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Government Intervenes in False Claims Act Lawsuits Against Kaiser Permanente Affiliates for Submitting Inaccurate Diagnosis Codes to the Medicare Advantage Program

The United States has intervened in six complaints alleging that members of the Kaiser Permanente consortium violated the False Claims Act by submitting inaccurate diagnosis codes for its Medicare Advantage Plan enrollees in order to receive higher reimbursements.

The Kaiser Permanente consortium members (collectively Kaiser) are Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group Inc., Southern California Permanente Medical Group Inc. and Colorado Permanente Medical Group P.C. Kaiser is headquartered in Oakland, California.

"Medicare's managed care program relies on the accuracy of information submitted by health care providers and plans to ensure that patients receive the appropriate level of care, and that plans receive the appropriate compensation," said Deputy Assistant Attorney General Sarah E. Harrington of the Justice Department's Civil Division. "Today's action sends a clear message that we will hold health care providers and plans accountable if they seek to game the system by submitting false information."

"The integrity of government health care programs must be protected," said Acting U.S. Attorney Stephanie Hinds for the Northern District of California. "The Medicare Advantage Program maintains the health of millions, and wrongful acts that defraud the program cannot continue and will be pursued."

"The federal government pays hundreds of billions of dollars every year to Medicare Advantage Plans," said Acting U.S. Attorney Matt Kirsch for the District of Colorado. "The District of Colorado will vigorously pursue investigations with our partners to make sure that money supports necessary health care, not fraud."

Under Medicare Advantage, also known as the Medicare Part C program, Medicare beneficiaries have the option of enrolling in managed care insurance plans called Medicare Advantage Plans (MA Plans). MA Plans are paid a per-person amount to provide Medicare-covered benefits to beneficiaries who enroll in one of their plans. The Centers for Medicare and Medicaid Services (CMS), which oversees the Medicare program, adjusts the payments to MA Plans based on demographic information and the diagnoses of each plan beneficiary. The adjustments are commonly referred to as "risk scores." In general, a beneficiary with more severe diagnoses will have a higher risk score, and CMS will make a larger risk-adjusted payment to the MA Plan for that beneficiary.

Medicare requires that, for outpatient medical encounters, MA Plans submit diagnoses to CMS only for conditions that required or affected patient care, treatment or management during an in-person encounter in the service year. In order to increase its Medicare reimbursements, Kaiser allegedly pressured its physicians to create addenda to medical records after the patient encounter, often months or over a year later, to add risk-adjusting diagnoses that patients did not actually have and/or were not actually considered or addressed during the encounter, in violation of Medicare requirements.

The lawsuits were filed under the *qui tam,* or whistleblower*,* provisions of the False Claims Act, which permit private parties to sue on behalf of the government for false claims and to receive a share of any recovery. The False Claims Act also permits the government to intervene in such lawsuits, as it has done, in part, in these cases. The cases are consolidated in the Northern District of California and captioned *United States ex rel. Osinek v. Kaiser Permanente*, 3:13-cv-03891 (N.D. Cal.); *United States ex rel. Taylor v. Kaiser Permanente*, et al., 3:21-cv-03894 (N.D. Cal.); *United States ex rel. Arefi, et al. v. Kaiser Foundation Health Plan, Inc., et al.*, 3:16-cv-01558 (N.D. Cal.); *United States ex rel. Stein, et al. v. Kaiser Foundation Health Plan, Inc., et al.*, 3:16-cv-05337 (N.D. Cal.); *United States ex rel. Bryant v. Kaiser Permanente, et al.*, 3:18-cv-01347 (N.D. Cal.); and *United States ex rel. Bicocca v. Permanente Med. Group, Inc., et al.*, No. 3:21-cv-03124 (N.D. Cal.).

This matter was investigated by the Civil Division's Commercial Litigation Branch, Fraud Section, and the U.S. Attorney's Offices for the Northern District of California and the District of Colorado, with assistance from HHS-OIG.

The claims in which the United States has intervened are allegations only, and there has been no determination of liability.

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