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Medicare Advantage Risk Adjustment:
Emerging Risk Areas

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Medicare Advantage Risk Adjustment
Political and Enforcement Spotlight on Risk Adjustment

CHUCK GRASSLEY
UNITED STATES SENATOR *for* IOWA

Grassley Continues Oversight of Medicare Advantage Payments, Seeks Updates, Answers

U.S. LEGAL NEWS FEBRUARY 13, 2018 / 10:53 AM / 2 MONTHS AGO

U.S. can sue UnitedHealth in $1 billion Medicare case, judge rules

United States Department of Justice

FOR IMMEDIATE RELEASE Friday, March 4, 2016

Doctor Who Falsely Diagnosed Hundreds Of Patients As Part of a Medicare Fraud Scheme Pleads Guilty

HHS / OIG Work Plan | Fiscal Year 2017

Risk Adjustment Data – Sufficiency of Documentation Supporting Diagnoses

MARKET NEWS MARCH 17, 2017 / 1:07 PM / A YEAR AGO

U.S. probing insurers beyond UnitedHealth over Medicare charges

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Medicare Advantage Risk Adjustment
Emerging Risk Areas

- Agenda
  - **Medicare Advantage Risk Adjustment**
    - Overview of Payment Methodology
    - Government Interest
    - Regulatory Landscape
  - **Emerging Risk Areas and Enforcement Landscape**
    - Retrospective Chart Reviews
    - In-Home Assessments
    - Filtering Logic
    - Coding Guidance
    - Retractions / Audits

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Medicare Advantage Risk Adjustment

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Risk Adjustment Payment Methodology

- **What is Risk Adjustment?**
  - Prospective payment model: CMS pays Medicare Advantage plans based on the risk score of each individual which takes into account certain demographics (age / sex) and health status
  - Individual risk scores based on prior year diagnosis codes
  - Submitted to CMS by the plans
  - Certain diagnoses codes have value (co-efficient) *i.e.*, Hierarchical Condition Category (HCC)
  - Program goal is to cover costs for sicker populations and prevent cherry picking and discrimination
  - Marketplace plans and Medicaid managed are plans in some states are also reimbursed using risk adjustment models

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Data Submission Processes

1. Provider documents member visit in the medical record
2. Provider's office assigns diagnosis codes
3. Provider submits claim or encounter to MA plan

1. MA plan processes and filters claims and encounter data from providers
2. MA plan submits risk adjustment data to CMS via RAPS and EDPS files

1. CMS processes data for risk adjustment factor calculation and payment
2. CMS returns data to MA plans with accepted or error code status

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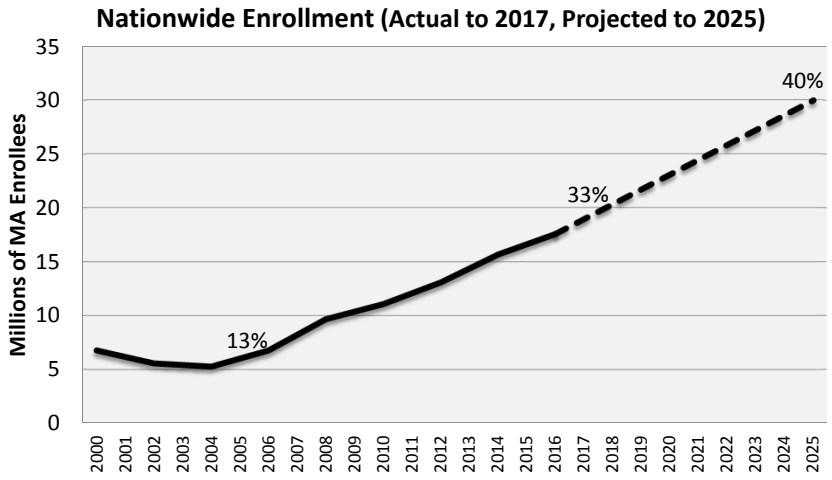
Government Focus as Enrollment Increasing



Sources: CMS, Congressional Budget Office

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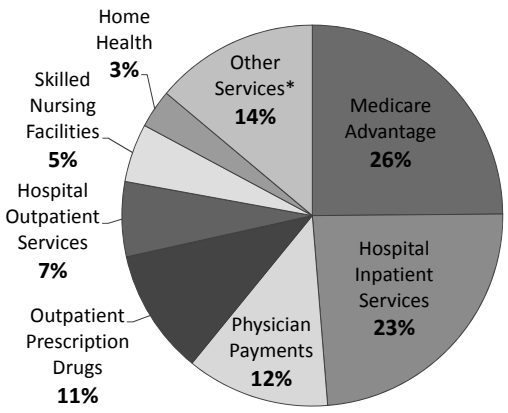
Government Focus as MA Significant Portion of CMS Spend



SOURCE: Kaiser Family Foundation analysis of data from Congressional Budget Office, 2015 Medicare Baseline (March 2015).

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Regulatory and Enforcement Players

- **Department of Justice (DOJ)**
  - Civil and Criminal Divisions
  - Various US Attorney Offices
- **Centers for Medicare and Medicaid Services (CMS)**
  - CMS sets policy and rules for Medicare Risk Adjustment
  - CMS Risk Adjustment Data Validation (RADV) Audits
- **HHS Office of the Inspector General (OIG)**
  - Since 2012, OIG has issued six reports on audits performed on 2007 risk adjustment data
  - Responsible for exclusions / corporate integrity obligations
- **Whistleblowers/Qui Tam Litigation**
  - Private citizen actions on behalf of the United States

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Regulatory and Enforcement Landscape

- **False Claims Act (31 U.S.C. § 3729)**
  - Enforcement driven by the DOJ and qui tam relators
    - Former or current employees
    - Other third parties
  - Submission of False Claims or Caused to be Submitted
    - Applies not just to plans, but potentially anyone who "causes" a false claim to be submitted for payment
    - Materiality standard in flux
    - Can apply to providers, vendors and other downstreams to plans
- **Reverse False Claim**
  - "…[K]nowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government"

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Regulatory and Enforcement Landscape

- **Medicare Part C Overpayment Rule (42 U.S.C. § 1320a-7k(d)(1)-(2)**
  - MAO must disclose to CMS any funds that an MAO has received or retained to which the MAO is not entitled to
  - 60 day clock once organization has identified an overpayment or potential FCA implications
  - Identification of an overpayment – when the MAO has determined, or should have determined, through the exercise of reasonable diligence, that the MAO has received an overpayment 42 U.S.C § 422.326(c), 423.360(c)
- The determination of whether and when something is an overpayment is highly "facts and circumstances" driven
- **** *Overpayment rule recently overturned in DC District Court and the entire ACA struck down in recent decision in a TX case; appeal status…stay tuned.*

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Regulatory Landscape

- **CMS Guidance in Risk Adjustment**
  - 2008 "Participant Guide" and Medicare Managed Care Manual, Chapter 7: Risk Adjustment
- **Key Diagnosis Submission Guidelines**
  - Diagnosis for risk adjustment purposes must originate from face-to-face encounter with an acceptable provider and setting type and in the service year
  - Report all conditions and diagnosis codes that exist
  - Apply ICD-9/10 coding guidelines to the available medical record documentation
- **Coding Standards**
  - MEAT: Monitor, Evaluate, Assess and /or Treat
  - TAMPER: Treat, Assess, Monitor or Medicate, Plan, Evaluate, or Referral

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Regulatory and Enforcement Landscape

- **CMS Risk Adjustment Data Validation Audits (RADV)**
  - Annual audits that ensure the integrity and accuracy of the risk-adjusted payments made to MA plans
  - Targeted and National (random) audits
  - Errors identified reconciled through contract level adjustments made on future payments

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Emerging Risk Areas and Enforcement Climate

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Risk Areas – Retrospective Chart Reviews

- **Retrospective Chart Review**
  - Review of medical records to identify any missing diagnosis codes not previously submitted to CMS
  - Often performed in the year following the year of the encounter
  - One way versus two way coding
    - CMS never required "two-way" coding in MA
    - Qui tam plaintiffs and some government attorneys have argued against one-way coding in FCA theories
  - Often blind coding
  - These cases often explore the knowledge element of the FCA, e.g., was the institution on notice that the retrospective coder did not support prior codes

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Risk Areas – Retrospective Chart Reviews

- **Retrospective Chart Review Cases**
  - Three recent cases where the government has intervened, alleging either the plan or the provider group conducted retrospective reviews one way and knowingly failed to delete, or notify the plan of, codes that were presumptively unsupported, triggering false claims liability
    - ***United States of America, ex rel. James M. Swoben v. Secure Horizons, et al.*** 2:09-cv-05013-JFW-JEM (Central District of California)
    - ***United States of America, ex rel. Benjamin Poehling v. UnitedHealth Group, et al.,*** 2:16-cv-08697-MWF-SS (Central District of California)
    - Additionally, **Davita'**s recent settlement related to Swoben's allegations against Davita Medical Group (formerly **Health Care Partners**)

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Risk Areas – Retrospective Chart Reviews

- **Retrospective Chart Review Considerations**
  - Analytics used to identify charts for review
  - Accuracy of coding vendors and quality control mechanisms
  - One way versus two way coding review
  - How to implement safeguards
  - Follow through by provider / plan when potentially unsupported codes are identified
  - Communications with PCP and / or quality programs

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Risk Areas – In-Home Assessments

- **In-Home Assessments (IHA)**
  - Typically non-patient initiated face-to-face encounter in a person's home to assess patient's health status
  - Typically performed by a physician or mid-level provider through a IHA vendor
  - At times viewed as a code mining activity and has been referred to as not medically necessary
  - CMS contemplated rejecting codes submitted from this site of service but instead provided plans with best practices in carrying out IHAs

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Risk Areas – In-Home Assessments

- **In-Home Assessments Cases**
  - Recent cases:
    - ***United States of America, ex rel. Anita Silingo v. Mobile Medical Examination Services, Inc., et al.,*** 8:13-cv-01348 (Central District of California)
    - ***United States of America, ex rel. Becky Ramsey-Ledesma v. CenseoHealth, LLC,*** 3:14-cv-00118-M (Northern District of Texas)
    - ***Davita*** settlement

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Risk Areas – In-Home Assessments

- **In-Home Assessments CMS Issued Best Practices**
  - Reconciliation of current medication
  - All components of an annual wellness exam, including a health risk assessment
  - Assessment for home safety risk, including need for adaptive equipment or other resources
  - Referral to the plan's disease / case management as appropriate
  - Provide to the beneficiary a summary of information including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources
  - Assistance with scheduling follow-up appointments
  - Ensure system in place to communicate findings to appropriate plan providers
  - Ensure system in place to make sure follow-up care is provided

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Risk Areas – In-Home Assessments

- **In-Home Assessments Other Considerations**
  - Suspect analytics
  - Vendor oversight
    - Type of provider
    - Reporting mechanisms
    - Reasonableness of visits and new diagnoses being made in the home setting
  - Documentation standards
  - In-home guidance to providers
  - Quality control

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Risk Areas – Filtering Logic

- **Filtering Logic**
  - While CMS applies its own filtering logic to data submitted through EDPS, plans must still filter the data submitted through RAPS
  - Some plans conduct filtering in-house while others use vendors
  - Filtering logic must be constructed in such a way that it ultimately identifies codes appropriate for risk adjustment submission
  - Faulty filtering logic can result in the submission of unsupported diagnosis codes to CMS leading to overpayments

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Risk Areas – Filtering Logic

- **Filtering Logic Cases**
  - ***United States of America, ex rel. Sewell v. Freedom Health, et al.,*** 8:09-cv-01625 (Middle District of Florida)
  - ***United States of America, ex rel. Jerald R. Conte and Catherine Brtva v. Blue Cross and Blue Shield of South Carolina, et al.,*** 3:13-cv-02251 (District of South Carolina (Columbia Division))

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Risk Areas – Filtering Logic

- **Filtering Logic Considerations**
  - End goal that RAPS submissions are appropriate according to CMS guidance
  - Implementation and validation of filtering logic
  - Vendor oversight
    - Transparency in filtering logic algorithm
    - Ability to customize filtering logic
    - No ROI or percentage based contractual stipulations
  - Quality control

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Risk Areas – Coding Guidance

- **<u>Provider / Coder Education and Guidance Considerations</u>**
  - Providers are not always educated on risk adjustment coding guidelines
  - Unlike FFS where a claim may be denied based on inaccurate diagnosis coding, inaccurate coding and /or lack of documentation to support the diagnosis can lead to a false claim submission under the MA program
  - ***Davita, Inc***. – the government alleged, as part of the recent settlement, Davita's coding guidance influenced providers and coders to code incorrectly resulting in the submission of inaccurate diagnoses to CMS
  - Plans and providers, can and do, issue guidance which may not be consistent with each other
  - Guidance can take the form of logic conditions in EMRs

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Risk Areas – Coding Guidance

- **<u>Provider / Coder Education and Guidance Considerations</u>**
  - Development of guidance
    - Focus of / messaging behind guidance – accuracy or financial reward
    - Who – MD, specialist review, other clinician / coder input
  - How providers / coders are educated / trained
  - Financial incentives associated with coding

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Risk Areas – Internal Controls and Audits

- **Internal Controls and Audits**
  - Lack of controls and oversight is itself an independent risk
  - Having controls and oversight is itself an independent risk
    - Many plans and providers conduct internal audits that identify in some way unsupported diagnosis codes
    - Internal audit categories
      - Outlier codes
      - Outlier physicians
      - Codes likely to be incorrect (cancer codes, acute condition in outpatient setting)
  - ***If codes are identified as unsupported, the plan / provider should take steps to remediate and if applicable, report and return any overpayments***

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Risk Areas – Internal Audits

- **Internal Controls and Audits –** internal audits would have captured some of the activity alleged in the following cases
  - ***United States of America, ex rel. Olivia Graves, M.D., v. Plaza Medical Centers, et al.,*** 1:10-cv-23382 (Southern District of Florida)
  - ***United States of America v. Walter Janke, M.D., Lalita Janke and Medical Resources, LLC.,*** 2:09-cv-14044-KMM (Southern District of Florida)
  - Criminal indictment of Florida physician, Dr. Isaac Thompson, in 2015
  - ***United States of America ex. rel. Ormsby v. Sutter Health, LLC, et al.*** 15-CV-01062-JD (Northern District of California)

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Risk Adjustment Overall Compliance Opportunities

- Be prepared, today, to demonstrate the effectiveness of your risk adjustment oversight
- Follow very closely developments in enforcement and do not expect that CMS will clarify areas under scrutiny
- Assess whether you are an outlier and take immediate action
- Be prepared for change and begin contingency planning if enforcement results in a new risk landscape