

Department of Justice Continues to Scrutinize Medicare Advantage Plans

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Medicare Advantage plans have been the target of a number of False Claims Act cases in recent years. In those cases, private whistleblowers – mostly former employees – have alleged that some of the nation’s largest insurance companies have systematically overbilled the Medicare program.

Created in 2003, Medicare Advantage is a popular alternative to traditional Medicare with more than 17 million enrollees. As opposed to traditional fee-for-service Medicare, Medicare Advantage plans receive a fixed amount per month for each beneficiary to provide all Part A and Part B services. The Medicare Advantage plans then contract with physicians, hospitals, and other providers to deliver services to enrollees. Nearly one-third of the Medicare population has opted for Medicare Advantage plans, due likely in part to additional benefits offered, including vision, dental, fitness, wellness, and out-of-pocket cost protections.

The monthly capitated payments from Medicare are based on “risk scores,” which measure the overall health and expected costs for enrollees. Under this system, sicker patients receive higher risk scores, resulting in higher capitated payments to Medicare Advantage plans. Critics claim that the plans are incentivized to inflate risk scores, and indeed a 2015 report from the National Bureau of Economic Research found that Medicare Advantage enrollees received 6 to 16 percent higher diagnosis-based risk scores than they would under traditional fee-for-service Medicare.¹

These findings – combined with the rising popularity of Medicare Advantage plans – have resulted in increased government enforcement activity. In 2016, for example, the Centers for Medicare and Medicaid Services (“CMS”) imposed nearly \$5 million in civil penalties on Medicare Advantage plans,² and HHS OIG issued a final rule expanding its authority to police Medicare Advantage providers.³

Several whistleblowers have also filed False Claims Act suits alleging that these insurance companies systemically inflated risk scores in order to increase risk adjustment payments. Although the Department of Justice initially allowed private whistleblowers to pursue these allegations, it recently intervened in two suits involving United Healthcare, the nation’s largest insurance company, and has sought to combine the two cases.⁴ With CMS estimating that it improperly paid over \$14 billion to Medicare Advantage plans in recent years, it is no surprise that the Department of Justice has stepped up its enforcement efforts.⁵ It can be expected that enforcement activities will continue and accordingly, Haynes Boone will continue to monitor these developments.

¹ Available [here](#).

² Available [here](#).

³ See 81 Fed. Reg. 88334 (Dec. 7, 2016).

⁴ See *United States v. UnitedHealth Group Inc.*, No. 2:16-cv-08697 (C.D. Cal.); *United States ex*

rel. Swoben v. United Healthcare Insurance Co., et al., 2:09-cv-05013 (C.D. Cal.).

⁵ Available [here](#).