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False Claims Act Watch: California Federal Judge Dismisses DOJ Complaint Alleging Medicare Advantage Fraud

By Jaimie Nawaday and Alexandra Barbee-Garrett*

In what was billed as a test case for the government, the U.S. Department of Justice intervened in a whistleblower suit alleging fraud in the Medicare Advantage program. The authors of this article explain the background of the case, the complaint, the government's intervention, and next steps.

The U.S. Department of Justice ("DOJ") recently suffered a setback when a California federal judge dismissed its complaint under the civil False Claims Act ("FCA").[1] Billed as a test case for the government, it marked the first time DOJ intervened in a whistleblower suit alleging fraud in the Medicare Advantage program. While the government was granted leave to amend several of its claims that the defendants violated the False Claims Act, the government's claims based on a "reverse false claim" theory, as well as those stemming from events occurring before March 13, 2007, were dismissed with prejudice.

FACTUAL BACKGROUND: THE MEDICARE ADVANTAGE PROGRAM

Medicare Advantage is a health insurance program within Medicare under which a private insurer is responsible for providing the benefits that traditional Medicare offers, and, in return, the insurer receives capitated, per-member-per-month payments from the government. Over time, the government developed a risk-based system for adjusting these payments to reflect the health status of patients enrolled in the plan. Higher payments go to higher risk (*i.e.*, less healthy) patients. To determine the appropriate risk level and payment amount for patients, Medicare Advantage relies primarily on diagnosis codes received from participating physicians and medical groups.

Not surprisingly, the Medicare Advantage payment model creates incentives to overstate the number and severity of patients' health risks. To help combat these incentives, the Centers for Medicare and Medicaid Services ("CMS") require that plans: (i) support their diagnosis codes with patients' medical

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[1] The case is *United States ex rel. Swoben v. Scan Health Plan, et al.*, No. 2:09-cv-05013 JFW (C.D. Cal. Oct. 5, 2017).

records; (ii) certify that the diagnosis codes they provide are accurate and truthful; and (iii) adopt and implement an effective compliance program. CMS also periodically audits and validates the diagnosis codes that it receives. In the course of those audits, CMS attempts to determine whether the diagnosis code was properly documented by reviewing medical charts to determine whether the patient was seen by a provider with an appropriate physician specialty who took the appropriate actions to diagnose that particular condition during that visit.

This case arose from allegedly faulty and unsupported diagnosis codes provided to CMS.

THE WHISTLEBLOWER COMPLAINT AND THE GOVERNMENT'S INTERVENTION

An initial whistleblower complaint was filed under seal against numerous Medicare Advantage participants in July 2009 in the Central District of California. In August 2012, the whistleblower settled with certain of the defendants and in January 2013, the United States and the State of California declined to intervene as to the remaining defendants.

In early 2017, however, following the whistleblower's fourth amended complaint, the government sought to intervene, stating that the "magnitude of the fraud was much larger than it had originally anticipated." Its request to intervene was granted without objection and the United States' Complaint-in-Intervention was filed on May 1, 2017 against defendants UnitedHealth Group Inc. ("UnitedHealth"), HealthCare Partners ("HCP") and others.

UnitedHealth owns and operates Medicare Advantage plans and HCP is a large provider of services to UnitedHealth beneficiaries in California. In exchange for providing services, UnitedHealth pays HCP a portion of its capitated rate for the beneficiaries who are part of the managed care plan. As part of its process, UnitedHealth regularly reviewed the diagnosis codes for the patients receiving care from HCP by paying either HCP or a third party to conduct audits of patient charts. The audits could result in adjusting a patient's risk score by changing a diagnosis code or removing an unsupported code.

The government's Complaint alleged that, as early as 2005, UnitedHealth knew that HCP's chart audits were flawed, resulting in skewed data and artificially inflated patients' risk scores, and that UnitedHealth submitted the flawed data anyway to avoid negative payment adjustments and keep overpayments to which it was not entitled.

THE DEFICIENCIES FOUND IN THE DOJ COMPLAINT

The UnitedHealth defendants moved to dismiss the government's complaint on the grounds that it:

1) failed to allege that the individuals who signed the relevant certifications to CMS knew the certifications were false;
2) failed to allege that the certifications were material to the government's decision to pay;
3) failed to identify with particularity the acts of each of the seven distinct corporate entities that comprise UnitedHealth;
4) attempted to revive an already-waived reverse false claims theory; and
5) asserted some claims that were time barred.

The court determined that all five grounds warranted dismissal of some or all of the complaint. In finding the allegations of *knowledge* were insufficient, the court noted that the government failed to identify the individual corporate officers who signed the certifications or allege that those individuals knew the certifications were false. In finding the allegations of *materiality* insufficient, the court stated that the Complaint contained "only conclusory allegations" of materiality and failed to allege that CMS would have refused to make the risk adjustment payments to UnitedHealth if it had known about its alleged involvement with the faulty HCP audits. Finding the allegations of particularity insufficient, the court stated that the Complaint was a "classic shotgun pleading" that generally referred to the defendants "as if they were a single collective entity." The court determined that each of these insufficiencies supported dismissal of the entire Complaint.

Additionally, the court ruled that the government could not assert a reverse false claims theory (*i.e.*, an FCA theory based on submitting a false statement to *avoid* payment) as a result of the whistleblower's waiver of that theory at an earlier stage of the proceedings. Finally, the court dismissed as time-barred any claims occurring before May 1, 2007, 10 years prior to the filing of the government's Complaint.

NEXT STEPS

The court allowed the government until October 13, 2017 to file an amended partial complaint that conforms with its order. Given the extensive nature of the investigation that preceded the complaint, the deficiencies noted in the complaint, and the short period of time afforded to the government to amend, it will take significant resources for the government to re-file within that time frame. It also remains to be seen whether the dismissal will be appealed, as this would require special approval, and the government can be reluctant to appeal unfavorable decisions and risk creating even more unfavorable case law.