Managed Care Organization ("MCO") Fraud

As more Medicare and Medicaid patients enroll in private managed care plans, fraud by managed care organizations poses an increasing risk to taxpayers, and an opportunity for whistleblowers to receive rewards. About one-third of people in Medicare and Medicaid are enrolled in managed care plans, and the numbers are growing. As such, this is an area that is an increasingly hot spot for potential fraud and abuse under the False Claims Act ("FCA") and in Texas under the Texas Medicaid Fraud and Prevention Act ("TMFPA").

Medicare and the State of Texas Medicaid programs have traditionally paid healthcare providers a fixed fee for each service provided to a Medicare or Medicaid beneficiary. This reimbursement model is known as "fee-for-service" and is still the most prevalent payment system for traditional Medicare beneficiaries. In contrast, a managed care system involves Medicare or Medicaid paying private insurance providers, also known as managed care organizations ("MCO's"), to provide healthcare coverage to Medicare or Medicaid beneficiaries through privately run insurance plans.

How MCO's Work

MCO's contract with the government to administer Medicare Part C and Medicaid Managed Care benefits, i.e. to submit beneficiaries' service claims to the government and to ensure that health care providers are paid for those services. The MCOs are required to offer only insurance plans that provide the same level of service to patients as available through traditional Medicare or Medicaid. Under these contracts, the government pays MCOs a capitated rate based on beneficiaries' risk scores. CMS calculates risk scores based on several factors, including the number of Medicare and Medicaid beneficiaries enrolled in a Plan as well as those beneficiaries' demographics. CMS makes these capitated, fixed per-member-per-month payments to the Plans regardless of the amount of services an enrollee actually uses during the Plan year. These payments also cover the MCO's administrative costs.

Health care providers, such as dentists, hospitals and doctors, contract with certain MCOs to provide enrollees with health care services. These dentists, hospitals and doctors bill MCOs for the medical services or procedures performed and receive a share of each treated beneficiary's capitated payment. Those bills, and the underlying medical records, contain diagnoses codes that correspond to the procedures and services provided.

MCOs are obligated to use due diligence to ensure the accuracy of all the data submitted. The MCOs and entities that contract with them are also required to have proper systems and procedures in place to ensure that they only pay for services that are determined to be medically necessary and reasonable based on objective medical criteria. However, managed care also creates powerful incentives for MCOs, health care providers, and others who contract with them to exaggerate the expected health care costs for the beneficiaries in their Plans and thereby increase government

payments per member. Our firm is currently pursuing one of the largest *qui tam* MCO fraud lawsuits in the country pursuant to the TMFPA (and other false claims statutes in other states) seeking a recovery of approximately $7 Billion on behalf of the State of Texas and several other states against a MCO and the organizations that contracted with the MCO, among other Defendants.

Common MCO Fraud Schemes

Whistleblowers and the government have already exposed many ways that MCOs and health care providers who contract with them, can and have defrauded the government. Examples of common fraud schemes by MCOs that can lead to FCA and/or TMFPA liability include:

- "upcoding" or exaggerating their members' diagnostic data to cause the government to pay out more risk adjustment reimbursement than is warranted.
- manipulating quality metrics to receive Quality Bonus Payments to which they are not entitled.
- improperly avoiding their obligations to repay to the government monies to which the MCOs. Plans, or others were not entitled.
- failing to maintain adequate fraud and abuse prevention and compliance programs.
- causing the government to set inaccurate, inflated capitation payment rates.
- misrepresenting the MCO's true profit margin.
- minimizing risk by enrolling a disproportionately healthy pool of beneficiaries.
- misrepresenting the proportion of funds spent on patient care and quality improvement measures.

Blow the Whistle on MCO Fraud

Individuals with knowledge of fraud committed by managed care organizations, or by providers and others doing business with managed care organizations, may be able to blow the whistle on this kind of fraud using the FCA, the TMFPA and other whistleblower reward programs. Whistleblowers play a critical role in bringing this type of MCO fraud to light and holding wrongdoers accountable. If you would like more information, please call MCO Attorney Rusty Tucker at 214-505-0097 or contact me online for a free consultation.

Example of Whistleblower Award in a Managed Care Case:

In August 0f 2019, the **whistleblower received $850,000** when a Medicare Advantage Provider and Physician agreed to pay more than **$5 million** to resolve allegations that they reported invalid diagnoses to Medicare Advantage plans and in doing so caused the plans to receive inflated payments from Medicare and increased their own share of payments received from the Medicare Advantage Organizations. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Medicare Advantage Provider and Physician to Pay $5 Million to Settle False Claims Act Allegations (Aug. 8, 2019), https://www.justice.gov/opa/pr/medicare-advantage-provider-and-physician-pay-5-million-settle-false-claims-act-allegations.