Are State Managed Care Medicaid Programs Fertile Ground for Fraud?

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Agenda

• Introduction

• I Overview of Medicaid and Medicaid Managed Care

• II Medicaid Managed Care Fraud – Systemic Issues

• III The Emerging Focus on Medicaid Managed Care MLR Measures

• IV False Claims Act - Medicaid Managed Care – Evolving Landscape
Overview of Medicaid and Medicaid Managed Care
Medicaid Programs

- Jointly funded by federal government and states
- Administered by states
- Overseen by CMS within HHS
- 50 distinct state-based programs that vary in how health care is delivered, financed, reimbursed, and overseen
- The size, growth, and diversity can create significant challenges for oversight
- Challenges between federal and state governments:
  - Fragmented program integrity activities
  - Coordination to avoid unnecessary duplication and overlap
Over 90% of Medicaid beneficiaries live in the 39 states that contract with MCOs.
Historical and Projected Medicaid Enrollment and Expenditures

MACPAC Report to the Congress on Medicaid and CHIP, June 2014.
Managed Care Medicaid Enrollment, 2007-2013

Source: Medicaid Managed Care Enrollment Reports, Medicaid.gov.
State Managed Care Medicaid Programs

- Medicaid enrollment and spending have increased exponentially over the past four decades and continue to increase.
- Medicaid is the largest health program measured by enrollment (second to Medicare when measured by spending) - In FY 2014:
  - $508 billion in Medicaid outlays
  - $304 billion financed by federal government
  - $204 billion financed by state governments
- Beginning FY 2014, ACA driving Medicaid enrollment and spending.
- State Managed Care Medicaid programs becoming increasingly more common, giving rise to federal and state false claims act risks:
  - 71% of Medicaid enrollees in some form of managed care
  - 55% of Medicaid enrollees in comprehensive managed care
Transformative Changes for Medicaid

• Medicaid undergoing a period of transformative change
  – ACA expands Medicaid coverage for most low-income adults to 138% of the federal poverty level (FPL)
  – States that participate receive 100% federal funding for newly eligible population through 2016; phasing to 90% by 2020. As of January 2016:
    • 32 states (including D.C) have adopted the Medicaid expansion
    • 3 states are under discussion
    • 16 states are not adopting the Medicaid expansion at this time
  – Medicaid spending projected to increase by nearly 60% by FY 2023
Transformative Changes for Medicaid

- June 1, 2015 Proposed Rule “would modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems.”
  - Standardizes risk adjustment definitions
  - Requires transparency in rate setting and rates that are “actuarially sound”
  - Expands Medicaid and CHIP managed care plans’ program integrity responsibilities
  - Requires network adequacy standards
  - Requires accurate, complete and timely encounter data submissions from states for federal financial participation
  - Establishes medical loss ratio (MLR) for Medicaid and CHIP plans
Fragmentation of Federal and Non Federal Entities with Oversight Responsibility

**FEDERAL ENTITIES**

- Department of Health and Human Services
  - Administration on Aging
  - Centers for Medicare & Medicaid Services
    - Center for Program Integrity
      - Medicaid Integrity Contractors
      - Zone Program Integrity Contractors
  - Office of the Inspector General
  - Office of Financial Management
  - Department of Justice

**STATE/LOCAL ENTITIES**

- Medicaid Managed Care Organizations
  - Special Investigation Units
- State Medicaid Agency/Single State Agency
  - Program Integrity Unit
    - Recovery Audit Contractors
    - Surveillance and Utilization Review Subsystem
- State Auditors Offices/Comptroller’s Office
- State Attorney General’s Office
  - Local District Attorneys
  - Medicaid Fraud Control Unit

Source: GAO / GAO-15-677
Consequences of Fragmentation and Need for Coordination

• GAO Report 2014 found
  – CMS and states not “well-positioned” to identify improper payments made to – or by—managed care organizations
  – CMS delegated managed care program integrity to oversight to state programs
  – States focused primarily on fee for service programs
  – States not consistently conducting audits of payments to and from managed care organizations
  – Duplication of efforts and overlap
  – Lack of CMS guidance to state programs on program integrity practices and recoveries

• Need to coordinate law enforcement activities
  – Fraud schemes may cross state lines
• Medicaid Managed Care Fraud – Systemic Issues
What is Managed Care Fraud?

- Medicaid Managed Fraud is any type of intentional deception or misrepresentation made by an entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or other person.
Size and Diversity of Program Makes Vulnerable to Fraud

- Payment for services and treatments not covered by the program
- Payment for services not medically necessary
- Payment for services billed but not provided or misbilled

Fraud in Medicaid Managed Care estimated $17.5 billion in 2014

Overall Medicaid improper payment rate increased -- 5.8% for FY13 to 6.7% for FY 14
Size Fosters Enrollment/Eligibility/Coverage Issues

• Enrollment –
  – Patient must be eligible on date of service to qualify for payment
  – Providers must be enrolled – not excluded, disbarred, or otherwise disqualified
  – GAO 2015 Report indicates 2011 data from 4 programs shows
    • 8,600 enrollees received payment from 2 state programs – $18.3 million
    • 200 deceased enrollees received payments -- $9.6 million
    • 50 Medicaid providers excluded from program continued to receive payments -- $60,000
    • 26,000 addresses of providers could not be confirmed
    • New computer tools developed by CMS to aid states, e.g., Data Services Hub
Size Fosters Enrollment/Eligibility/Coverage Issues (Cont.)

- Mobility of Patients
  - Patient enrolled in one state receive services in a different state
- Payer of last resort
  - 3rd party liability; coordination with Medicare for dual eligible patients
- Multiple MCOs in state Medicaid Managed Care programs
  - Obtaining actual dollar amounts from multiple MCOs in states hampers audit and the detection of fraud
  - Some states have 20 or more MCOs and may contract with other types of capitated plans to provide services
Design of Capitation Rates – Subjects of Fraud

- Capitation rates must be actuarially sound [42 CFR § 438.6]
- Rate key component of Medicaid managed care, i.e., the fixed, prospective monthly payment for each enrolled beneficiary
- Each state calculates its own capitation rates for services
- Capitated rate is determined by (simply put) forecasting the amount of health care a beneficiary will need = risk score; the higher the risk score, the higher the capitated rate
- Incentive for “cherry-picking” or “lemon dropping”
- Cases alleging inflation of risk scores
Discretion and Waivers Create “Diverse” Medicaid Managed Care Programs

• States can implement a managed care delivery system using different federal authorities:
  – State plan authority for voluntary managed care [Section 1915 (a)]
  – Approval to make mandatory by
    • State plan authority by amendment [Section 1932(a)] [42 USC 1396u-2]
    • Waiver authority [Section 1915 (a) and (b)] [42 USC 1396n]
    • Demonstration Project authority [Section 1115] [42 USC 1315a]
Discretion and Waivers Create “Diverse” Medicaid Managed Care Programs (Cont.)

- These authorities permit states to operate a managed care system in a specific area of a state, provide different benefits to different people, and specify specific providers
- Result: Over 50 different distinct state-based programs with different features
  - Proposed rule provides further flexibility to states
Diverse Models (Example)

- Hudson Health Plan
  - Serves 115,000 Medicaid Managed care and CHIP patients
  - Patient Specific, Pay for Performance Program to Improve Immunizations and Diabetes Care
  - Bonuses for timely treatment – based on Individuals not Groups
  - Physicians participating in small group practices
  - Bonuses for meeting clinical performance standards, affording recommended treatments in a timely manner and meeting state quality standards
    - Variety of bonuses
    - $100 for each child immunized by 2nd birthday
    - Additional dollars for meeting immunization schedule
Fraud Prevention Measures/Programs

- Medicaid Management Information System (MMIS)
- Medicaid Statistical Information System (MSIS)
- Transformed Medicaid Statistical Information System (T-MSIS)
- Medicaid Integrity Program/Medicaid Integrity Group
- MCO Surveillance and Review (SURS)
- “Big Data” Analytics/Data Mining
- Medical Review
Types of Managed Care Fraud Schemes

- Contract Procurement Fraud
- Marketing and Enrollment Fraud
- Underutilization Fraud
- Claims Submission and Billing Procedures Fraud
- Compliance Fraud
- Fee-For-Service Fraud in Managed Care
- Embezzlement, Theft, and Related Fee-For-Service Fraud
- Misrepresentation and False Advertising of Health Maintenance Contracts
- False Information and Advertising Generally
- False Statements and Entries
- False Claim Settlement Practices
- Misrepresentation in Health Maintenance Organization Applications
Possible Sources of Fraud Allegations

- Referral from single state agency
- OIG Fraud hotline complaint
- *Qui tam* False Claims Act lawsuit
- Referral from MCO SIU
- Complaint-handling procedures of HMO
- Health care provider and/or billing agent
- Another competing MCO
- Another competing MCO SIU
- MCO subcontractor
- Medicaid recipients
- Fact witnesses connected to Medicaid recipients, such as relatives, co-workers, caregivers, etc.
- Current/former employees of MCO
- Current/former employees of health care provider
- Providers terminated from provider networks
Specific Allegations of Managed Care Fraud

Contract Procurement Fraud

• Falsification of health care provider credentials
• Falsification of financial solvency
• Falsified or inadequate provider network
• Fraudulent subcontract
• Fraudulent subcontractor
• Bid-rigging or self-dealing
• Collusion among providers
• Contracts with related parties
• Illegal tying agreements
Specific Allegations of Managed Care Fraud, cont’d

**Marketing and Enrollment Fraud**

- MCO paying fee/bonus for individuals enrolled
- Misrepresentations to beneficiaries (a/k/a slamming)
- Misrepresentation to beneficiaries by charging non-existent fees
- Enrolling ineligible or non-existent recipients
- Enrolling ineligible or non-existent family members
- Cherry-picking (selecting healthier segments of the enrollment population)
- Disenrolling undesirable members (lemon-dropping)
- Kickbacks for referrals
- Failing to notify the state of deceased members
- Beneficiary enrollment fraud
Specific Allegations of Managed Care Fraud, cont’d

Claims Submission and Billing Procedures Fraud

- Inflating the bills for services/goods provided, and double billing, balance billing
- Improper coding (upcoding/unbundling)
- Billing for ineligible consumers or services never rendered
- Billing for services that are not medically necessary
- Federally excluded provider
- Inappropriate physician incentive plans
- Reporting phantom visits and improper cost reporting
- Inappropriate cost-shifting to carved out services
- Misrepresenting kick-payment-eligible services or incentivized services
- Encounter data fraud (e.g. submitting data for services not rendered)
- Misrepresenting Medical Loss Ratio
- Submitting encounter data for services not rendered
- Submitting false cost reports and other financial documents
- Submitting false encounter data, medical services payments, or other false statements to inflate the capitation rate
- Submitting false statements or false records to inflate risk adjustment
Specific Allegations of Managed Care Fraud, cont’d

Underutilization Fraud

- Untimely first contact with clients
- Untimely assignment of a primary care physician
- Delay in reassigning a PCP upon an individual’s request
- Discouragement of treatment using geographic or time barriers
- Engagement in any Federally-prohibited activities
- Failure to serve individuals with cultural or language barriers
- Failure to provide educational services
- Failure to provide outreach and follow-up care or Federally-required referrals
- Defining “appropriateness of care” and/or “experimental procedures” in a manner inconsistent with standards of care
- Cumbersome appeal processes for enrollees or providers
- Inadequate prior authorization “hotline”
- Unreasonable prior authorization requirements
- Delay or failure of the PCP to perform necessary referrals for additional care
- Incentives to illegally limit services or referral
- Routine denial of claims
The Emerging Focus on Medicaid Managed Care MLR Measures
Medical Loss Ratio (MLR)

\[
\text{ACA MLR} = \frac{\text{Medical care claims + quality improvement expenses}}{\text{Premiums} - \text{taxes}}
\]

- ACA requires health insurance issuers to submit data annually on the proportion of medical care claims and quality improvement expenses to premiums net of taxes.

- ACA requires rebates if the ratio does not meet minimum standards.

- MLR has a long history. Prior to ACA, 34 states had MLR requirements with varying levels of enforcement (very few required rebates). States primarily used MLRs to assess solvency and reasonableness of premium rates.
### MLR Expands to Medicaid and CHIP Plans

<table>
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<th>Plan Type</th>
<th>MLR</th>
<th>Aggregated by and for</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<td>Individual</td>
<td>80%</td>
<td>State</td>
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<td>X</td>
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<tr>
<td>Small Group</td>
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<td>State</td>
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<tr>
<td>Large Group</td>
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<td>State</td>
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<td>Student Health</td>
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<td>National</td>
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<td></td>
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<tr>
<td>Medicare Advantage</td>
<td>85%</td>
<td>Contract</td>
<td></td>
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<tr>
<td>Medicare Part D</td>
<td>85%</td>
<td>Contract</td>
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<tr>
<td>Medicaid</td>
<td>85%</td>
<td>MCO, PIHP or PAHP</td>
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<td>CHIP</td>
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<td>MCO, PIHP or PAHP</td>
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<td>X</td>
</tr>
</tbody>
</table>
Changes to Minimum MLR Rates

• The ACA allows the Secretary to adjust the minimum MLR for a state for up to 3 years beginning in 2011 if it is determined that meeting the 80% minimum MLR may destabilize the individual market
  – 17 states plus Guam applied for waivers
  – 7 states were granted waivers

• States may also set higher minimum MLRs, but “must seek to ensure adequate participation … competition in the health insurance market … and value for consumers so that premiums are used for clinical services and quality improvements” (45 CFR §158.301)
Attestation Statement

The officers of this reporting issuer being duly sworn, each attest that he/she is the described officer of the reporting issuer, and that this MLR Reporting Form, the Company/Issuer Associations, and any supplemental submission that the issuer includes are full and true statements of all the elements included therein for the MLR reporting year stated above, and that the MLR Reporting Form has been completed in accordance with the Department of Health and Human Services’ reporting instructions, according to the best of his/her information, knowledge and belief. Furthermore, the scope of this attestation by the described officer includes any related electronic filings and postings for the MLR reporting year stated above and which are required by Department of Health and Human Services under section 2718 of the Public Health Service Act and implementing regulation.

____________________________
Chief Executive Officer/President

____________________________
Chief Financial Officer
MLR Fraud Enforcement

• **U.S. v. Farha, et al.**
  – March 2011: Five former WellCare executives indicted for health care fraud and making false statements; four of them sentenced, pending an appellate ruling

• **U.S. Securities and Exchange Commission v. Farha, et al.**
  – Alleges securities fraud
  – Case is stayed pending the outcome of the criminal trial

• **Other matters**

  **Monetary Settlements** of $80 million (DPA), $137 million (DOJ) and $200 million (securities class action); plus $200 million in legal fees
False Claims Risks

• For states that choose to require a rebate if MLR standards are not met, the federal government would receive its share
  – Potential federal False Claims Act risks

• Potential State false claims risks:
  – 30 States with false claims acts, some allowing whistleblowers to file suit
  – Deficit Reduction Act of 2005 – allows states to recover its share of Medicaid funds and also a portion of the federal government’s share, under certain requirements

• Reverse false claims
• False Claims Acts and Medicaid Managed Care Fraud – Evolving Landscape
Mechanics of an FCA Claim

• Filed under seal in federal or state court by the qui tam plaintiff, or relator (or by the government)
  – *Qui tam* action: FCA action filed by an individual ("relator")
  – Suit remains sealed pending conclusion of government investigation

• DOJ and/or States may intervene to:
  – Pursue one or more counts;
  – Dismiss the complaint; or
  – Settle the case

• Relator may prosecute on behalf of government(s) if government(s) elects not to intervene
Elements of an FCA Claim

• Liability stems from
  – Knowingly submitting a false claim to the government for payment or approval
  – Knowingly causing another to submit a false claim to the government for payment or approval
  – Knowingly making a false record or statement to get a false claim paid by the government
  – Reverse false claims where one acts improperly to avoid paying money to the government

• “Knowingly” means actual knowledge, deliberate ignorance of the truth or falsity, or reckless disregard of the truth or falsity
Recent Medicaid Managed Care Fraud Settlements

- **United States et al. ex rel. Torres v. Shire Specialty Pharmaceuticals et al., No. 08-4795 (E.D. Pa.)** (National Supplier Fraud) Joint Fed/NAMFCU investigation; damages model included fee-for-service and managed care claims

- **United States ex rel. Cederoth v. CRC Health Corporation Comprehensive Addiction Programs, Inc. and CRC Health Tennessee, Inc. d/b/a New Life Lodge, No. 03-11-00897 (M.D. Tenn.)** (Provider Fraud) CRC had contracts with both DCS and MCO (TennCare Program) Case arose out of a *qui tam* alleging False Claims

- **United States v. Edelstein, et al., 07-CV-52-KKC (ED KY)** (Fee for Service/Managed Care Fraud) Alleged FCA violation for repacking and selling prescription drugs. Edelstein and Bond had previously entered guilty pleas based on same conduct
Reverse False Claims

• **U.S. ex rel. Kane v. Continuum Health Partners (SDNY 2014)**
  
  – DOJ intervened for first time in case premised solely on untimely return of overpayments
  
  – Dispute over when an overpayment is “identified”
  
  – Government asserts an entity “has identified an overpayment when [it] has determined, or should have determined through the exercise of reasonable diligence, that [it] has received an overpayment.” 42 C.F.R. § 422.326(c), 423.360(c)
  
  – “Reasonable diligence might require an investigation conducted in good faith and in a timely manner by qualified individuals in response to credible information of a potential overpayment.” 79 Fed. Reg. at 29,923-24
Certification Theories

- Increasing use of express and implied certification theories in FCA matters
- Cost reports, claims, and other submissions require certifications of compliance with rules applicable to government health care program
- Condition of participation vs. condition of payment
- Government has started to expressly mandate in statutes and regulations that compliance is “condition of payment”
- **BUT**: by granting certiorari in *Universal Health Services, Inc. v. United States ex rel. Escobar*, No. 15-7 (U.S. Dec. 4, 2015), the Supreme Court will address: (1) the validity of the implied false certification theory and (2) the application of the theory, and, in particular, whether the relevant statute, regulation, or contractual provision must expressly state that compliance is a condition of payment
Statistical Sampling

- Use of statistical sampling to establish FCA liability
  - *U.S. ex rel. Martin v. Life Care Centers of America, Inc.* (Tenn. 2014)
    - Government alleged nursing facilities urged therapists to overstate amount and intensity of treatment to obtain greater reimbursement
    - Government sought to examine random sample of 400 claims, and extrapolate findings to 150,000+ claims
    - Court permitted use of statistical sampling to establish liability, reasoning that a "claim-by-claim" review would be contrary to FCA’s policy goals
    - Relator’s reliance on crude statistical analysis was sufficient to survive motion to dismiss
Drive Toward Increased Transparency

• Federal and state authorities increasingly mine reported data for possible false claims
• “Fraud Prevention System” utilizes three data analytic strategies
  – Anomaly detection models
  – Predictive models
  – Social network analysis
• Bolsters relators’ claims
• Data analysis by sophisticate corporate relators could give rise to new breed of *qui tam*
• CMS release of prescriber-level Medicare data
Aggressive State AG Enforcement

- Increased emphasis on going after fraud in Medicaid Managed Care

- Three fundamental reasons for sea change:
  - 1 - FERA amendments provide for liability for fraud committed at expense of Medicaid Managed Care
  - 2 - MFCUs are required to pursue Medicaid Managed Care fraud (HHS-OIG performance standards for MFCUs)
  - 3 – As previously noted, Medicaid Managed Care dominates state Medicaid programs
Reason # 1

- Make it clear that government reach under the federal and analogous state FCAs extends to fraudulent payments made in any program operating within a contractual arrangement deriving from the advancement of a government interest (e.g., Medicaid), when the government has provided any money at any point in the underlying process.

(*Fraud Enforcement and Recovery Act of 2009)
FERA Amendments – Definition of “Claim”

(A) means any 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—

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government—

(l) provides or has provided any portion of the money or property requested or demanded

31 USC s3729(b)(2)
From the Senate report that accompanied FERA:

• “…[FERA] clarifies that] the FCA reaches all false claims submitted to State administered Medicaid programs [and]… that direct presentment [to the government] is not required for liability to attach.”

  – 2009 WL 787872 at *11
FERA Amendments – impact in current litigation

- “…liability under section 3729(a) attaches whenever a person knowingly makes a false claim to obtain money or property, any part of which is provided by the Government without regard to whether the wrongdoer deals directly with the Federal Government; with an agent acting on the Government's behalf, or with a third party contractor, grantee, or other recipient of such money or property.”

“...the fact that the United States Treasury is being cheated indirectly rather than directly is a distinction without a difference...[I]ndeed, ...federal funds granted to third parties are as much in need of protection from fraudulent claims as any other federal money...”

FERA IMPACT –
a defense perspective

• Under this definition, claims to Medicare Advantage (MA) Plans and Medicaid Managed Care Organizations (MCOs) can surely now trigger an FCA claim whereas previously it was unclear. In an environment such as healthcare where all of the entities eventually get federal dollars, the Government could certainly claim an interest in virtually every aspect of its delivery. It is important to keep an eye on just how far this could be taken.

Calculating Damages

• Risk areas
  – Federal False Claims Act
  – State false claims acts
  – Reverse false claims

• Possible categories of damages:
  – Actual damages up to the amount of the alleged false claims
    • There is no single rule for calculating damages
    • Damages should be determined based on the facts of the particular case at issue. The guiding principle is to make the government whole for any damages incurred because of alleged violations of federal or state false claims acts
  – Double or treble damages
  – Penalties