Managed Care Enforcement Trends and Compliance Concerns in Risk Adjustment

HEALTH ETHICS TRUST COMPLIANCE INSTITUTE

Washington Executives Course

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MEDICARE ADVANTAGE AND RISK ADJUSTMENT BACKGROUND

What is Risk Adjustment and how is it used?

1. Process of measuring the relative health status and health spending of a population of patients

1. Diagnosis code based models
2. Prescription medicine based models
3. Combination based models

2. Used for a variety of purposes including:

1. Minimize incentives that lead to adverse selection in beneficiary enrollment
2. Re-allocating premiums in a "zero-sum" model using equitable comparisons of underlying membership
3. Aligning premium payments with health risk and expected costs

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Risk Adjustment in Government Programs

	Medicare Risk Adjustment	Medicaid Risk Adjustment	Affordable Care Act (ACA) Risk Adjustment
1	Diagnosis code-based model	All types of models	Diagnosis code-based model that is averaged at the plan level
2	Determines payments prospectively	Adjusts payments retrospectively	Redistributes a premium pool among participating plans
3	Accounts for demographic and health factors	Accounts for demographic and health factors	Accounts for demographic and health factors
4	Payment impact is not capped	Payment impact is capped	Payment impact is capped

Medicare Risk Adjustment: Implementation Timeline

1997: Medicare+Choice mandated to have risk-adjustment component by 2000

2000: PIP-DCG Model used for risk adjusting 10% of premiums; remaining 90% based solely on demographics

2004: CMS-HCC model first used for risk adjusting 30% of premiums; remaining 70% based solely on demographics

2007: CMS-HCC model used for risk adjusting 100% of premiums

Medicare Risk Adjustment: Data Submission Process

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

Medicare Risk Adjustment: Risk Score Calculation

Risk Adjustment Impact Example (Community, NonDual, Aged Member: V24 Model)

Scenario 1: Comprehensively Coded		
Male: 90-94 Years		0.841
HCC 18: Diabetes with Chronic Complications		0.302
HCC 51: Dementia With Complications		0.346
HCC 85: Congestive Heart Failure		0.331
HCC 96: Specified Heart Arrhythmias		0.268
HCC 138: Chronic Kidney Disease, Moderate (Stage 3)		0.069
Interaction: Diabetes and CHF		0.121
Interaction: CHF and Renal		0.156
Interaction: CHF and Specified Heart Arrhythmias		0.085
HCC Count: 5		0.042
Subtotal		**2.561**
FFS Normalization Factor		1.069
Coding Intensity Factor		5.9%
Adjusted Risk Score		2.255
Base Premium	$	800
Monthly Premium	$	1,804
Annual Premium	**$**	**21,648**

Scenario 2: Partially Coded		
Male: 90-94 Years		0.841
HCC 19: Diabetes without Complication		0.105
HCC 52: Dementia Without Complication		0.346
HCC 85: Congestive Heart Failure		0.331
No Specified Heart Arrhythmias Coded		-
CKD 2 (Does Not Risk Adjust)		-
Interaction: Diabetes and CHF		0.121
No CHF and Renal Interaction		-
No CHF and Specified Heart Arrhythmias Interaction		-
HCC Count: 3		-
Subtotal		**1.744**
FFS Normalization Factor		1.069
Coding Intensity Factor		5.9%
Adjusted Risk Score		1.535
Base Premium	$	800
Monthly Premium	$	1,228
Annual Premium	**$**	**14,736**

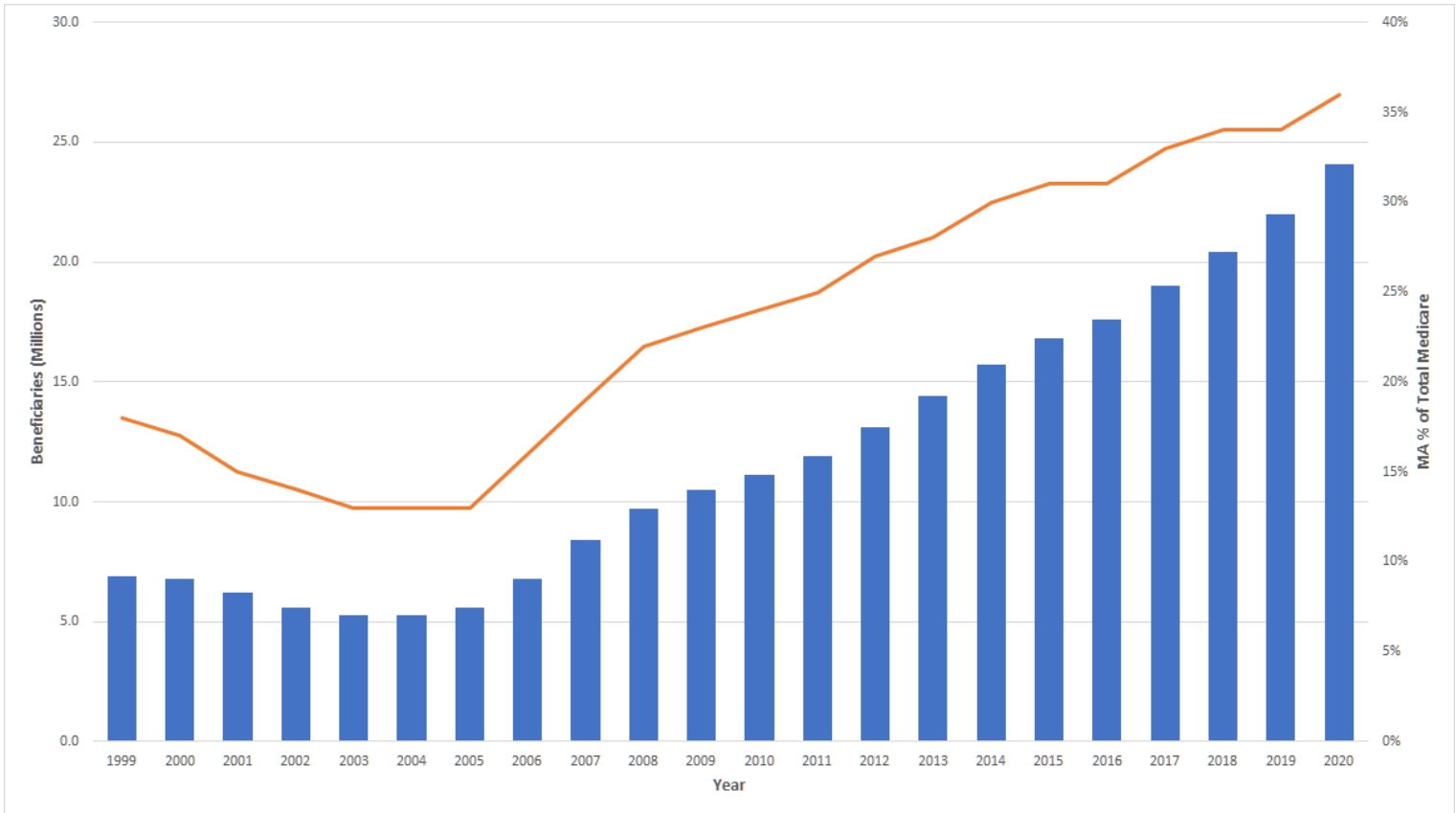
Scenario 3: No Coding		
Male: 90-94 Years		0.841
No Diabetes Coded		-
No Dementia Coded		-
No CHF Coded		-
No Specified Heart Arrhythmias Coded		-
No CKD Coded		-
No Diabetes and CHF Interaction		-
No CHF and Renal Interaction		-
No CHF and Specified Heart Arrhythmias Interaction		-
HCC Count: 0		-
Subtotal		**0.841**
FFS Normalization Factor		1.069
Coding Intensity Factor		5.9%
Adjusted Risk Score		0.741
Base Premium	$	800
Monthly Premium	$	593
Annual Premium	**$**	**7,114**

GOVERNMENT FOCUS

Medicare Advantage Enrollment Trends

- The health care world is changing
- FFS environment → Managed Care
- MA enrollment has more than doubled in the last decade
- 24M beneficiaries (36% of Medicare beneficiaries) enrolled in MA in 2020
- Payments to MA plans total over $200B annually
- By 2023, expenditures by MAOs expected to reach ~ $250 billion

Medicare Advantage Enrollment Trends



Government Focus

- HHS-OIG is focused on MA reimbursement
  - Recent reports on topics such as MA chart reviews, MA health risk assessments, and MA encounter data
  - Ongoing audits of particular MAO contracts
- DOJ is focused on MA reimbursement
  - In February 2020, the DOJ Civil Division noted in various speeches that one of its three priorities for the year is MA
  - Ongoing enforcement activity

Data Accuracy & Payment Accuracy Obligations

- CMS RADV Audits
  - Conducted "to ensure risk adjusted payment integrity and accuracy" (42 C.F.R. § 422.311(a))
  - Review medical records to determine whether diagnoses are properly supported
- HHS-OIG RADV Audits
  - In early RADV audits, HHS-OIG appeared to apply a more stringent coding standard than CMS applies in its RADV audits.
  - In October 2017, HHS-OIG updated its work plan to include a review of "Risk Adjustment Data – Sufficiency of Documentation Supporting Diagnoses."
  - In January 2018, HHS-OIG also indicated its plan to report on "Financial Impact of Health Risk Assessments and Chart Reviews on Risk Scores in Medicare Advantage."
  - Reports can be an excellent resource for understanding RA compliance and audit risk areas.

FALSE CLAIMS ACT AND LITIGATION BACKGROUND

False Claims Act (31 U.S.C. §3729)

- Prohibits knowingly presenting a false claim or knowingly making a false record or statement material to a false claim
- Reverse false claims
- Damages, penalties and whistleblowers:
  - Government may recover treble damages
  - Civil penalties of $21,000+ per claim
  - *Qui tam* provisions allow individuals to sue and share in recovery

Regulatory and Enforcement Landscape

- **Medicare Part C Overpayment Rule (42 C.F.R. §422.326)**
  - Under the ACA, MAOs must report and return "overpayments" to CMS within 60 days of identification (42 U.S.C. §1320a-7k(d)(1)-(2))
  - CMS promulgated a Final Rule implementing the ACA's requirement for Part C overpayments (42 C.F.R. §422.326)
- ***UnitedHealthcare Ins. Co. v. Azar (Sept. 2018)***
  - D.C. District Court Judge Rosemary Collyer vacated the Overpayment Rule because it was "arbitrary and capricious" and "violate[d] the statutory mandate of 'actuarial equivalence.'"
  - The Court denied the government's motion for reconsideration

Regulatory and Enforcement Landscape (cont.)

- **Brand Memo and *Azar v. Allina Health Services***
  - January 2018 -- AAG Rachel Brand issued a memorandum noting that:
    - Informal government agency guidance documents, "cannot create binding requirements that do not already exist by statute or regulation"
    - DOJ "may not use its enforcement authority to effectively convert agency guidance documents into binding rules"
  - *Azar v. Allina Health Services*
    - June 2019 -- Supreme Court reinforced the Brand memo's principals
    - The Court invalidated an informal policy posted by a government agency
    - The policy altered a "substantive legal standard" affecting Medicare payments without going through the Medicare Act's required notice-and-comment process
  - October 2019 -- CMS acknowledged that its informal guidance may inform an existing statutory or regulatory requirement, but it "may not be used as the sole basis for an enforcement action."

ENFORCEMENT ACTIVITY

Enforcement Activity

Provider Submissions

- Janke settlement
- *Baez/Thompson*
- *Graves*
- *Nutter*
- DaVita settlement
- Sutter settlement

Chart Review

- *Swoben*
- *Poehling*
- *Sewell*
- *Ross*
- Anthem

In-Home Assessments

- *Silingo*
- *Ramsey-Ledesma*
- *Gray*
- *Cutler*

Provider Assessments

- *Ormsby*
- *Rasmussen*
- *Zafirov*
- *Mansour*

Select Enforcement Activity

Swoben, No. 09-05013 (C.D. Cal.) (unsealed *qui tam*, 9th Circuit revived on appeal, dismissal of DOJ complaint-in-intervention)

- Network provider of SCAN and other health plans allegedly inflated risk scores through retrospective chart reviews
- $320M settlement with SCAN in August 2012 (with $4M related to MA allegations)
- DOJ Complaint-in-Intervention dismissed; DOJ elected not to amend

Silingo, No. 13-01348 (C.D. Cal.) (unsealed *qui tam*, DOJ declined, dismissal reversed on appeal, case settled)

- In-home assessment vendor allegedly submitted false diagnoses to health plan defendants
- Plan defendants allegedly submitted those diagnoses to CMS without adequate vendor oversight

Select Enforcement Activity (cont.)

Poehling, No. 11-0258 (C.D. Cal.) (unsealed *qui tam*, DOJ intervention, case proceeding, trial scheduled for 2/21/2023)

- Health plan allegedly manipulated risk scores, by, among other things, performing "one-way" chart reviews and failing to delete specific codes determined to be inaccurate via temporary "two-way" chart review process
- Attestation-based claims dismissed; MTD reverse FCA-based claims denied; DOJ's partial summary judgment motion was denied in March 2019

Ormsby, 15-CV-01062-JD (N.D. Cal.) (civil *qui tam*, DOJ intervened, MTD denied, case proceeding)

- Defendants, Sutter Health and Palo Alto Medical Foundation, allegedly knowingly submitted unsupported diagnosis codes to the MAOs with which they contracted
- DOJ intervention in December 2018
- Court denied defendants' motions to dismiss, rejecting defenses regarding actuarial equivalence and knowledge

2020: Enforcement Activity

2020 Settlements:

- **Kaiser Foundation Health Plan of Washington** $6.3 million settlement with DOJ to resolve allegations that it submitted inflated and invalid diagnoses codes for MA beneficiaries, by knowingly allowing a third-party vendor to routinely "upcode" claims (Nov. 2020)
- **Independence Blue Cross (IBC**) agreed to pay $2.25 million to resolve allegations that it incorrectly calculated actual prior costs in the financial bids it submitted, resulting in inflated reimbursement to IBC (Sept. 2020)

2020: Enforcement Activity

Pending Litigation:

- ***U.S. v. Anthem, Inc***. March 2020 FCA action related to Anthem's alleged failure to delete inaccurate diagnosis codes submitted to CMS for risk adjustment purposes, effectuated in part through one-way chart review. Anthem's motion to dismiss is pending
- ***U.S. ex rel. Cutler v. Cigna Corp.*** Unsealed FCA q*ui tam* in which relator alleges Cigna-HealthSpring inappropriately captured diagnoses not supported in the underlying medical record by encouraging nurses to diagnose beneficiaries with exaggerated medical problems, promoted falsification of diagnoses, and reported health conditions not supported by medical documentation or reliable clinical information.
- DOJ declined in part to intervene. Case recently reassigned to SDNY. Case proceeding.

HHS-OIG REPORTS & CORPORATE INTEGRITY AGREEMENTS

Essence Healthcare, Inc.
Targeted RADV

- Some of the diagnoses codes that Essence submitted for use in CMS's risk adjustment program did not comply with Federal requirements
  - Diagnoses codes submitted to CMS either were not supported in the medical records or
  - Diagnoses codes could not be supported because Essence could not locate the medical records
  - 75 of 218 had unsupported codes
  - $158,904 in identified overpayments
  - Cause: Policies and procedures to detect and correct noncompliance were ineffective

MA Payments From Chart Reviews

- Review of 2016 diagnoses data that resulted from chart reviews
  - Diagnoses that MAOs reported only on chart reviews (and not on any service records) resulted in an estimated $6.7 billion in risk adjusted payments for 2017
  - Almost half of MAOs reviewed had payments from unlinked chart reviews
    - OIG could not identify the specific service or encounter associated with the diagnosis.
    - $2.6 billion of the chart review payments did not link to specific services
  - MAOs often used chart reviews to add, rather than to delete, diagnoses
  - Raised concerns about:
    - completeness of payment data
    - validity of diagnoses on chart reviews
    - quality of care provided to beneficiaries

Billions in Estimated MA Payments from Diagnoses Supported Solely through HRAs

- Diagnoses that MAOs reported only on HRAs -- and on no other service records -- resulted in an estimated $2.6 billion in risk-adjusted payments for 2017
  - in-home HRAs generated 80 percent of these estimated payments
- Most in-home HRAs were conducted by companies that partner with or are hired by MAOs to conduct these assessments
  - not likely conducted by the beneficiary's own primary care provider\
- Raises concerns about:
  - completeness of data
  - validity of diagnoses
  - quality of care coordination

MAO Encounter Data Lack Essential Information

- Almost all MAOs have data systems that receive and store NPIs when providers submit them to MAOs on claims or encounter records
- MAOs reported that providers are already submitting the ordering provider NPIs on claims or encounter records for DMEPOS, laboratory services, and imaging services
- MAOs require NPIs to be submitted for their other lines of business (such as commercial and private health insurance, Medicaid, and the Children's Health Insurance Program)
- MAOs believe that NPIs for ordering providers are critical for combating fraud

Corporate Integrity Agreements

- Freedom Health (May 2017)
  - Provider Network Review:
    - Network Adequacy / New contract / Expanded Service Area Contracts
  - Diagnosis Coding Review
    - Filtering logic / 100 member sample
- Beaver Medical Group (December 2019)
  - Annual chart review / Sample of 100 members enrolled in MA plans
  - Review of diagnosis data and medical records

ENFORCEMENT ACTIVITY

Compliance Program Basics

Seven Fundamental Elements

1. Written policies and procedures
2. Compliance professionals
3. Effective training
4. Effective communication
5. Internal monitoring
6. Enforcement of standards
7. Prompt response

Compliance Guidance for Managed Care

- 2012 – HHS-OIG issued guidance for Medicare Advantage Organizations

- February 8, 2017 – DOJ's Fraud Section issued "Evaluation of Corporate Compliance Programs"

Compliance Guidelines

- Medicare Managed Care Manual. Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual. Chapter 9 - Compliance Program (2012).
  - Monthly checks for excluded individuals among employees and first-tier, downstream, and related entities.
  - Processes to identify, deny, prevent payment of claims from excluded providers at point of sale.
  - Requires disclosure by employees and first tier, downstream or related entities of new exclusions.
  - Establish SIU unit or perform SIU functions through compliance.

Plan Duty to Investigate Providers

Medicare Advantage

- Sponsors are required to investigate potential FWA [Fraud, Waste, Abuse] activity to make a determination whether potential FWA has occurred.
- Sponsors must conclude investigations of potential FWA within a reasonable time period after the activity is discovered."
  - CMS Medicare Managed Care Manual
- OIG Work Plan

Compliance Guidance for Managed Care

DOJ will evaluate adequacy of compliance program and oversight

HHS-OIG Guidance (Civil)

- "Employees, managers and the Government will focus on the **words and actions (including decisions made on resources devoted to compliance)** of an organization's leadership as a measure of the organization's commitment to compliance."
- "The use of **audits or other risk evaluation techniques** to monitor compliance and assist in the reduction of identified problem areas."

DOJ Criminal Division Guidance

- "How have senior leaders, through their **words and actions**, encouraged or discouraged the type of misconduct in question? What concrete actions have they taken to **demonstrate leadership in the company's compliance and remediation efforts**?"
- "What types of **audits** would have identified issues relevant to the misconduct? Did those audits occur and what were the findings? …. How often has the company updated its **risk assessments** and reviewed its compliance policies, procedures, and practices?"

Questions?