Gov’t Gets Its Day in Court: CA Judge Dismisses DOJ’s Medicare Advantage False Claims Act Complaint

Typically when you hear about the government involved in False Claims Act (FCA) litigation, it’s because the U.S. Department of Justice (DOJ) has intervened and added its might to a whistleblower case alleging billing fraud. Last month, however, the juxtaposition of DOJ and FCA included a different twist … and the government didn’t emerge appearing especially mighty.

A California federal judge dismissed (with prejudice) the DOJ’s complaint in what was the first False Claims Act case alleging Medicare Advantage program fraud the government had thrown its weight behind.

Does the Medicare Advantage program have a bigger Achilles’ heel than other plans?

Fraud is no stranger to the Medicare Advantage program. Indeed, some say its payment structure leaves the program (and therefore the government) vulnerable to a higher rate of misrepresentation, manipulation, and deception than other plans.

Under Medicare Advantage, private insurers provide enrollees with the same benefits they’d find under Medicare; the Centers for Medicare & Medicaid Services (CMS) pays the insurers monthly fees for each Medicare Advantage member. Those fees are no longer flat rates, however. CMS implemented a risk-based, health-status-centric rubric to scale those payments.

Understandably, insurers receive higher payments for Medicare Advantage patients considered to be less healthy. And although where individuals fall on the spectrum of health relies on relatively objective doctors’ diagnosis codes, there is still room for making a patient seem sicker on paper than s/he is in reality…in other words, there is room for billing fraud.

Aware of this vulnerability, CMS conducts regular audits that include review of patient medical charts to assess whether the diagnosis codes have come at the appropriate medical visit and from a practitioner with relevant training. Further, CMS stipulates that Medicare Advantage program insurers must use patient medical records to buttress their diagnosis codes, must attest to the truthfulness and accuracy of those codes through certification, and must implement a program for compliance.

Whistleblower case is over eight years old; gov’t not on board at first

The *qui tam* case in question (*United States ex rel. Swoben v. Scan Health Plan, et al.*, No. 2:09-cv-05013 JFW [C.D. Cal. Oct. 5, 2017]) was filed (under seal) in the Central District of California in the summer of 2009. It alleged that several Medicare Advantage providers were billing the program fraudulently and therefore committing CMS Medicare fraud. Although the relator settled with some of the defendants in 2012, the whistleblower continued to press on against the others. In 2013, the federal government and the State of California decided not to intervene in this particular False Claims Act case.

The relator’s fourth amended complaint was filed earlier this year, at which time the DOJ decided to reverse its earlier hands-off decision, saying the “magnitude of the fraud was much larger than it had originally anticipated.” Therefore, the government became a complainant against UnitedHealth Group Inc. and HealthCare Partners

(HCP), as well as additional defendants.

With a major presence in California, UnitedHealth operates Medicare Advantage plans. HCP provides services to many UnitedHealth members in the Golden State. UnitedHealth gives HCP some of what it receives from CMS for its Medicare Advantage beneficiaries. UnitedHealth has routinely contracted with third parties to audit HCP's diagnosis codes or has paid HCP to audit its own Medicare Advantage patients' medical files.

The DOJ alleged that going back more than 12 years, UnitedHealth was aware of HCP undertaking incomplete, sloppy, or biased audits that served to misrepresent patients' health status in order to justify higher risk scores (and therefore higher capitated payment rates for those beneficiaries). The government accused UnitedHealth of knowingly submitting false claims and collecting — and keeping — overpayments.

Right out of the gate, the scope of the government's case was automatically limited when the Court determined any claims prior to 2007 would not be considered (10 years before the DOJ filed its complaint). Further, the Court decided that because the relator had much earlier waived a false claims theory, the CMS could not assert that theory at present.

The Court went on to agree with UnitedHealth in the insurer's request to dismiss the government's complaint on additional grounds, including: The Court said that the government did not sufficiently allege that the company employees who signed off on the certifications were aware that those documents had been falsified. Also, the Court pointed to the DOJ's failure to name the UnitedHealth officers who had signed the certifications in question.