The New York Times https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html

'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions

By next year, half of Medicare beneficiaries will have a private Medicare Advantage plan. Most large insurers in the program have been accused in court of fraud.

Top 10 Medicare Advantage Providers	Accused of fraud by whistle-blower	Accused of fraud by U.S. government	Overbilled, according to Inspector General
UnitedHealth Group 27.1% of market	✓	✓	✓
Humana 17.4%	✓		✓
CVS Health 10.7%			✓
Elevance Health 6.5%		✓	✓
Kaiser Permanente 6.1%	✓	✓	
Centene 5.0%			
Blue Cross Blue Shield of Mich. 2.2%			✓
Cigna 1.9%	✓	✓	✓
Highmark 1.3%			✓
Scan Group 0.9%	✓	✓	✓

Note: The lawsuit against Scan was settled in 2012, and the lawsuit against Humana was settled in 2018. Lawsuits against other insurers are ongoing, and the insurers have disputed the claims. The government has joined the lawsuit against Cigna, but will not file detailed allegations until later this month. • Source: Market share data from Mark Farrah Associates • The New York Times


By Reed Abelson and Margot Sanger-Katz

Oct. 8, 2022

The health system Kaiser Permanente called doctors in during lunch and after work and urged them to add additional illnesses to the medical records of patients they hadn't seen in weeks. Doctors who found enough new diagnoses could earn bottles of Champagne, or a bonus in their paycheck.

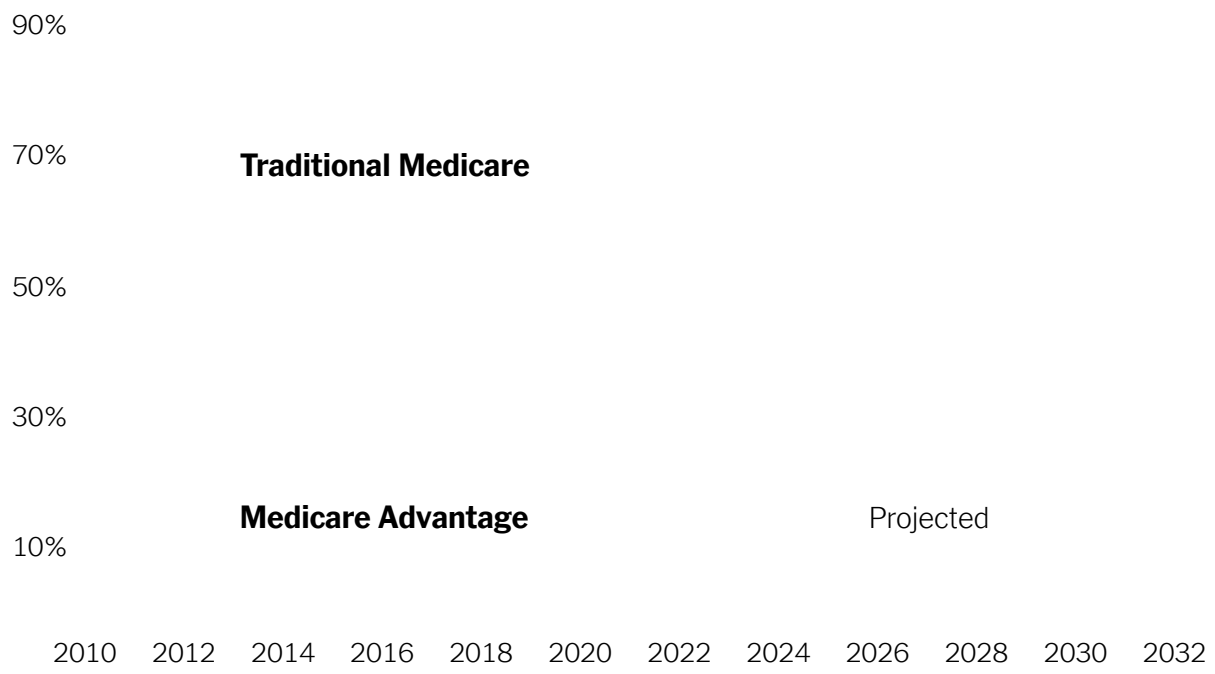
Anthem, a large insurer now called Elevance Health, paid more to doctors who said their patients were sicker. And executives at UnitedHealth Group, the country's largest insurer, told their workers to mine old medical records for more illnesses — and when they couldn't find enough, sent them back to try again.

Each of the strategies — which were described by the Justice Department in lawsuits against the companies — led to diagnoses of serious diseases that might have never existed. But the diagnoses had a lucrative side effect: They let the insurers collect more money from the federal government's Medicare Advantage program.

Medicare Advantage, a private-sector alternative to traditional Medicare, was designed by Congress two decades ago to encourage health insurers to find innovative ways to provide better care at lower cost. If trends hold, by next year, more than half of Medicare recipients will be in a private plan.

Soon, Half of Medicare Will be Privatized

Medicare Advantage is on track to enroll most Medicare beneficiaries by next year.



Note: Traditional Medicare share based on enrollment in Medicare Part B. • Source: Kaiser Family Foundation analysis of data from Medicare and the Congressional Budget Office • The New York Times

But a New York Times review of dozens of fraud lawsuits, inspector general audits and investigations by watchdogs shows how major health insurers exploited the program to inflate their profits by billions of dollars.

The government pays Medicare Advantage insurers a set amount for each person who enrolls, with higher rates for sicker patients. And the insurers, among the largest and most prosperous American companies, have developed elaborate systems to make their patients appear as sick as possible, often without providing additional treatment, according to the lawsuits.

As a result, a program devised to help lower health care spending has instead become substantially more costly than the traditional government program it was meant to improve.

Eight of the 10 biggest Medicare Advantage insurers — representing more than two-thirds of the market — have submitted inflated bills, according to the federal audits. And four of the five largest players — UnitedHealth, Humana, Elevance and Kaiser — have faced federal lawsuits alleging that efforts to overdiagnose their customers crossed the line into fraud.

The fifth company, CVS Health, which owns Aetna, told investors its practices were being investigated by the Department of Justice.

In statements, most of the insurers disputed the allegations in the lawsuits and said the federal audits were flawed. They said their aim in documenting more conditions was to improve care by accurately describing their patients' health.

Many of the accusations reflect missing documentation rather than any willful attempt to inflate diagnoses, said Mark Hamelburg, an executive at AHIP, an industry trade group. "Professionals can look at the same medical record in different ways," he said.

The government now spends nearly as much on Medicare Advantage's 29 million beneficiaries as on the Army and Navy combined. It's enough money that even a small increase in the average patient's bill adds up: The additional diagnoses led to $12 billion in overpayments in 2020, according to an estimate from the group that advises Medicare on payment policies — enough to cover hearing and vision care for every American over 65.

Another estimate, from a former top government health official, suggested the overpayments in 2020 were double that, more than $25 billion.

Medicare Advantage Overbilling Exceeds Entire Agency Budgets

Medicare Advantage overbilling	**Between $12 and $25 billion**
NASA	$21.5
Children's Health Insurance Program (CHIP)	$16.9
U.S. Customs and Border Protection	$16.7
Federal Bureau of Investigation	$9.8
Environmental Protection Agency	$8.7
Federal prison system	$7.8

Note: Figures represent outlays in the 2020 fiscal year. • Sources: White House Office of Management and Budget; Medicare Payment Advisory Commission; Richard Kronick and F. Michael Chua • The New York Times

The increased privatization has come as Medicare's finances have been strained by the aging of baby boomers. But for insurers that already dominate health care for workers, the program is strikingly lucrative: A study from the Kaiser Family Foundation, a research group unaffiliated with the insurer Kaiser, found the companies typically earn twice as much gross profit from their Medicare Advantage plans as from other types of insurance.

For people choosing between traditional Medicare and Medicare Advantage, there are trade-offs. Medicare Advantage plans can limit patients' choice of doctors, and sometimes require jumping through more hoops before getting certain types of expensive care.

But they often have lower premiums or perks like dental benefits — extras that draw beneficiaries to the programs. The more the plans are overpaid by Medicare, the more generous to customers they can afford to be.

"Medicare Advantage is an important option for America's seniors, but as Medicare Advantage adds more patients and spends billions of dollars of taxpayer money, aggressive oversight is needed," said Senator Charles Grassley of Iowa, who has investigated the industry. The efforts to make patients look sicker and other abuses of the program have "resulted in billions of dollars in improper payments," he said.

Many of the fraud lawsuits were initially brought by former employees under a federal whistle-blower law that allows them to get a percentage of any money repaid to the government if their suits prevail. But most have been joined by the Justice Department, a step the government takes only if it believes the fraud allegations have merit. Last year, the department's civil division listed Medicare Advantage as one of its top areas of fraud recovery.

"It's an extremely high priority for us," said Michael Granston, a deputy assistant attorney general for the civil division.

In contrast, regulators overseeing the plans at the Centers for Medicare and Medicaid Services, or C.M.S., have been less aggressive, even as the overpayments have been described in inspector general investigations, academic research, Government Accountability Office studies, MedPAC reports and numerous news articles, over the course of four presidential administrations.

Congress gave the agency the power to reduce the insurers' rates in response to evidence of systematic overbilling, but C.M.S. has never chosen to do so. A regulation proposed in the Trump administration to force the plans to refund the government for more of the incorrect payments has not been finalized four years later. Several top officials have swapped jobs between the industry and the agency.

C.M.S. officials declined interview requests. In a statement, the C.M.S. administrator, Chiquita Brooks-LaSure, said the agency recently sought feedback on how to improve the program. "We are committed to making sure that Medicare dollars are used efficiently and effectively in Medicare Advantage," she said.

The popularity of Medicare Advantage plans has helped them avoid legislative reforms. The plans have become popular in urban areas, and have been increasingly embraced by Democrats as well as Republicans. Nearly 80 percent of U.S. House members signed a letter this year saying they were "ready to protect the program from policies that would undermine" its stability.

"You have a powerful insurance lobby, and their lobbyists have built strong support for this in Congress," said Representative Lloyd Doggett, a Texas Democrat who chairs the House Ways and Means Health subcommittee.

Some critics say the lack of oversight has encouraged the industry to compete over who can most effectively game the system rather than who can provide the best care.

"Even when they're playing the game legally, we are lining the pockets of very wealthy corporations that are not improving patient care," said Dr. Donald Berwick, a C.M.S. administrator under the Obama administration, who recently published a series of blog posts on the industry. "When you skate to the edge of the ice, sometimes you're going to fall in."

Medicare Advantage Is Especially Popular in Many Urban and Suburban Areas

The program's growth in Democratic strongholds has helped secure it widespread political support.

Share of Medicare patients enrolled

0% 15% 35% 50% 65%

Source: Kaiser Family Foundation analysis of Medicare enrollment data • The New York Times

The program's promise

Congress's first attempt to design a privatized Medicare plan paid insurers the same amount for every patient with similar demographic characteristics.

In theory, if the insurers could do better than traditional Medicare — by better managing patients' care, or otherwise improving their health — their patients would cost less and the insurers would make more money.

But some insurers engaged in strategies — like locating their enrollment offices upstairs, or offering gym memberships — to entice only the healthiest seniors, who would require less care, to join. To deter such tactics, Congress decided to pay more for sicker patients.

Almost immediately, companies saw ways to exploit that system. The traditional Medicare program provided no financial incentive to doctors to document every diagnosis, so many records were incomplete. Under the new program, insurers began rigorously documenting all of a patient's health conditions — say depression, or a long-ago stroke — even when they had nothing to do with the patient's current medical care.

In one early case, a Florida medical practice was accused of falsifying diagnoses to enrich its owner and Humana. When Humana told the doctor who owned the practice that his Medicare risk adjustment, or M.R.A., scores had increased significantly, he responded by

email, according to the whistle-blower lawsuit: “Good, I am trying to buy that house based on M.R.A. scores.” The case was settled for more than $3 million.

The doctor denied any wrongdoing. Humana declined to comment on the lawsuit and said it takes compliance “seriously.” The company recently told investors it had been questioned by the Justice Department about its billing practices and expected additional litigation.

At least three insurers were accused of paying doctors or nurses more for recording additional diagnoses.

UnitedHealth Group	Humana	Elevance Health	Kaiser Permanente	Cigna	Scan Group

Note: Table includes insurers among the top 10 Medicare Advantage providers that face or have settled lawsuits for risk adjustment fraud. • The New York Times

At conferences, companies pitched digital services to analyze insurers’ medical records and suggest additional codes. Such consultants were often paid on commission; the more money the analysis turned up, the more the companies kept.

The insurers also began hiring agencies that sent doctors or nurses to patients’ homes, where they could diagnose them with more diseases.

One company, Mobile Medical Examination Services, worked with Anthem and Molina, among others. Its doctors and nurses were pushed to document a range of diagnoses, including some — vertebral fractures, pneumonia and cancer — they lacked the equipment to detect, according to a whistle-blower lawsuit. According to the lawsuit, employees who drew patients’ blood often were not provided with a centrifuge or cooler; spoiled blood analyzed a day later produced strange results that could be used to justify valuable diagnoses, including kidney disease and leukemia. The company was acquired by Quest Diagnostics after the case was settled for an undisclosed amount in 2016; Quest said the company complies with all federal and state laws and regulations.

concern about making such changes. According to that executive, she told two of her peers in March 2016 that she was "not inclined to change" chart review in any way because "[chart review] is a cash cow" for Anthem by virtue of its having "a high ROI."

Anthem: The Justice Department suit quotes an executive describing her reluctance to change how it mined medical records for additional diagnoses. The case is continuing.

Cigna hired firms to perform similar at-home assessments that generated billions in extra payments, according to a 2017 whistle-blower lawsuit, which was recently joined by the Justice Department. The firms told nurses to document new diagnoses without adjusting medications, treating patients or sending them to a specialist.

According to the lawsuit, some patients were diagnosed with cancer and heart disease. Nurses were told to especially look for patients with a history of diabetes because it was not "curable," even if the patient now had normal lab findings or had undergone surgery to treat the condition.

The company declined to comment. "We will vigorously defend our Medicare Advantage business against these allegations," Cigna said in an earlier statement regarding the lawsuit.

Adding the code for a single diagnosis could yield a substantial payoff. In a 2020 lawsuit, the government said Anthem instructed programmers to scour patient charts for "revenue-generating" codes. One patient was diagnosed with bipolar disorder, although no other doctor reported the condition, and Anthem received an additional $2,693.27, the lawsuit said. Another patient was said to have been coded for "active lung cancer," despite no evidence of the disease in other records; Anthem was paid an additional $7,080.74. The case is continuing.

The most common allegation against the companies was that they did not correct potentially invalid diagnoses after becoming aware of them. At Anthem, for example, the Justice Department said "thousands" of inaccurate diagnoses were not deleted. According to the lawsuit, a finance executive calculated that eliminating the inaccurate diagnoses would reduce the company's 2017 earnings from reviewing medical charts by $86 million, or 72 percent.

At least five insurers were accused of failing to remove potentially invalid diagnoses.

UnitedHealth Elevance Kaiser

Group Humana Health Permanente Cigna Scan Group

Note: Table includes insurers among the top 10 Medicare Advantage providers that face or have settled lawsuits for risk adjustment fraud. • The New York Times

In a statement, the company, now named Elevance, said it would "vigorously defend our Medicare risk adjustment practices" and accused the government of holding it to standards "that are not grounded in formal statutory and regulatory rules."

Some of the companies took steps to ensure the extra diagnoses didn't lead to expensive care. In an October 2021 lawsuit, the Justice Department estimated that Kaiser earned $1 billion between 2009 and 2018 from additional diagnoses, including roughly 100,000 findings of aortic atherosclerosis, or hardening of the arteries. But the plan stopped automatically enrolling those patients in a heart attack prevention program because doctors would be forced to follow up on too many people, the lawsuit said.

At least two insurers were accused of discouraging care for the new diseases they added.

UnitedHealth Group Humana Elevance Health Kaiser Permanente Cigna Scan Group

Note: Table includes insurers among the top 10 Medicare Advantage providers that face or have settled lawsuits for risk adjustment fraud. • The New York Times

Kaiser, which both runs a health plan and provides medical care, is often seen as a model system. But its control over providers gave it additional leverage to demand additional diagnoses from the doctors themselves, according to the lawsuit.

"The cash monster was insatiable," said Dr. James Taylor, a former coding expert at Kaiser who is one of 10 whistle-blowers to accuse the organization of fraud.

At meetings with supervisors, he was instructed to find additional conditions worth tens of millions of dollars. "It was an actual agenda item and how could we get this," Dr. Taylor said.

Dr. James Taylor is one of 10 whistle-blowers who have accused Kaiser of fraud. “The cash monster was insatiable,” he said. Rachel Woolf for The New York Times

Marc T. Brown, a Kaiser spokesman, said in a statement, “We are confident in our compliance with Medicare Advantage risk-adjustment program requirements,” and added, “Our policies and practices represent well-reasoned and good-faith interpretations of sometimes vague and incomplete guidance from C.M.S.”

Last year, the inspector general’s office noted that one company “stood out” for collecting 40 percent of all Medicare Advantage’s payments from chart reviews and home assessments despite serving only 22 percent of the program’s beneficiaries. It recommended Medicare pay extra attention to the company, which it did not name, but the enrollment figure matched UnitedHealth’s.

A civil trial accusing UnitedHealth of fraudulent overbilling is scheduled for next year. The company’s internal audits found numerous mistakes, according to the lawsuit, which was joined by the Justice Department. Some doctors diagnosed problems like drug and alcohol dependence or severe malnutrition at three times the national rate. But UnitedHealth declined to investigate those patterns, according to the suit.

> Wanted to get together with you and discuss what we can do in the short term and long term to really go after the potential risk scoring you have consistently indicated is out there. . . . You mentioned vasculatory disease opportunities, screening opportunities, etc with huge $ opportunities. Lets turn on the gas!
>
> **UnitedHealth Group:** A whistle-blower complaint quotes an executive’s email to a firm that was helping the company review patient medical records. A trial is scheduled for next year.

Matthew Wiggin, a spokesman for the company, called the inspector general’s report “misleading.” He said the company uses diagnostic coding to improve patient care, and noted that the whistle-blower in the lawsuit had not worked for the company in nearly a decade. “Our chart review process complies with regulatory standards,” he said, adding, “Our robust compliance program also proactively seeks to identify fraud, waste and abuse in the system.”

The company countered by suing Medicare, arguing that it wasn't required to fix inaccurate records before regulations changed in 2014. It won at first, then lost on appeal. In June, the Supreme Court declined to hear the case.

Inaction at Medicare

Even before the first lawsuits were filed, regulators and government watchdogs could see the number of profitable diagnoses escalating. But Medicare has done little to tamp down overcharging.

Several experts, including Medicare's advisory commission, have recommended reducing all the plans' payments. Congress has ordered several rounds of cuts and gave C.M.S. the power to make additional reductions if the plans continued to overbill. The agency has not exercised that power.

The agency does periodically audit insurers by looking at a few hundred of their customers' cases. But insurers are fined for billing mistakes found only in those specific patients. A rule proposed during the Trump administration to extrapolate the fines to the rest of the plan's customers has not been finalized.

Some of the agency's top leaders have had close ties to industry. Marilyn Tavenner, a former C.M.S. administrator, left in 2015, then ran the main trade group for health insurers; she was replaced by Andy Slavitt, a former executive at UnitedHealth. Jonathan Blum, the agency's current chief operating officer, worked for an insurer after leaving the agency in 2014, then became an industry consultant, before returning to Medicare last year.

Ted Doolittle, who served as a senior official for the agency's Center for Program Integrity from 2011 to 2014, said officials at Medicare seemed uninterested in confronting the industry over these practices. "It was clear that there was some resistance coming from inside" the agency, he said. "There was foot dragging."

There are signs the problem is continuing.

"We are hearing about it more and more," said Jacqualine Reid, a government research analyst at the Office of Inspector General who has analyzed Medicare Advantage overbilling.

> *Each of these diagnoses adds about $2500 to our bottom line*." (Emphasis added.) Reflective of how focused Kaiser was on getting this money, she offered to "drive around and sit with people personally if that is what it takes, usually it just takes the chief telling them to do it. In past years, I recall doctors were placed on a work improvement plan if they didn't complete this work. I will let you operations guys decide if that is what it takes."

Kaiser Permanente: An executive discussed punishing doctors who failed to review patient records for more diseases, according to a Justice Department lawsuit. The case is continuing.

The Justice Department has brought or joined 12 of the 21 cases that have been made public. But whistle-blower cases remain secret until the department has evaluated them. "We're aware of other cases that are under seal," said Mary Inman, a partner at the firm Constantine Cannon, which represents many of the whistle-blowers.

But few analysts expect major legislative or regulatory changes to the program.

"Medicare Advantage overpayments are a political third rail," said Dr. Richard Gilfillan, a former hospital and insurance executive and a former top regulator at Medicare, in an email. "The big health care plans know it's wrong, and they know how to fix it, but they're making too much money to stop. Their C.E.O.s should come to the table with Medicare as they did for the Affordable Care Act, end the coding frenzy, and let providers focus on better care, not more dollars for plans."

Alicia Parlapiano contributed graphics.