PRESS RELEASE

Manhattan U.S. Attorney Files Civil Fraud Suit Against Anthem, Inc., For Falsely Certifying The Accuracy Of Its Diagnosis Data

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For Immediate Release

U.S. Attorney's Office, Southern District of New York

Geoffrey S. Berman, the United States Attorney for the Southern District of New York, announced that the United States filed a civil fraud lawsuit today against ANTHEM, INC. ("ANTHEM"), alleging that ANTHEM falsely certified the accuracy of the diagnosis data it submitted to the Centers for Medicare and Medicaid Services ("CMS") for risk-adjustment purposes under Medicare Part C and knowingly failed to delete inaccurate diagnosis codes. As a result of these acts, ANTHEM caused CMS to calculate the risk-adjustment payments to ANTHEM based on inaccurate, and inflated, diagnosis information, which enabled ANTHEM to obtain millions of dollars in Medicare funds to which it was not entitled.

Manhattan U.S. Attorney Geoffrey Berman said: "The integrity of Medicare's payment system is critical to our healthcare. This Office is dedicated to vigorously using all of the legal tools available, including the False Claims Act, to ensure the integrity of Medicare payments. The case against Anthem today is an illustration of that commitment."

As set forth in the Complaint, Medicare Part C, also known as Medicare Advantage, provides health insurance coverage for tens of millions of Americans who opt out of traditional Medicare. Under Medicare Part C, Medicare Advantage Organizations ("MAOs"), typically private insurers like ANTHEM, provide coverage for Medicare beneficiaries. In return, MAOs receive capitated payments from CMS based on the patients' medical conditions and demographic factors. More specifically, MAOs like ANTHEM submit diagnosis data, typically

passed along from beneficiaries' healthcare providers, to CMS. CMS then uses that diagnosis data, in conjunction with demographic factors, to calculate a "risk score" for each beneficiary and, in turn, the amount of the capitated payment that the MAO will receive for covering that beneficiary.

The Complaint alleges that ANTHEM, as one of the nation's largest MAOs, operated dozens of Medicare Part C plans, including the Empire MediBlue plan in New York. To supplement its collection of diagnosis codes besides what it received from healthcare providers, ANTHEM implemented a "retrospective chart review" program using a vendor called Medi-Connect. Specifically, ANTHEM paid Medi-Connect to collect medical records from healthcare providers corresponding to services they rendered to ANTHEM's Part C beneficiaries and then review those records to identify all diagnosis codes supported by the medical records. ANTHEM then submitted to CMS any diagnosis codes identified by Medi-Connect that ANTHEM had not already submitted to CMS based on what providers initially reported.

The Complaint further alleges that when ANTHEM asked healthcare providers to provide records to Medi-Connect, ANTHEM characterized its chart review program as an "oversight activity" that would "help ensure that the [diagnosis] codes have been reported accurately." In fact, however, ANTHEM did not use the information it received from Medi-Connect to check the accuracy of diagnosis codes it had submitted to CMS. Specifically, when Medi-Connect's review did not validate diagnosis codes that ANTHEM previously submitted to CMS, ANTHEM did not make any effort to verify or delete those codes.

According to the Complaint, ANTHEM did not do so because deleting invalid diagnosis codes would have substantially reduced the additional revenue the chart review program generated for ANTHEM, which frequently exceeded $100 million per year. Instead, ANTHEM treated its chart review program solely as a tool for revenue enhancement and viewed it as ANTHEM's "cash cow."

As alleged in the Complaint, ANTHEM not only knowingly failed to delete diagnosis codes shown by its chart review program to be unsupported by the medical records, but also repeatedly made false statements to CMS. Specifically, ANTHEM made false annual attestations to CMS certifying that its risk-adjustment data submissions were "accurate" according to its "best knowledge, information and belief." ANTHEM also falsely told CMS that it would "research and correct" risk adjustment data discrepancies. As result of its false statements and its failure to delete inaccurate diagnosis codes, ANTHEM improperly obtained or retained millions of dollars in payments from CMS to which it was not entitled, in violation of the False Claims Act.

Mr. Berman thanked the Office of Counsel to the Inspector General for the Department of Health and Human Services and the Commercial Litigation Branch at the Civil Division of the Department of Justice for their extensive assistance.