SPEAK UP:

A Whistleblower's Guide to **Exposing Fraud in Managed Care Insurance**

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Are you being ***manipulated into participating*** in fraudulent managed care insurance practices?

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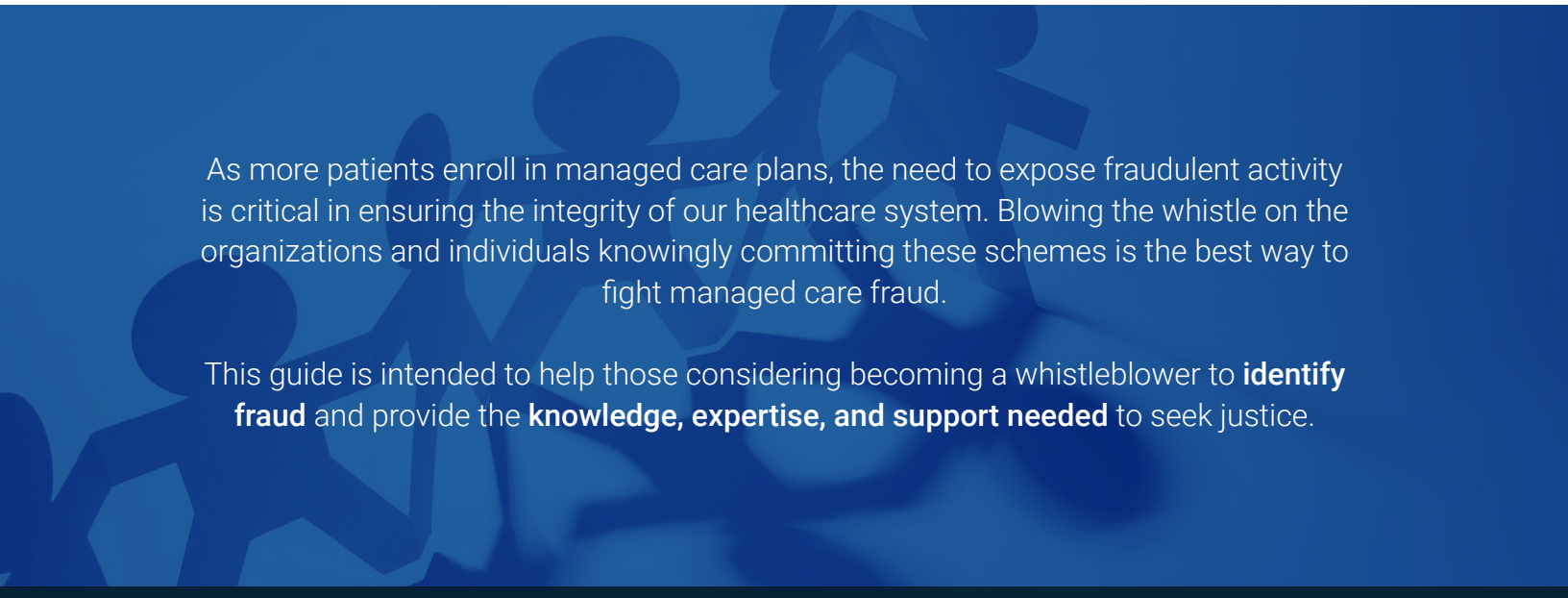
Introduction

Fraud in managed care is an unfortunate reality that costs the government and taxpayers billions of dollars each year. Schemes like falsifying patient records, upcoding, adverse selection, and enrollment fraud siphon money away from the 160 million Americans enrolled in legitimate government healthcare programs, increase taxes, and contribute to rising healthcare costs.

However, financial losses aren't the only consequence as a result of managed care fraud. There's also a human side to fraud in managed care. Innocent people become victims when dishonest Managed Care Organizations (MCOs) and middleman coding companies compromise an individual's medical records by submitting falsified claims and miscoding patient diagnoses in order to line their pockets with additional funds. When these organizations and their employees upcode medical bills for Medicare and Medicaid patients, they cheat those healthcare programs of needed funds.

Additional victims of managed care fraud are the employees and physicians who are forced or manipulated into participating in the company's criminal activities. Fraud in managed care is a crime against the community, families, the government, and all the honest doctors across the medical field. It has a massive chain of impact that leads to rising healthcare costs, higher taxes, and reduced care.

Managed Care Fraud
has a **massive**
chain of impact.



As more patients enroll in managed care plans, the need to expose fraudulent activity is critical in ensuring the integrity of our healthcare system. Blowing the whistle on the organizations and individuals knowingly committing these schemes is the best way to fight managed care fraud.

This guide is intended to help those considering becoming a whistleblower to **identify fraud** and provide the **knowledge, expertise, and support needed** to seek justice.

The History of Managed Care

Managed care is a form of health insurance that aims to reduce costs and improve quality of care by leveraging contracts with care providers and medical facilities, which increases the efficiency of coordinated patient care. Managed care programs are used in both federal and state healthcare programs.

Before managed care, healthcare was financed by a fee-for-service system in which a physician would perform a service and charge the patient a fee. The patient would either pay for the service out-out-of-pocket or send the bill to their insurer for reimbursement. However, the fee-for-service lacked cost efficiency. In response to this inefficient and often unaffordable system, the Nixon administration passed the Health Maintenance Organization (HMO) Act of 1973 to decrease costs for healthcare for consumers through the establishment and expansion of HMOs. By emphasizing health maintenance, HMOs could prevent health problems before they developed and, thus, efficiently manage healthcare inflation, which was spiraling out of control in the fee-for-service system. The mechanisms and aims of managed care, such as cost-sharing, admissions controls, and service reviews, were originally pioneered by HMOs.

In managed care, federal and state governments contract private insurers, also known as Managed Care Organizations (MCO), to provide health insurance benefits to government beneficiaries enrolled in Medicare and Medicaid plans. The plans are paid a capitated, or per-person, amount to provide 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 — this was intended to solve a growing problem in our country. Unfortunately, this is typically when fraud occurs. Corrupt MCOs involved in managed care fraud will often game the reimbursement system to retain more than their fair share of government funds by falsifying patient records and miscoding patient diagnoses.

WAS IT FRAUD?
How To Know if What You Witnessed Was Illegal

Whistleblowers and the government have uncovered several schemes, like upcoding, phantom billing, and inflated risk scores, that MCOs, and others in business with MCOs, have used to defraud the healthcare system.

Here are some examples of fraudulent schemes in managed care:

Risk Adjustment Fraud occurs when MCOs, coding companies, and others contracted to work with other government insurers seek to game the healthcare system by inflating the risk profile of patients. This can involve a physician IPA or even a third party medical coding company that is contracted to the MCOs. Because risk adjustment payments are calculated based on members' diagnoses, plans have developed a number of schemes aimed at "upcoding" or exaggerating the severity of members' diagnoses or medical conditions to cause the government to pay out more risk adjustment reimbursement than is warranted.

Medical Loss Ratio (MLR) Fraud occurs when plans knowingly misrepresent a proportion of funds spent on patient care and quality improvement measures as opposed to administrative expenses and profits. The MLR rule, implemented by the Patient Protection and Affordable Care Act (ACA), mandates that funds are spent primarily on healthcare, effectively limiting the ratio of funds that can be allocated to the profit of the insurance companies.

Healthcare Effectiveness Data & Information Set (HEDIS) Fraud occurs when plans manipulate their quality and effectiveness metrics to enhance their ratings and receive unearned benefits from the ACAs quality incentive program. By falsifying a higher rating, plans receive Quality Bonus Payments (QBP) to which they are not entitled.

Enrollment Fraud occurs when MCOs enroll members outside of the established pre-approved periods using false data to qualify the member.

Adverse Selection occurs when operators of managed care plans try to minimize risk by choosing to enroll a larger pool of healthy people choosing managed care and avoiding less healthy people choosing more generous plans.

Weighing the Pros and Cons of Reporting Fraud

Weighing the potential reward of doing the right thing with the potential risk of whistleblowing is not something that should be taken lightly. Fortunately, there are whistleblower protections that forbid discrimination and retaliation by employers against employees for reporting fraud.

The False Claims Act (FCA) is the statute most commonly employed by whistleblowers to report fraud against the federal government. The FCA is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program. This includes any plan or program that provides health benefits such as Medicare, Medicaid, or Tricare. Under the FCA, individuals can file a qui tam lawsuit on the government's behalf. If the government decides to prosecute and the case is successful, the whistleblower responsible for providing the information may receive a significant monetary reward of up to 25% of the total amount recovered.

Speaking up about fraud is a courageous act, and many whistleblowers feel a sense of fulfillment for doing what is right. Exposing wrongdoing is the best way to fight the corruption that negatively affects the greater good and larger collective.

How Much Information is Enough Information for a Case?

When coming forward with information about fraud, individuals want to be assured that they are receiving the highest possible reward for the information they are providing. How can one ensure that their information is applicable?

Some factors for ensuring your information is applicable and potentially receiving a higher financial reward include how extensive and detailed the information is about the reported fraud, whether the fraud involved a serious safety issue, and the quality of the assistance the whistleblower and lawyers provide to the case. It is important to note that an individual should not take too long to report fraud as the case, and the potential reward will go to the person who first shared the information. Documentation of fraudulent activities is important when bringing a potential case. The more information and documentation you have, the better your case will be. These documents should display intent and the extent of the fraud.

Many individuals choose to document:

- Meetings
- Marketing & Sales Materials
- Phone Conversations
- Patient-Specific Information
- Emails
- Billing Records
- Research
- Test Results

What to Expect When Reporting Managed Care Fraud

Becoming a whistleblower may seem overwhelming, but working with an experienced and knowledgeable law firm provides a level of calmness when walking through the arduous but rewarding process of blowing the whistle.

step 1

First Things First - Get Guidance From a Fraud Expert and/or Whistleblower Attorney

The first step of the process is talking to a fraud expert and/or whistleblower attorney to confidentially review what you witnessed. This is the safest and most secure way to expose fraud. It's best to consult with an experienced whistleblower attorney who will offer confidential consultations, give advice, guide you through the process, help you file a claim, support you through the investigation, and help you potentially secure a financial reward for bringing injustices to light.

step 2

Then Present Your Evidence

Once you've talked to the experts and have selected your legal representation, your lawyers will ask questions about the incident to extract all valuable information that will be used against the defendant. During this time, you'll want to make sure you present all of your evidence. This is crucial to your case and can include email communications, internal studies, billing records, test results, etc. – the more evidence you have, the stronger your case will be. Your lawyers will then review your evidence, investigate further, and begin building the case.

step 3

Next, File a Claim

Under the federal False Claims Act, a whistleblower must file a qui tam complaint in court and submit it to the government, along with a Disclosure Statement that details the alleged fraud. It's important to note that your representation will assist you in submitting the Disclosure Statement and other paperwork necessary for filing your report.

Once your claim is submitted, you and your attorney will likely meet with government attorneys to discuss your allegations. These initial meetings often influence the direction of your case, so it's important to be completely honest and present your evidence as best you can.

step 4

After that, Your Claim will be Investigated

As part of its investigation, the government will likely interview witnesses, examine evidence, review documents and also request documents relating to the alleged fraud. During this time, your experienced whistleblower attorney will be by your side to make sure you provide whatever information the government requests. Your attorney will also be there to remind you not to discuss your case with anyone while it's under seal.

(While a case is under seal, a whistleblower is not permitted to discuss the suit with anyone other than their whistleblower lawyer and the government attorneys and agents assigned to the case.)

Keep in mind investigations often take a very long time–typically several years or more. Therefore, having the right representation who can guide you through the entire process is invaluable.

step 5

After the Investigation

After the government has concluded its investigation, it has the opportunity to decide whether it wants to bring a formal legal action against the accused. If the government does decide to intervene and take over the prosecution, the case will then proceed through the process of litigation or settlement.

step 6

Earn a Significant Potential Whistleblower Reward

Whistleblowers who bring original information to the government can be entitled to receive a share of the government's recovery. An individual (called a false claims plaintiff or relator) who is an original source of information can sue for violations of the FCA. If the government prosecutes, a relator can receive up to 25% of the total amount recovered.

Other Helpful Resources

If you're considering blowing the whistle on fraud in managed care, take a look at these resources. They list examples of common schemes used to defraud government healthcare programs and highlight successful whistleblower cases in managed care.

Managed Care Fraud: Schemes That Can Lead to FCA Liability

Managed Care: 3 Successful Fraud Cases and Awards

About Daniel J. Ocasio Whistleblower Law Group:

Earning a Potential Whistleblower Reward Starts Here

Getting started on your whistleblower journey may seem overwhelming, but the team at the DJO Whistleblower Law Group is here to make it as stress-free as possible. We are prepared to take on even the most complicated and arduous cases to ensure that your valuable information will help bring fraud to light. Our team of attorney experts and former whistleblowers will work alongside you every step of the way in support, as together we deliver justice.

If you have witnessed upcoding, inflated risk scores, or exaggerated Medicare and Medicaid claims, report it to reap whistleblower rewards financially and morally. We need to work collectively to protect the collective.

Simply send our team a message with a brief description of your situation and the misconduct you've witnessed, and our experts will respond to you quickly, with your confidentiality guaranteed.