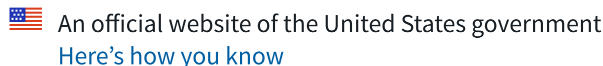

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Medicare Advantage Provider to Pay $270 Million to Settle False Claims Act Liabilities

HealthCare Partners Holdings LLC, doing business as DaVita Medical Holdings LLC (DaVita), has agreed to pay $270 million to resolve its False Claims Act liability for providing inaccurate information that caused Medicare Advantage Plans to receive inflated Medicare payments, the Justice Department announced today. DaVita is headquartered in El Segundo, California.

"Federal healthcare programs rely on the accuracy of information submitted by healthcare providers to ensure that managed care plans receive the appropriate compensation," said Assistant Attorney General Joseph H. Hunt of the Department of Justice's Civil Division. "We will pursue those who undermine the integrity of the Medicare program and the data it relies upon. This also illustrates that the Department encourages and incentivizes health care organizations to make voluntary disclosures to the government when they identify false claims."

Under Medicare Advantage, also known as the Medicare Part C program, Medicare beneficiaries have the option of enrolling in and obtaining health care from Medicare Advantage Plans (MA Plans) that are owned and operated by private Medicare Advantage Organizations (MAOs). Unlike traditional Medicare, where payments to health providers are based on the services they render to the patient, MA Plans are paid a fixed, monthly amount to provide health care to beneficiaries who enroll in their plans. To accommodate costs that may be associated with patients that require more care than an average patient, Medicare payments to MA plans are "risk adjusted" to reflect, in significant part, the health status of the beneficiary. The result is that MAO plans receive higher payments for patients who are diagnosed with conditions that require greater care.

To provide the patient care, MAOs may contract directly with physicians and other healthcare providers, or they may contract with Medical Services Organizations (MSOs), which in turn either employ or contract with healthcare providers. These health care providers then render the patient care and provide the diagnoses that MAOs submit, in turn, to Medicare to obtain the risk-adjusted payments from CMS.

DaVita operated an MSO and contracted with MAOs in various states, including California, Nevada, and Florida, to provide care to the MAOs' enrolled Medicare beneficiaries. In connection with the medical services it provided to those beneficiaries, DaVita collected and submitted diagnoses to the MAOs. As payment for its services, DaVita received from the MAOs a share of the payments that the MAOs received from CMS for the beneficiaries under DaVita's care.

DaVita voluntarily disclosed to the government various practices that were instituted by HealthCare Partners, a large California-based independent physician association that DaVita acquired in 2012, that caused MAOs to submit incorrect diagnosis codes to CMS and obtain inflated payments in which DaVita and HealthCare Partners shared. For example, HealthCare Partners disseminated improper medical coding guidance instructing its physicians to use an improper diagnosis code for a particular spinal condition that yielded increased reimbursement from CMS. Based on these self-disclosures, and DaVita's cooperation with the government's subsequent investigation, the United States agreed to a favorable resolution of potential claims arising from the conduct.

The settlement also resolves allegations made by a whistleblower that HealthCare Partners engaged in “one-way” chart reviews in which it scoured its patients’ medical records for diagnoses its providers may have failed to record. It then submitted these “missed” diagnoses to MAOs to be used by them in obtaining increased Medicare payments. At the same time, it ignored inaccurate diagnosis codes that should have been deleted and that would have decreased Medicare reimbursement or required the MAOs to repay money to Medicare.

“This settlement demonstrates our tireless commitment to rooting out fraud that drains too many taxpayer dollars from public health programs like Medicare,” said United States Attorney Nick Hanna. “This case involved illegal conduct in which patients’ medical conditions were improperly reported and were not corrected after further review – all for the purpose of boosting the bottom line. We will continue to pursue and hold accountable any entity that seeks to illegally increase revenue at the expense of the Medicare Advantage so that the program may continue to remain viable for all who need it.”

“DaVita’s alleged conduct was irresponsible and compromised the integrity of the Medicare program,” said Special Agent in Charge Scott J. Lampert of the U.S. Department of Health and Human Services, Office of Inspector General’s New York Region. “HHS-OIG will continue to ensure that companies that do business with federally funded health care programs do so in an honest fashion.”

The allegations of “one way” chart reviews were brought in a lawsuit under the qui tam, or whistleblower, provisions of the Federal False Claims Act. This statute permits private parties to sue on behalf of the government for false claims and to receive a share of any recovery. The whistleblower in this action is James Swoben, who was a former employee of an MAO that did business with DaVita. Mr. Swoben will receive $10,199,100 for the settlement of the “one way” allegations.

The corporate affiliates related to Health Care Partners and which are part of today’s settlement are: DaVita Medical Group Nevada (Coats), Ltd; DaVita Medical Group California, P.C.; DaVita Medical Group Associates California, Inc.; HealthCare Partners Affiliates Medical Group and its subsidiary medical groups; DaVita Medical Group ARTA Health Network California, P.C.; and DaVita Medical Group ARTA Western California, Inc.

The settlement was the result of a coordinated effort by the Civil Division’s Commercial Litigation Branch, the United States Attorneys Office for the Central District of California, and HHS-OIG.

The claims resolved by the settlement are allegations only, and there has been no determination of liability. The case is captioned *United States ex rel. Swoben v. Secure Horizons, et al.*, 09-5013 (C.D. Cal.).

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