Managed Care and the False Claims Act:  
A Brief Survey of Cases  

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For many years, managed care organizations (MCOs) operated largely outside the orbit of False Claims Act enforcement, as they primarily or even exclusively provided plans for employers and other non-governmental payers. As the Centers for Medicare and Medicaid Services (CMS) and most state Medicaid programs have been allowing or requiring an increasing number of beneficiaries to move into managed care plans operated by MCOs under contract with CMS or the states’ Medicaid programs, however, MCOs have been finding themselves under the microscope of the False Claims Act (FCA).² Likewise, providers who had managed to evade scrutiny by providing services primarily or solely to MCOs are now finding themselves under that same microscope, sometimes for potential arrangements they allegedly entered into with the MCOs.

In an effort to examine the trends within these cases and certain key risk areas for MCOs and their contracted providers, this paper reviews a number of recent FCA cases brought against MCOs and, in some cases, also providers. This paper does not purport to analyze every case that has been brought under the FCA.

Although the initial intent was to identify the substantive areas that invite scrutiny under the FCA, one of the most obvious trends to emerge is the frequent declination of cases by the DOJ. Those cases that have gone on to litigation – and there are quite a few discussed below – mostly have been litigated by the *qui tam* relators after the government declined to intervene. Whether the government declines so many of these cases because the cases tend to lack merit, because the government attorneys do not have a strong enough understanding of how managed care works in the Medicare and Medicaid context, or because the DOJ attorneys are simply too busy to handle the cases, is difficult to determine and likely varies somewhat among cases.

In terms of substantive patterns of alleged violations, three categories emerge from this review. First, in the Medicare Advantage (MA) context in which MCOs are paid a capitated rate for each patient³ in their plan, MCOs are sometimes alleged to have failed to provide required or necessary care to their patients in order to save money. Providers do not tend to be implicated in these cases.

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² 31 U.S.C. §3729 et seq.

³ MA plans themselves do not provide health care services directly to patients, of course, and thus the individual patients are often referred to as “members” or “beneficiaries.” Many of the court decisions discussed below, however, refer to them as “patients.” For consistency’s sake, we will refer to them throughout this paper as “patients.”
The second trend that emerges is the common allegation that the MCO improperly manipulated or even fabricated information about its patients’ level of illness, in order to drive up the reimbursement it received on a per patient basis from Medicare. Since the MCOs can share those reimbursements with their contracted physicians, and the physicians are responsible for providing much of the information on which the MCOs rely, the cases reflect a tendency to allege that the physicians or other providers, as well as consultants contracted to provide assessment services, participated in the alleged FCA violations.

Third, we see a general tendency for relators to allege that violations of various other statutes, regulations and contract terms rendered the claims submitted by providers to the MCOs and/or by the MCOs to Medicare false or fraudulent. These other statutes, regulations and contract terms can include a variety of provisions, such as medical loss ratio requirements in state Medicaid contracts, CMS bidding requirements, the federal Antikickback Statute, and marketing rules. The key issue in the cases in this third, more general category is whether compliance with the statute, regulation or contract term alleged to have been violated is, in fact, a condition of payment under Medicare or Medicaid.

FAILURE TO PROVIDE SERVICES TO MEMBERS/BENEFICIARIES

In several cases, relators and the Department of Justice (DOJ) have alleged that MCOs have failed to provide medically necessary services to their patients and/or provided subquality services to those patients.

United States v. Kaiser Foundation Health Plan, Inc.

In a recent case out of California, an ambulance provider filed an action under the federal and California FCAs alleging that defendant Kaiser Foundation Health Plan, Inc. “refused to pay [plaintiff] ProTransport for its services transporting Kaiser patients with End Stage Renal Disease (ESRD) to and from dialysis treatments and instead required ProTransport to seek reimbursement for its services from Medi-Cal.” The relator asserted that Kaiser was required to pay ProTransport for the services, and requiring the ambulance company to seek reimbursement from Medi-Cal instead was improper and fraudulent. The relator ambulance provider also alleged that after it complained to Kaiser about this practice, Kaiser retaliated by refusing to pay for any ProTransport transports and by excluding ProTransport from bidding for future transport services with Kaiser. Both the United States and California declined to intervene in the case.

Kaiser filed a motion to dismiss the case, arguing that (1) ProTransport’s case was a disguised effort to obtain payment for its services, and thus was subject to Medicare’s administrative procedures and exhaustion requirements, and (2) the complaint failed to satisfy Federal Rule of Civil Procedure Rule 9(b)’s requirement that fraud allegations be pled with particularity. The court denied the motion on the first basis but granted it on the second.


5 Id. at *3.
Although the relator’s allegations did arise from Kaiser’s alleged non-payment for ProTransport’s services, the court held that the fact that the relator had brought the FCA action on behalf of the United States removed the case from the realm of matters that Medicare’s administrative review process can address. Since Medi-Cal ultimately paid ProTransport for the services, the court noted that “payments to ProTransport for services provided in the past are not at issue.” Moreover, “there is no indication that the claims asserted on behalf of the United States – return of money paid as premiums to Kaiser – could be addressed in the administrative process.” Since the United States’ claims could not be addressed through the administrative review process, the court refused to dismiss the relator’s FCA claims on the basis of failure to exhaust administrative remedies.

The relator’s claims did not, however, survive the defendant’s challenge under Rule 9(b). In its opposition brief, the relator had argued that its allegations under the infrequently used subsection 31 U.S.C. §3729(a)(1)(D) were based on the “implied certification theory.” Under the implied certification theory of liability, the defendant does not make any express representation that it complied with another statute, regulation or contract term that is a condition of payment; but by submitting a claim to the government, the defendant implicitly represents to the government that it is entitled to payment, i.e., that it has complied with all conditions of payment imposed by the government through the contract, statute, or regulation at issue. The court held that in cases based on the implied certification theory, Rule 9(b)’s specificity standards require that the complaint “plead with particularity allegations that provide a reasonable basis to infer that (1) the defendant explicitly undertook to comply with a law, rule or regulation that is implicated in submitting a claim for payment and that (2) claims were submitted (3) even though the defendant was not in compliance with that law, rule or regulation.”

The court observed that although the complaint cited various statutes and regulations for the proposition that Kaiser’s MA plan was required to provide the same level of coverage as that required under original Medicare, and that original Medicare covers medically necessary transports, the complaint failed to allege noncompliance with any provision that constituted a condition of payment under Medicare. In addition, although the relator identified six ESRD patients whose claims Kaiser denied, the relator failed to identify any claims that Kaiser submitted to the government, which the court said is required under the FCA. Finally, the court also noted that the relator did not make clear in its complaint how the implied certification theory (which frequently is used in matters brought under the sections of the FCA prohibiting the submission of false claims for payment and false statements in support of such payments) could

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6 Id. at *12.
7 This provision imposes liability on anyone who “has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property.”
8 2013 U.S. Dist. LEXIS 122859 at *17.
9 Id. at *18.
apply to this section of the FCA, “which prohibits a person or entity having custody of the
government’s money or property from delivering ‘less than all of that money or property.””\(^{10}\)

**United States ex rel. Cianciolo v. Wellcare Health Plans, Inc.**

In another recent case, the relators alleged that the insurer pressured its employees to
raise the denial rate for hospital admissions.\(^{11}\) In the Complaint filed in that matter in May 2013,
a group of former employees including the Vice Presidents of Care Management and of Clinical
Management sued their former employer, which operated Medicare and Medicaid MCOs in
various states. They alleged that WellCare management directed them to increase Medicare and
Medicaid inpatient hospital denials through the authorization review process without regard to
whether the services sought were medically necessary for the patients.

As a result of this alleged conduct, the former employees asserted claims against the
MCO for submitting claims to CMS and various State programs that were false on two grounds.
First, they alleged that by submitting claims for per member/per month capitated payments,
while refusing to provide services that were medically necessary, the defendant was making
“implied certifications that it was in compliance with a material condition of payment” under
contract and statute. They also alleged that the claims were false because they resulted from
“fraudulently induced Medicare Advantage contracts [and] state Medicaid contracts” by
“promising to provide medical services based on the contractually required and statutorily
required medical necessity standard while having no intention of complying with that standard.”
The former employees also alleged that WellCare violated the FCA’s reverse false claims
provisions\(^{12}\) by failing to repay funds that it owed back to CMS and the states for not providing
all inpatient hospital services that were medically necessary for its members. Notably, the
relators did not identify any particular patient for whom inpatient hospital services were
improperly denied, much less explain in what way any of the denials were improper based on the
patient’s needs.

As with the case above, the government declined to intervene in this case. After that,
relator’s counsel withdrew and the court dismissed the case based on the relators’ failure to
obtain substitute counsel in timely fashion. Thus, the court was never required to determine
whether the relators had pled fraud with sufficient particularity in their complaint to survive a
motion to dismiss.

**United States ex rel. Willard v. Humana Health Plan of Texas Inc.**

This much older case was filed in 1999 by a former sales representative against his
former employer, Humana Health Plan of Texas, Inc. (Humana), alleging the submission of false

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\(^{10}\) Id. at *19.

\(^{11}\) United States ex rel. Cianciolo v. Wellcare Health Plans, Inc., Case No. 8:13-cv-01377-JSM-EAJ (M.D.
Fla.).

claims in connection with Humana’s capitated MA plan. He alleged that Humana “cherrypicked” its members by refusing to enter into contracts for services in counties outside of Houston. As with the cases above, the government declined to intervene in this case.

In the appeal from the district court’s dismissal of the case, the Fifth Circuit reviewed the relator’s three claims based on the alleged cherrypicking and found them all lacking in merit. First, the relator had alleged that the plan effectively overcharged the government by not providing services to less healthy persons as a result of its cherrypicking conduct. Since the MCO received payment at a pre-established capitation rate, as well as a premium “to offset anticipated costs it expects to incur from providing services to less healthy persons,” the relator reasoned that it was “effectively overcharging” the United States. But the court disagreed. The court found that, because rates were set on a county-by-county basis, and the relator alleged that the defendant’s misconduct consisted of not enrolling members from entire counties outside of Houston, “Humana accrued no unwarranted benefit and the government no loss by virtue of Humana enrolling more beneficiaries in some counties than others.”

The relator also asserted that the defendant submitted false claims under an implied certification theory: by submitting enrollment lists monthly to the government to obtain payment, he alleged, Humana was implicitly representing that it had complied with all statutes, regulations and contract terms that were central to the MA contract when in fact it was violating anti-discriminatory marketing requirements. The Fifth Circuit noted that it had not previously recognized the implied certification theory and need not do so in this case either, because the claims would fail even under an implied certification theory. Not only did the relator fail to allege that the government conditioned payment to the MCO on any implied certification of compliance with anti-discriminatory regulations; the relator failed to allege facts sufficient to show that there was any regulatory violation whatsoever. The court noted that the relator never alleged that the defendant took any action to discourage less healthy individuals from enrolling, nor did it actually turn any such individuals away. Simply alleging that the MCO less aggressively marketed its plan in rural counties outside of Houston versus in Houston did not sufficiently allege any violation, particularly where the relator did not allege that a lower percentage of Medicare-eligible beneficiaries were enrolled in the plan in rural counties versus in Houston.

Finally, the court also rejected the relator’s fraud-in-the-inducement theory that the MCO “entered [into] contracts to serve [the outlying] counties with no intention of actually enrolling Medicare participants there.” With respect to this theory, the court found that the relator had

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13 336 F.3d 375 (5th Cir. 2003).
14 Id. at 380.
15 Id.
16 Id. at 382-83.
17 Id. at 383-84.
18 Id. at 384 (internal quotations omitted).
failed to allege any specific information about the supposed agreement to serve counties outside Houston, if Humana was awarded the contract from the government. He did not allege that the commitment was set out in writing, nor did he allege how it was made or who at Humana was responsible for making it.\textsuperscript{19} Even if he had alleged more specifics about the alleged agreement, though, the court held that his theory also failed because he did not allege that Humana subsequently failed to perform the requirements of its contracts. To establish fraud in the inducement, the Fifth Circuit noted, “[i]t must be shown that the defendant promptly followed through on its intent not to perform by substantially failing to carry out its obligations under the contract.” Because the relator did not allege that the MCO failed to perform the requirements of its contract, this claim failed as well.

**IMPROPER USE OF RISK ADJUSTMENT FACTORS**

A second category of cases brought under the FCA in the managed care context involves matters in which the relator alleges that the MCO (or its agent) improperly reported the severity of the disease level of its patients, thus affecting the plan’s risk adjustment factor (RAF) scores. When the RAF scores are increased, the amount of capitated payment that the MCO receives per patient also increases. Thus, increasing RAF scores can be an effective way of raising an MCO’s profitability. Increasing RAF scores improperly, however, also can be an effective way of inviting FCA allegations. Note that because the interests of the MCOs and the providers in raising RAF scores can be aligned, since the money paid by CMS to the MCO is sometimes shared with the providers, providers can be implicated along with MCOs in allegedly improper efforts to alter RAF scores.

Before reviewing some of the FCA cases that have alleged improper conduct in this context, it may be helpful to understand at a high level how the individual patients’ medical conditions can impact the payments the physician and MCO receive. The diagnosis codes assigned to the patient by his or her provider(s) based on the patient’s medical condition(s) are grouped into a smaller number of diagnostic groups, which are then grouped into an even smaller number of condition codes. Those condition codes then result in a smaller number of Hierarchical Condition Codes (HCCs), which then are used to risk-adjust Medicare capitation payments.\textsuperscript{20} Thus, upcoding the diagnoses for a particular patient ultimately can increase the capitation payments that Medicare pays to the MCO and that may be shared with the physician and his practice, depending on the nature of the agreement between the MCO and the provider. A pattern of upcoding diagnoses for a number of patients likewise could increase the MCO’s and physician’s payments on a larger scale.


The relator in this case filed FCA allegations against a physician to whom she had sold her practice (physician), a medical clinic that employed that physician, the president of the

\textsuperscript{19} Id. at 385.

medical clinic, and Humana, Inc., which operated the MA plan at issue. Specifically, the relator alleged that the physician falsely diagnosed twenty-eight patients with greater illnesses and illness-related complications than was appropriate, which resulted in the submission of false claims to Medicare. As a result of this activity, the relator alleged, Medicare increased the monthly capitation payments it made to the MA plan for each patient. A portion of those increased payments then was shared by the MA plan with the other defendants: the physician, the clinic, and the clinic president. The government declined to intervene in the case, and the defendants filed separate motions to dismiss the relator’s complaint.

In its opinion on the motion to dismiss, the court granted the clinic president’s motion on the grounds that the relator had failed to specify any wrongdoing whatsoever by that individual. The court noted that the allegation that he was the president of the clinic or worked closely with the physician and may have profited from the scheme “is not, standing alone, sufficient to survive a motion to dismiss.” Nor were allegations that “the Defendants” submitted false claims or overbilled Medicare adequate, without some detail as to what activity each defendant engaged in. Noting that the relator’s proposed second amended complaint added no further detail, the court therefore dismissed the claim against the clinic president with prejudice.

The court also found the relator’s allegations against the clinic fatally lacking in specifics, even though the relator alleged that the physician engaged in specific fraudulent conduct and that he was employed by the clinic. The clinic “has not been put on notice of its role in the alleged fraud other than its status as a medical office in which [the physician] practiced.” In an “abundance of caution,” however, recognizing “the relationship between Humana, as plan administrator, and [the clinic], as recipient of reimbursements, and the relationship between [the clinic], as medical office, and [the physician], as a primary physician in the medical office and recipient of the reimbursements,” the court dismissed the claims against the clinic without prejudice, so that the relator could amend her complaint.

The court also dismissed without prejudice the claims against the physician and MA plan for submitting false claims to Medicare and for submitting false statements in support of false claims. The court dismissed the false claims allegations on the basis that the relator had failed completely either to allege specifically identified false claims submitted by either the clinic or Humana, or even to include “some indicia of reliability” in the complaint to support the allegation of an actual false claim having actually been made to the government. The court dismissed the false statements allegations because the relator failed to allege whether the pre- or

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21 2014 U.S. Dist. LEXIS 143269 at *3 (S. D. Fla. 10/7/2014).
22 Id. at *7.
23 Id. at *8.
24 Id. at *13.
post-2009 version of the statute applied, even though the court found that under either version of
the statute the relator had sufficiently pled her claims.25

The relator filed an amended complaint against the physician, the clinic, and the MA plan.
The court denied the defendants’ motions to dismiss that second amended complaint, holding
that it contained enough detail of the alleged fraud and the claims allegedly submitted (even
without an example of a claim) to satisfy Rule 9(b) requirements.26 The court found that by
alleging that she sold her practice to the physician who then retained the clinic to operate the
practice; that the physician was “also an owner, officer, and director of [the clinic] and ‘at all
times material was acting as its agent and/or apparent agent,’” that the physician “was acting
within the course and scope of his employment and corporate office,” and that the clinic received
the Medicare reimbursements, the relator had sufficiently alleged that the clinic was vicariously
liable for the physician’s conduct. The complaint as a whole alleged the physician’s “guilty
intent,” which was sufficient to allege scienter by the clinic as well.27 With respect to the
MCO’s scienter, the court further found that “Humana’s knowledge, which can be averred
generally, is plausible given the allegations and Humana’s admission that it was obligated to
have in place measures to detect, correct, and prevent fraud and that it affirmatively reviewed
and audited elected patient files.”28

United States v. Janke

Whereas the providers were swept into the FCA allegations along with the MA plan in
Graves, above, they became the sole focus in another earlier case, United States v. Janke.29 The
United States filed this case against a physician, his wife, and their medical practice, alleging that
they violated the FCA by making false statements and claims that resulted in Medicare
overpayments. The physician and his wife had been sole shareholders of America’s Health
Choice Medical Plan (AHC), a MA plan that had become defunct before the FCA action was
filed. The DOJ alleged that the physician and his wife falsely represented or caused the medical
practice and AHC to falsely represent “that AHC beneficiaries had serious illnesses that were not
supported by the patients’ own medical records.”

The defendants in this case sought dismissal of the action on the grounds that AHC was a
required party that must be joined under the federal procedural rules, and yet because it was in

25 Id. at *9. The FCA was amended on May 20, 2009 by S. 386, the Fraud Enforcement and Recovery
Act of 2009 (FERA). The FERA amendments, among other things, broadened the language in the prohibition
against submitting false statements in support of false claims so that the false statements need no longer be presented
directly to the federal government and need only be capable of influencing payment by the government. Thus, the
application of the correct version of the statute could impact the outcome of the case.

251 at p. 3 (S.D. Fla., 7/6/2015).

27 Id. at p. 8.

28 Id. at p. 9 (internal quotations omitted).

receivership in Florida court it could not be joined due to the receivership court’s stay prohibiting suit against it. The court rejected this argument and held that the case could proceed without AHC because not only were the defendants joint tortfeasors, but they were active participants and even “central figure[s] in the fraud.” They had allegedly “orchestrated the scheme” and simply used AHC “as an instrument.” Thus, the court held, the United States was entitled to seek recovery directly from them without joining AHC at all.

In so finding, the court pointed to a number of specific allegations that the United States made against the defendants in its complaint. The government had alleged that not only were the physician and his wife sole shareholders and operators of AHC, but their medical practice was the sole primary care provider and received more than 80% of the funds that AHC received from Medicare. They also allegedly “personally directed ‘data sweeps’ of thousands of beneficiary medical files to collect additional, unjustified diagnoses to inflate Medicare payments” and “hired unlicensed physicians to conduct these sweeps.” Moreover, the physician’s wife allegedly “personally urged these physicians to seek out any evidence of major medical diagnoses to inflate fraudulent Medicare claims,” and both she and her husband “knowingly took part in meetings and correspondence discussing a computer system that reported false data to” CMS. And finally, the court noted that the DOJ alleged that the defendants “received independent confirmation from two potential buyers and from their own hired expert that AHC’s risk adjustment submissions contained false claims,” yet they failed to report that information to CMS.

United States ex rel. Silingo v. Mobile Medical Examination Services, Inc.

Sometimes MCOs contract with third parties, for example to help document HCC risk scores. In one such situation, a relator alleged that a consultant that contracted with various MCOs to perform in-person physical exams of their MA patients to document risk scores, provided false and fraudulent risk adjustment data to the MCOs, and the MCOs then included that false information in their submissions to CMS, resulting in higher risk scores and thus higher payments by CMS to the MCOs. The relator named the consultant, MedXM, as a defendant in the case, and also named as defendants several of the MCOs that contracted with MedXM for these services. She alleged that the defendants collectively knowingly submitted or caused to be submitted false claims to Medicare.

With respect to MedXM, the relator alleged a variety of misconduct. She alleged that MedXM improperly relied on nurse practitioners (NPs) and physician assistants (PAs) to perform HCC assessments without the physician supervision allegedly required by federal and state law; submitted and relied upon false blood test results; and relied upon medical examinations conducted by a physician who was not licensed in the states in which she

30 Id. at *3-4.
31 Id. at *8 (internal quotations omitted).
32 Id. at *10.
33 Id. at *8-9.
performed examinations. The relator also alleged that MedXM and the physicians/NPs/PAs performing the assessments improperly revised electronic medical records after they were created, in order to add or upcode diagnoses, and without preserving the original text or otherwise indicating that alterations had been made; and submitted assessments despite not having conducted face-to-face visits.\textsuperscript{34} She further alleged that MedXM falsely represented to its MCO clients that it complied with all applicable laws and regulations and that the data it submitted to the MCOs was complete and accurate. As a result, she alleged, those MCOs in turn “submitted to the Government risk adjustment data based on MedXM’s improperly performed medical assessments and false and fraudulent HCC diagnoses codes, resulting in the Government paying excessive payments to MedXM’s Medicare Advantage HMO clients.”\textsuperscript{35}

Despite the fact that she alleged that the MCOs were duped by MedXM, the relator also alleged liability on the part of those same MCOs on the grounds that they acted with deliberate ignorance or reckless disregard of the accuracy of the information provided by MedXM. She asserted that all MA plans are required to have an effective compliance program that meets CMS requirements to prevent, detect and correct fraud, waste and abuse. In addition, she alleged, such plans “are required to ensure that their first tier contracted entities are also in compliance with all of the regulations and laws affecting the HMOs and their requirements under their Medicare Advantage contracts.”\textsuperscript{36} She alleged that only one MCO performed an audit of MedXM’s performance, and that MCO continued doing business with MedXM despite the contractor’s failure to make the necessary corrective actions because of the increased risk scores they received resulting from MedXM’s submissions.\textsuperscript{37} By failing to operate effective compliance programs, failing to audit MedXM, and failing to require corrective action by MedXM, the relator alleged, the MCOs acted with the level of “knowledge” of falsity required under the FCA.

As with most of the managed care-related cases discussed above, the government declined to intervene in this case. Motions to dismiss were filed in February 2015 and, as of the date of the submission of this paper, are still pending.

\textit{Poffinbarger v. Priority Health}

The cases discussed above involved allegations of substantive FCA violations, although some also included retaliation claims under the statute.\textsuperscript{38} An FCA retaliation claim brought by a former employee in federal court after her employment had been terminated and after she had filed a separate retaliation claim in state court also provides interesting insights into how FCA claims could be constructed against an MCO.\textsuperscript{39} Although the court dismissed some of her FCA

\begin{itemize}
  \item \textsuperscript{34} Compl., ¶¶ 17-68.
  \item \textsuperscript{35} Id. at ¶ 70.
  \item \textsuperscript{36} Id. at ¶ 74, citing 42 C.F.R. §§422.504(i), (l)(3); 422.503(b)(4)(iv)(C)(1)-(3), D.
  \item \textsuperscript{37} Id. at ¶¶ 78-84.
  \item \textsuperscript{38} 31 U.S.C. §3729(h) prohibits retaliation against employees and agents who identify and try to stop FCA violations or bring an FCA action.
\end{itemize}
retaliation claims because actions taken in the state court case did not constitute an adverse action against her employment, the complaint sets forth an interesting fact pattern that could provide the model for future relators.

According to the relator’s Complaint, the relator worked as a Medicare Risk Adjustment Analyst for the defendant, Priority Health Managed Benefits, Inc., which operated a MA program. As part of her job, she was responsible for reviewing the actual medical records of the beneficiaries under the program and verifying that the medical conditions that the providers reported for those patients, which conditions then formed the basis for the payments that the MCO received from Medicare, met all Medicare requirements. As she reviewed the records, she was responsible for inputting corrected diagnosis codes, which she referred to as “adds” and “deletes,” into an in-house computer program at the MCO. Once these codes were submitted, CMS would then determine whether it needed to adjust the capitated payments it already had made to the MCO. The relator alleged that because of financial pressures, her employer prohibited her and her colleagues from making any “deletes” (i.e., from deleting diagnoses that would lead to higher capitated payment rates) and ordered them to focus solely on finding “adds” (i.e., situations where they could add diagnoses that would lead to higher capitated payment rates). She alleged that her employment was terminated on the basis of her objections to following those orders and thus violating the law. The court allowed those claims to proceed.

VIOLATIONS OF OTHER LAWS THAT MAY OR MAY NOT CONSTITUTE CONDITIONS OF PAYMENT

Not all filed or decided FCA cases have focused on allegations of failure to provide services or submitting false information to increase capitated payments. Other cases have alleged that the MCOs violated other statutes or regulations, which may or may not have affected the MCOs’ right to payment from Medicare.

United States v. WellCare Health Plans, Inc.

One of the most publicized cases involving an MCO was initiated by four separate qui tam actions filed over two years and three states. The United States intervened in each of the cases, conducted a criminal investigation into the allegations, and entered into a Deferred Prosecution Agreement (DPA) with the MCO in 2009, under which the defendant paid $40 million in restitution and forfeited an additional $40 million. The government and relators

40 Poffinbarger v. Priority Health Managed Benefits, Inc., Case 1:11-cv-00993-RHB, Doc. #1, Complaint & Jury Demand, at pp. 3-4.
41 Compl. at pp. 6-9; 2011 U.S. Dist. LEXIS 142995 at *3-4, 12.
42 See United States ex rel. Hellein v. WellCare Health Plans, Inc., et al., Case No. 8:06-cv-01079 – T-30TGW (M.D. Fla.); United States ex rel. Bolton v. WellCare Health Plans, Inc., et al., Case No. 8:07-cv-1909-T-30TGW (M.D. Fla.); United States ex rel. SF United Partners v. WellCare Health Plans, Inc., et al., Case No. 3:07cv1688 (SRU) (D. Conn.); and United States ex rel. Gonzalez v. WellCare Health Plans, Ind., et al., Case No. CV 08 0723 (E.D. N.Y.).
subsequently entered into a civil settlement agreement with the company resolving all four _qui tam_ actions in 2012 in exchange for $137.5 million.

While the DPA’s Statement of Facts focused on allegations that WellCare had improperly manipulated its Medical Loss Ratio (discussed below) in Florida, the civil FCA settlement resolved a significantly broader number of allegations. Not surprisingly given the DPA’s focus, the FCA settlement focused significantly on allegations relating to the Medical Loss Ratio (MLR), which reflects the percentage of premium revenue that is paid out for medical care for the plan’s patients. Under its contract with certain Medicaid programs, if WellCare’s MLR fell below a certain percentage, the company was contractually obligated to refund all or part of the difference to those Medicaid programs. Relying on the reverse false claims prong contained in the pre-2009 version of the FCA, the government alleged that WellCare knowingly concealed its contractual obligation to repay funds to Florida’s Medicaid program for certain behavioral health care services and induced the Medicaid program to increase premiums by falsely inflating the amount it reportedly spent on behavioral health care services for Medicaid patients, using those improperly inflated expenses to calculate the relevant MLR, submitting those inflated expenses and/or improperly calculated MLRs to Medicaid, coordinating its billing practices with other entities to avoid detection by Medicaid, and then retaining the funds that it owed back to Medicaid. The government alleged improper manipulation of the MLR with respect to other Medicaid programs as well, and alleged that WellCare thus avoided repaying funds to those programs in addition to Florida’s.

In addition to the MLR-related allegations, and among other allegations, the government also joined the relators in alleging that WellCare paid improper remuneration to physicians and other providers to induce them to upcode or deny services to patients, to reward them for marketing and for switching patients to WellCare unlawfully, and to reward providers who terminated sick patients and sent them to other health plans or providers. The government also alleged that WellCare sanctioned or terminated providers who exceeded claims payment thresholds. WellCare also was alleged to have engaged in improper sales and marketing activity by illegally disenrolling some Medicaid patients and “cherrypicking” others; and marketing its products in a way that was designed to discriminate among potential enrollees on the basis of their health status or need for services. The government also joined allegations that WellCare had improperly upcoded services, claims, and disease states by manipulating the system CMS used to calculate the per member per month premium it paid to health plans.

### Pricing/Bidding

In a case that was very recently resolved in the Northern District of California, a relator alleged that his former employer, Kaiser Foundation Health Plan, Inc. (Kaiser), improperly violated CMS’s bid instructions when bidding on MA contracts. Although his specific legal theory evolved between his original Complaint and his Third Amended Complaint, his final

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allegations were that entities bidding for CMS MA contracts were obligated to submit profit margins in their bid filings that were within a certain range of the profit margin for the entities’ other lines of business.\textsuperscript{46} In submitting this information for plan years 2008 and 2009, the relator alleged, Kaiser improperly limited the profit margin information it submitted to commercial plans.

As with many of the cases above, the United States declined to intervene in this case following its investigation, and the relator proceeded to litigate the case. The defendant sought to dismiss the case after each amended complaint but was unable to convince the court to dispose of the case. After the defendant filed its motion for summary judgment, however, the United States filed a Statement of Interest informing the court that Kaiser’s alleged conduct complied with CMS requirements in effect at the time, and thus “Kaiser’s bid submissions for the 2008 and 2009 contract years did not contain false statements, and were not false claims for payment.”\textsuperscript{47}

Although DOJ often declines to intervene in \textit{qui tam} cases because it believes they lack merit, it is highly unusual for DOJ to file a statement of interest undercutting the relator’s allegations, and extraordinarily rare for DOJ to seek to dismiss such cases. Nevertheless, four months after filing its Statement of Interest, and before the judge ruled on the defendant’s summary judgment motion, DOJ filed a Motion to Dismiss Relator’s Third Amended Complaint, seeking dismissal under 31 U.S.C. §3730(c)(2)(A).\textsuperscript{48} DOJ asserted that it had a “valid governmental purpose” in dismissing the case, specifically, the United States’ interests in not spending any further resources on the case. DOJ stated expressly that it had “determined that Relator’s allegations did not support False Claims Act liability,” and also had “made clear its position that Relator’s current theory of liability lacks merit.”\textsuperscript{49} Given the relator’s decision to continue pursuing the litigation notwithstanding the government’s position, “the government has concluded that the burden that would be imposed on it from continued litigation of this case outweighs any potential benefit.”\textsuperscript{50} DOJ noted that it had devoted significant resources to monitoring the pleadings, participating in mediation, and filing its Statement of Interest, and that CMS had devoted significant resources to responding to discovery requests from the defendant and would likely receive additional discovery requests from the relator. In addition, if the case went to trial, the trial “would further burden CMS personnel and the government’s counsel, as one or both parties would seek to call CMS employees as witnesses.”\textsuperscript{51}

\textsuperscript{46} McGowan, Third Am. Complaint, Dkt. 76, at ¶¶27-28 (7/19/2013).

\textsuperscript{47} McGowan, United States’ Statement of Interest, Dkt. 139, at p. 3 (5/23/2014).

\textsuperscript{48} This subsection provides that “the Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.”

\textsuperscript{49} McGowan, U.S. Notice of Motion and Motion to Dismiss Rel’s Third Am. Compl.; Memo. Of Pts. And Auths. In Supp. (MTD), Dkt. 182, at p. 5 (9/26/2014).

\textsuperscript{50} Id.

\textsuperscript{51} Id. at p. 6.
The parties agreed to settle shortly before the motion hearing date, obviating any need for the court to rule on the DOJ’s motion or the defendant’s summary judgment motion.52

Marketing Activity and Kickbacks

In another case in which DOJ declined to intervene, the relator alleged that the MCO’s claims to CMS were rendered false by its violations of Medicare marketing rules and by offering kickbacks to physicians to switch their patients to the MCO’s plan.53 The district court dismissed the case because the relators did not identify any specific false claims in their complaint; compliance with marketing guidelines and regulations was not a condition of payment by Medicare; and compliance with the federal Antikickback Statute (AKS)54 was not alleged to have been certified by the defendants nor to be a condition of government payment.55

On appeal, the Third Circuit upheld the dismissal of the claims predicated on alleged violations of Medicare marketing rules. The court examined the marketing rules closely and interpreted those rules to permit Medicare to terminate the MCO’s contract for failing to comply with the marketing rules, but also to require Medicare to provide the MCO the opportunity to correct its violations before termination is imposed, and even to avoid termination in some circumstances. Nowhere did the court find any language indicating that Medicare conditioned its payments to the MCO on compliance with the marketing regulations.56

With respect to the alleged violations of the AKS, however, the Third Circuit considered DOJ’s amicus brief argument that MA plans are required to “operate under agreements with CMS which include a provision requiring that the organization comply with the AKS.”57 The relators had asserted that the MCO paid a medical group money to change dual eligible beneficiaries from another MCO’s plan to the defendant’s, and offered physicians additional income for providing insurance agents with the names of their patients.58 The court held that dismissal of the AKS-based claims was inappropriate because the relators had pleaded that the MCO knowingly violated the AKS at the same time that it submitted claims to Medicare for payment, and that compliance with the AKS “is clearly a condition of payment under Parts C and D.”59

Violations of Contractual Terms Between MCO and State

53 United States ex rel. Wilkins v. United Health Group, Inc., 659 F.3d 295 (3rd Cir. 2011).
54 42 U.S.C. §1320a-7b(b).
55 Id. at 301.
56 Id. at 309-310.
57 Id. at 312.
58 Id. at 312.
59 Id. at 313.
In yet another declined case decided more than a decade ago, the relator alleged that the Vision Service Plan (VSP), which contracted with two state Medicaid MCOs, violated the FCA by improperly charging co-payments to patients participating in Hawaii’s Medicaid managed care program.60 Two MCOs had been awarded contracts under the Hawaii program and subcontracted with VSP to provide the vision care component of their services. The MCOs’ agreements with the state prohibited them from charging co-payments, and such co-payments also were prohibited under applicable law. Nevertheless, VSP allegedly charged patients $7 co-payments, under agreement with the two MCOs.61

VSP submitted monthly bills for its services to the MCOs, containing only billing data and calculations but no certifications of compliance with any laws or regulations. The MCOs then billed the state Medicaid program for vision services pursuant to their contracts with the program. The relator asserted that VSP’s charging of co-payments rendered VSP’s claims to the MCOs false because “those bills contained an implied certification that VSP would not violate applicable law, including laws prohibiting co-payments.”62 (She does not appear to have asserted that the MCOs’ subsequent claims to the state were also false.)

On summary judgment, the court rejected the relator’s implied certification argument, finding that “there was nothing false about the bills. The bills did not impose the $7 co-payment. Nor did the bills promise compliance with any law. The bills merely contained billing information.”63 The court found the implied certification theory inapplicable because “there is no evidence that the $7 co-payment assessed by VSP caused the government to pay out funds” – “VSP charged the QUEST program members, not the government.”64 The court’s focus on the submission of claims to the MCOs by VSP rather than the MCOs’ claims to Hawaii Medicaid may be attributable to the relator’s limited arguments, or perhaps to the fact that the case was brought fairly early in implied certification jurisprudence.

CONCLUSION

Although a comparatively large amount of press has focused on FCA actions alleging that MCOs and others have falsified and misrepresented patient information to drive up capitated reimbursement rates, both providers and MCOs should be aware that FCA liability in the managed care context can be predicated on the violation of any statute, regulation or contract term that constitutes a condition of payment under the federal health care program involved. Thus, for example, the payment and acceptance of kickbacks can serve as a predicate for liability in this context as well as in the fee-for-service context.

61 Id. at 1239.
62 Id. at 1239-40.
63 Id. at 1241.
64 Id. at 1242.
In addition, the DOJ’s tendency to decline all but the very largest of these cases should not provide much comfort to MCOs and providers. Most of the cases discussed above were pursued by the relators after the government declined to intervene, and although many ultimately were dismissed, the relator’s bar is becoming increasingly savvy as to how to avoid dismissal. Moreover, as DOJ attorneys become more familiar with the managed care context, and as more and more Medicare and Medicaid dollars are being steered into managed care, the likelihood of DOJ involvement in future cases increases.