JUSTICE NEWS

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United States Intervenes in Second False Claims Act Lawsuit Alleging that UnitedHealth Group Inc. Mischarged the Medicare Advantage and Prescription Drug Programs

For the second time in two weeks, the United States has filed a complaint against UnitedHealth Group Inc. (UHG) that alleges UHG knowingly obtained inflated risk adjustment payments based on untruthful and inaccurate information about the health status of beneficiaries enrolled in UHG's Medicare Advantage Plans throughout the United States, the Justice Department announced today. Today's action follows the government's filing of a complaint earlier this month in United States ex rel. Swoben v. Secure Horizons, a related action that also alleges that UHG submitted false claims for payment to the Medicare Program.

"The Department of Justice's pursuit of this matter illustrates its firm commitment to ensure the integrity of the Medicare Program, including those parts of the program that rely on the services of Medicare Advantage Organizations," said Acting Assistant Attorney General Chad A. Readler of the Justice Department's Civil Division.

UHG is the nation's largest Medicare Advantage Organization, with more than 50 Medicare Advantage and Drug Prescription plans providing healthcare services and prescription drug benefits to millions of Medicare beneficiaries throughout the United States. receives a monthly "risk adjustment" payment from Medicare for each enrolled beneficiary. The risk adjustment payments are based, in significant part, on the health status of the beneficiary, which are reflected by diagnosis that receives from treating physicians and subsequently submits to Medicare for each beneficiary.

The complaint filed today by the United States alleges that UHG knowingly disregarded information about beneficiaries' medical conditions, which increased the risk adjustment payments UHG received from Medicare. In particular, the lawsuit contends that, for many years, UHG conducted a national Chart Review Program designed to identify additional diagnoses not reported by treating physicians that would increase UHG's risk adjustment payments. However, UHG allegedly ignored information from these chart reviews showing that hundreds of thousands of diagnoses provided by treating physicians and submitted by it to Medicare were invalid and did not support the Medicare payments it had previously requested and obtained. By ignoring this information, UHG avoided repaying Medicare monies to which it was not entitled.

The complaint also alleges that UHG ignored information about invalid diagnoses from health care providers with financial incentives to furnish such diagnoses. These providers received payments from UHG tied to the amount of payments that UHG received from Medicare, and thus benefitted financially from any increase in Medicare payments resulting from the diagnoses they provided. UHG allegedly knew that its financial arrangements with these providers created a strong incentive for and increased the risk of these providers to report invalid diagnoses. UHG's own reviews of these providers' medical records confirmed that the providers were reporting invalid diagnoses. But upon obtaining such evidence, UHG knowingly avoided further efforts to identify invalid diagnoses from these providers and repay Medicare monies to which neither it nor these providers were entitled.

"To ensure that the program remains viable for all beneficiaries, the Justice Department remains tireless in its pursuit of Medicare fraud perpetrated by healthcare providers and insurers," said Acting U.S. Attorney Sandra R. Brown for the Central District of California. "The primary goal of publicly funded healthcare programs like Medicare is to provide high-quality medical services to those in need – not to line the pockets of participants willing to abuse the system."

"As the nation's largest Medicare Advantage Organization, UHG received substantial overpayments based upon untruthful and inaccurate information about the health status of those enrolled in its plans," said Acting U.S. Attorney James P. Kennedy Jr. for the Western District of New York. "Such fraudulent spending of taxpayer's dollars will not be tolerated."

"With approximately one third of Medicare beneficiaries enrolled in Medicare Advantage plans, careful investigation of charges is more important than ever," said Special Agent in Charge Scott J. Lampert of the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). "People receiving health care through these programs and taxpayers deserve nothing less."

The lawsuit was filed by Benjamin Poehling, the former finance director for the UHG group that managed UHG's Medicare Advantage Plans. The lawsuit was filed under the qui tam provisions of the False Claims Act, which permit private parties to sue on behalf of the United States for false claims for government funds, and to receive a share of any recovery. The False Claims Act permits the government to intervene in such a lawsuit, as it has done, in part, in this case.

The government's intervention in this matter illustrates the government's emphasis on combating healthcare fraud. One of the most powerful tools in this effort is the False Claims Act. Tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement, can be reported to the Department of Health and Human Services, at 800-HHS-TIPS (800-447-8477).

This matter was investigated by the Civil Division's Commercial Litigation Branch, the U.S. Attorneys' Offices for the Western District of New York and the Central District of California and HHS-OIG.

The claims asserted against UHG are allegations only, and there has been no determination of liability.

The case is captioned United States of America ex rel. Benjamin Poehling v. UnitedHealth Group, Inc., No. 16-08697. The Swoben complaint is captioned United States ex rel. Swoben v. Secure Horizons, et al., 09-5013. Both are pending in the United States District Court for the Central District of California.

Attachment(s):
Download Complaint in Intervention

Topic(s):
False Claims Act
Healthcare Fraud

Component(s):
Civil Division
USAO - California, Central
USAO - New York, Western

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