

Enforcement Standards Tighten on Private Insurers: Sutter Health Settles for \$90 Million Following Dispute With DOJ

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by Samuel F.B. Audley

On August 30, 2021, the Department of Justice (“DOJ”) announced that Sutter Health and several of its affiliated entities (“Sutter”) agreed to pay a total of \$90 million to settle allegations that Sutter violated the False Claims Act (“FCA”), 31 U.S.C. §§ 3729-3733, by “knowingly submitting inaccurate information about the health status of beneficiaries enrolled in Medicare Advantage Plans.” *Sutter Health and Affiliates to Pay \$90 Million to Settle False Claims Act Allegations of Mischarging the Medicare Advantage Program*, Department of Justice (Aug. 30, 2021), <https://www.justice.gov/opa/pr/sutter-health-and-affiliates-pay-90-million-settle-false-claims-act-allegations-mischarging>. As a part of its settlement, Sutter also entered into a five-year Corporate Integrity Agreement with the U.S. Department of Health and Human Services to implement a centralized risk assessment program. *Id.*

The central allegation from *qui tam* Plaintiff Kathy Ormsby (“Ormsby”) was that Sutter had submitted inaccurate and unsupported medical information that artificially inflated Medicare reimbursement for Sutter’s Medicare Advantage patients. *United States ex rel. Kathy Ormsby v. Sutter Health*, No. 3:15-cv-01062-LB, 444 F. Supp. 3d 1010 (N.D. Cal. 2020).

In December of 2018, the United States formally intervened in the case and took primary responsibility for prosecuting the action. Shortly thereafter, Sutter agreed to pay \$30 million to settle some of the allegations in April of 2019, but explicitly denied any liability related to the allegations. In so doing, Sutter argued that the United States had taken a mistaken approach to the case by applying an analysis involving traditional Medicare programs (using a fee-for-service model) as opposed to focusing on the unique nature of Medicare Advantage, which Sutter argued “is a fundamentally different program with its own unique standards for establishing overpayments” and thus the United States was relying on an inapplicable FCA theory of liability. Sutter argued the United States had not, and indeed could not, prove that Sutter had knowingly submitted false claims or received overpayments for submitted claims that they failed to return.

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- Samuel F.B. Audley

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Ultimately, Sutter returned to the table to discuss settling the Medicare Advantage claims following recent FCA decisions holding that the overpayment rule did not improperly hold private insurers to higher standards on the basis that nothing in the FCA renders actuarial equivalence a defense against the obligation to refund any individual, known overpayment. This is expected to buttress FCA enforcement by rejecting the idea that Medicare Advantage insurers receive apples-to-apples reimbursement with traditional Medicare.

Sutter eventually settled the remaining claims for \$60 million, bringing the total amount of the settlement to \$90 million in addition to implementing further oversight and compliance mandates. The settlement between Sutter and the United States makes clear that defendants claiming protection against FCA enforcement should be careful when relying on rapidly changing FCA precedent. Though defendants may be tempted to highlight and defend their actions under novel legal theories, the attention brought by said action may invite unwanted scrutiny, and ultimately, harsher penalties as opposed to settling and adjusting internal procedures early in the dispute.