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Florida-Based Wellcare Health Plans Agrees to Pay $137.5 Million to Resolve False Claims Act Allegations

WASHINGTON – WellCare Health Plans Inc. will pay $137.5 million to the federal government and nine states to resolve four lawsuits alleging violations of the False Claims Act, the Justice Department announced today. WellCare, based in Tampa, Fla., provides managed health care services for approximately 2.6 million Medicare and Medicaid beneficiaries nationwide.

The lawsuits alleged a number of schemes to submit false claims to Medicare and various Medicaid programs, including allegations that WellCare falsely inflated the amount it claimed to be spending on medical care in order to avoid returning money to Medicaid and other programs in various states, including the Florida Medicaid and Florida Healthy Kids programs; knowingly retained overpayments it had received from Florida Medicaid for infant care; and falsified data that misrepresented the medical conditions of patients and the treatments they received.

Additionally, it was alleged that WellCare engaged in certain marketing abuses, including the "cherrypicking" of healthy patients in order to avoid future costs; manipulated "grades of service" or other performance metrics regarding its call center; and operated a sham special investigations unit.

The settlement requires that Wellcare pay the United States and nine states – Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio – a total of $137.5 million. WellCare may also be required to pay an additional $35 million in the event that the company is sold or experiences a change in control within three years of this agreement.

"Government health plans increasingly rely on managed care organizations to provide patient care. This case illustrates our commitment to ensure that government funds are in fact used to render care and not to line the pockets of those more concerned with the bottom line," said Stuart F. Delery, Acting Assistant Attorney General for the Justice Department's Civil Division.

This is the second monetary settlement reached with WellCare since the government initiated a criminal and civil investigation of WellCare in 2006. On May 5, 2009, in order to resolve potential criminal charges related to losses by the Florida Medicaid and Healthy Kids programs, WellCare entered a Deferred Prosecution Agreement (DPA) with the U.S. Attorney in the Middle District of Florida, under which WellCare paid $40 million in restitution and forfeited an additional $40 million. The U.S. Attorney's office also has pursued criminal charges against several former Wellcare employees. One former WellCare analyst, Gregory West, entered into a plea agreement and pleaded guilty to a conspiracy charge shortly after execution of a search warrant on WellCare's corporate headquarters in Tampa; he is currently awaiting sentencing. Five former executives – including former CEO Todd Farha, former CFO Paul Behrens and former general counsel Thaddeus Bereday – were indicted in March 2011 and are currently awaiting trial, which is presently scheduled for January 2013. Additionally, Wellcare previously executed a Corporate Integrity Agreement (CIA) with the Office of Inspector General of the U.S. Department of Health and Human Services (HHS-OIG) that imposes compliance obligations on the company for a period of five years.

The resolution of the civil suits announced today brings the total recoveries from WellCare to $217.5 million, a number that will rise to over a quarter billion ($252.5 million) if the contingency payment provision is triggered.

"The monies recovered in restitution and from this settlement agreement will go to the federal and state programs which suffered these losses, while the forfeited funds will go to law enforcement to help fund future investigations," said Robert E. O'Neill, U.S. Attorney for the Middle District of Florida. O'Neill continued, "In an era of decreasing federal and state budgets, and increasing healthcare costs, we must pursue all available civil remedies to recover losses suffered by government healthcare programs. This settlement should serve as notice to those defrauding state and federal healthcare programs that, in addition to appropriate criminal prosecutions, we will utilize civil suits to root out their conduct and recover their ill-gotten gains."

"Fraud committed by managed care companies harms the integrity of the Medicare and Medicaid programs and increases the healthcare burden for all of us," said David B. Fein, U.S. Attorney for the District of Connecticut. "The government is committed to preventing fraud in federal and state health care programs, and managed care companies that are dishonest will be held accountable."

"Ensuring the integrity of the Medicaid and Medicare managed care programs is one of our highest priorities " said Daniel R. Levinson, Inspector General of the U.S. Department of Health & Human Services. "OIG will work vigilantly with law enforcement partners at all levels of government to safeguard this vital program."

The four lawsuits were filed by whistleblowers, known as relators, under the *qui tam* provisions of the False Claims Act, which allows private parties to file suit on behalf of the United States and share in any recovery. Sean Hellein, a financial analyst formerly employed by WellCare whose *qui tam* complaint initiated the government's investigation, will receive approximately $20.75 million. The other three relators – Clark Bolton, SF United Partners Inc. and Eugene Gonzalez – will split about $4.66 million and will be entitled to receive an additional share of any contingency payment.

This resolution is part of the government's emphasis on combating health care fraud and another step for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced by Attorney General Eric Holder and Kathleen Sebelius, Secretary of the Department of Health and Human Services in May 2009. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in that effort is the False Claims Act, which the Justice Department has used to recover more than $6.7 billion since January 2009 in cases involving fraud against federal health care programs. The Justice Department's total recoveries in False Claims Act cases since January 2009 are over $9 billion.

This case was investigated jointly by the Commercial Litigation Branch of the Justice Department's Civil Division, the United States Attorney's Office for the Middle District of Florida and the District of Connecticut, the National Association of Medicaid Fraud Control Units, the FBI, and the HHS-OIG.

The claims settled by today's agreement are allegations only; there has been no determination of liability except as noted in the referenced criminal proceeding.

12-425 Civil Division