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Insurers Gaming Medicare Might Cost Washington Billions a Year

Health plans get paid more for covering sicker patients. Are they exaggerating how ill people really are?

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by John Tozzi
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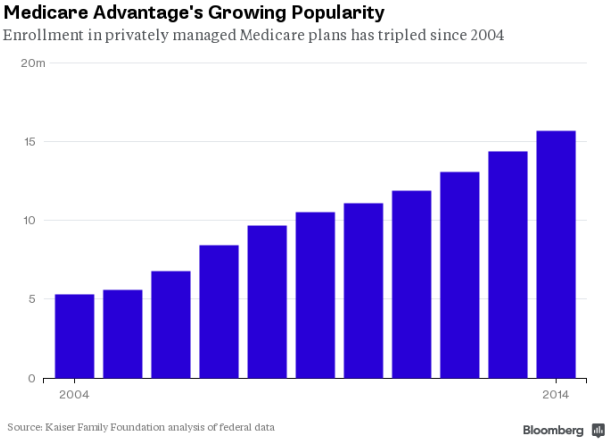
Two years ago, Anita Silingo accused health insurance companies of brazenly ripping off the government. Silingo, who worked at a company called MedXM that consulted for health insurance companies, filed a sealed whistleblower lawsuit claiming that MedXM exaggerated or outright fabricated illnesses to get its clients higher fees from Medicare. The Justice Department hasn't taken up the suit and the companies have sought to dismiss it in court. But new research suggests that the kind of inflated diagnoses Silingo described costs the government billions a year.

Silingo is one of a handful of whistleblowers who have come forward with claims that health plans have profited by illegally claiming patients are sicker than they are. According to her complaint, MedXM altered medical records to make diagnoses appear more severe and often created records without doing the face-to-face patient visits required by law. Health insurers, including Anthem, Health Net, and Molina, "all turned a blind eye to the truth in exchange for receiving" bigger Medicare payments, Silingo alleged. Representatives for the companies named declined to comment.

Until about 15 years ago, the U.S. government didn't care how sick people were for the purposes of paying for health care. Medicare generally paid physicians directly for each procedure performed. In the mid-2000s, the government tried to reduce costs by promoting privately managed Medicare Advantage plans, which pay insurance companies a fixed sum to manage health care for a group of patients. To keep insurers from cherry picking the healthiest people, the contracts pay more if sicker people sign up. The extra payment is based on a risk score calculated from diagnostic codes that physicians submit. This approach, called risk adjustment, has now permeated the U.S. health-care system—and it gives health plans incentives to do exactly what Silingo alleges they did.



"If you look back over 15 years ago, almost no American consumers were enrolled in a risk-adjusted health insurance market," says Michael Geruso, an economist at the University of Texas at Austin who recently co-authored a working paper on the practice. He estimates that 50 million people are enrolled in health plans that get paid more depending on diagnoses. That includes about 16 million in Medicare Advantage plans, as well as many patients in Medicaid managed care and health plans in the Obamacare exchanges.

The big money at stake has bred a cottage industry of consultants and software that promises to maximize health plans' payouts. Insurance companies can hire companies such as MedXM to conduct checkups on enrollees in their homes, which helps insurers record medical conditions that influence how much revenue they get for that patient. Insurers also use software that scans medical records and suggests diagnoses that may have been overlooked, says Timothy Layton, a Harvard Medical School economist and Geruso's co-author.

The two estimate that inflated risk scores cost Medicare about $2 billion in 2014, or $120 for each of the 16 million Medicare Advantage enrollees. It would cost even more if the federal government hadn't attempted to address the problem, starting in 2010. That year, Medicare began to apply a blanket reduction in rates paid to Medicare Advantage plans to compensate for differences in what the government calls "coding intensity"—the tendency of Medicare Advantage plans to report overall sicker patients.

Federal watchdogs have warned about inflated risk scores for years. A 2012 review by the Health and Human Services Office of the Inspector General, which oversees Medicare, questioned "whether all [Medicare Advantage] organizations are implementing their programs to detect and address potential fraud and abuse effectively." The watchdog called the improper payments a "significant vulnerability" for Medicare. Last month, Senators Chuck Grassley, a Republican from Iowa, and Claire McCaskill, a Democrat from Missouri, asked the federal Centers for Medicare and Medicaid Services (CMS) to increase

oversight. CMS didn't respond to several requests for comment.

The economists' paper didn't say whether the higher risk scores for Medicare Advantage patients reflected deliberate manipulation. Doctors may simply be documenting legitimate diagnoses they didn't have incentives to record without risk-adjusted payments. A hypothetical example, posted on insurer Anthem's website, describes the symptoms of an 85-year-old diabetic treated for a urinary tract infection. The documentation many physicians would submit under Medicare's traditional payment system—in which they're paid for the services provided, not the underlying illness—misses five diagnoses that could be claimed. With risk-adjusted payments, reporting all the diagnoses would mean Anthem gets paid $2,475 instead of $481.

It's not clear how much the kind of fraud alleged by whistleblower Silingo might be responsible for the differences the economists observed. There are signs that federal authorities are poking around. Insurer Humana, in regulatory filings this year, disclosed that it had received an "information request" from the Department of Justice about "our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network." Humana did not respond to requests for comment. In its quarterly report filed April 29, the company suggested it's not the only one under scrutiny: "We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers, and vendors."