CRISIS MANAGEMENT AND FIRST AID: WHEN GOVERNMENT CONTRACTORS ARE THE HEADLINERS
FEDERAL HEALTH CARE PROGRAMS: New FCA Enforcement Risks in a Post-ACA World

Bob Rhoad
Troy Barsky
Jacinta Alves
Roadmap

- FCA Basics
- Recent FCA Amendments
- Heightened FCA Enforcement
- New Risks for Health Plans
- Compliance Tips & Best Practices
FCA BASICS
1. **False Claim** – *knowing submission* of or causing another to submit a false claim to the Government or a recipient of Government funds.

2. **False Record or Statement** – *knowingly making or using* a false record or statement material to a false claim.

3. **Reverse False Claim** – *knowingly making* a false record or statement material to an obligation to pay money to the Government, or *knowingly and improperly avoiding* an obligation to pay money to the Government.

4. **Conspiracy** – when a contractor *conspires to do* any of the above.
FCA – Qui Tam Provisions

- FCA actions may be initiated by individuals under the FCA’s qui tam provisions
  - “Relators” (a/k/a “whistleblowers”)

- Procedure:
  - Relator must file a complaint under seal
  - Relator must also serve written disclosures on DoJ describing “substantially all material evidence and information the person possesses”
  - DoJ has 60 days to investigate and make intervention decision (extensions are common)
FCA – Qui Tam Provisions

• Government Action (following investigation)
  – Intervene in the case and assume primary responsibility for the litigation
  – Decline intervention, allowing relator to proceed
  – Move to dismiss the case (even if relator objects)
  – Seek settlement

• Bars to *Qui Tam* Actions
  – Public Disclosure
  – First-To-File Rule
  – Previous Government Action
• **Damages:** Difference between what the government actually paid and what it should have paid absent the alleged FCA violation – **TREBLED**!

• **Penalties:** $5,500 to $11,000 *per claim* and may be applied even in the absence of actual damages

• “Whistleblower” Share & Retaliation Claims
FCA – Collateral Consequences

• Corporate “Death Penalty”
  – Suspension & Debarment (Gov’t Contractors)
  – Exclusion (Health Care) from federal health programs (e.g., Medicaid and Medicare)

• Criminal Conviction & Fines
  – If parallel proceedings under the “Criminal” Federal False Claims Act, 18 U.S.C. § 287
RECENT FCA AMENDMENTS
2009: FERA

• FERA significantly amended the FCA for the first time since 1986:
  – “Clarifies” that the FCA was “intended” to extend to any false or fraudulent claim for Government money or property, regardless of whether:
    • A claim is actually “presented” directly to the Government;
    • The Government has physical custody of the money; or
    • The defendant specifically intended to defraud the government
What is an “Obligation”? 

(3) the term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

• “Obligation” is confusingly defined as “an established duty, whether or not fixed” that arises from “a contractual, grantee, licensure or fee based relationship, from a statute or regulation, or from the retention of any overpayment.”
Medicare/Medicaid “Obligations”?

“There can be no doubt but that the statutes and provisions ... involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them ... with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.”

Rehabilitation Assoc. of Va. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994)
2010: ACA

Anti-Kickback Statute ("AKS")

• Establishes that a violation of the AKS can be the basis for FCA liability

• Changes the intent-and-knowledge requirements under the AKS. Now, a “person need not have actual knowledge or specific intent to commit a violation”

• Affects the “Hanlester” defense, which interpreted the AKS to require proof the defendant (1) had specific knowledge of the law, and (2) had specific intent to disobey the law. Hanlester Network v. Shalala, 51 F.3d 1390 (9th Cir. 1995)
ACA’s Changes to the FCA

• Creates *Per Se* FCA Violation for Failure to Report and Return Overpayments:
  – Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

• Does not add a new liability provision to the FCA, but stipulates with only limited detail the procedural steps and time period to report and return an identified overpayment obligation in order to avoid potential FCA liability.
HEIGHTENED FCA ENFORCEMENT
## FCA Statistics: FY 2012

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<th>FY 2013</th>
<th>Total since 1986</th>
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<td>New matters</td>
<td>846</td>
<td>19,649</td>
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<tr>
<td><em>Qui tam</em></td>
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<td>Recoveries</td>
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<td>Relator share</td>
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New Matter Filings: 2000 - 2013
Relator’s Share of Awards: 2000 - 2013

- Where U.S. Intervened
- U.S. Declined
Total Awards by Industry: 2000 - 2013
NEW RISKS FOR HEALTH PLANS
New Flows of Government Dollars

• A whole new “commercially insured” population is subject to the False Claims Act and federal enforcement arena if an insurer makes a false statement in connection with:
  – Its medical loss ratio data
  – Its reinsurance submissions
  – Its justification for any rate increase
  – Its risk corridor calculations
  – Its risk adjustments submissions
  – In qualifying its products for participation in the Exchange ...
“The Three R’s” and The False Claims Act

Risk Adjustment
- Premium adjustments to offset adverse selection
- Individual & Small Group Markets
- Both inside and outside the Exchange

Risk Corridors
- Government shares gains/losses beyond +/- 3% of Target
- Individual & Small Group Markets
- Inside the Exchange

Reinsurance
- Government provides “stop loss” style reinsurance
- Individual Market Only
- Both inside and outside the Exchange
Risk Adjustment Program

• A permanent risk adjust program will apply to individual and small group plans inside and outside of the Exchanges.

• Transfer funds from plans with lower risk members to plans with higher risk members.

• HHS will operate a risk adjustment program for each State that does not operate its own.
Risk adjustment FCA risk

• Risk adjustment scores can increase CMS reimbursement for Medicare Advantage organizations and DOJ has used the FCA where it has concluded that those scores were knowingly false.

• In *U.S. v. Janke*, DOJ alleged that the owners of an MAO made false claims and statements to CMS by improperly assigning ICD-9-CM codes that were not documented or supported by the medical conditions of the MAO’s members. The case was settled for $22 million dollars.

• Government has said FCA will apply.
Risk adjustment FCA risk

• Under the ACA, HHS will use risk scores to determine the funds that must be transferred among plans as charges or payments.

• If those risk scores are knowingly false as DOJ claimed they were in the Janke case, then a violation of the FCA has occurred and this is so even though the money at issue is not Government money.

• Under the FERA definition of “claim”, the Government does not have to have title to the money for there to be FCA liability.
Exchange Product Risk Corridors

- HHS sets risk corridors for 2014-2016 for qualified health plans in the individual and small group market based on ration of allowable costs to the plan’s aggregate premium.
  - Plans and federal government share upside and downside experience outside 3% corridor around target budget for allowable costs
  - Plans to report “allowable costs”
Risk Corridor FCA Risk

• If the issuer’s allowable costs are less than 97% of its target amount, the plan will pay HHS a percentage of the difference.

• If an issuer’s allowable costs are more than 103% of its target amount, HHS pays it a percentage of the difference.

• If a plan’s reported “allowable costs (claims and quality improvement)” or “target amount (premiums earned less allowable administrative costs)” are knowingly false, it is exposed to FCA liability.
Reinsurance

• A transitional reinsurance program must be established in each State.
• All health insurance issuers and TPAs on behalf of self-insured group plans must make contributions.
• If State does not establish program, HHS will.
• HHS will collect contributions for self-insured plans and for programs that it’s set up.
Reinsurance FCA Risk

• Contributions will be collected using a national per-capita rate.

• Issuer/TPA contributions will be used for payments of $10 billion in 2014, $6 billion in 2015 and $4 billion in 2016 and for $2 billion to the United States in 2014/2015 and $1 billion for 2016.

• If an issuer or TPA uses a false record material to its obligation to make a reinsurance contribution to HHS or knowingly and improperly avoids or decreases the obligation, this can give rise to “reverse false claims” liability (State FCA risk too).
Reinsurance FCA Risk

• Reinsurance payments are based on total annual medical costs for covered benefits of an enrollee in an individual market plan, and compensates for those costs incurred above an attachment point;

• FCA exposure if the total medical costs for covered benefits are “knowingly” false in some way, AND

• The “claim” for the payment was made to the United States or it was made to a State and the money was to be used to advance a Government program and the United States provided a portion of it.
Exchange Standards

• HHS set minimum standards that Exchanges must use in certifying QHPs for participation. Standards set for:
  – marketing;
  – network adequacy;
  – inclusion of “essential community providers” willing to accept the “generally applicable payment rates” of the plan;
  – accreditation;
  – quality improvement;
  – uniform enrollment forms; and
  – standardized benefit presentation format permitting consumer comparisons.
FCA Reaches Payments Via Exchange

• Under Sec. 1313 of PPACA, payments made by, through or in connection with an Exchange are subject to the FCA if the payments include any federal funds; AND

• “Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer’s entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange”.
Payors, Plans, MCO Risk Areas

• Recent amendments to the FCA bring health plans further into the Government’s FCA “cross-hairs”

• Any false claim, record, or statement resulting in the receipt of federal funds can expose a health plan to FCA liability. Such risk areas include the following:
  – Federal Employees Health Benefits Program (e.g., certification of community rate or, starting in 2013, accuracy of MLR data submission);
  – Medicare Advantage (e.g., plan rate bid certs);
  – Contractor Performance (e.g., timeliness of claims payments, notices of claim denials, reconsiderations, and appeals, marketing, enrollment/disenrollment, under utilization, accessibility of services);
Payors, Plans, MCO Risk Areas

- **Falsification of Reports/Certifications** (*e.g.*, regarding encounter data, quality-of-care review, enrollee health status reports, or data required to be submitted to the government);

- **“Red-Lining”** (*e.g.*, insurance companies that provide Medicare Advantage insurance coverage and paid on a per patient basis, improperly discourage enrollment by persons they deem to be sicker or at higher risk for serious illness, to decrease risk and enhance revenue); and,

- **Medicare Part D Fraud**

- **Intermediary Services** (*e.g.*, failure to provide appropriate level of services and/or to ferret out issues and fraud)
COMPLIANCE TIPS AND BEST PRACTICES
Taking it to Your World

• Risks from submissions on rates and costs for commercially insured populations make fraud and abuse a more critical company compliance need outside of traditional “government program” arenas
  – Bucketing of expenses in medical loss ratio and risk corridor reporting will be a key risk area
  – Not just a bookkeeping exercise-manipulation of business terms to impact subsequent report could trigger risk
• FCA risks created by false statements regarding qualification for Exchange participation
• Government attorneys will likely have greater access to approval to use compulsory process
• Broader whistleblower protection
Key Risk Areas

• Inaccurately reporting or certifying data in premiums, bids and rate proposals or annual reports, even if not financial.

• Using inaccurate or “mis-bucketed” data to support reported claims experience and loss ratios and risk corridor performance.

• Sloppy tracking or reporting of actuarial risk or member diagnoses used in risk adjustment scoring for government or commercial populations.

• Not promptly addressing possible “overpayments”
• Falsely certifying compliance with rate or bid requirements.
Key Risk Areas

• Falsely certifying compliance with marketing or other program requirements or restrictions on de facto “red-lining”.
• Inaccurately reporting enrollment or failing to correct inaccurate enrollment or other demographics.
• Manipulating provider or vendor dealings to distort reported claims or administrative expenses.
• Government concern about “paper” compliance programs fuels allegations that mistakes were “reckless” and therefore support False Claims allegations.
Predicting Risk Path

• Prior government and qui tam actions are clues to predicting future cases.

• Government’s own stated areas of interest.

• Playing with “other people’s money”.
Possible Plan Responses

• Identification of priority risk areas in operations – government contracts and commercial operations affecting government payments.

• Update and expand, if necessary, compliance policies and procedures, notice requirements, and record retention policies.

• Independent review of structure, scope and design of compliance programs.
Plan Responses

• Confirming protocols and internal reporting and decision tree for detecting and addressing overpayments and identified fraud and abuse problems.

• Confirm adequacy of anti-retaliation/whistleblower policies, not only for employees but also for contractors.

• Provide training on expanded fraud and abuse risk for operations staff.

• Evaluate potential use of internal or outside independent reviews of selected high risk areas.
Questions?

Robert T. Rhoad
202-624-2545
rrhoad@crowell.com

Troy A. Barsky
202-624-2890
tbarsky@crowell.com

Jacinta Alves
202-624-2573
jalves@crowell.com