HEALTH CARE COMPLIANCE ASSOCIATION

Managed Care
Compliance Conference

It's Risky Business: Medicare Risk Adjustment

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Agenda

- Overview of Medicare Advantage risk adjustment regulatory framework and history
- Discussion of recent litigation
- Developing an effective compliance program that addresses risk adjustment
- Internal audit strategies to consider

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Statutory Authority

Pre-MMA

1997: The **Balanced Budget Act** establishes Medicare + Choice and Risk Adjustment Payments

1999: The **Balanced Budget Refinement Act** adopted a phased-in approach to Risk-Adjusted payments based on health status

2000: The **Benefits and Improvements Protection Act** expanded the allowable data sources from which M+C plans could collect diagnosis data to include inpatient hospital and ambulatory settings

The MMA and Beyond

2003: The **Medicare Modernization Act** established a bidding process that requires MAOs to submit monthly bids "for the provision of all items and services under the plan … based on … *an enrollee with a national average risk profile*."

2010: The **Patient Protection and Affordable Care Act** requires CMS to periodically evaluate the risk adjustment system "to … account for higher medical and care coordination costs …"

2016: The **21st Century Cures Act** requires that CMS improve the determination methodology of a beneficiary's health status by factoring in the count of an individual's total conditions.

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Regulatory Authority

Key Regulations	
42 C.F.R. § 422.308- Adjustments to capitation rates, benchmarks, bids and payments	• Clarifies that CMS will adjust payment amounts to account for health status • Adjustments are intended to "improve the determination of actuarial equivalence"
42 C.F.R. § 422.310- Risk Adjustment data	Governs risk adjustment data submitted by MAOs • includes all data that are used in the risk adjustment payment model • must conform to CMS' requirements for Medicare fee-for-service data, when appropriate • Data comes from the provider, supplier, physician, or other practitioner that furnished the item or service. • Permits MAOs to impose financial penalties for failure to complete data used for risk adjustment in contracts with providers • Authorizes RADV audits
42 C.F.R. § 422.311 – RADV audit dispute and appeals processes	MAOs may appeal • Medical record review determinations • RADV payment error calculation Level 1: Request for Reconsideration Level 2: Request for CMS Hearing Official Review Level 3: Request for CMS Administrator Review
42 C.F.R. §422.504 (l)(2) – Payment Data Certification	Requires that data submitted to support payment must be accurate, complete and truthful

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Subregulatory Guidance

Examples:

- Medicare Managed Care Manual, Chapter 7
- CMS Website: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html
- CMS Notices and Memoranda
  - 45- Day Advance Notice
  - Annual Announcement and Call Letter
  - Advance Notice of Methodological Changes for the MA CMS-HCC Risk Adjustment Model
  - HPMS Memos
- Bid Pricing Tool
- Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide and Related Training (CSS Operations)

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Basic Concepts and Terminology

- **Prospective Payments Based on Retroactive Data**. CMS uses retroactive claims data to predict a future year's expenditures for MA beneficiaries
- **HCCs**. CMS selects diagnosis codes that predict costs and places them in categories with hierarchies based on severity
  - "Hierarchical Condition Categories (HCCs)"
  - Risk factors are additive when diseases are not related
  - Groups may be in hierarchies when disease are related (e.g., diabetes with complications vs. diabetes without complications)
- **Adjustments**. Risk Adjustment model includes downward adjustments, e.g.,
  - "Normalization factor"
  - "MA Coding Adjustment"
- **FFS Data**. CMS supplements MA plan-submitted data with enrollees' FFS claims data
- **Reporting**. Final data submission deadline of January 1 for prior year diagnoses

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Risk Scoring Under CMS-HCC Risk Adjustment Model

Demographic Factors

- Age
- Sex
- Disabled status
- Original reason for Medicare entitlement (age or disability)
- Medicaid eligibility
- Institutional status

Disease Factors

- HCCs specific to each enrollee's diagnoses
- Disease and disabled "interactions"
- "Hierarchical" – counts disease with highest severity in a category:
  - *Diabetes with Acute Complications (HCC17 = 0.318)*
  - *Diabetes without Complications (HCC19 = 0.104)*

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Risk Adjustment Payments – HCCs

- HCC Model groups medical conditions with similar costs of treatment to establish a risk score for each enrollee
  - Developed using Medicare Fee-For-Service claims data
  - Classifies over 70,000 ICD-10 codes into 805 diagnostic categories
  - The 805 diagnostic categories are aggregated into 189 Condition Categories
  - Hierarchies are then imposed among related Condition Categories, creating 87 HCCs
- Each HCC has an assigned coefficient, which represents the incremental predicted expenditures

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ICD-10 – HCC Mapping

John Doe visits his physician and is diagnosed with diabetes mellitus due to underlying condition with other diabetic kidney complication (E0829). The provider submits diagnosis code E0829 to the MAO.

The MAO submits the diagnosis code to EDS on an encounter data record. Upon applying the filtering methodology, CMS determines that E0829 is a risk adjustment eligible diagnosis code and, in risk score calculation, is mapped to HCC-18.

Source: Risk Adjustment for EDS & RAPS User Group, November 17, 2016

HCC18 is Diabetes with Chronic complications, and its coefficient depends on community model:

Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual Disabled	Community, PBDual Aged	Community, PBDual, Disabled	Institutional
0.318	0.371	0.346	0.431	0.354	0.423	0.441

Source: Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter

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Risk Adjustment Payments – HCCs

- A 1.0 risk score represents average annual Medicare costs for an individual based on FFS data.
- A risk score ***higher*** than 1.0 means the individual is likely to incur costs higher than average.
- A risk score ***less*** than 1.0 means the individual will incur costs less than average.

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Risk Adjustment (Oversimplified) Process

Provider encounter with member

Provider submits encounter and claims data to MA plan with diagnosis

MA Plan submits diagnosis data to CMS

CMS assigns risk score based on diagnoses and demographic factors

CMS adjusts PMPM payment to plan
(County benchmark x risk score = payment)

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Risk Adjustment Data Types

Risk Adjustment Processing System (RAPS)	Encounter Data System (EDS)

RAPS submissions are diagnosis codes that have been filtered for RA by MAOs

- Basic data elements
  - ✓Health Insurance Claim (HIC) Number
  - ✓ICD Diagnosis Code
  - ✓Service from and through dates
  - ✓Provider type
- Submitted to CMS throughout year at least quarterly
- CMS responds with return files and error reports
- Relatively simple system – being phased out

EDS submissions require full claims detail to be submitted to CMS for RA

- Captured from provider claims (or data submissions for capitated providers) and transmitted by plans to CMS
- All data elements (30+) from HIPAA version ANSI v5010 electronic claim format
- Includes procedure codes and provider payments
- Submitted weekly, biweekly, or monthly depending on enrollment
- Complex - more diagnoses filtered out

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Weighting of RAPS and EDS

2015
RAPS 100%

2016
RAPS 90%
EDS 10%

2017
RAPS 75%
EDS 25%

2018
RAPS 85%
EDS 15%

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Plan Sponsor Obligations

Ensure accuracy and integrity of risk adjustment data submitted

- All codes submitted must be documented in medical record as result of face-to-face visit
- Diagnoses must be coded according to ICD Guidelines

Implement procedures to ensure that diagnoses are from acceptable data sources

- Hospital inpatient facilities, hospital outpatient facilities, physicians, etc.
- Not Acceptable: Diagnostic Radiology; Skilled Nursing Facility; Freestanding Ambulatory Surgical Center; Home Health Care, Durable Medical Equipment

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Plan Sponsor Obligations

- ✓ Timely receipt and reconciliation of CMS Risk Adjustment Reports
- ✓ Delete previously submitted codes that do not meet risk adjustment submission requirements
- ✓ Inform CMS immediately upon finding that inaccurate data was submitted to CMS
- ✓ After final risk scores calculated by CMS, plan may request recalculation upon discovering submission of inaccurate diagnosis codes that impacted final payment

See Chapter 7 (Risk Adjustment) of Medicare Managed Care Manual (last updated 9/19/14)

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CMS Oversight – RADV Audits

- ✓ Risk adjustment data validation (RADV) audits are the process CMS uses to audit HCCs
- ✓ RADV Audits designed to ensure accuracy and integrity of risk adjustment data
- ✓ CMS selects a subset of MA plan contracts to audit
- ✓ RADV Audits review medical record documentation to verify diagnosis submitted to support HCCs
- ✓ Beginning in 2011, CMS used sample results to extrapolate overpayment estimates

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CMS Oversight – RADV Audits

CMS Selects Sampling Frame

- Enrolled in an MA Contract in January of the payment year
- Continuously enrolled in the same MA contract from January of data collection year – January of payment year
- Excludes ESRD and Hospice members
- Enrolled in Part B coverage for all 12 months

CMS Selects Sample Size and Strata

- CMS selects sample from cohort of RADV- eligible members
- Stratifies members from lowest to highest based on community risk score
- Members then divided into three equal groups based on total number of eligible members (highest, lowest, middle)
- CMS will select 201 members for medical record review (67 from each stratum)
- MA contract must submit medical records for audited members to support all HCCs reflected in the members' risk scores

Payment Error and Calculation

- CMS will calculate RADV-corrected risk score based on HCCs supported on the medical record
- Member-level payment errors defined as the difference between the original payment and the RADV-corrected payment
- CMS will extrapolate payment errors, and will incorporate a FFS adjuster

Appeals

- 42 C.F.R. § 422.311
- May appeal medical record review determinations and RADV payment error calculation
- Request for reconsideration
- Request for CMS Hearing Official Review
- Request for CMS Administrator Review

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CMS Oversight – RADV Audits

Pilot 2007 RADV Audits	Targeted 2007 RADV Audits	2011 RADV Audits	2012 RADV Audits	2013 RADV Audits
5 Contracts*	32 Contracts*	30 Contracts	30 Contracts	30 Contracts

*13.7 million in overpayments associated with sampled beneficiaries from 2007 Pilot and Targeted RADV audits, appeals ongoing

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Legal Risk Environment

False Claims Act (FCA) risk for exaggerated or unsubstantiated diagnoses that lead to overpayments to MA plans

April 2016 GAO Report: *Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*

CMS under pressure from multiple sources to intensify Risk Adjustment Data Validation (RADV) Audit program

Active area for *qui tam* whistleblower litigation

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The False Claims Act

- Makes it illegal to:
  - "Knowingly" present, or cause to be presented, a false claim for payment to the government;
  - Falsely certify information that was material to a claim or payment; or
  - Knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the government.
- False Claim liability includes treble damages, fines and penalties ($10,957 to $21,916 ***per claim***, adjusted annually)
- Allows individuals, known as Whistleblowers, to file lawsuits on behalf of the government.
- Lawsuits are initially sealed to the public.
- The Department of Justice may elect to intervene.

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Medicare Risk Adjustment Litigation

Case	Government Intervention	Status
United States v. Janke	Yes	Settled in 2010 for $22.6M
United States ex rel. Swoben v. SCAN Health Plan	No*	Settled in 2012 for $3.8M
*United States ex rel. Swoben Secure Horizons	Yes	Voluntarily dismissed October 2017
United States ex rel. Valdez v. Aveta, Inc. et al.	No	Ongoing
United States ex rel. Olivia Graves v. Plaza Medical Centers Corp., et al.	No	Settled in October 2017
United States ex rel . Silingo, et al ., v. Mobile Medical Examination Services Inc., et al.	No	Ongoing
United States ex rel. Ledesma v. Censeo Health LLC, et al.	No	Ongoing
United States ex rel. Sewell v. Freedom Health, Inc., et al.	Yes	Settled in 2017 for $32.5M
United States of America ex rel Benjamin Poehling v. Unitedhealth Group Inc.	Yes	Ongoing

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Medicare Risk Adjustment Litigation

Key Issues in Risk Adjustment Cases:

- One-sided chart reviews designed to find missing diagnosis but didn't identify unsupported diagnosis
- Ineffective Compliance Programs that don't oversee or monitor risk adjustment processes
- Certification of data submitted to CMS for payment

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Medicare Risk Adjustment Litigation

UnitedHealthcare Insurance Company, et al. v. Hargan et al.

- ✓ Challenges the 2014 overpayment rule that requires MA plans to report and return an overpayment to CMS the later of (i) 60 days from the date when the overpayment was identified or (ii) the date of any corresponding cost report is due
- ✓ United argues it imposes a different standard on MA plans than on other Medicare providers for purposes of the False Claims Act
- ✓ United also argues that the rule results in underpayments to MA plans

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Risk Adjustment and Key Issues

- RAPS → EDS implementation issues
- RADV extrapolation challenges
- Regulatory updates?
  - Chapter 7 last updated in 2014
  - CMS released RFI for RADV auditor in late 2015
  - CMS was supposed to release FFS adjuster in 2016
- Litigation
- Additional compliance program obligations

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Broad Evaluation of Process

Risk adjustment evaluation may begin with coding assessments, but data submission and population health processes should also be included.

Coding & Documentation	Population Health	Compliance
• Process begins with patient care and Provider recording Face to Face Encounter • To assist Providers, profiling (e.g. prescriptions w/o corresponding dx) and, • Provider outreach and education opportunities (e.g. scorecards)	• Population segmentation for tailored outreach • Member outreach and education opportunities • Gaps in care (follow-up visit scheduled, outreach w/in 2 days of discharge, etc.)	• Accuracy of data fields for submission • Timeline adherence with contract standards • Controls and policies & procedures in place • Chart reviews (random or targeted sample)

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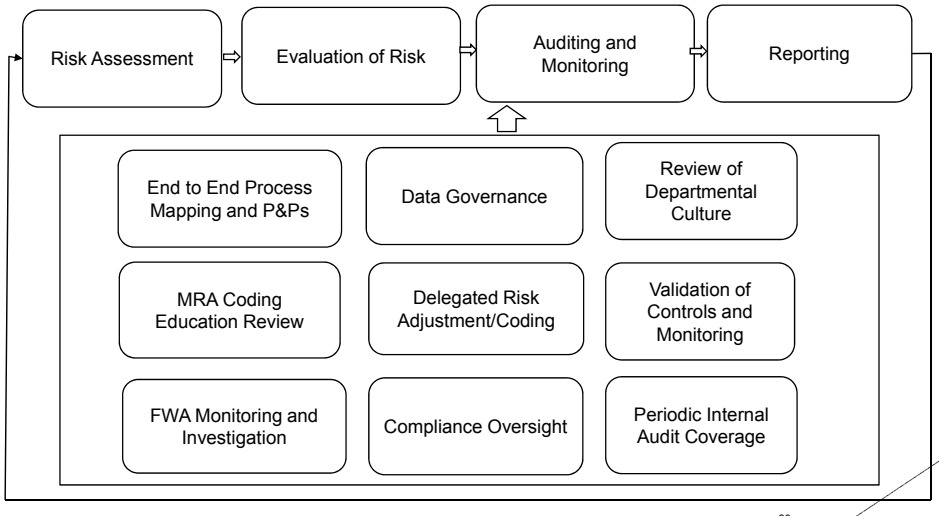
The Risk Adjustment Compliance Program



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Business Process Controls and Monitoring

1. **Clinical Care Management:** Complete and accurate clinical diagnosis coding leads to earlier identification of members in need of Care Management, which in turn drives costs down.
   A. Ensure that this important follow up aspect is a part of the work that is done to identify complete and accurate diagnosis.
   B. Integration of Care Management into Risk Adjustment starts with Suspecting and Analytics and continues on through the process until they make it to Clinical Care Managers and Provider Education.
2. **Coding Quality Audit:** It's important to measure the quality of the work performed and to use those results to drive improvement in the programs through internal and external education.
3. **Vendor Management:** Vendors should be managed by the plan, not the other way around.
   A. No Black Boxes: The plan needs to understand how and what the vendor does on its behalf.
   B. Data provided by vendors must meet plan standards and be capable of augmenting plan quality and education programs.

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How Risk Adjustment affects the whole organization

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Risk Adjustment Processes and Oversight

1. Identifying and Collaborating with the right accountable associates throughout the organization.
   A. The Chief Medical Officer (CMO) or their Delegate
   B. Appropriate layers of your Market based Leadership
   C. Medicare Finance Leadership
   D. Medicare Compliance Leadership
   E. Legal
   F. The Special Investigation Unit
   G. Information Technology
   H. Internal Audit
2. Getting the Message Right: Risk Adjustment Compliance is about ensuring the accurate reflection of health status
   A. Internal Policies and Procedures
   B. External Contracts
   C. Educational Materials
   D. Internal and External Communication (Email and Verbal)

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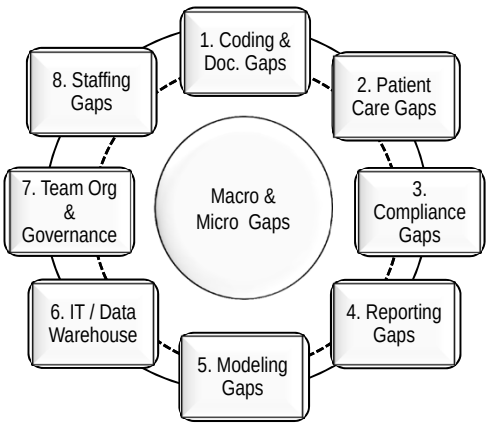
Multiple Areas Involved in Mitigating Risk

A. Claims & Encounter Processing
Data sources & feeds
Data validation checks
Payer data considerations

B. Clinical / Provider
Pop. health innovation
Member outreach
Provider education

C. Coding / ICD-10
Chart reviews
Audit readiness
ICD-10 readiness

D. Contacting
Physician incentives
Payer relations
Uniform provisions



E. Finance
Strategic initiatives
Cross collaboration
Vendor performance

F. Information Technology
Data warehouse
Data infrastructure
Data submissions

G. Decision Support
Reporting & modeling
Population segmentation
Predictive analytics

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Controls and Monitoring

Risk Adjustment Oversight

The roles of the following committees should be considered:

1. Risk Adjustment Steering/Oversight Committee
   A. This group oversees the Risk Adjustment Operations, as well as, represents the decision making body when vendors or providers do not meet the accuracy expectations of the organization.
   B. This group should drive the Provider Coding Risk Assessment and the Provider Auditing process, including but not limited to Provider based Risk Adjustment Operations and Coding Activity.
   C. This group should have direct authority to approve pilot programs, which should be fully developed and planned prior to even test implementation. Any results from these programs need to be fully run to ground.
2. Coding Compliance Committee
   A. This group should have Clinical, Legal, and Compliance Leadership, as well as appropriate ICD-10-DM coding SMEs.
   B. This function should set policy and provide educational guides on how the organization codes.
   C. This function should oversee coding reviews results, drive education materials, and ensure those are provided to the correct sources; vendors, providers, internal resources.

Risk Adjustment Oversight (cont'd)

3. Fraud Waste and Abuse (FWA)
   A. In Risk Adjustment, this is a collaborative effort among Special Investigations, Legal, Clinical Leadership, and Provider Risk Assessment/Auditing.
   B. Proper Data Governance that allows combinations of all chart review and QA results, as well as, operational data metrics is key to identifying outliers.
   C. Provider Audit results, clinical knowledge, and market based knowledge will be necessary to understand outliers.
   D. The standard plan FWA reporting methods must be appropriately informed to ensure Risk Adjustment issues can be appropriately identified and routed to the appropriate parties.

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Sample Risk Adjustment Metrics

Rank	Metric	Context/Rationale
1	Risk Score by market and provider grouping. (Differentiated by clinical vs. demographic score, with and without normalization.)	Comparison and trends of risk scores by markets and provider groups can point to general coding trends. It is important to separate clinical HCCs from other components of the Risk Score (demographic and CMS normalization components) to measure what may be impacted by process and education changes.
2	HCC Prevalence Rates	Prevalence rates that are outside regional norms may indicate poor documentation or inconsistent coding patterns.
3	Coding Quality Accuracy Rates	Medical Record coders should be subject to regular quality assessments, sometimes referred to as IRRs (Inter Rater Reliability reviews). Coders are generally expected to code at a 95% or higher accuracy rate.
4	Risk Score Distribution vs. National Averages	Groups or PCPs with risk distribution outside of averages may be at risk of under- or over-coding.
5	Rate of Chronic HCCs Re-Documented by group, by PCP	HCCs are required to be re-documented each year. Low re-documentation rates of known chronic conditions may indicate inconsistent patient interaction or poor documentation.
6	Non Corroboration Rate	Rather than looking only at Non-Corroborated Codes alone and their impact to the provider look at the non corroboration rate amongst providers. Who stands out in the market compared to others.
7	RAPS and Encounter Data Error Rates, particularly provider- preventable errors such as ICD9/ICD10 coding issues.	CMS performs basic ICD9/ICD10 level edits (gender- appropriate coding, for example). Health plans should monitor these errors and correct prior to submission to the plan.
8	# of Acute Diagnosis made in an outpatient setting	Acute diagnosis in general should appear in an inpatient setting, so outliers in this area will warrant further review.
9	Percent of Members with at least one PCP visitor percent of Members with a completed annual comprehensive exam, by group, by PCP	This metric indicates which PCPs are seeing members regularly. Regular PCP visits (at least annually) provide an opportunity to re-document chronic conditions and assess members for new or worsening conditions.

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Internal Audit Strategies

1. Risk Assessment
   A. Appropriate Identification of Financial, Compliance, Strategic and Operational Risk
   B. Escalation of Issues
2. Process and Controls Review and Testing
   A. Validation of the Oversight functionality and Operations
   B. Validation of Accuracy of Data Submission
   C. Audit of Vendors and supporting activity
   D. Validation of QA Methodology
   E. Baseline and Accuracy of Reporting/ Analytics
   F. Review of Market Operations to ensure consistency with Corporate Oversight expectations
3. Internal Investigatory Support

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Take Aways

- Risk Adjustment is a High Risk for every Payer
- Risk Adjustment Compliance is a team effort
- Compliance and Legal need Subject Matter Experts to help address Risk Adjustment
- View Capitated Provider Risk Adjustment Programs with the Delegation lens, similar to Claims or Utilization Management
- The integration of Risk Adjustment and Clinical Care Management programs improves compliance and financial outcomes.

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