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Medicare Advantage Remains a Top Enforcement Priority

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Medicare Advantage (Medicare Part C) remained a top enforcement priority in 2022, and Medicare Advantage Organizations (MAOs) are the subject of intense scrutiny by the Department of Justice (DOJ); the Office of Inspector General for the Department of Health and Human Services (HHS OIG); and the press. MAOs undoubtedly will continue to face considerable enforcement in 2023 and beyond, particularly as Medicare Advantage continues to grow in both number of enrollees and in federal spending. As of January 31, 2023, more than 30 million people are enrolled in MAOs—nearly half of all Medicare enrollees.

Reinforcing DOJ's continued scrutiny of MAOs, Deputy Assistant Attorney General Michael Granston emphasized in remarks at ACI's annual False Claims Act Conference on January 23, 2023 that Medicare Advantage remains one of DOJ's top enforcement priorities. In fact, DOJ is investigating and litigating against many MAOs under the False Claims Act (FCA), and many of the nation's largest MAOs remain embroiled with DOJ in active FCA lawsuits.

As background, and as we have previously discussed, the Centers for Medicare & Medicaid Services (CMS) pays MAOs a capitated payment for each plan member. CMS adjusts capitated payments to MAOs based on each member's demographic information and health conditions, which are captured by diagnosis codes. Generally, MAOs receive higher payments for sicker members because the cost of care for these members is typically higher. CMS requires MAOs to submit data, including diagnosis codes, which CMS uses to adjust payments to MAOs in accordance with CMS's risk adjustment system. MAOs obtain diagnosis codes through claims submitted by providers, Health Risk Assessments (HRAs), and the review of members' medical records (i.e., chart reviews), and then the MAOs submit these diagnoses to CMS. CMS has repeatedly advised that chart reviews and HRAs are allowable sources of diagnoses for risk adjustment payments.

FCA enforcement against MAOs has primarily involved these risk adjustment activities. In the large majority of allegations against MAOs, DOJ contends that MAOs improperly identified and submitted diagnosis codes to CMS. The FCA allegations vary by MAO, but they fall into a few categories, including: adding unsupported diagnosis codes; conducting "one sided" reviews of patient charts to identify codes but not to delete them; developing data mining programs to identify missed diagnosis codes and using addenda to retroactively add diagnoses; using vendors to identify diagnosis codes through in-home assessments; and failing to delete unsupported diagnosis codes.

DOJ recently has focused on the nexus between diagnoses codes and treatment, and DOJ has

alleged that MAOs violated the FCA by submitting diagnoses that providers did not actually consider or address during the patient encounter.

Some of these FCA lawsuits are in their early stages, and motions to dismiss are pending. Others have proceeded beyond the motion to dismiss stage, including DOJ's FCA lawsuit against a diagnosis-coding vendor that identified diagnosis codes for MAOs. At least one case, *Poehling v. UnitedHealth Group, Inc. et al.,* is moving toward the summary judgment phase, with the trial scheduled in 2023. The court decisions and outcomes in these FCA lawsuits will continue to shape the Medicare Advantage enforcement landscape.

DOJ also has targeted MAOs for alleged conduct beyond risk adjustment activities. On July 1, 2022, an MAO paid $4.2 million to resolve allegations that it violated the Anti-Kickback Statute (AKS) by giving gift cards to physicians' administrative assistants to induce them to refer, recommend, or arrange for the enrollment of 1,646 new Medicare beneficiaries in the MAO. This settlement is a reminder of the breadth and significance of the AKS in many areas subject to health care enforcement, including in Medicare Advantage.

HHS OIG Also Continued to Scrutinize MAOs

The HHS OIG also has scrutinized MAOs. In 2022, for example, HHS OIG issued a report entitled Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. The report criticized MAOs for purportedly using prior authorization to deny members' access to medically necessary services and to deny payments to health care providers for these services. HHS OIG explained, "a central concern about the capitated payment model used in Medicare Advantage is the potential incentive for [MAOs] to deny beneficiary access to services and deny payments to providers in an attempt to increase profits." HHS OIG's report may foreshadow increasing enforcement against MAOs for the denial of medically necessary services.

CMS Issues Proposed Rules that May Affect Enforcement Against MAOs

In late December 2022, CMS issued a proposed rule that would apply to MAOs. Among other things, the proposed rule clarifies the circumstances under which MAOs can deny requests to provide care to members. If CMS finalizes the rule, MAOs will have to ensure that they comply with these new standards as relators and DOJ may increasingly focus on denials by MAOs.

CMS's proposed rule also would amend the existing Medicare overpayment regulations for parts A-D, including in Medicare Advantage, 42 C.F.R. § 422.326(c) (the 60-day Overpayment Rule), as my colleagues discussed. The 60-day Overpayment Rule is significant for MAOs because it defines MAOs' obligations to identify and return potential overpayments they may have received from CMS. The failure to identify and return an overpayment could subject an MAO to FCA liability.

In the proposed rule, CMS would redefine the term "identified overpayment" to align the phrase with the FCA's "knowledge" requirement.[1] Currently, an MAO has "identified" an overpayment when it has determined, or should have determined through the exercise of *reasonable diligence*, that it received an overpayment, and quantified the amount. An MAO has 60 days to return an overpayment once it has been identified (or when a cost report is due, if applicable). Under the proposed rule, however, an MAO has identified an overpayment—and the 60-day clock starts running—if the MAO has actual knowledge of the existence of the overpayment, or acts in *reckless disregard or deliberate ignorance* of the overpayment. If CMS implements the proposed rule, use of the "reckless disregard"

standard, while eliminating the investigation period to quantify any overpayment, may create confusion for MAOs as they examine whether they might have received an overpayment. The application of the overpayment rule is significant as a misstep in assessing, reporting, and returning an overpayment in compliance with the 60-day Overpayment Rule would subject an MAO to FCA liability.

Given these enforcement and regulatory developments, MAOs will almost certainly remain subject to intense scrutiny and enforcement in 2023 and beyond. MAOs should continue to monitor HHS OIG reports and proposed rules to help mitigate their enforcement risks. In addition, because the regulatory guidance that applies risk adjustment activities is relatively limited, MAOs have been, to a degree, subject to regulation through enforcement, so they should also follow enforcement activities. By doing so, MAOs can identify potential risks as enforcement authorities bring new enforcement actions and continue to litigate ongoing FCA cases. We will continue to monitor and report on the evolving landscape of risks for MAOs.

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[1] The 60-day Overpayment Rule was the subject of litigation in the United States District Court for the District of Columbia and the D.C. Circuit Court of Appeals in recent years. In explaining the changes in the proposed rule, CMS cites the D.C. Circuit's opinion upholding the 60-day Overpayment Rule.

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