Managed Medicaid and the Increasing Exposure of Managed Care Organizations Under the False Claims Laws

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The federal and state governments’ use of managed care to deliver Medicaid and Medicare benefits is growing, with upwards of 50 million beneficiaries presently enrolled. As new beneficiaries enroll in state-managed Medicaid and federal Medicare Advantage plans, and more beneficiaries participate in the Medicare Part D drug benefit, the numbers will only increase. Mindful of this trend, the federal and state governments are turning their eyes to the managed care organizations (MCOs) and ramping up false claims enforcement.

This article identifies the industry and legislative developments behind the increasing enforcement actions against Medicaid MCOs, explores the legal theories used against those MCOs, and highlights the potential for applying the same theories to Medicare Part D plan sponsors. In many ways, the legal theories are merely old wine in a new bottle, with enforcers prosecuting the MCOs under the federal False Claims Act (FCA), and state false claims laws for allegedly submitting claims for services they did not provide, keeping overpayments to which they are not entitled, and making false statements to the government. In other ways, however, the theories are novel and seek to impose liability for attempts to increase profits by suppressing utilization, denying care, submitting inaccurate encounter data, denying coverage to less healthy enrollees or enrollees who may pose higher costs, or inappropriately marketing benefits. Managed care fraud enforcement is an expanding frontier, with federal and now state enforcers developing creative theories to combat new perceived frauds on both Medicaid and Medicare.

I. States increasingly rely on Medicaid MCOs to control costs, even as government enforcers ratchet up false claims actions after the Deficit Reduction Act of 2005.

Many states began using private MCOs to manage the healthcare of Medicaid beneficiaries in the 1990s. Under these managed Medicaid programs, the MCOs receive capitated payments for each enrollee. If the MCOs hold program costs below the total capitated payments, they keep the difference (with certain limitations). Just like private health maintenance organizations (HMOs), Medicaid MCOs have come under fire from some providers and critics who contend that the MCOs control costs by reducing provider reimbursement, decreasing access to care, and limiting patient choice.

This hostility, coupled with the challenges inherent in managing Medicaid patients, led many MCOs to withdraw from the market in the 1990s. Despite the pull-back, there are signs that the public and the states are again warming to managed Medicaid, especially as Medicaid spending grows and alternative models prove costly.

Against this backdrop, President George W. Bush signed the Deficit Reduction Act of 2005 (DRA). The DRA aims to control Medicaid spending by creating a financial incentive for the states to adopt false claims laws modeled on the FCA and join the federal government in suing to recover Medicaid funds. Since the DRA became effective, the false claims laws of 13 states have qualified for the incentive. An additional nine states, plus the District of Columbia, maintain false claims laws, and legislation is pending elsewhere.

Among the 22 states with false claims laws, the most aggressive enforcer is New York.

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2008, New York’s newly created Office of the Medicaid Inspector General (OMIG) issued its ambitious first Work Plan.¹⁰ The Work Plan included a managed care data mining project to identify overpayments ranging from payments for deceased enrollees to payments made without the proper encounter data.¹¹ The project dovetails with OMIG’s enforcement focus on Medicaid enrollment and marketing fraud.¹² A mere eight months after issuing the Work Plan, New York announced that it recovered a stunning $551 million in Medicaid funds in Fiscal Year 2008.¹³ While the recovery encompasses more than just MCO overpayments, its magnitude will encourage other states to empower their inspectors general, mine MCO data, and implement and enforce their own false claims laws. This is especially true as the recession squeezes state budgets and the DRA provides a potential avenue to make up some of the shortfall.

II. The courts have rarely endorsed the government enforcers’ primary legal theory against the Medicaid MCOs: falsely certifying compliance with the conditions for participating in Medicaid creates false claims liability.

In the early 2000s, before the DRA’s implementation, federal and state enforcers began applying well-worn theories of provider liability to MCOs. The theories included over-billing for the care provided by doctors and hospitals, and reporting inflated costs.¹⁴ Federal enforcers even argued that MCOs’ utilization review services can be so deficient that the MCOs fraudulently bill for worthless services.¹⁵ While some courts seemed to accept these widely used theories as viable against the MCOs, the courts have yet to agree that billing for capitated Medicaid payments while at the same time failing to comply with the regulatory and contractual conditions for participating in Medicaid creates FCA liability.¹⁶ Nevertheless, that has typically been the government’s legal theory in false claims actions against the Medicaid MCOs.

A. Allegations of false certifications of compliance with conditions for participating in Medicaid have routinely served as grounds for FCA settlements.

Government enforcers, following the “conditions of participation” theory, have repeatedly used the FCA as a device for correcting or prosecuting deficient or fraudulent claims processing, data reporting, or financial management by the Medicaid MCOs:

• In 2005, Americhoice of Pennsylvania paid $1.6 million to settle allegations that it violated the FCA by failing to process or timely process managed Medicaid claims and also reporting inaccurate claims processing data.¹⁷ Such conduct allegedly violated state Medicaid regulations and Americhoice’s contract with the state. It also reduced the capitated Medicaid funds used for patient care below the regulatory and contractual threshold, allowing Americhoice to retain more funds than allowed. Americhoice’s presenting of claims for capitated payments while violating the regulatory and contractual requirements supposedly created FCA liability.

• In 2006, Keystone Mercy Health Plan paid $5 million to settle similar allegations of regulatory and contractual non-compliance, financial manipulation, and false claims liability.¹⁸ Keystone allegedly recovered overpayments from Medicaid providers, which it retained past the regulatory and contractual deadlines for remitting the amounts to the state. By presenting claims for capitated payments while holding the overpayments past the deadlines, Keystone supposedly created false claims liability.

• In 2007, Gregory West, a billing analyst for WellCare Health Plans Inc., pled guilty to conspiring to defraud Florida’s managed Medicaid program.¹⁹ He admitted that regulations and WellCare’s contract with Florida required WellCare to remit to the state any unspent capitated Medicaid payments in excess of 20% of all such payments.²⁰ In addition, the regulations and contract required periodic reporting of expenditures on beneficiaries.²¹ West admitted that WellCare reported improper or inflated expenditures, and thereby concealed its practice of retaining more than 20% of the capitated payments.²² Presumably, West’s allegations mirror the qui tam action now pending against WellCare in Florida state court.²³ While the court accepted the settlement or plea in at least some of these cases, in no instance did the court appear to reach a holding endorsing the government’s theory as the law.

B. Government enforcers premise their “conditions of participation” theory on appellate precedent that does not apply to federal healthcare.

The most high-profile decision endorsing the application of the “conditions of participation” view to Medicaid MCOs is United States ex rel. Tyson v. Amerigroup Illinois, Inc.²⁴ In Tyson, the government proved at trial that the Medicaid MCOs fraudulently induced Illinois to sign a Medicaid MCO agreement by falsely promising not to discriminate against any beneficiaries.²⁵ The government also proved that beneficiary enrollment applications
submitted by the MCOs to obtain capitated payments under the agreement were false claims since Illinois conditioned payment on the nondiscrimination promise made during contracting. The MCOs argued that the applications were not false claims because neither the applications nor the agreement expressly stated that payment was conditioned on the MCOs fulfilling their nondiscrimination promise. The district court disagreed, finding that “a condition to participation is a condition to payment.”

That rule, however, was first articulated by the U.S. Court of Appeals for the Ninth Circuit in *United States ex rel. Hendow v. University of Phoenix,* a FCA action for fraud on federal education programs. In Hendow, the University of Phoenix allegedly made false statements about its admissions department’s incentive compensation plan when it first applied to become eligible for federal education funds. The issue was whether the university’s subsequent claims for federal funds could be fraudulent because a federal statute expressly conditioned payment on eligibility, and eligibility on compliance with an incentive compensation ban. The Ninth Circuit, persuaded by a Seventh Circuit ruling in a similar case, held that the claims could be fraudulent. The Ninth Circuit, rejecting as semantics the university’s argument that the ban was a mere condition of participation, reasoned: “[I]f we held that conditions of participation were not conditions of payment, there would be no conditions of payment at all.” The Ninth Circuit then contrasted federal education contracting with healthcare, where the distinction between conditions of payment and participation is meaningful due to the complex web of federal and state agencies and regulations governing the delivery of services.

Consistent with *Hendow,* the U.S. Court of Appeals for the Fifth Circuit declined to apply the “conditions of participation” view to a MCO in *United States ex rel. Willard v. Humana Health Plan of Texas, Inc.* a case similar to *Tyson.* In *Willard,* the relator argued that the MCO violated the FCA by presenting claims for capitated payments to Medicare while failing to comply with regulations prohibiting it from discriminating against enrollees based on their health status. But neither the regulations nor the MCO’s contract with Medicare conditioned payment under the contract on nondiscrimination. So the Fifth Circuit affirmed the dismissal of the relator’s complaint for lack of a viable theory of FCA liability.

Despite the limitations of *Hendow* and the dearth of case law endorsing the state and federal enforcers’ theory that a condition for MCO participation in Medicaid is the same as a condition of payment, the enforcers continue to press the theory—and obtain settlements.

### C. The *Allison Engine* decision raises new questions concerning the viability of the “conditions of participation” theory, which Congress may resolve by passing the *False Claims Act Correction Act.*

The forward march against the MCOs might slow under the U.S. Supreme Court’s landmark decision in *Allison Engine Co. Inc. v. United States ex rel. Sanders.* In *Allison Engine,* the Supreme Court held that presenting a claim directly to the federal government is not required for FCA liability. But when presenting a false claim or making a false statement in support of a claim, the defendant must intend for the federal government to pay the claim. The Supreme Court’s holding led to the district court’s dismissal of the FCA action in *United States ex rel. Sterling v. Health Insurance Plan of Greater New York, Inc.* In *Sterling,* the MCO allegedly violated state contractual and regulatory provisions requiring accreditation with the National Committee for Quality Assurance (NCQA) by supplying NCQA with false data to obtain the accreditation. The alleged violations were legally insufficient because the relator never asserted that the MCO intended for the government to pay false claims when it submitted the false data to NCQA. NCQA is also not a payment intermediary, so the relator did not satisfy the FCA’s presentment requirement. Thus, the district court dismissed the action. *Sterling* places an important limit on Medicaid MCOs’ false claims exposure, as the states often require Medicaid MCOs to obtain third-party certifications of their operations, and may also require certifications of the MCOs’ quality ratings systems for hospitals and physicians. Theoretically, however, *Allison Engine* should immunize Medicaid MCOs against more than liability for credentialing fraud. Since Medicaid is a state-administered program, paid for with comingled state and federal funds, under which the Medicaid MCOs only present claims for payment to the states, the MCOs arguably cannot have the requisite intent under *Allison Engine* to “get” claims paid the federal government. The limits of *Allison Engine*’s impact on Medicaid were recently considered by the U.S. District Court for the Southern District of New York, which held that the relator created a jury question by alleging that the defendant intended to present Medicaid claims to the state in order to “get” them paid by the federal government. The Southern District seemed to gloss over the fact that the federal government pays the state’s aggregate Medicaid expenditures, and not claims presented to the state by MCOs.

The debate about *Allison Engine* may ultimately be resolved legislatively and not judicially. In the 110th
Congress, the House and Senate each considered a version of the False Claims Act Correction Act.\(^50\) Both versions would abrogate Allison Engine by amending the FCA to create liability where a false claim or statement is material to an intermediary’s payment of the claim using the federal government’s money.\(^51\) Plainly, this change would end any debate about the FCA’s application to Medicaid MCOs.\(^52\)

### III. Medicare Part D: The new front line for managed care liability?

As with Medicaid, the role of MCOs in administering Medicare has grown in the 2000s. This trend follows the passage of the Medicare Modernization Act of 2003 (MMA),\(^53\) which created Medicare Part D, a voluntary prescription drug benefit for persons eligible for benefits under Medicare Part A, enrolled in Medicare Part B, or enrolled in a private MCO plan under Medicare Part C.\(^54\) An eligible person may obtain prescription drug coverage through private, stand-alone prescription drug plans (PDPs) or one of the Medicare Advantage (MA) plans now available under Part C.\(^55\) Only PDPs and MA plans (together called “Part D sponsors”) may furnish prescription drug coverage to eligible beneficiaries under Part D.\(^56\)

To implement the Part D benefit, CMS has orchestrated the efforts of the federal government, the states, the Part D sponsors, private contractors, and providers.\(^57\) The complex process has moved gradually, and the program’s vulnerabilities are many.\(^58\) For example:

- One-quarter of CMS’ bid audits reveal “material findings,” which are findings that if corrected would lead to reduced payments, more benefits, or reduced premiums.\(^59\) CMS only uses the findings to influence Part D sponsors’ future bids.

- CMS does not currently have a mechanism in place to collect the $4.4 billion that the sponsors owe to Medicare under Part D’s risk-sharing requirements.\(^60\)

- CMS required all plans to complete self-assessments of their compliance programs in 2007, and 20% of the plans self-reported non-compliance with CMS’ requirements.\(^61\)

- By late 2008, all of the plans had adopted compliance programs. But only 72% had identified potential fraud and abuse incidents.\(^62\)

These vulnerabilities have made oversight of Part D the number one management issue for the Department of Health and Human Services Office of Inspector General (HHS-OIG).\(^63\)

Consistent with its growing focus on Part D oversight, HHS-OIG recently issued its Fiscal Year 2009 Work Plan.\(^64\) The Work Plan identifies several data mining projects and audits targeting Part D sponsors. HHS-OIG will (among other things) audit the cost estimates in Part D bids and review the data submitted by the Part D sponsors for reconciliation purposes.\(^65\) HHS-OIG also will conduct investigations related to the Medicare Part D drug benefit, including investigations of enrollment and marketing schemes.\(^66\) These elements of the Work Plan suggest a sharp turn from collaboration to enforcement, with special emphasis on Part D sponsors’ noncompliance with the regulatory and contractual requirements for: bidding, furnishing the Part D benefit, reporting data, reconciling funds, and identifying and reporting fraud and abuse.

Similar regulatory and contractual requirements for managed Medicaid are viewed by government enforcers as conditions for participating in Medicaid, and thus as foundations for false claims actions against the Medicaid MCOs. Going forward, federal enforcers seem poised and likely to apply the same basic legal theory against the Part D sponsors in order to reduce perceived fraud and abuse on the Part D benefit.
IV. Conclusion

For Medicaid MCOs, the theories of false claims liability are still developing and will expand considerably if the False Claims Act Correction Act becomes law. At the same time, the potential targets of such theories are broadening to include Part D plan sponsors. MCOs should be mindful of their potential exposure under new false claims theories focused on noncompliance with contractual and regulatory provisions governing marketing, reporting encounter data, and financial management. Such concerns should become a part of every MCO’s compliance program to help avoid false claims liability.

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Endnotes


2 Adela de la Torre, On Health Care, Think Locally: A California experiment for the poor and uninsured may be the model for the rest of the country, L.A. TIMES, July 7, 1993, at Metro p.7; Mary Sit-DuVall, Texas’ Move to HMO-Type Medicaid Causes Confusion, but Might Cut Costs, HOUSTON CHRONICLE, Mar. 15, 1998 (copy on file with author); Jennifer Steinhauer, New York Bracing for Medicaid Managed Care, N.Y. TIMES, Oct. 7, 1998 at A1.


4 Peter T. Kilborn, Some HMOs End Programs for Poor, Elderly, HOUSTON CHRONICLE, July 6, 1998 at A1.


7 The financial incentive is an additional 10% share of any recovery under a qualifying state false claims law. In order to qualify for the incentive, a state’s false claims law must: (1) Establish liability to the state for the false or fraudulent claims described in the FCA, for any expenditures related to Medicaid, as described in Section 1903(a) of the DRA; (2) contain provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in the FCA; (3) contain a requirement for filing an action under seal for 60 days with review by the state Attorney General; and (4) contain a civil penalty that is not less than the amount of the civil penalty authorized by the FCA. U.S. Department of Health and Human Services – Office of Inspector General, State False Claims Act Reviews, available at www.oig.hhs.gov/fraud/falseclaimsact.asp (last visited Jan. 19, 2009).


9 Id. (listing the false claims statutes of Delaware, Florida, Louisiana, Michigan, Montana, New Hampshire, New Jersey, New Mexico, and Oklahoma). Ironically, some of the states failing to qualify for the additional 10% share have still made mammoth recoveries. Florida, for instance, recovered as much as $51 million in Medicaid funds during FY 2008-09. Florida Recovered Nearly $57 Million in Medicaid Overpayments, Report Says, 13 BNA’S HEALTH CARE FRAUD REPORT 30 (Jan. 14, 2009). It is still not clear whether the states qualifying for the additional 10% share under the DRA are actually better off, since paying the relator’s bounty under the provisions may offset or exceed the additional 10% share.


11 Id. at 8-13.

12 Id. at 27.

agrees that Hendow does not purport to create a sweeping new rule that all conditions of participation give rise to liability under the FCA.

35 336 F.3d 375, 382-83 (5th Cir. 2003).

36 Id.

37 Id.

38 Id.


40 Id. at 2129-30.

41 Id.

42 No. 06 CIV. 1141 (PAC), 2008 WL 4449448, at *5-6 (S.D.N.Y. Sep. 30, 2008).

43 Id.

44 Id.

45 Id.

46 Id.

47 Fraud and Abuse: CRS Report Analyzes How High Court Decision May Affect FCA Health Care Claims, BNAs HEALTH CARE DAILY REPORT: DS (Nov. 12, 2008).


49 Id.


51 Id.

52 Allison Engineeonly applies to the FCA and is persuasive authority for the states. The states’ false claims laws are probably not impacted by Allison Engi ne because the local governments do not serve as Medicaid payment intermediaries for the states in the same way the states do for the federal government.


55 In addition to creating Part D, the MMA enhanced Part B by boosting the funding of benefits from HMO levels to what are essentially fee-for-service levels. CMS Legislative Summary, supra note 54, at 32-34. The MMA coupled this increase with a new preferred provider organization (PPO) option that delivers the cost benefits of an HMO to beneficiaries along with coverage for out-of-network services. Id. at 34. The existing HMO option (known as “Medicare+ Choice”) and new PPO option were together renamed the Medicare Advantage program. Id. at 32.

56 CMS Legislative Summary, supra note 54, at 1. The Part D sponsors market the benefit, enroll the beneficiaries, and administer the prescription drug coverage, all with oversight by the Centers for Medicare & Medicaid Services (“CMS”). See id. Initially, CMS determines which sponsors will participate through a competitive bidding process. Id. at 7-11. In addition to vetting and paying the sponsors, CMS creates and enforces marketing and enrollment guidelines. See William Jordan, Brian Stimson, & Jeff Hester, Trends in Federal Preemption Under the Medicare Modernization Act of 2003 2008-9 Bender’S HEALTH CARE REPORT: LAW & MONITOR 1, 2-3 (2008).


58 Id.


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