

The In-House Counsel and Compliance Officer Forum on  
**Preventing Fraud, Abuse and Waste in Medicare Advantage & Medicare Prescription Drug Plans**

The Complete Guide To Investigations, Enforcement Actions, Regulatory Initiatives and Compliance Programs Relative to Medicare Part C, Part D and MAPD Plans

January 30–31, 2012 • Union League • Philadelphia

Department of Justice Keynote: Federal Enforcement in the Medicare Managed Care Arena

Robert E. O'Neill  
United States Attorney  
Middle District of Florida  
(Tampa, FL)

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Interactive Working Group and Master Class Sessions

**A** January 30, 2012: Working Group Session on Structuring Internal Investigations for Medicare Managed Care Plans: Information Gathering and Analytical Strategies to Assess Fraud, Abuse and Waste Allegations

**B** January 31, 2012: Master Class on Pro-Active Audit Preparation: Strategies and Tools for CMS, RAC, ZPIC and Other Applicable Audits for Medicare Advantage and Part D Plans

Leading attorneys, compliance and audit executives for Medicare Managed Care and Medicare Prescription Drug Plans, and federal enforcement officials will provide insights into the latest challenges affecting fraud, abuse and waste prevention tactics relative to Medicare Parts C and D. They will help you:

- UNDERSTAND the link between Health Care Reform and enforcement in Medicare Managed Care and related prescription drug plans
- ANALYZE theories brought — by both the prosecution and the defense — in FCA actions involving Medicare Managed Care, including *Janke* (America's Health Choice Medical Plans) and *Well Care*
- DEFINE kick-backs and NAVIGATE safe harbors under the AKB law
- DEVELOP an “effective compliance plan” for Medicare Advantage and Medicare Prescription Drug Plans under CMS guidance
- IDENTIFY and PROTECT against legal risks related to risk adjustment
- AVOID operational practices that have resulted in government sanctions, including marketing/enrollment suspensions.
- MASTER the CMS Marketing Rules for Medicare Advantage plans
- COMPREHEND the compliance and enforcement implications of the Medical Loss Ratio Final Rule for Medicare Managed Care plans

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**Robert D. Belfort**  
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**Mark R. Chilson**  
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Manager, Medicare Compliance  
Horizon Blue Cross Blue Shield of New Jersey  
(Newark, NJ)

**Danielle Trostorff**  
Shareholder, Healthcare Practice Group  
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PC (New Orleans, LA)

**Prasanta KR Wells**  
Senior Associate General Counsel  
UnitedHealthcare Medicare & Retirement  
(Minnetonka, MN)

**Richard W. Westling**  
Partner  
Waller Lansden Dortch & Davis, LLP  
(Nashville, TN)

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- Health Care
- Medicare/ Medicaid
- Health Insurance
- Government/ white Collar Investigations



## Medicare Advantage and Medicare Prescription Drug Plans are the Latest Focus of Government Scrutiny for Health Care Fraud, Abuse and Waste.

### Assess Whether Your Current Investigatory, Compliance and Audit Competencies Are Up to Par in the Era of Health Care Reform.

A key tenant of Health Care Reform is to stop fraud, abuse and waste at every opportunity. The government has enhanced the powers of the enforcement authorities to perform this task — a fact that Medicare Advantage and Medicare Prescription Drug plans are well aware of. Medicare Advantage plans — already under scrutiny for alleged service inefficiencies — are now, along with their drug plan counterparts, the subject of investigations and sanctions with which the pharmaceutical industry has become well acquainted in the last decade. Recent government actions brought under the False Claims Act and sanctions for non-adherence to CMS-mandated compliance protocols beg the question as to whether this industry will soon encounter a TAP case of its own.

### Prepare Now for New Enforcement Activity and Sanctions.

### Attend ACI's In-House Counsel and Compliance Officer Forum on Preventing Fraud, Abuse and Waste in Medicare Advantage and Medicare Prescription Drug Plans and Get the Essential Strategies that You Need to Meet Your Compliance Challenges Front and Center.

ACI's In-House Counsel and Compliance Officer Forum on Preventing Fraud, Abuse and Waste in Medicare Advantage and Medicare Prescription Drug Plans will give you a complete understanding of the latest legal, regulatory, legislative and political developments affecting compliance and enforcement in the Medicare Advantage and Medicare Prescription Drug Plan arena. Our expert faculty will show you how to ensure against fraud, waste and abuse. They will help you develop the strategies that you need to put robust compliance, marketing, coding and audit protocols in place as you prepare for new compliance challenges in 2014. This program will also help you prepare for, respond to and defend against government investigations and enforcement actions.

### Special Working Group and Master Class on Essential Enforcement and Compliance-Related Functions

To enhance and complete your conference experience, we are pleased to offer the following working group and master class sessions:

**A** The Working Group Session on Structuring Internal Investigations for Medicare Managed Care Plans: Information Gathering and Analytical Strategies to Assess Fraud, Abuse and Waste Allegations will provide you with skills and competencies that you need to conduct thorough internal investigations. It will also help you with critical considerations necessary for government inquiries; and

**B** The Master Class on Pro-Active Audit Preparation: Strategies and Tools for CMS, RAC, ZPIC and Other Applicable Audits for Medicare Advantage and Part D Plans will help you fine tune your audit skills, address simultaneous audit obligations, and develop protocols to streamline information gathering processes and benchmark progress.

As an added bonus, your conference registration includes your choice of one of these sessions.

### Reserve Your Place Now at Critical Medicare Managed Care Event!

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**A**

Monday, January 30, 2012 | 8:30 am – 11:30 am  
(Registration Opens at 7:30 am– Continental Breakfast Will Be Served)

## Working Group Session on Structuring Internal Investigations for Medicare Managed Care Plans: Information Gathering and Analytical Strategies to Assess Fraud, Abuse and Waste Allegations

*David Deaton*

Partner  
O'Melveny & Myers LLP  
(Los Angeles, CA)

In this era of heightened scrutiny of the health care industry, the art of conducting an effective internal investigation is now a critical competency for Medicare Managed Care Plans. CMS mandates for compliance programs and audits, as well as government enforcement activities and qui tam actions have acted as a catalyst for the development of guidelines for internal investigations for these government funded health care plans.

Plans must develop effective protocols to conduct internal investigations to discover the truth and determine whether prohibited conduct will occur. It is important that these protocols give your company the ability to identify the problem, preserve its rights and institute appropriate remedial measures — before the government investigators appear on the doorstep — and even more importantly, have procedures in place for when the government investigators do knock.

This in-depth working session will provide you with a step-by-step guide for every phase of an internal investigation. It will also make you aware of concerns applicable to Medicare Managed Care plans – and Medicare Prescription Drug Plans – in such instances. Our workshop leaders will address such points as:

### Investigation Triggers

- Reportable v. non-reportable compliance issues
  - how do you define a reportable issue?
- Hot line calls
  - what's being reported?
  - is it an HR issue?
  - a compliance issue?
  - a criminal matter?
- Findings/discrepancies in routine audits
  - can the suspicious findings and discrepancies be accounted for?
    - o is there an error?
    - o is there a pattern?
  - what are you obligated to disclose under the Federal Sentencing Guidelines, CMS Medicare Part C/ D manual?
  - remediations
- Government inquiries
- Qui tams

*Tri MacDonald*

Director  
Berkeley Research Group, LLC  
(Washington, DC)

### Preliminary Determinations:

- Looking at corporate structure and organization
- Advising the company of its rights at the beginning of the process: “corporate Miranda”
- Where does the subject activity occur?

### Particulars of the Investigation:

- Who will conduct the investigation?
  - what is the nature of the investigation?
  - advantages v. disadvantages of:
    - o in-house counsel and other in-house personnel v. outside counsel
    - o internal investigators
    - o auditors, forensic accountants
    - o compliance officer –pros and cons?
  - with respect to outside counsel – when should you use different counsel than you normally use?
- Who do you interview?
  - who will interview whom?
- To whom do you report your findings?
  - compliance?
  - legal?
  - outside counsel?
- When in the course of an investigation is it in your company's best interest to go to the government?
- Methods of documentation
  - what do you and don't you put into writing?
  - what will ultimately be discoverable?
  - should findings and results only be given orally?
- Methods of communication
  - what restrictions or guidelines should be put on e-mails?

### Privilege

- How do you structure an internal investigation so as to preserve privilege in an internal investigation?
  - how far does the privilege extend, e.g., from in-house counsel to outside counsel to counsel retained by outside counsel?
  - attorney-client
  - work product
  - waiver

## Main Conference Day 1 – Monday January 30, 2012

12:00 **Registration**

12:45 **Co-Chairs' Opening Remarks**

*Thomas E. Hutchinson*  
Managing Director  
SNR Denton (Washington, DC)

*David W. O'Brien*  
Partner  
Crowell & Moring LLP (Washington, DC)

1:00 **Assessing How Health Care Reform and the Current Health Care Enforcement Environment are Impacting Medicare Managed Care Plans**

*Perry Sekus*  
Deputy General Counsel  
Special Counsel for Fraud, Waste & Abuse  
UnitedHealth Group (Minnetonka, MN)

*Richard W. Westling*  
Partner  
Waller Lansden Dortch & Davis, LLP (Nashville, TN)

*Jack E. Fernandez*  
Partner  
Zuckerman Spaeder LLP (Tampa, FL)

- Understanding how the current health care enforcement environment came into being
  - tracing the evolution of enforcement
    - o lessons learned from big pharma
    - o TAP
  - assessing the eventuality of a TAP equivalent for the health care industry
- Evaluating the role of health care reform (PPACA) in the current enforcement environment
  - False Claims Act aggrandizement
  - expansion of investigatory powers of responsible regulatory agencies
  - increased penalties for non-compliance
    - o termination of provider/plan participation in Medicare Part C/D and Medicaid programs
  - establishment of mandatory compliance programs
- State v. federal enforcement in this area
- Comprehending why Medicare and Medicaid Managed Care plans are now the focus of newfound scrutiny
  - criteria for program cuts under health care reform
    - o were these cuts a foreshadowing of enforcement in this area?
- Overview of Part D reforms and how this will factor into new enforcement initiatives of MAPD plans
- Examining the Independent Payment Advisory Board (IPAB's) power under Health Care Reform relative to Medicare Advantage and Part D programs

### Department of Justice Keynote

1:45 **Federal Enforcement in the Medicare Managed Care Arena**

*Robert E. O'Neill*  
United States Attorney  
Middle District of Florida (Tampa, FL)

Florida is a hot bed of activity in the area of fraud and abuse enforcement in the Medicare Managed Care industry. The first MA FCA enforcement action, *U.S. v. Janke* took place in the Southern District of Florida.

Now, all eyes in the Medicare Managed Care Industry are on the Middle District of Florida in view of the *Well Care* case. Robert O'Neill, U.S. Attorney for the Middle District of Florida will discuss *Well Care* in addition to DOJ enforcement in this area.

2:30 **Afternoon Refreshment Break**

2:45 **FCA Actions Impacting Medicare Managed Care: Qui Tams and More**

*Elizabeth S. Ferguson*  
Senior Vice President & Associate General Counsel  
Medco Health Solutions, Inc. (Franklin Lakes, NJ)

*Thomas Hill*  
Partner  
Pillsbury Winthrop Shaw Pittman LLP  
(Washington, DC)

*Enu A. Mainigi*  
Partner  
Williams & Connolly LLP (Washington, DC)

*Timothy S. Susanin*  
former General Counsel  
WellCare Health Plans, Inc. (Villanova, PA.)

- Overview of recent False Claims Actions impacting Managed Care plans
  - understanding how these actions affect and influence FCA actions concerning Medicare Advantage plans
  - analyzing how the FCA can legitimately apply to the concept of capitated payment
  - RAC audits and false claims findings
  - questions of preemption
    - o federal FCA vs. individual state FCA
    - o removal of state action to federal jurisdiction
- *U.S. v. Janke* (America's Health Choice Medical Plans)
  - diagnosis code errors and intent
  - civil FCA liabilities
  - individual culpability
- *Well Care*
  - qui tam investigations and civil and criminal consequences
  - questions of :
    - o non repayment of overpayments
    - o cherry-picking/disenrollment
  - reverse false claims
    - o changes to FCA in 2009
  - understanding to juxtaposition of Medicaid Managed Care to Medicare Managed Care
    - o question of dual eligibles and disproportionate enrollment
  - individual indictments
    - o understanding how this action and outcome will influence FCA actions involving Medicare and Medicaid Managed Care plans going forward
- Other matters of interest
  - matters under seal
- FCA matters impacting Part D

4:15 **A Question of Kick-Backs: Avoiding Real and Present Dangers in Medicare Managed Care**

*Robert D. Belfort*

Partner  
Manatt, Phelps & Phillips, LLP (New York, NY)

*Mark R. Chilson*

Executive Vice President & General Counsel  
CareSource (Dayton, OH)

*Allan A. Thoen*

Partner  
Pepper Hamilton LLP (Philadelphia, PA)

- Defining a “kickback” under the Antikickback statute
  - prohibitions
  - safe harbors/exceptions
  - state antikickback law provisions
- Examining scenarios for Medicare Advantage Plans which may give rise to violation of the Antikickback statute
  - plan recommendations by physicians
  - incentives
  - ancillary financial arrangements between plans and physicians
- Evaluation of safe harbors that may be applicable to business dealings between plans and third parties
  - Part D safe harbors
- Devising compliance and internal code of conduct strategies for avoiding suspect behaviors

5:15 **Developing and Implementing a Robust Compliance Program for Medicare Managed Care Plans**

*Heidi E. Garwood*

Senior Legal Counsel  
Law Department  
Humana Inc. (Miramar, FL)

*Janet Grant*

Executive Vice President of External Affairs and  
Corporate Compliance Officer  
CareSource (Dayton, OH)

*Demetrios L. Kouzoukas*

Of Counsel  
Covington & Burling LLP (Washington, DC)

- Defining an effective compliance plan to meet overlapping requirements
  - CMS Manuals and other guidance
  - U.S. Sentencing Commission guidelines
  - HIPAA
  - state insurance regulations
- Developing practical strategies for implementation
- Structuring your compliance department
  - juxtaposition of compliance department to other departments
  - choosing the right compliance officer
- Incorporating provisions for flow down compliance requirements for third parties, contractors, etc. into your program
  - dealing with offshore subcontractors

- Exploring CMS penalties for non-compliance
  - operational non-compliance
  - sanctions, marketing/enrolments suspensions, terminations, debarments
- Lessons learned from other health care sectors

6:30 **Conference Adjourns to Day 2**

**Main Conference Day 2 – Tuesday, January 31, 2012**

7:45 **Continental Breakfast**

8:30 **Co-Chairs’ Opening Remarks and Recap of Day 1**

8:45 **Risk Adjustment: Understanding Legal Risks and Strategies for Compliance**

*Keith Dobbins*

Senior Associate General Counsel  
UnitedHealthcare Medicare & Retirement  
(Minnetonka, MN)

*Ankur J. Goel*

Partner  
McDermott Will & Emery LLP (Washington, DC)

- Understanding risk adjustment and how it affects payments to plans and plan bids
- Identifying potential legal risks associated with risk adjustment
- Analyzing the impact of diagnosis coding and provider documentation
- Exploring CMS Risk Adjustment Data Validation audits and other governmental activity
- Assessing uncertainties that affect your legal and compliance strategies
- Managing the providers role in risk adjustment
- Perfecting internal auditing strategies and techniques
- Previewing how risk adjustment will affect the health insurance exchanges

10:00 **Morning Coffee Break**

10:15 **Developing Compliant Marketing Guidelines that Meet CMS Muster**

*Darryl T. Landahl*

Of Counsel  
Brownstein Hyatt Farber Schreck, LLP (Phoenix, AZ)

*Deborah A. Schreiber*

Materials & Fulfillment Compliance Officer  
UnitedHealthcare Medicare & Retirement  
(Minnetonka, MN)

*Danielle Trostorff*

Shareholder, Healthcare Practice Group  
Baker Donelson Bearman Caldwell & Berkowitz, PC  
(New Orleans, LA)

*Prasanta KR Wells*

Senior Associate General Counsel  
UnitedHealthcare Medicare & Retirement  
(Minnetonka, MN)

- Overview of CMS Marketing Rules for Medicare Advantage Plans
- Developing compliant marketing materials
- Identifying marketing behaviors which have been called suspect by CMS
- CMS surveillance activities and “secret shoppers”
- Predicting possible DOJ and OIG activity in the marketing arena
- Developing compliant marketing materials
  - avoiding behaviors that can be labeled as misleading marketing
  - identifying target market and message
    - o question of vulnerable population
- Managing the broker network
  - the importance of employed and contracted agent oversight
  - developing compliant compensation structures and payment practices
  - core principles of effective broker contracting, training and oversight
- Incorporating marketing guidelines into your compliance program

11:30 **Minimum Medical Loss Ratio: Preparing Now for Compliance and Enforcement Challenges in 2014**

*Patrick Morrissey*

Partner

King & Spalding (Washington, DC)

- Review of Medical Loss Ratio Final Rule and its applicability to Medicare Advantage Plans
- Defining and differentiating medical from administrative expenses
  - defining medical care and quality improvement costs
  - identifying administrative costs under the Rule
    - o how to ensure that monies are still allocated for plan fraud, abuse and waste prevention and compliance programs
  - rebates
- Examining penalties for failing to meet the minimum Medical Loss Ratio
  - payment deductions
  - enrollment suspensions
- Proactively developing strategies now to meet the 85% minimum medical loss ratio in advance of 2014

12:30 **Conference ends**

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**Tuesday, January 31, 2012**

**2:00 pm – 5:00 pm**

*(Registration Opens at 1:30 pm)*

**Master Class on Pro-Active Audit Preparation: Strategies and Tools for CMS, RAC, ZPIC and Other Applicable Audits for Medicare Advantage and Part D Plans**

*Dorothy DeAngelis*

Senior Managing Director

Forensic and Litigation Consulting

F T I (Charlotte, NC)

*Tricia L. Fringer*

President & CEO

OmniSYS, LLC

(Dallas, TX)

*Andrew Toppin, MPA*

Manager, Medicare Compliance

Horizon Blue Cross Blue Shield of New Jersey

(Newark, NJ)

*Danielle Trostorff*

Shareholder, Healthcare Practice Group

Baker Donelson Bearman Caldwell & Berkowitz, PC

(New Orleans, LA)

To ensure industry observance of its compliance mandate for Medicare Advantage plans, CMS instituted Compliance Plan Effectiveness Audits in 2010. These audits are on-site investigations where CMS examines data, documents and interviews personnel. Medicare Managed Care plans must ensure that their compliance house is in order at all times as the notice period for these audits is relatively short. In addition to Compliance Effectiveness Audits, plans must also be prepared for other CMS run audits such as Risk Adjustment Evaluation Audits, Data Validation Audits and Part D audits. Plans are also subject to government contracted audits such Recovery Audit Contractors (RAC) audits and Zone Program Integrity Contractors (ZPIC) audits.

This Master Class will give you the tools that you need to be audit ready and prepared to supply all information required by the aforementioned audits and any other audit your plan may encounter. Points of discussion include:

- Pro-active v. reactive auditing
- Internal auditing and extra compliance measures that can help mitigate negative audit findings
- Common areas of audit scrutiny
- Preparing your team for audit
- Implementing internal review process to catch any billing, coding and medical necessity review error in advance of audits
- Special considerations for delegation audits
  - assessment of 3rd party relationships
  - PBM activities

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The Complete Guide To Investigations, Enforcement Actions, Regulatory Initiatives and Compliance Programs Relative to Medicare Part C, Part D and MAPD Plans

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