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DOJ Intervenes in FCA Complaints Against Kaiser Plan, Medical Groups

By Nina Youngstrom

The Department of Justice (DOJ) has intervened in six whistleblower lawsuits alleging that Kaiser Foundation Health Plan and other members of the Kaiser "consortium," including medical groups, submitted inaccurate diagnosis codes to increase Medicare Advantage (MA) reimbursement. The false claims complaints allege Kaiser pressured physicians to produce addenda to medical records after the fact with risk-adjusting diagnoses that patients didn't have and/or weren't addressed, DOJ said July 30.[1] The higher the risk, the more money CMS pays MA plans for their enrollees.

MA is fertile ground for False Claims Act (FCA) lawsuits because about one third of Medicare beneficiaries are enrolled in MA plans, said attorney Max Voldman, with Constantine Cannon, who represents one of the whistleblowers, James Taylor, M.D. Cases have been filed against other MA plans, and OIG has identified large overpayments to MA plans, including Anthem Community Insurance Company, in its compliance audits.[2]

Some MA plans have settled cases. For example, Kaiser Foundation Health Plan of Washington, formerly known as Group Health Cooperative, paid $6.3 million to settle an MA false claims lawsuit in November 2020.[3]

"It feels like a tipping point," said attorney Mary Inman, with Constantine Cannon, who represents the same whistleblower as Voldman. DOJ's deadline for filing a complaint in intervention is Oct. 25, Voldman noted.

In a statement, Kaiser Permanente said, "We are confident that Kaiser Permanente is compliant with Medicare Advantage program requirements and we intend to strongly defend against the lawsuits alleging otherwise."

Generally, MA cases focus on plans, not providers, but this time DOJ is also alleging false claims were submitted by The Permanente Medical Group Inc., Southern California Permanente Medical Group Inc., and Colorado Permanente Medical Group P.C., Inman noted. "Kaiser is both the plan and a provider in most of the allegations," Voldman added. The other members of the consortium are Kaiser Foundation Health Plan Inc. and Kaiser Foundation Health Plan of Colorado.

"If you are a member of a doctors' group with a capitated arrangement, which means you share risk with a Medicare Advantage plan, you need to be concerned because DOJ will look at you differently," Inman contended.

Also, in 2019, Sutter Health LLC in California and several affiliates, including Sutter Medical Foundation, agreed to pay $30 million to settle allegations the affiliated entities "submitted inaccurate information about the health status of beneficiaries enrolled" in MA plans, which resulted in overpayments to the plans and providers, DOJ said.[4]

Meanwhile, in an Aug. 13 opinion, the U.S. Court of Appeals for the D.C. Circuit revived Medicare's 60-day overpayment refund rule for MA plans.[5] They now will have to report and return overpayments within 60 days of quantifying them, the same as Part A and B providers, and could face FCA lawsuits if they knowingly hold on to

them. The appeals court reversed a lower court ruling that had nixed the 60-day rule for Parts C and D. According to the new ruling in *UnitedHealthcare Insurance Company et al. v. Xavier Becerra*, "the Overpayment Rule does not violate the Medicare statute's 'actuarial equivalence' and 'same methodology' requirements and is not arbitrary and capricious as an unexplained departure from prior policy."

The Money Is in Risk Adjustment

Risk adjustment is at the heart of FCA allegations against MA plans. CMS makes advance payments every month to MA plans for the anticipated costs of caring for their enrollees. The payments are based on a base rate and a risk score for every enrollee. The risk score "reflects the additional or reduced costs that each enrollee is expected to incur compared with the costs incurred by enrollees on average," OIG explained in one of its audits. The risk scores are calculated based on an enrollee's health status and demographics (e.g., age, gender). "To determine an enrollee's health status for purposes of calculating the risk score, CMS uses diagnoses that the enrollee receives from face-to-face encounters with a physician (in an office or in an inpatient or outpatient setting). MA organizations collect the diagnosis codes that physicians document on the medical records and submit these codes to CMS," OIG said. "CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs)."

CMS consolidates some HCCs into related-disease groups. "Within each of these groups, CMS assigns an HCC for only the most severe manifestation of a disease in a related-disease group," OIG said. Enrollees with certain combinations of HCCs will be assigned a separate factor that further raises the risk score (e.g., acute stroke, acute myocardial infarction, and chronic obstructive pulmonary disease).

The risk adjustment program is prospective; the diagnosis codes the enrollee received for one year are used by CMS to assign HCCs and calculate risk scores for the subsequent year. "Miscoded diagnoses submitted to CMS may result in HCCs that are not validated and incorrect enrollee risk scores, which may lead to improper payments (overpayments) from CMS to MA organizations," OIG said.

Whistleblower Alleged Kaiser Audits Found Errors

One of the whistleblower complaints that DOJ intervened in last month was filed by James Taylor, M.D., who became an employee of Colorado Permanente Medical Group in 1995.[6] At the time the complaint was filed in 2014, Taylor was Kaiser's national co-chair of the Compliance Committee for ICD-10 and a member of Kaiser's national Coding Governance Group. He left Kaiser in 2015.

According to Taylor's complaint, Kaiser's national, regional and diagnosis-specific audits of risk adjustment claims identified categories of claims with "high rates of falsity," but "Kaiser rarely took even minimal steps to filter its claims to prevent submission of these claims, or to audit prior submissions to find the previously submitted" false claims.

Every year, the national compliance office does a national probe audit to test the accuracy of risk adjustment claims submitted the previous year. "Kaiser deliberately designs these audits so that the sample size is too small for the results to be used for statistically significant extrapolation with respect to the error rates for individual HCCs," the whistleblower alleged. "Instead, it is intended to provide an overall accuracy rate, by region, and to serve as a 'flag' or 'tripwire' to identify potential problems with individual HCCs."

Kaiser also did national audits in anticipation of CMS's Risk Adjustment Data Validation audits. Although the various audits showed a trend of increasing accuracy in risk adjustment claims across Kaiser, they also found "many errors" and made Kaiser aware it was submitting false risk adjustment claims, the complaint alleged.

Cancer (HCCs 7 to 10) was the most upcoded condition, according to the complaint. "The most significant and consistent error is that Kaiser providers submit diagnosis codes representing active, current treatment of cancer when, in fact, the patient's cancer is cured, in remission, or otherwise irrelevant to the services provided to the patient."

With a diagnosis of active cancer, the patient's medical records should have evidence of treatment (chemotherapy, radiation, surgery or palliative care). "Once there is no evidence of an existing malignancy, the proper diagnosis code is for 'history of cancer,'" which doesn't risk adjust, the complaint states.

Kaiser's probe audits also identified problems with claims for HCC 96, ischemic or unspecified stroke. "A patient typically is not allowed to leave the hospital until after the stroke is over. Once the acute incident is over, the patient should be diagnosed as either having a history of stroke, or receiving treatment for the late effects of the prior stroke," the complaint alleged. "Thus, in almost all cases, if a physician submits a diagnosis for acute stroke for a patient treated in the physician's office (or any setting other than a hospital), that diagnosis is likely erroneous."

Taylor said he convinced Kaiser to pay a physician to review all acute stroke diagnoses in physician offices in 2010. She allegedly found that all except two were false, but Kaiser didn't delete the codes or repay Medicare, the complaint alleges.

In its statement, Kaiser Permanente noted that "our medical record documentation and risk adjustment diagnosis data submitted to the Centers for Medicare & Medicaid Services comply with applicable laws and Medicare Advantage program requirements. Our policies and practices represent well-reasoned and good-faith interpretations of sometimes vague and incomplete guidance from CMS. For nearly a decade, Kaiser Permanente has achieved consistently strong performance on Risk Adjustment Data Validation audits conducted by CMS. With such a strong track record with CMS, we are disappointed the Department of Justice would pursue this path. While Kaiser Permanente plans to vigorously defend against these allegations, we will not allow this litigation to distract from our mission. Our dedicated health care teams will remain focused on continuing to provide our patients and members with leading-edge treatment, prevention, and the whole-person care that is the cornerstone of our integrated health system."

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1 Department of Justice, "Government Intervenes in False Claims Act Lawsuits Against Kaiser Permanente Affiliates for Submitting Inaccurate Diagnosis Codes to the Medicare Advantage Program," news release, July 30, 2021, https://bit.ly/2W0qJnn. https://www.justice.gov/opa/pr/government-intervenes-false-claims-act-lawsuits-against-kaiser-permanente-affiliates
2 Amy J. Frontz, "Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Anthem Community Insurance Company, Inc. (Contract H3655) Submitted to CMS," A-07-19-01187, May 2021, https://bit.ly/3D0l0ye.
3 Department of Justice, "Medicare Advantage Provider to Pay $6.3 Million to Settle False Claims Act Allegations," November 16, 2020, https://bit.ly/3ly0Anf.
4 Department of Justice, "Medicare Advantage Provider to Pay $30 Million to Settle Alleged Overpayment of Medicare Advantage Funds," news release, April 12, 2019, https://bit.ly/33MEJm1.
5 UnitedHealthcare Insurance Company et al. v. Xavier Becerra, No. 1:16-cv-00157 (D.C. Cir. 2021), https://bit.ly/3ggb5Ln.
6 United States, ex rel. Dr. James M. Taylor, M.D. v. Kaiser Permanente et al., Case No. 1:14-cv-02889 (D. Colo. 2014), https://bit.ly/3j0az5W.