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Medicare Advantage False Claims Act Cases: Not a Guaranteed Slam Dunk for DOJ

Two years ago, the U.S. Supreme Court set a standard for limiting liability in False Claims Act (FCA) litigation: the plaintiff must prove that statements made by the defendant about the accuracy of billing information would have had an impact on the government's payment of Medicare Advantage claims. Last month a U.S. District judge used that test to dismiss some of the Department of Justice's (DOJ) action against Minnesota-based UnitedHealth Group in an ongoing FCA case.

Mega-insurer accused of exaggerating severity of patient illness

The *qui tam* lawsuit alleges that the country's largest insurer collected millions of dollars in fraudulent Medicare Advantage payments by falsely inflating patient illness in order to inflate Medicare reimbursement. In addition to the bad news the DOJ received in February, in October UnitedHealth emerged victorious in another suit in which the government claimed that the insurer (along with some associated health plans) attempted to make patients appear sicker on paper than they were in reality in order to boost risk-adjusted Medicare Advantage payments. UnitedHealth has consistently met that accusation with denial.

In February, U.S. District Judge Michael Fitzgerald said that although the billing data on its own seemed to drive the payment decision by the Centers for Medicare & Medicaid Services (CMS) to the insurer, the government's allegations pertaining to UnitedHealth's statements about the data itself "do not suggest they are likely to influence the payment of money." On those grounds, Fitzgerald dismissed CMS's claims that UnitedHealth attested to the accuracy of the billing data, noting that the proof that those attestations impacted payment was "missing" in the case.

Earlier this month, the DOJ submitted a notice to a federal court in Los Angeles saying that it would not revise its lawsuit in order to try again to dissect the insurer's statements about the reliability of its Medicare Advantage claims data. Rather, the DOJ plans to narrow its legal action to determining whether over $1 billion in Medicare Advantage payments made to UnitedHealth were based on inaccurate billing data and therefore should be returned.

Matt Burns, vice president of communications for UnitedHealth, has said that the insurer will "continue to contest aggressively the remaining claims" brought by the government.

Seven-year-old whistleblower case continues to age

The government intervened in the whistleblower suit against UnitedHealth last year, though the action was initiated in 2011. The case alleges that the health system manipulated patients' risk scores — the measure used to prioritize the health needs of seniors and pay out claims accordingly — over the course of several years.

The relator, Benjamin Poehling, accused the insurer of falsifying claims information; for example, fraudulently claiming that Medicare Advantage enrollees were treated for medical conditions with which they were not afflicted in reality, or exaggerating how sick they actually were, or claiming they were undergoing treatment for medical conditions that had previously been resolved.

Other insurers under the DOJ microscope

The DOJ is not limiting its scrutiny of Medicare billing practices to UnitedHealth alone. Aetna, Health Net, Humana

and Cigna are being investigated for possible “upcoding” practices. But the Supreme Court’s limitation has made the government’s job that much harder, and the way the DOJ approaches future cases is likely to be shaped by recent developments in the UnitedHealth dispute.