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Las Vegas | Venetian – Palazzo – Sands Expo Center

The Compliance Landscape

Opening Keynote (Com 1): Compliance March 5, 2018

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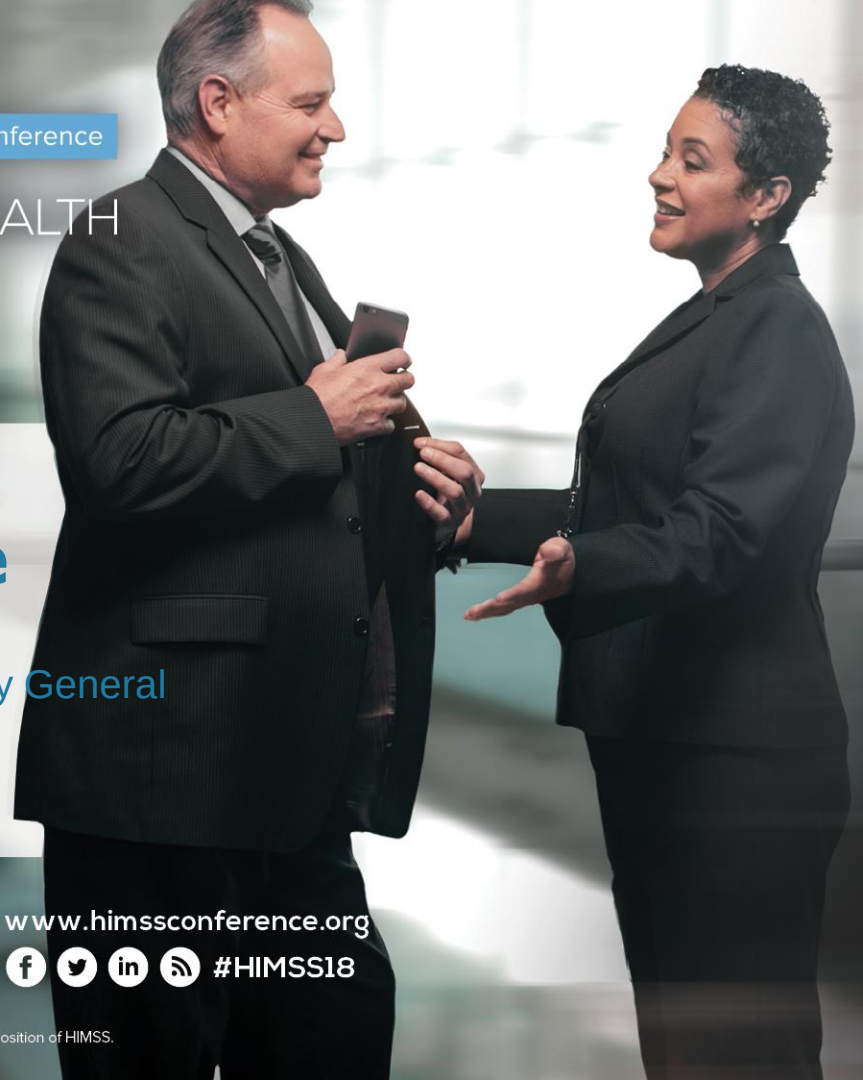

COMMITMENT

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No Conflict of Interest

James G. Sheehan J.D.

-employed by agency with responsibility for regulation and enforcement

Has no real or apparent conflicts of interest to report.

Learning Objectives

- How identifying risks and proactive management of risk can shape your 2018 compliance program
- Risk in value-based and diagnosis based payments
- Provider and hospital perils in mergers, acquisitions, and affiliations

Thinking about Risks and Compliance

- Claims
- Data-based payments
- Duty to refund, report, explain overpayments
- Stark relationships with providers
- Data disclosures and breaches

Claims risk

- The chargemaster (CDM) (code translator)
- Encounter data systems/cutting and pasting
- Third party claims processors/billers Claims optimizers-next slide
- The yellow sticky on the screen

The Accretive Case (Me. 2017)

- addition of modifiers 25 (significant separate E&M service same day), 59(significant separate same day non-E&M service) or 91 same lab test, same day)to CPT codes;
- edit evasion by unbundling of previously denied claims
- Deleting accident and injury information to obtain payment for denied claims
- Resubmitting Medicare claims without accessing underlying clinical documentation or communicating with coders
- Altering discharge status indicators to “discharge to home”

Reducing Claims Risk

- Annual chargemaster reviews
- Review of third party claims contracts
- Cutting and pasting text analysis
- Claims processor walk through
- Mergers and acquisitions: complaints, audits, enforcement requests, suits, chargemaster review

Data and Value based payment

- Paying for outcomes, not inputs
- Severity-adjusted DRGs; Grouper software
- Hospital Value-Based Purchasing (HVBP) Program
- Hospital Readmission Reduction (HRR) Program
- Hospital Acquired Conditions (HAC) Program
- alternative payments rely on high-quality data

QUIZ:

- Your health plan is required to submit an annual certification to the Center for Medicare and Medicaid Services that your patient data is "true, accurate, and complete."
- In response, you should:

  -have your compliance officer sign the certification

  -refuse to sign because patient data is never completely true, accurate, and complete.

  -sign, but require your vendors to sign subcertifications certifying that the data they submitted to your plan is true, accurate, and complete

The Paradox of Risk Adjustment and coding intensity in value-based programs

- "Recent research has found that risk scores for MA plan members have been growing more rapidly than risk scores for FFS beneficiaries."
- ". . . MA plan enrollees have higher risk scores than similar FFS beneficiaries because of plans' more intensive coding efforts. . . CMS makes an across-the-board (downward) adjustment to the risk scores of MA plan enrollees to make them more consistent with FFS coding."
- 2016 MedPac Report to Congress
- The RADV FFS Adjuster – expected error rate in coding
- "CMS estimates that 9.5% of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations." OIG 2017 Work Plan at 29 "Risk Adjustment Data-Sufficiency of Documentation Supporting Diagnoses"(expected issue date 2018)

False Reporting by health plan about health status of Medicare Advantage Plan beneficiaries

- 5/16/17 USA False Claims Complaint vs. UnitedHealth Group (second UHG case)
- “UHG conducted a national Chart Review Program designed to identify additional diagnoses not reported by treating physicians that would increase UHG’s risk adjustment payments. However, UHG allegedly ignored information from these chart reviews showing that hundreds of thousands of diagnoses provided by treating physicians and submitted by it to Medicare were invalid and did not support the Medicare payments it had previously requested and obtained.”

US ex rel Swoben v. United Healthcare 832 F. 3d 1084 (9th Cir. 2016)

- United allegedly submitted false certifications under this provision(certification that the risk adjustment data is “accurate, complete, and truthful”) in violation of the False Claims Act, by conducting retrospective reviews (of medical records provided by treating physicians) designed to identify and report only under-reported diagnosis codes (diagnosis codes erroneously not submitted to CMS despite adequate support in an enrollee’s medical records), not over-reported codes (codes erroneously submitted to CMS absent adequate record support).

False Reporting by health care providers of invalid diagnoses to health plan

- 5/16/17 complaint " UHG allegedly knew that its financial arrangements with these providers created a strong incentive for and increased the risk of these providers to report invalid diagnoses. UHG's own reviews of these providers' medical records confirmed that the providers were reporting invalid diagnoses."
- 5/2/17 -UHG funded chart reviews conducted by HealthCare Partners (HCP), one of the largest providers of services to UHG beneficiaries in California, to increase the risk adjustment payments received from the Medicare Program for beneficiaries under HCP's care.
- UHG allegedly ignored information from these chart reviews about invalid diagnoses and thus avoided repaying Medicare monies to which it was not entitled.

Reducing data risk

- Subcertifications
- Third party contract review
- Practice audits? (has its own risks)
- Diagnosis Validation as part of provider review
- Data caveats
- Systems review in acquisitions, mergers-what controls?

Duty to Report, Refund, Explain Overpayments

- **Patient Protection and Affordable Care Act**, P.L. 111-148, Section 6402, 42 U.S.C. 1320a-7k(d)
- **Reporting and Returning of Overpayments—**
- (1) In general. If a person has received an overpayment, the person shall—
- (A) **report and return** the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
- (B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of **the reason** for the overpayment.

MANDATORY REPORTING OF CONDITIONS AFFECTING RIGHT TO PAYMENT

- Every Health Care Provider billing Medicare or Medicaid has a duty to report, refund, explain any overpayment to the provider within 60 days
- Failure to report a known overpayment is a false claim(triple damages and penalties) even if original claim was in good faith
- Stark violations create a duty to report
- Subsequent events can create duty to report (e.g., hospital readmission)
- 42 CFR Part 401, Subpart D, Reporting and Returning of Overpayments, 81 Fed. Reg. 7654 (Feb. 12, 2016)

Reducing Mandatory Reporting Risks

- Compliance program-internal reporting expectations
- Identify high risk departments-balance billing, collections
- Tracking of potential overpayments
- Standard letters-we are reviewing
- What to do about credit balances?
- Protocol for review in mergers and acquisitions-how many reports? (“zero is a bad number”)

Stark Law: relationships with providers

- Prohibits a physician from referring designated health services to an entity payable by Medicare where the physician has a financial relationship unless relationship meets specified exceptions.
- This issue is discussed in more detail by Amy Leopard and Leslie Cumber later in today's program
- full employment act for attorneys, compliance officers, and merger/ acquisition due diligence specialists
- Virtually impossible to automate-1000 pages of rules, explanations

Stark Law: Reducing Risks

- Conflict of interest reporting for physicians, with crosschecks
- All physician contracts through compliance review, legal review
- Mergers and Acquisitions-certification of compliance, fund set aside for violations

Data disclosures and breaches

- Covered in more detail by Peter McLaughlin later today
- HIPAA
- State laws
- Common law (court decisions)
- Reporting requirements for breach (both to government agencies and affected consumers)

QUIZ

- You receive a court subpoena for patient records from a government agency in a paternity case. You should:
- --refuse to provide the records because they are covered under HIPAA
- --provide the records because a government agency has given you a subpoena commanding you to do so.
- --refuse to provide the records unless the government agency provides you with proof that the patient has consented to the release
- --refuse to provide the records unless the government agency provides proof that the patient has received notice of the subpoena

Subpoena should not be complied with unless . . .

- EMILY BYRNE *v.* AVERY CENTER FOR OBSTETRICS AND GYNECOLOGY, P.C.(2018)
- No disclosure by physician unless the patient has received adequate notice of the request or a qualified protective order has been sought. See 45 C.F.R. § 164.512 (e)
- Patient can bring tort action for breach of fiduciary duty

Data Breach

- **IN RE: HORIZON HEALTHCARE SERVICES INC. DATA BREACH LITIGATION 846 F.3d 625 (3d Cir. 2017)**
- Theft of laptops containing personal credit and healthcare information can give rise to class actions for violations of the Fair Credit Reporting Act ("FCRA"), 15 U.S.C. § 1681, et seq., even in absence of evidence of specific harm. Horizon allegedly inadequately protected their personal information.
- **CVS PHARMACY, INC. v. PRESS AMERICA, INC. (SDNY 2018)** Press America incorrectly addressed mail containing beneficiaries' PHI, resulting in 41 unauthorized disclosures of IBM health plan beneficiaries' PHI.” Protection of Information Failure,“ clause required CVS to pay IBM, and Press America to indemnify CVS $1.8 million

DATA BREACH: Minimizing Risks

- Critical review of contracts, breaches, and reporting in mergers and affiliations
- Protocol for identifying and reporting breaches
- Protection of Information failure clauses in contracts with vendors
- Careful review of Protection of Information clauses applied to providers
- Data encryption
- Laptop use and removal control
- Unauthorized access oversight programs
- Audit work plan item?

Questions

- Thank you for your attention.
- James. Sheehan@AG.NY.GOV.
- Chief, Charities Bureau, NY AG

- Please complete online session evaluation