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Feds Shine a Light on Medicare Advantage Plans and Physicians Related to Risk Adjustment Practices

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Although the sufficiency of medical records documentation supporting beneficiary diagnoses for Medicare Advantage (MA) risk adjustment has been on the OIG's work plan since 2013, the Department of Justice has upped the ante with a 2016 physician criminal conviction and recent intervention in two *qui tam* cases related to MA risk adjustment. These initiatives allege that MA plans made false claims by submitting diagnoses for risk adjustment that were unsupported by medical documentation or medical condition and that both insurers and providers engaged in a variety of questionable practices.

Medicare Advantage Risk Adjustment

Generally, MA plans are paid a capitated rate per beneficiary. Base rates are established using the average amount of spending for traditional Medicare beneficiaries as a benchmark. The process of adjusting the capitation rate to reflect a MA plan's members' health status is known as risk adjustment. Risk-adjusted payment is designed to discourage MA plans from cherry picking the healthiest beneficiaries by ensuring that plans receive adequate payments for high-cost enrollees.

The Centers for Medicare & Medicaid Services (CMS) has been using a Hierarchical Condition Categories (HCC) risk adjustment model since 2004. It is a prospective, individual-based risk assessment program and payment is calculated prospectively based on the previous year's diagnosis codes submitted by hospitals and physicians. CMS uses thousands of diagnosis codes and groups them into 79 HCCs which are chronic disease groups comprised of multiple, clinically-related diagnoses. Each HCC is assigned a score that reflects its relative contribution to health care costs and MA plans receive additional reimbursement in an amount that corresponds to the anticipated increase in expenditures for a particular patient.

MA plans are required to filter the content of risk adjustment data to ensure that it is from appropriate providers and that only diagnosis codes treated through approved procedure types (physician CPT codes or hospital procedure codes) are included in the data submitted to CMS. CMS requires the diagnosis data to be based on face to face patient encounters and substantiated by medical records documentation. MA plans are required to certify (based on best knowledge, information and belief) that the data submitted is "accurate, complete and truthful".

Recent Developments

Since 2009, there have been several enforcement actions by the government as well as numerous *qui tam* actions initiated against MA plans and physicians relating to MA risk adjustment practices. The government and *qui tam* relators assert that the actions of the defendants violate the False Claims Act (FCA), which can result in treble damages and civil monetary penalties of up to $21,986 per claim. The common themes among the cases include:

- Lack of medical records documentation confirming reported diagnoses
- False diagnoses not supported by medical condition
- Claiming current treatment of a condition rather than a history of treatment
- Overstating the severity of patient medical conditions
- Performing chart reviews or audits that look only for upward adjustments
- Ignoring information that would have lowered reimbursement
- Providing improper incentives to providers
- Failing to verify provider diagnoses.

Notable Civil Cases:

- *United States v. Janke*. In 2010 the owners of a MA plan in Florida (Dr. Walter Janke and his wife) agreed to pay the federal government $22.6M to resolve allegations that they worked through Dr. Janke's medical clinic to submit false diagnosis data causing overpayments to the MA plan. The government alleged that the defendants submitted diagnosis codes to CMS that were neither documented in the medical record nor supported by an actual medical condition and that chart auditors were hired to review medical records for additional or upcoded diagnoses that could be submitted to CMS for increased payment. The MA plan and the medical practice are now defunct.
- *United States ex rel. Sewell v. Freedom Health, Inc., et al.* As a result of a *qui tam* suit initiated by its Vice President of Special Projects in the Medicare Revenue Management Department (and former Chief Medical Officer) Freedom Health and its related corporate entities entered into a $32.45M settlement with the federal government and the State of Florida. The government alleged that Freedom Health submitted or caused others to submit unsupported diagnosis codes to CMS, which resulted in inflated reimbursements in connection with two of their Florida MA plans ($16.7M recovery). Additionally, Freedom allegedly falsely represented that it had a sufficient number of providers in an application for expansion ($15M recovery). Notably, Freedom's former Chief Operating Officer agreed to pay $750,000 to resolve his alleged role in these schemes.
- *U.S. ex rel. Swoben v. United Health Care, et al.* (appellate decision). On August 10, 2016, the 9th Circuit Court of Appeals vacated the lower court's judgment dismissing *qui tam* relator James Swoben's complaint, which alleged that defendant MA plans submitted false certifications in violation of the False Claims Act. Swoben argued that four defendant MA plans were on notice of erroneous risk adjustment data as a result of retrospective risk adjustment data validation audits performed by CMS and that "upcoding" violated data certification obligations under MA regulations. The complaint also named a physician group with a sub-capitation arrangement as a defendant. Although the physician practice was not required to certify the accuracy of risk adjustment data, as a sub-capitated provider the practice shared in the reimbursement paid to the MA plan. Additionally, the practice was alleged to have participated in retrospective medical reviews designed to find only under-reported diagnoses. Notably, the appeals court held that the relator's assertion that defendants designed their retrospective review procedures to not reveal erroneously reported diagnosis codes stated a cognizable legal theory under the False Claims Act. The case was remanded to the lower court.
- *United States ex rel. Swoben v. Secure Horizons, et al.* In early May 2017, after a five (5) year investigation the federal government partially intervened in a *qui tam* action alleging United Health Group (UHG) obtained inflated risk adjustment payments based on untruthful and inaccurate information about the health status of beneficiaries enrolled in UHG's largest MA plan, UHC of California. The lawsuit contends that UHG funded blind, retrospective reviews of the charts of HealthCare Partners (HCP), one of the largest providers of services to UHG beneficiaries in California, to increase the risk adjustment payments for beneficiaries under HCP's care, ignoring information from those reviews about invalid diagnoses. UHG allegedly failed to compare the results of the blind chart reviews to the diagnosis codes submitted by HCP, which resulted in false data certifications by UHG.
- *United States ex rel. Poehling v. United HealthGroup, Inc. et al.* Within weeks of intervening in Swoben, the government intervened in a second *qui tam* suit involving UHG. The complaint contends that UHG's subsidiary Ingenix conducted a retrospective Chart Review Program that was a "one-sided revenue generating program" designed to identify undercoding not reported by treating physicians that would increase UHG's risk adjustment payments. The complaint asserts that UHG ignored information from these chart reviews that would have led to reduced payments. Notably, the complaint also alleges that UHG incentivized large physician groups paid under capitation arrangements to submit data that inflated the number and severity of patient medical conditions because the providers' capitation amounts: 1) were a percentage of the payments that UHG received from the Medicare program, or 2) fluctuated based on increases in the risk adjustment scores. The complaint further alleges UHG's reviews of providers' medical records confirmed that the providers were reporting invalid diagnoses but UHG knowingly avoided further efforts to identify invalid diagnoses from the providers and did not repay Medicare.

The government says UHG's conduct damaged the Medicare program by over $1.14B from 2011 to 2014. The Justice Department is seeking triple damages under the False Claims Act as well as penalties. Because of the 9th Circuit's favorable appellate decision regarding application of the FCA, the federal government has moved this case from New York to California to consolidate it with *Swoben*.

Criminal Case:

- *U.S. v. Isaac Kojo Anakwah Thompson*. In July 2016, the U.S. Attorney from the Southern District of Florida obtained a criminal conviction against a physician who falsely diagnosed 387 beneficiaries with a rare chronic disease of the spine in connection with a Humana MA plan. The physician had a sub-capitation arrangement with Humana and received 80% of the $2.1M in capitation fees that were generated from the false diagnoses. Dr. Thompson received 46 months prison time with three (3) years supervised release, is obligated to make restitution in the amount of $2.11M, and was excluded from governmental payor plans for 25 years. Humana reimbursed the government the remaining 20% of the capitation fees associated with the false diagnoses. Humana is said to have "cooperated fully with authorities" in their pursuit of Dr. Thompson. The Thompson criminal conviction was the result of a *qui tam* suit initiated by one of Dr. Thompson's former business partners. Three other physicians, two medical clinics and a medical practice were also named as defendants in the *qui tam* suit. The government intervened in the *qui tam* suit, which is ongoing.

Recommendations

In light of these developments it is important for physicians, medical practices, and their compliance officers to take immediate steps to review their MA agreements, both written and oral, to understand how compensation is calculated as a first step to determining whether their MA arrangements have any of the attributes that raise red flags or create compliance risks. Additionally, these agreements should be reviewed to evaluate whether there may be any special screening or auditing programs requested by MA plans that could have resulted in more frequent or more severe medical conditions being reported to CMS for risk adjustment purposes. If the compensation under your agreements fluctuates based on the severity or number of diagnoses for MA beneficiaries or you receive payment as a percentage of the capitation amounts a MA plan receives you may be at risk for audit, fraud and abuse enforcement action or a *qui tam* suit. To reduce these risks, steps should be taken to initiate audits on a regular basis related to MA beneficiaries as part of your overall compliance program. Depending on the findings of those reviews, it may also be appropriate to conduct education sessions with billing staff and physicians to ensure they understand the issues and pitfalls related to MA beneficiaries, supporting diagnosis codes, and risk adjustment. Lastly, to the extent an MA plan provides you with an opportunity to review and adjust diagnosis codes, such reviews should be carefully undertaken to ensure that only appropriate and documented diagnosis codes are reported and that information with downside reimbursement potential are also reported. If anything troubling is found as part of your contract review or audits, you should contact your compliance officer or health care attorney to assist you with determining any possible remedial actions that may be necessary.

Please contact Kelly Leahy at (614) 628-6815, kleahy@slk-law.com or Rachel Goodman at (813) 227-2328, rgoodman@slk-law.com or your regular Shumaker, Loop & Kendrick attorney if we can be of assistance to you.

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