

Sutter Health LLC Pays \$30 Million to Settle Alleged Overpayment of Medicare Advantage Funds, but Faces Similar Allegations in Separate Qui Tam

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On April 12, 2019, the U.S. Department of Justice announced Sutter Health LLC—along with its affiliates Sutter East Bay Medical Foundation, Sutter Pacific Medical Foundation, Sutter Gould Medical Foundation, and Sutter Medical Foundation—would pay \$30 million to settle allegations they provided inaccurate information about Medicare Advantage Plan beneficiaries in order to receive inflated payments. The settlement stems from a coordinated effort between the U.S. Department of Health and the Department of Justice to combat waste, fraud, and abuse in health care.

Approximately one third of Medicare recipients are enrolled in managed care “Medicare Advantage” plans, which are run by Medicare Advantage Organizations. Under Medicare Advantage plans, the federal government pays Medicare Advantage Organizations a monthly fee per enrollee (“capitation”), instead of paying the care provider on a fee-for-service basis. The federal government does not pay a flat per-beneficiary fee; instead it adjusts capitation payments based on beneficiaries’ “risk scores.” Risk scores are informed by patient diagnostics and reflect the relative cost and complexity of beneficiaries’ medical needs. Medicare Advantage Organizations receive bigger capitation payments for beneficiaries who have higher risk scores.

Sutter Health was not a Medicare Advantage Organization. Instead, it was a healthcare service provider, which contracted with several Medicare Advantage Organizations to provide care to certain Medicare Advantage Plans’ enrollees. In exchange, Sutter received a share of the Medicare Advantage Organizations’ federal capitation payments.

Justice and the Centers for Medicare and Medicaid Services alleged the federal government overpaid for capitation payments. The government claimed Sutter Health based capitation payments upon inflated diagnostic codes that the Medicare Advantage Organizations fraudulently submitted to the federal government. With its \$30 million payment, Sutter Health settles allegations that it reported inflated and unsubstantiated diagnoses and procedures to the Medicare Advantage Organizations for the patients it

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treated, thus settling its alleged role in the overpayments.

In March of this year, DOJ filed a complaint alleging substantially similar conduct against Sutter Health et al. after intervening in a separate qui tam suit. See *United States ex rel. Ormsby v. Sutter Health, et al.*, Case No. 15-CV-01062-JD (N.D. Cal.). That suit remains ongoing.