THE UNITED STATES DEPARTMENT of JUSTICE
STICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Monday, November 16, 2020

Medicare Advantage Provider to Pay $6.3 Million to Settle False Claims Act Allegations

Kaiser Foundation Health Plan of Washington, formerly known as Group Health Cooperative (GHC), agreed to pay $6,375,000 to resolve allegations that it submitted invalid diagnoses to Medicare for Medicare Advantage beneficiaries and received inflated payments from Medicare as a result, the Justice Department announced today. Kaiser Foundation Health Plan is headquartered in Oakland, California.

"The United States relies on Medicare Advantage Organizations to submit accurate diagnosis data to Medicare to ensure that the compensation they receive is appropriate," said Assistant Attorney General Jeffrey Bossert Clark of the Department of Justice's Civil Division. "We will continue to pursue those who undermine the integrity of the Medicare program and the data it relies upon."

"When insurance providers take advantage of Medicare and falsely claim that they are entitled to repayment for unsupported diagnoses, American taxpayers suffer in the form of higher costs," stated U.S. Attorney James Kennedy, Jr. of the Western District of New York. "We will continue to work to ensure that these programs are not defrauded and that monies are not paid for unwarranted claims."

Under the Medicare Advantage program, also known as Medicare Part C, Medicare beneficiaries may opt to obtain health care coverage through private insurance plans that are owned and operated by private insurers known as Medicare Advantage Organizations (MAOs). Medicare pays MAOs a fixed, monthly amount to provide health care coverage to Medicare beneficiaries who enroll in their plans. Medicare adjusts these monthly payments to reflect the health status of each beneficiary. In general, Medicare pays MAOs more for sicker beneficiaries and less for healthier ones.

MAOs report beneficiary diagnoses and other information to Medicare on an annual basis and Medicare uses this information to adjust the payments that the MAO receives from Medicare. The settlement resolves allegations that GHC knowingly submitted diagnoses that were not supported by the beneficiaries' medical records to inflate the payments that it received from Medicare.

The settlement resolves allegations originally brought in a lawsuit filed under the *qui tam*, or whistleblower, provisions of the False Claims Act by Teresa Ross, a former employee of Group Health. The act permits private parties to sue on behalf of the government for false claims for government funds and to receive a share of any recovery. Ms. Ross will receive approximately $1,500,000.

The government's intervention in this matter illustrates its emphasis on combating health care 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 handled by the Civil Division's Commercial Litigation Branch, the United States Attorney's Office for the Western District of New York, and the Department of Health and Human Services, Office of Inspector General.

The case is docketed as *United States ex rel. Teresa Ross v. Group Health Cooperative, Independent Health Association, Independent Health Corporation, DxID LLC, Elizabeth Gaffney, and John Haughton, M.D.*, No. 12-CV-0299S (W.D.N.Y.).

The claims resolved by the settlement are allegations only; there has been no determination of liability.

Topic(s):
False Claims Act

Component(s):
Civil Division

Press Release Number:
20-1241

Updated November 16, 2020