THE
NATIONAL LAW REVIEW

Justice Department Joins Whistleblower Suit Accusing UnitedHealth Group of Overcharging Medicare by "Hundreds of Millions"

Thursday, February 23, 2017

SheppardMullin

Article By
Kenneth Yood
Sheppard, Mullin, Richter & Hampton LLP
Healthcare Law Blog

Health Law & Managed Care
Litigation / Trial Practice
All Federal

The ***U.S. Department of Justice (DOJ)*** has joined a whistleblower lawsuit, ***United States of America ex rel Benjamin Poehling v. Unitedhealth Group Inc***., No. 16-08697 (Cent. Dist. Cal. Sep. 17, 2010), ECF No. 79, against UnitedHealth Group (United) and its subsidiary, UnitedHealthcare Medicare & Retirement—the nation's largest provider of Medicare Advantage (MA) plans. The suit accuses United of operating an "up-coding" scheme to receive higher payments under MA's risk adjustment program called the HCC-RAF Program (see below). The complaint alleges that United fraudulently collected "hundreds of millions—and likely billions—of dollars" by claiming patients were sicker than they really were. The suit was originally filed in 2011 by a former United finance director under the False Claims Act (FCA), which allows private citizens to sue those that commit fraud against government programs. Pursuant to the FCA, the case was sealed for five years while the DOJ investigated the claims.

The Medicare Advantage Risk Adjustment Program

MA plans are the privately administered, managed care alternative to hospital, physician, and drug coverage under Traditional Medicare. The MA program has tripled in size in the last decade to nearly 16 million enrollees, or 30 percent of all Medicare beneficiaries.

The Centers for Medicare & Medicaid Services (CMS) reimburses MA plans with capitated payments which are identified by the applicable diagnostic classification codes called "Hierarchical Condition Categories" (HCC). The payments are risk-adjusted for patient health and complexity through "Risk Adjustment Factors" (RAF) that reflect financial utilization and risk. Because of the RAF adjustments, MA plans receive increased reimbursement for the treatment of sicker patients, i.e. patients who cost more to treat. As described by CMS, the purpose of the HCC-RAF program is to provide increased payments to MA plans that attract higher-risk populations, e.g. patients with chronic conditions, and, in turn, reduce the incentives for issuers to avoid higher-risk enrollees.

The HCC-RAF program requires that a patient's condition be verified in-person and on a regular basis by a qualified professional.

Justice Department Crackdown on MA Fraud

The lawsuit at issue alleges that in 2010, United implemented an organization-wide upcoding scheme called "Project 7" to increase its operating income by $100 million. Under the scheme, United instructed its coding specialists to code patients for high-risk, long-term conditions by "mining" patient records for evidence of possible conditions without completing the required in-person verification. The suit also alleges that United offered incentives to its contracted provider groups to code patients for more severe conditions than were diagnosed.

Although the suit names 15 insurers, the DOJ is only seeking to intervene on FCA violations involving United and its subsidiary. United, which serves 2.9 million Medicare beneficiaries, has since denied the claims, contending the accusations are based on a faulty interpretation of the applicable Medicare rules.

Under the FCA, United may be subjected to a civil penalty of up to $11,000 for each violation, plus three times the amount of the damages sustained by the United States.[1]

The case follows more than a half-dozen whistleblower suits filed against MA plans in the past five years. For example, in March 2016, a court unsealed a lawsuit against MA plan provider Humana, alleging the insurer had encouraged physicians to inflate patient risk scores. United States of America ex rel. Olivia Graves v. Plaza Medical Centers Corp., et al., 1:10-cv-23382-FAM. In August 2016, the Ninth Circuit reopened the Swoben case (Swoben v. United Healthcare, No. 13-56746 (9th Cir. 2016))[2]; a case in which James Swoben alleged that multiple MA organizations, including United, routinely performed retrospective reviews that were structured: (1) to identify services that were under-coded, allowing the organizations to up-code and, in turn, increase their payments under the HCC-RAF program; but (2) to avoid the identification of over-coded services that, if corrected, would decrease payments under the HCC-RAF program. In short, Swoben alleged that the defendants' use of **one-sided retrospective reviews** to identify under-coding instead of **two-sided retrospective reviews** to identify both under-coding and over-coding meant that the MA organizations were either (1) acting in deliberate ignorance of the truth or the falsity of their certifications, or (2) were acting in reckless disregard for the truth or the falsity of their certifications.

In 2013, CMS estimated that it improperly paid $14.1 billion to MA organizations, primarily due to fraudulent risk adjustment claims. These lawsuits, including the Poehling case, indicate federal fraud enforcement agencies may double down on efforts to bring MA plans into compliance by investigating, and potentially imposing significant penalties on, MA plans that are shown to have improperly collected millions of dollars by overcharging Medicare through the HCC-RAF program and other devices. Certainly, the United States' refusal to intervene in the Swoben case in 2013, followed by the 2017 decision to intervene in the Poehling case, may be an indication of a more aggressive stance being taken by the United States Attorney General in the prosecution of MA-related fraud cases.

---

[1] Please note that the 2016 increase in FCA per-claim penalties does not apply in this case. In 2016, the minimum penalties for FCA violations were increased from $5,500 to $10,781 and the maximum penalties from $11,000 to $21,563—per claim. By regulation, the adjusted penalty amounts apply only to civil penalties assessed after August 1, 2016, whose violations occurred after November 2, 2015. Violations that occurred on or before November 2, 2015 and assessments made before August 1, 2016 (which is the case here) remain subject to the $5,500 to $11,000 per claim penalty amounts.

[2] Unlike in the Poehling case, in January 2013, the United States declined to intervene in the Swoben. Accordingly, the district court ordered the complaints unsealed and served on United and the other defendants.