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DOJ Intervenes in FCA Case Against Providers Over MA Coding; Lawyer Sees Flaws in Case

By Nina Youngstrom

The Department of Justice said Dec. 11 it has intervened in a whistleblower lawsuit alleging Sutter Health and Palo Alto Medical Foundation (PAMF) in California submitted false claims to Medicare because they gave incorrect information about patient conditions to Medicare Advantage (MA) plans. That allegedly resulted in higher risk scores, which inflated Sutter Health's capitated payments, with CMS ultimately picking up the tab, according to the False Claims Act (FCA) complaint.

"Sutter has taken and continues to take hundreds of millions of dollars in inflated capitation payments for the care of eligible beneficiaries based on risk adjustment data Sutter knows to be inaccurate, incomplete or false," the whistleblower, who was PAMF's risk assessment factor manager, alleged in the 2015 complaint.

Sacramento-based Sutter Health is a non-profit health system with hospitals and affiliated physician foundations, including PAMF, which has more than 900 physicians. They contract with MA plans, which receive capitated payments for Medicare beneficiaries. CMS pays MA plans based on hierarchical condition categories (HCCs), a risk adjustment model, which means capitation payments are adjusted for the patient population based on their acute and chronic conditions. Thousands of ICD-10 diagnosis codes are mapped to 70 HCCs, which are assigned to patients based on coding and documentation in the medical record. Medicare pays higher capitation rates for sicker patients.