Lessons From DOJ's Handling Of Rare Medicare Fraud Case

By **Ericka Aiken, Kevin Lamb and Charlotte Mostertz** (January 9, 2024)

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In October, the U.S. Department of Justice announced[1] a rare criminal indictment involving the Medicare Advantage program — a contrast from the DOJ's more typical use of its civil enforcement authority to pursue similar issues under the False Claims Act.

The indictment alleges that from 2015 to 2020, a former employee of a Florida company that administers Medicare Advantage plans falsified, and caused others to falsify, diagnoses that were submitted to the Centers for Medicare and Medicaid Services and that resulted in millions of dollars in overpayments. The U.S. District Court for the Southern District of Florida has scheduled a two-week trial beginning July 29.

This indictment comes as the DOJ has pledged to increase investigations related to fraud involving Medicare Advantage plans. Notably, consistent with the DOJ's recent pronouncements regarding self-disclosure, cooperation and remediation, the DOJ declined to prosecute the former employee's company, HealthSun Health Plans Inc.

Medicare Advantage

The alleged fraud in this case concerns false information that was the basis for payment to HealthSun for its Medicare Advantage plans.

In 1997, Congress created the Medicare Advantage program, originally called Medicare+Choice, as a public-private partnership to leverage the efficiencies and other advantages of managed care as an alternative to traditional Medicare, in which CMS pays providers directly per service.

The Medicare Advantage program, also known as Medicare Part C, allows seniors to receive their Medicare benefits by enrolling in private health care plans. In exchange for managing these beneficiaries' care, CMS prospectively pays Medicare Advantage organizations that offer these plans a monthly amount for each enrollee.

These monthly per-member payments to each Medicare Advantage organization are adjusted based on its plan enrollees' age, gender and health status — a process known as risk adjustment.

To determine enrollees' health status, CMS relies on diagnoses reported from patient encounters. Those diagnoses are reported to CMS using a standard set of codes that trained medical coders assign based on the conditions documented by the provider in the medical record for the patient's visit.

These diagnoses in turn help CMS calculate a risk score for each enrollee based on the expected cost to provide Medicare benefits to that person relative to the average Medicare beneficiary.

Only certain diagnoses increase an enrollee's score — those that predict higher health care expenditures. In short, CMS pays plans more for sicker members it expects to be costlier, and it pays plans less for healthier patients it expects to be less costly.

CMS guidance provides that all diagnosis codes submitted by Medicare Advantage organizations for payment must be documented in the patient's medical chart from a face-to-face medical encounter with a qualified health care provider.[2]

To ensure that those codes are adequately documented, both CMS and the U.S. Department of Health and Human Services Office of Inspector General conduct audits that require plans to retrieve a sample of patient medical charts for review by the respective agency.[3]

The Indictment

The indictment filed on Oct. 26 accuses Kenia Valle Boza, a certified coder and former director of Medicare risk adjustment analytics at HealthSun, of participating in a scheme to defraud Medicare by falsifying diagnoses that were submitted to CMS and triggered higher risk-adjustment payments to HealthSun's Medicare Advantage plans.

In particular, the government alleges that in 2015, Boza and other coders began falsely diagnosing Medicare Advantage plan members with various chronic risk-adjusting conditions that were not diagnosed by the doctors who saw the members. At the time, Boza and the other coders were working for Pasteur Medical Group LLC, a company that operates a chain of medical centers.

They allegedly continued this scheme when HealthSun acquired Pasteur in 2016, causing CMS to overpay HealthSun millions of dollars.

Boza and her co-conspirators carried out the scheme in part by obtaining Pasteur physicians' credentials to fraudulently add conditions to the members' electronic medical records days or weeks after the member was seen. CMS then relied on the codes for these fraudulent diagnoses to increase HealthSun's risk-adjustment payments.

Boza was indicted on six related charges: one count of conspiracy to commit health care fraud and wire fraud, two counts of wire fraud, and three counts of major fraud against the U.S. government. Collectively, those charges carry potential penalties of decades in prison.

Declination to Prosecute HealthSun

One day after issuing its indictment against Boza, the DOJ announced it had declined to prosecute HealthSun and its parent company, Elevance Health Inc., citing the Criminal Division's newly revised corporate enforcement and voluntary self-disclosure policy.[4]

The revised policy is aimed at incentivizing companies to develop and maintain robust corporate compliance programs, to swiftly and voluntarily self-disclose suspected corporate misconduct, to cooperate fully with government investigations, and to take timely and appropriate remedial measures.

In its declination letter, the DOJ explained that its decision was based on:

- The timely and voluntary self-disclosure of the misconduct;

- HealthSun's full and proactive cooperation in the matter and its ongoing agreement to cooperate with any related government investigations and any future prosecutions;

- The nature and seriousness of the offense;

- Timely and appropriate remediation, including the termination of employees who were involved in the misconduct, reporting and correcting the false and fraudulent information submitted to CMS, and substantially improving their compliance program and internal controls; and

- The immediate return of the estimated $53 million overpayment HealthSun received as a result of the scheme.

Takeaways

The DOJ has rarely pursued criminal charges for fraud involving Medicare Advantage. Instead, the DOJ has historically relied on its civil enforcement authority under the False Claims Act to investigate and litigate alleged fraud involving diagnosis codes submitted for payment by Medicare Advantage organizations.

The infrequency of criminal charges in Medicare Advantage may be due at least in part to the complexity of risk adjustment. In traditional Medicare, CMS reimburses providers for the items and services they bill, and criminal charges for fraudulently billing items or services that were unnecessary or never provided are not uncommon.[5]

Medicare Advantage organizations, in contrast, do not bill CMS for items or services and are instead paid per member based on diagnoses that come from an outside source — providers who saw plan members in the prior service year.

Because providers are often paid per service, they may have little or no financial incentive to focus on documenting and reporting diagnoses.

Even where Medicare Advantage organizations' and providers' incentives are aligned through risk-sharing arrangements that encourage a greater focus on documenting and reporting diagnoses, under the Medicare Advantage payment model, a new diagnosis by a provider will have no impact on plan payment for a patient until the year after the diagnosis was made, when the patient may have switched providers or plans.

Notwithstanding this more complex payment structure, the Medicare Advantage program has come under greater scrutiny from the DOJ, OIG and the press in recent years as the program's share of Medicare spending has grown.[6] For the first time, in 2023, more than half of Medicare beneficiaries are enrolled in a Medicare Advantage plan, and the program is

responsible for more than half of Medicare spending.[7]

Correspondingly, the scrutiny of Medicare Advantage has largely been targeted at programs by Medicare Advantage organizations to report additional diagnoses for payment.

In 2021, for example, the OIG conducted a study[8] of 162 Medicare Advantage organizations' use of chart reviews and health-risk assessments.[9] Although CMS reiterated in response that such activities are permissible,[10] the OIG recommended oversight of 20 unnamed Medicare Advantage organizations that it found disproportionately drove $9.2 billion in additional payments. Continued regulatory attention appears likely to follow the money.

Although consistent with growing scrutiny of Medicare Advantage more broadly, the criminal indictment of Boza is unusual in at least two respects. First, it appears to involve truly rogue conduct by individual coders that was not sanctioned — and was later condemned — by their employer. And second, the indictment nowhere explains how Boza and her co-conspirators financially benefited from the scheme. Their motive thus remains unclear.

The last time the DOJ appears to have filed criminal charges for similarly egregious conduct involving Medicare Advantage was in 2016, when a doctor, Isaac Thompson, pleaded guilty[11] to fraudulently misdiagnosing over 300 patients with a spinal disorder.

He was sentenced to 46 months in prison and ordered to pay approximately $2.1 million in restitution. But in that case, unlike Boza's, the doctor's motive was clear: He received 80% of the risk adjustment payments for members who had selected him as their primary care provider.

While the gravity of the underlying allegations in this case may have contributed to the DOJ's decision to charge Boza criminally, this indictment is a reminder that the DOJ is able — and willing when it deems necessary — to bring criminal charges for fraud against those who participate in the Medicare Advantage program.

Indeed, the DOJ has said recently that it will increase the number of investigations into Medicare Advantage fraud. Heightened scrutiny may result in additional criminal prosecutions of individuals and even companies alongside increased civil enforcement.

HealthSun is also the latest example of a company benefiting from declination under the DOJ's public commitment to providing incentives for voluntary self-disclosure and swift remediation.

Corporations that proactively disclose employee misconduct and demonstrate extraordinary cooperation with the government in criminal enforcement matters stand to benefit from the Criminal Division's corporate enforcement and voluntary self-disclosure policy, which was revised earlier this year.

They stand to benefit as well from the DOJ's voluntary self-disclosure policy,[12] which was issued in February and applies to U.S.attorney's offices nationwide.

These policies encourage companies to self-disclose misconduct, maintain effective compliance programs to detect and ameliorate misconduct, and cooperate fully with any ensuing criminal investigations.

Both policies specify that a disclosure must be truly voluntary and timely. In other words, it

must be made in the absence of a preexisting duty to disclose the conduct and before the misconduct is publicly recorded, before an imminent threat of disclosure or investigation, and within a reasonably prompt time after the company becomes aware of the misconduct.

The Criminal Division's corporate enforcement and voluntary self-disclosure policy provides additional guidance for companies that hope to earn cooperation credit.

The decision not to prosecute HealthSun after indicting Boza underscores the DOJ's commitment to promoting corporate self-disclosure, even as the DOJ targets fraud involving Medicare Advantage and renews its focus on combating corporate misconduct by holding individuals accountable.

Together, the declination and indictment signal the importance of functioning compliance programs[13] and the ability to detect and address potential risks to the company, including employee misconduct, promptly and effectively.

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[1] https://www.justice.gov/opa/pr/former-executive-medicare-advantage-organization-charged-multimillion-dollar-medicare-fraud.

[2] CMS, Medicare Managed Care Manual, ch. 7, § 40.

[3] 42 C.F.R. § 422.310(e).

[4] https://www.wilmerhale.com/en/insights/client-alerts/20230118-doj-announces-updates-to-corporate-enforcement-policy.

[5] See, e.g, DOJ Press Release No. 23-1351, Man Charged in $148M Medicare and Medicaid Fraud Scheme (Nov. 30, 2023) (announcing charges against Louisiana man who participated in scheme to defraud Medicare and Medicaid by ordering more than $148 million in superfluous tests); DOJ Press Release No. 22-773, Justice Department Charges Dozens for $1.2 Billion in Health Care Fraud (Jul. 20, 2022) (announcing criminal charges against 36 defendants in 13 federal districts alleging over $1.2 billion in fraud in telemedicine kickback scheme involving orders for unnecessary genetic testing and other durable medical equipment).

[6] Jody H. Hunt, Assistant Attorney General, DOJ Civil Division, Remarks to the Federal Bar Association 2020 Qui Tam Conference (February 27, 2020) (highlighting that DOJ "is investigating and litigating a growing number of matters related to [Medicare Advantage]" with a particular focus on "schemes to manipulate the risk adjustment process"); Christi A. Grimm, Inspector General, OIG, Some Medicare Advantage Organization Denials of Prior

Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (2021) (scrutinizing MAOs' denials of medical care); Reed Abelson and Margot Sanger-Katz, 'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions, N.Y. Times (Oct. 8, 2022) (covering increasing popularity of Medicare Advantage plans and alleged overbilling by MAOs).

[7] Nancy Ochieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF, (Aug. 9, 2023).

[8] https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf.

[9] Health risk assessments occur when a provider meets with a Medicare patient to determine "any gaps in care." Suzanne Murrin, Deputy Inspector General for Evaluation and Inspections, OIG, Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments (2021).

[10] See id., Appendix A: Agency Comments.

[11] https://www.justice.gov/usao-sdfl/pr/doctor-who-falsely-diagnosed-hundreds-patients-part-medicare-fraud-scheme-sentenced.

[12] https://www.wilmerhale.com/insights/client-alerts/20230224-department-of-justice-issues-voluntary-self-disclosure-policy-for-corporate-criminal-enforcement-applicable-to-us-attorneys-offices-nationwide#:~:text=On%20February%2022%2C%202023%2C%20the,to%20corporate%20criminal%20enforcement%20matters.#:~:text=On%20February%2022%2C%202023%2C%20the,to%20corporate%20criminal%20enforcement%20matters.

[13] https://www.wilmerhale.com/en/insights/client-alerts/20230303-doj-announces-significant-guidance-on-compliance-compensation-communications-and-cooperation.