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‘Cloud of secrecy’ in Medicare Advantage plans can create an environment for fraud

By Jeanne A. Markey *and* Raymond M. Sarola

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Over the last two decades, federal and state governments have dramatically increased their payments to private health care companies that manage Medicare Advantage[1] and Medicaid managed care[2] plans, now paying them around $400 billion a year[3]. For the more than 20 million Americans enrolled in one of these plans, these companies function as the control center for payment decisions, receiving payments from the government and making payments to providers.

Although these companies take in a tremendous amount of taxpayer money, and have immense power regarding how to distribute these funds, a cloud of secrecy shields from public view their financial operations and profitability. The unique environment in which Medicare Advantage and Medicaid Managed Care plans operate — enormous amounts of money to be spent, a thicket of government reimbursement guidelines, little transparency, typically no party with equal bargaining power, and what amounts to an honor system — can create a recipe for cooking up fraud.

Unlike the traditional Medicare fee-for-service approach, Medicare Advantage is a capitated payment system. These private companies receive from the government a fixed amount of money per patient (depending on the patient’s health), make payments to providers for that patient’s covered services, and

keep the difference as their profit. Medicaid Managed Care programs operate in a similar way under state Medicaid programs. They have grown in popularity[3] as states have expanded Medicaid eligibility under the Affordable Care Act.

Capitated payments provide a profit motive to Medicare Advantage and Managed Care companies to operate efficiently and rein in overall health care spending. In practice, though, this payment structure can also provide incentives for companies to unlawfully increase their profits by manipulating cash flows on both ends of the equation. At one end, they can represent to the government that their patient population is less healthy than it is, and thereby obtain artificially increased capitation payments. At the other end, they can pay providers less than they are obliged to in order to maximize the cash they retain.

These aren't merely theoretical problems. A recent government audit[6] found that Medicare overpaid Medicare Advantage plans by approximately $7 billion in 2016 alone. And this audit did not examine possible underpayments to providers, nor did it examine the approximately $200 billion the federal government and states jointly pay through Medicaid.

Because the internal workings of these companies are largely kept secret from the government, enforcement actions by the Department of Justice are often prompted by lawsuits filed under the False Claims Act[7]. This law, enacted in 1863, was initially aimed at shady contractors who sold the Union Army faulty rifles and ammunition, spoiled food, and other unusable goods. Having been amended and its scope expanded through the years, it today prohibits companies from defrauding the government in a broad array of contexts. The False Claims Act allows whistleblowers to initiate lawsuits on the government's behalf. If the government recovers money from a lawsuit, the whistleblower earns a financial reward.

In October 2018, HealthCare Partners Holdings LLC, a company owned by DaVita, agreed to a $270 million false claims settlement[8] with the Department of Justice. HealthCare Partners, which provides services to Medicare Advantage beneficiaries, allegedly reported that its patients had more severe diagnoses as a way to generate increased capitation payments from the government. The company also allegedly engaged in a "one-way" review of its past diagnoses, looking for mistakes that led to lower payments from the government but ignoring mistakes that led to higher payments. The whistleblower who brought this fraud to light received an award of more than $10 million.

In December 2018, the Department of Justice joined in another whistleblower lawsuit, this one against Sutter Health[9], a California health system with 24 hospitals and more than 5,000 physicians. The whistleblower, an employee of Sutter Health, alleged that the organization knowingly submitted false diagnosis codes for its patients that resulted in larger capitation payments from the government and larger profits to itself. The whistleblower detailed in her complaint the results of numerous internal audits she performed that revealed this fraud, but which the company ignored.

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Given the complexity of Medicare Advantage and Medicaid Managed Care plans, many types of fraud can occur. In addition to inflating patient diagnoses and performing one-way reviews, companies can

deny covered benefits and underpay providers, lie about patient demographics, and manipulate reported administrative costs[12].

In September 2018, the federal government issued a report[13] that revealed another type of fraud in this area: "widespread and persistent performance problems related to denials of care and payment." This report found that Medicare Advantage organizations improperly denied coverage for health care services in many cases, and forced patients to endure lengthy appeals processes to obtain their proper coverage. The types of fraud that can arise are likely to increase over time.

When companies that manage Medicare Advantage and Medicaid managed care plans receive hundreds of billions of dollars from the government on what is basically an honor system without sufficient transparency into how that money is spent or retained, fraud almost always ensues. Anyone who witnesses such unscrupulous activities and steps forward to bring it to light is doing the right thing for his or her fellow Americans.

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