Risk Adjustment Compliance: Can You Afford the Risk?

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Medicare Advantage Risk Adjustment

Political and Enforcement Spotlight on Risk Adjustment

U.S. Department of Health and Human Services
Office of Inspector General

Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns

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

THE UNITED STATES ATTORNEY'S OFFICE
NORTHERN DISTRICT of CALIFORNIA

Medicare Advantage Provider To Pay $30 Million To Settle Alleged Overpayment Of Medicare Advantage Funds

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

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Discussion Topics

- **Medicare Advantage Risk Adjustment**
  - Life Cycle of Risk Adjustment Payment Methodology
  - Government Interest
  - Regulatory Landscape
- **Emerging Risk Areas and Enforcement Landscape**
  - Retrospective Chart Reviews
  - In-Home Assessments
  - Data Submissions – RAPS and EDPS
  - Provider Engagement/Coding Guidance
  - Internal Control and Audits
  - RADV and OIG Audits

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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
  - Program goal is to cover costs for sicker populations and prevent cherry picking and discrimination
  - Diagnosis data submitted to CMS by the plans
  - Certain diagnoses codes have value (co-efficient) *i.e.*, Hierarchical Condition Category (HCC)
  - Individual risk scores based on prior year diagnoses
  - Marketplace plans and Medicaid managed care 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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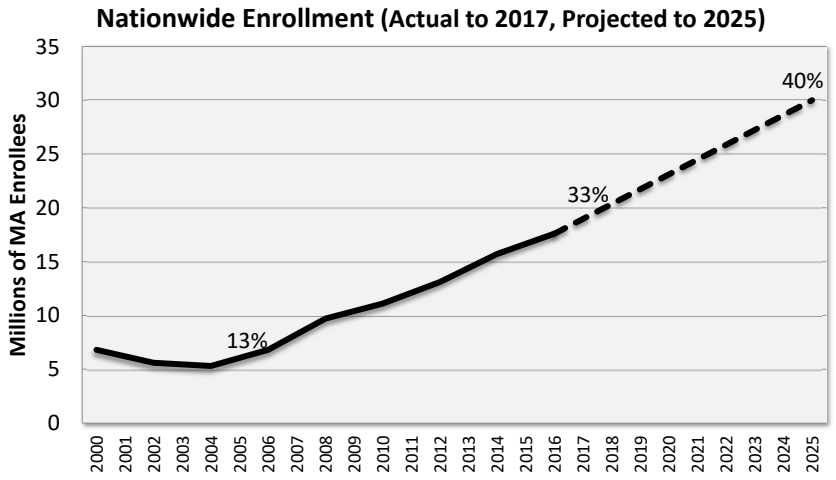
Government Focus as MA Enrollment Increasing



Sources: CMS, Congressional Budget Office

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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)**
  - New OIG targeted code audits and site visits
  - 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 C.F.R. § 422.326(c))**
  - 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
  - The determination of whether and when something is an overpayment is highly "facts and circumstances" driven

**** *Overpayment rule overturned in DC District Court and the entire ACA struck down in 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
  - 2019 Contract-Level Risk Adjustment Data Validation, Medical Record Review Guidance
- **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 current conditions that exist
  - Apply ICD-9/10 coding guidelines to the available medical record documentation
- **Voluntary Industry Coding Methodologies**
  - MEAT: Monitor, Evaluate, Assess and/or Treat
  - TAMPER: Treat, Assess, Monitor or Medicate, Plan, Evaluate, or Referral
  - Other

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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
  - 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
  - OIG released report in December 2019 estimating that diagnoses sourced from retrospective chart reviews accounted for $6.7 billion in payments to MA plans in 2017 (*Office of Inspector General, "Billions in Estimated Medicare Advantage Payments from Chart Reviews Raise Concerns," December 2019*)
  - 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 settlement in 2018 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, including PCP
  - 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 – Data Submissions

- **RAPS Filtering Logic**
  - Faulty filtering logic can result in the submission of unsupported diagnosis codes to CMS leading to overpayments
  - Recent 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))

- **Reconciliation of Unlinked Codes with Encounter Data Submissions**
  - In the December 2019 OIG report on chart reviews, the OIG claims that CMS paid $2.7 billion dollars to MA plans for risk adjusted payments originating from diagnosis codes submitted that were not linked to a specific encounter; questioned integrity of data and payments

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Risk Areas – Provider Engagement

- **Provider Engagement**
  - Providers are typically uneducated 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
  - Non-comprehensive coding can also lead to loss of revenue
  - MAOs increasingly attempting to engage both risk sharing and FFS providers to code more accurately and comprehensively:
    - Embedded Coders
    - Provider Chart Review
    - Coding Guidance
    - EMR prompts
  - To compensate or not compensate and how to structure these payments

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Risk Areas – Coding Guidance

- **Provider Coding Education and Guidance**
  - Plans or large provider groups issue coding guidance – varies from general risk adjustment overview to detailed clinical guidance on certain diagnosis codes
  - EMR prompts can be viewed as coding guidance
    - Drop downs when choosing diagnosis code
    - Real time prompts
    - Prompts based on history of patient
  - ***Davita, Inc***. – the government alleged, as part of its settlement, Davita's coding guidance influenced providers and coders to code incorrectly resulting in the submission of inaccurate diagnoses to CMS

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Risk Areas – Coding Guidance

- **Provider/Coder Education and Guidance Considerations**
  - Development of guidance
    - Focus of/messaging behind guidance – accuracy or financial reward
    - Who developed and reviewed the guidance – MD, specialist review, other clinician/coder input
    - Clinical accuracy
    - Balance of diagnostic conditions addressed
    - Quality of patient care perspective
  - How providers/coders are educated/trained
  - Financial incentives associated with capturing diagnostic 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 Controls and Audits

- **Internal Controls and Audits –** strong internal controls and/or audits may have identified some of the activity alleged in the following cases:
  - ***United States of America v. Walter Janke, M.D., Lalita Janke and Medical Resources, LLC.,*** 2:09-cv-14044-KMM (Southern District of Florida)
  - ***United States of America ex. rel. Ormsby v. Sutter Health, LLC, et al.*** 15-CV-01062-JD (Northern District of California)
  - ***United States ex rel. David Nutter, M.D., and David Nutter, M.D., individually, v. Sherif F. Khalil, M.D., Beaver Medical group, L.P., The Beaver Medical Clinic, Inc., Epic Management, L.P., and Epic Management*** No. CVC17-02035-PSG-KKX (Central District of California)

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Risk Areas – RADV and OIG Audits

- **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 cohort based, focused sample
    - Diabetes for PY2014
    - Renal for PY2015
- **OIG-OAS Audits**
  - Targeted audits focused on certain plans
  - Sample focused on single instance codes with high prevalence of coding errors (e.g. in office myocardial infarction)
  - Plans directed to resolve findings with CMS

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Risk Adjustment Overall Compliance Opportunities

- Develop a comprehensive and well-documented risk adjustment compliance program and be sure to follow it and revise it based on the known and anticipated risk landscape
- 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
- Thoughtfully 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

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