the annual wellness visit
  - Medication review and reconciliation;
  - Scheduling appointments with appropriate providers and making referrals and/or connections for the enrollee to appropriate community resources;
  - Conduct an environmental scan of the enrollee's home for safety risks, and need for adaptive equipment;
  - A process to verify that needed follow-up care is provided;
  - A process to verify that information obtained during the assessment is provided to the appropriate plan provider(s);
  - Provision to the enrollee of a summary of the information, including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources; and
  - Enrollment of assessed enrollees into the plan's disease management/case management programs, as appropriate.

Speakers – Contact Information

Christine Clements
202.624.2595
cclements@crowell.com

Scott Douglas
202.508.8944
sdouglas@crowell.com



David O'Brien
202.624.2850
dobrien@crowell.com

Health Care Industry Emerging Legal Issues Webinar Series

- *Privacy & Cybersecurity: Evolving Risks and Liability Trends*: September 29 – Robin Campbell, Elliot Golding
- *How to Survive a Subpoena/CID:* November 17 - John Brennan, David O'Brien
- *Advertising and Marketing Issues in the Health Care Industry:* TBD - Chris Cole, David Ervin