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Sutter Health and Affiliates to Pay $90 Million to Settle False Claims Act Allegations of Mischarging the Medicare Advantage Program

Sutter Health, a California-based health care services provider, and several affiliated entities including Sutter Bay Medical Foundation (dba Palo Alto Medical Foundation, Sutter East Bay Medical Foundation, and Sutter Pacific Medical Foundation) and Sutter Valley Medical Foundation (dba Sutter Gould Medical Foundation and Sutter Medical Foundation) (collectively, "Sutter Health"), have agreed to pay $90 million to resolve allegations that Sutter Health violated the False Claims Act by knowingly submitting inaccurate information about the health status of beneficiaries enrolled in Medicare Advantage Plans.

Under Medicare Advantage, also known as the Medicare Part C program, Medicare beneficiaries have the option of enrolling in managed health care insurance plans called Medicare Advantage Plans. The plans are paid a capitated, or per-person, amount to provide Medicare-covered benefits to beneficiaries who enroll in one of their plans. Payments to plans are based on demographic information and the health status of each plan beneficiary. In general, plans receive larger payments for beneficiaries with more severe diagnoses.

Sutter Health, headquartered in Sacramento, contracted to provide health care services to California beneficiaries enrolled in certain plans. In exchange, Sutter Health received a portion of the payments for treating the beneficiaries under its care.

The government alleged that Sutter Health knowingly submitted unsupported diagnosis codes for certain patient encounters for beneficiaries under its care. These unsupported diagnosis codes caused inflated payments to be made to the plans and to Sutter Health. The lawsuit further alleged that, once Sutter Health became aware of these unsupported diagnosis codes, it failed to take sufficient corrective action to identify and delete additional unsupported diagnosis codes.

"The government relies on health care providers, including those furnishing services to Medicare Part C beneficiaries, to submit accurate information to ensure proper payment," said Deputy Assistant Attorney General Sarah E. Harrington of the Justice Department's Civil Division. "Today's result sends a clear message that we will hold health care providers responsible if they knowingly provide or fail to correct information that is untruthful."

"Today's settlement exemplifies our commitment to fighting fraud in the Medicare program," said Acting U.S. Attorney Stephanie M. Hinds for the Northern District of California. "Health care providers who flout the law need to know that my office will hold accountable those who pad their bottom line at taxpayer expense."

"The knowing submission of inaccurate information to Medicare diverts funds from this vital health care program, which is a disservice to patients needing care," said Special Agent in Charge Steven J. Ryan for the Office of Inspector General of the U.S. Department of Health and Human Services. "We will continue to work with our law enforcement partners to protect the integrity of federal health care programs and hold accountable entities who engage in false claims practices."

In connection with the settlement, Sutter Health, Sutter Bay Medical Foundation and Sutter Valley Medical Foundation entered into a five-year Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). The CIA requires, among other things, that Sutter Health implement a centralized risk assessment program as part of its compliance program and hire an Independent Review Organization to annually review a sample of Sutter Health's Medicare Advantage patients' medical records and associated diagnoses data.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Kathleen Ormsby, a former employee of Palo Alto Medical Foundation. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The Act permits the government to intervene in such lawsuits, as it has done in this case as to claims submitted for the Palo Alto Medical Foundation. Although the United States did not intervene as to claims submitted by the remaining Sutter affiliates, Ms. Ormsby continued to pursue those claims, some of which are also being resolved by this settlement. The *qui tam* case is captioned *United States ex rel. Ormsby v. Sutter Health, et al.*, No. 15-CV-01062-LB (N.D. Cal.).

The resolution obtained in this matter resulted from a coordinated effort between the Justice Department's Civil Division, Commercial Litigation Branch, Fraud Section, and the U.S. Attorney's Office for the Northern District of California, with assistance from HHS-OIG.

The investigation and resolution of this matter illustrate the government's emphasis on combating health care fraud. One of the most powerful tools in this effort is the False Claims Act. Tips and complaints from all sources about potential fraud, waste, abuse and mismanagement, can be reported to the Department of Health and Human Services at 800-HHS-TIPS (800-447-8477).

The matter was handled by Attorneys Olga Yevtukhova, Jennifer J. Koh, Thomas Morris and Lyle Gruby of the Civil Division's Fraud Section and by Assistant U.S. Attorney Benjamin Wolinsky for the Northern District of California, with assistance from Jonathan Birch.

The claims resolved by the settlement are allegations only and there has been no determination of liability.

Attachment(s):
Download Sutter Settlement Agreement.pdf
Download Sutter Complaint-in-Intervention.pdf

Topic(s):
Health Care Fraud

Component(s):
Civil Division
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