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MEDICARE ADVANTAGE PROGRAMS FACE INCREASING GOVERNMENT SCRUTINY

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Recent court decisions and Justice Department actions should put ever-growing Medicare Advantage Organization (MAOs)—and, quite likely, their state counterparts, Medicaid Managed Care Organizations (MCOs)—on alert. Increasingly, Medicare and Medicaid benefits flow through these organizations. New developments strongly suggest that these entities will face increased scrutiny by government enforcement agencies, especially under the False Claims Act.

The False Claims Act

The False Claims Act (FCA) empowers the government to collect treble damages and penalties against recipients of government funds for overbilling and submitting other false claims. The government brings FCA cases on its own and when initiated by whistleblowers, who are entitled to a share of any successful government claim. In the health care context, the government often brings FCA claims against health care providers that knowingly overbill. The government or a whistleblower may also sue for so-called "reverse" false claims, which arise when overpayments—even if innocently received—are wrongfully retained. The health care sector has long been a major focus of FCA enforcement, with federal recoveries averaging more than $2 billion a year over the last decade. Along the way, federal and state governments have often partnered with managed care organizations to address their mutual concerns with fraudulent or improper practices triggering overpayments to providers.

Medicare and Medicaid Managed Care

Now, however, managed care organizations themselves receive massive government funds. The reason is the meteoric rise in the number of Medicare and Medicaid benefits distributed through managed care organizations. According to the Centers for Medicare and Medicaid Services (CMS) data, more than 34% of Medicare enrollees now obtain their benefits through MAOs, and more than 46% of Medicaid expenditures now run through MCOs. Not surprisingly then, even as the government often continues to partner with managed care organizations in addressing provider fraud, the government has turned its attention to those historical partners, as MAOs and MCOs become targets of FCA enforcement.

Courts and the Justice Department

This past August, the U.S. Court of Appeals for the Ninth Circuit allowed an FCA case to proceed against an MAO. In *United States ex rel. Silingo v. Wellpoint, Inc.*, a whistleblower had alleged that the MAO submitted inflated diagnosis information to Medicare, which increased enrollees' risk-adjustment and triggered higher reimbursements for the MAO. Among other things, the court concluded that the whistleblower plausibly alleged that the MAO was reckless under the FCA by accepting contractor data that was "too good to be true." The *Wellpoint* decision followed a 2016 decision from the same court, *United States ex rel. Swoben v. United Healthcare Insurance Company*, which had concluded that MAOs could violate the FCA by burying their proverbial heads in the sand as to diagnosis data.

The *Swoben* case is tied to another significant trend in this space: government intervention. Last year, the Justice Department announced in *Swoben* and in another UnitedHealth Group case, *United States ex rel. Poehling*, that it would intervene in whistleblower-initiated FCA suits against MAOs. In both cases, the government adopted the whistleblowers' allegations that the MAO had knowingly obtained inflated risk adjustment payments based on inaccurate enrollee health information. And this year, on October 1, 2018, the Justice Department settled claims in the *Swoben* case against defendant DaVita Medical Holdings for $270 million. According to the government's press release, DaVita had caused various MAOs to submit incorrect diagnosis codes to the government, which triggered inflated payments. The government announced its intention to pursue MAOs and others triggering MAO overpayments in no uncertain terms: "We will continue to pursue and hold accountable any entity that seeks to illegally increase revenue at the expense of the Medicare Advantage" program.

A little-noted public filing in federal court in Manhattan, also this past August, proves that the government is continuing to pursue new MAO cases. There, the U.S. Attorney for the Southern District of New York filed papers revealing an open investigation into whether Anthem, as an MAO, "unlawfully obtained upwards of hundreds of millions of dollars in Medicare risk-adjustment payments while knowingly disregarding its duty to ensure the validity of data it submitted to Medicare for purposes of calculating these payments." Those papers suggest that similar investigations are being pursued throughout the country. It stands to reason that state attorneys general and whistleblowers are likewise turning their attention to these issues, where they might exist, with MCOs.

Additional Information

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