

False Claims Act Risks For Sponsors of Medicare Advantage Plans

SUMMARY: Over the last several years, the Department of Justice (DOJ) and *qui tam* relators have been targeting Medicare Advantage (MA) plans with allegations of risk adjustment fraud. We expect the next wave of enforcement actions and *qui tam* complaints to target the accuracy of other types of data submitted by MA plans. One areas of focus will likely be the accuracy of star rating data, which can be manipulated by reversing denials of coverage and approving claims that lack medical necessity.

I. Background

As more federal and state government money flows into managed care, DOJ and relators have sharpened their focus on companies that manage health insurance plans. To date, enforcement actions against Medicare Advantage plans have focused on allegations of “risk adjustment fraud,” which is the practice of manipulating diagnosis codes to increase member risk scores and boost payments to the plan. We expect the next wave of enforcement actions to focus on the accuracy of other types of data submitted by MA plans.

II. MA Star Ratings

The MA Star Rating system is intended to assess the quality of Medicare Advantage Part C plans. Star Rating performance metrics evaluate beneficiary outcomes, beneficiary satisfaction, population health, and health care efficiency. The Star Rating system calculates ratings using metrics under 33 unique quality measures, grouped into five broad categories: Staying Healthy, Managing Chronic Conditions, Member Experience, Member Complaints, and Health Plan Customer Service. Higher star ratings have concrete financial benefits, including: (1) an upward adjustment in the benchmark used by CMS for determining capitated payments paid to the MA plan by CMS for beneficiary coverage, and (2) annual Quality Bonus Payments paid by CMS to MA plans.

III. Manipulation of MA Star Rating Data

One individual MA contract measure under the “Health Plans Customer Service” domain is “Reviewing Appeals Decisions,” which measures how often an Independent Review Entity (IRE) determined that the health plan’s decision to deny an appeal was fair. In 2015, to obtain a five-star rating on the “Reviewing Appeals Decisions” metric, the MA contract data must show that greater than 95% of its appeal decisions are upheld on review by the IRE.

Most MA plans have implemented rigorous processes to review denials of coverage for accuracy and consistency before forwarding any appeal to the IRE. In this case, however, operational best practices could also be a compliance risk. A liberal policy of paying most claims on appeal could be misconstrued as an effort to manipulate the Plan’s Reviewing Appeals Decision. And since only non-participating providers may act as party to an appeal, a track record of consistently granting appeals from non-participating providers could be viewed as violation of the Plan’s duty to identify plan enrollees with overutilization issues and reduce Part C costs due to fraud, waste and abuse.

CONCLUSION: With only limited guidance from HHS-OIG on these issues, a robust compliance review and monitoring can be effective ways to the mitigate FCA risk.