Risk Adjustment: Key Standards, Developments, and Risks in Medicare Advantage and Beyond

This roundtable discussion is brought to you by the Medicare Advantage (MA) and Part D Affinity Group of the Payors, Plans, and Managed Care (PPMC) Practice Group.

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Why Focus on Risk Adjustment?

- Each Medicare Advantage member receives a risk score, and these risk scores drive a significant percentage of overall revenue for Medicare Advantage plans.

- Because the risk adjustment model is complex and sometimes counterintuitive, it has taken the industry several years to understand the reimbursement system (and its related business, legal, and compliance risks).
Why Focus on Risk Adjustment?

- Medicare Advantage plans and providers—and more importantly regulatory and enforcement agencies—are becoming increasingly attuned to financial incentives associated with risk adjustment data submissions.

- This has manifested itself in several ways, including a notable uptick in enforcement activity as the government and the *qui tam* bar have become more sophisticated on risk adjustment.

- And state and federal governments are applying the risk adjustment concept to other areas within the managed care industry—
  - State Medicaid programs
  - Policies issued under the Affordable Care Act
Presentation Agenda

1. Medicare Advantage Program Overview

2. Legal Standards & Enforcement Actions

3. Risk Adjustment Data Submission Process: Areas Impacting Legal Exposure

4. Additional Risk Adjustment Trends
1. Medicare Advantage Program Overview
Risk Adjustment Basics

2013 Medicare Advantage ("MA") Program Spending
- Payments to Medicare Advantage plans projected to total $140B
- 22% of total Medicare spending

What Is MA Risk Adjustment?
- MA reimbursement model designed to encourage competition based on efficiencies and quality of care, and to mitigate financial incentives for insurers to target low-risk individuals and avoid high-risk individuals
- Fully implemented for MA plans beginning in 2007

MA Risk Adjustment Guiding Principles
- All diagnoses submitted for risk adjustment payment purposes must be:
  - Documented in a medical record that was based on a face-to-face encounter between a patient and a healthcare provider;
  - Coded in accordance with official coding guidelines;
  - Assigned based on dates of service within the data collection period; and
  - From an acceptable provider type and physician specialty.

Medicare Advantage Plan Premiums

Key Concepts
- Premiums presently set based on costs associated with treating patients with similar conditions in traditional fee-for-service Medicare.
- Impact of an enrollee’s risk factor is not immediate (plans receive increased premiums in the following year).
- CMS requires plans to submit risk adjusted conditions each year (even chronic conditions).
### Risk Adjustment Factor Example

<table>
<thead>
<tr>
<th></th>
<th>Several HCCs</th>
<th>Some HCCs</th>
<th>No HCCs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>82 year-old male</strong></td>
<td>0.597</td>
<td>0.597</td>
<td>0.597</td>
</tr>
<tr>
<td><strong>Medicaid Eligible</strong></td>
<td>0.166</td>
<td>0.166</td>
<td>0.166</td>
</tr>
<tr>
<td><strong>Diabetes w/ Renal Disease (HCC 15)</strong></td>
<td>0.508</td>
<td>Diabetes (HCC 19)</td>
<td>Diabetes - Not Coded</td>
</tr>
<tr>
<td><strong>Rheumatoid Arthritis (HCC 38)</strong></td>
<td>0.346</td>
<td>Rheumatoid Arthritis</td>
<td>Rheumatoid Arthritis - Not Coded</td>
</tr>
<tr>
<td><strong>Renal Failure (HCC 131)</strong></td>
<td>0.368</td>
<td>Renal Failure - Not Coded</td>
<td>Renal Failure - Not Coded</td>
</tr>
<tr>
<td><strong>Hemiplegia (HCC 100)</strong></td>
<td>0.437</td>
<td>Hemiplegia - Not Coded</td>
<td>Hemiplegia - Not Coded</td>
</tr>
<tr>
<td><strong>Disease Interaction: HCC 15 + HCC 100</strong></td>
<td>0.102</td>
<td>No Disease Interaction</td>
<td>No Disease Interaction</td>
</tr>
<tr>
<td><strong>Risk Adjustment Factor</strong></td>
<td>2.524</td>
<td>Risk Adjustment Factor</td>
<td>1.271</td>
</tr>
<tr>
<td><strong>Monthly Premium</strong></td>
<td>$2,282</td>
<td>Monthly Premium</td>
<td>$1,149</td>
</tr>
<tr>
<td><strong>Annual Premium</strong></td>
<td>$27,382</td>
<td>Annual Premium</td>
<td>$13,789</td>
</tr>
</tbody>
</table>
Diagnosis Submission Process

Provider Documents Member Visit in the Medical Record
↓
Provider’s Office Assigns Diagnosis Codes
↓
Provider Submits Encounter to MA Plan

MA Plan Processes and Filters Provider Encounter Data
↓
MA Plan Submits Eligible Encounter Data to CMS

CMS Processes Data for Risk Adjustment Calculation and Payment
↓
CMS Returns Data (Accepted or Error Code Status)

Retrospective Chart Reviews
2. Legal Standards and Enforcement Actions
Risk Adjustment Data Accuracy

**Annual Attestation**

- MA plans must certify that risk adjustment data is accurate, complete and truthful (based on best knowledge, information, and belief) (42 C.F.R. § 422.504(l))

- Creates a duty to, at a minimum, “put in place an information collection and reporting system reasonably designed to yield accurate information,” including ordinarily conducting “sample audits and spot checks . . . to verify whether [the system] is yielding accurate information” (64 F.R. 61893, 61900 (Nov. 15, 1999))
Risk Adjustment Data Accuracy

**Accuracy Standards**
- MA plans must “ensure the accuracy and integrity of risk adjustment data submitted to CMS . . . [and] [i]f upon conducting an internal review of submitted diagnosis codes, the plan sponsor determines that any . . . codes have been erroneously submitted, the plan sponsor is responsible for deleting the submitted . . . codes as soon as possible” (Draft Medicare Managed Care Manual § 40)

- MA organizations are required to delete records when an erroneous diagnosis cluster has been accepted by CMS (CMS 2008 MA Participant Guide § 4.16)

**Data Filtering**
- MA plans must filter risk adjustment data to ensure diagnosis submissions comply with CMS’s MA “guiding principles” (e.g., face-to-face encounter, in accordance with diagnosis coding guidelines, acceptable provider type and physician specialty) (CMS 2008 MA Participant Guide § 4.11)

**Provider Education**
- “Communicating risk adjustment requirements to physicians and providers can help to improve the quality and quantity of the data submitted by MA organizations. It can also help physicians and providers understand the importance of accurate coding and medical record documentation, and their role in data validation.” (CMS 2008 MA Participant Guide § 3.5)
False Claims Act

Civil False Claims Act (“FCA”)
- Prohibits knowingly presenting a false claim or knowingly making a false record or statement material to a false claim

- “Knowingly” includes acting in reckless disregard or deliberate ignorance of the truth or falsity of the information

- Penalties include treble damages, civil penalties, injunctive relief and potential exclusion from Medicare and Medicaid

- Qui tam provision allows a plaintiff to sue in the standing of the government and share in any recovery

2009 Fraud Enforcement and Recovery Act (“FERA”)
- Expands FCA liability by explicitly including the “knowing” retention of overpayments of government funds, applying the same definition of “knowledge” as above

- Clarifies that “claim” includes any request or demand for money that is made to a government contractor if the money is to be spent or used on the government’s behalf or to advance a government program or interest
  - Overrules short-lived Supreme Court decision in Alison Engine, which interpreted “claim” more narrowly
  - FCA applies to government claims and funds passed between contractors (e.g., MA plans) and subcontractors (e.g., providers)
Affordable Care Act: 60-Day Overpayment Rule

- The Affordable Care Act requires that overpayments be reported and repaid within 60 days after identification.

- Overpayments that are not reported and repaid within the 60-day window become “obligations” under the FCA.

- CMS has issued proposed guidance related to the 60-day overpayment rule for Medicare Parts A & B, though it remains unclear when the guidance will be finalized:
  - 10-year lookback period
  - Duty to take affirmative investigative action related to potential overpayments
    - “Timely” and “reasonable” inquiry
    - *E.g.*, compliance hotline complaints create an obligation to timely investigate the matter

- CMS has yet to issue similar proposed guidance related to Medicare Advantage (Part C) or Medicare Part D.
FCA Whistleblower Provision

- Between 2009 and 2012, the government recovered more than $13 billion in FCA cases

- The FCA’s *qui tam* whistleblower provision offers significant potential paydays for plaintiffs
  - If government intervenes, 15-25% of any recovery
  - If government declines, 25-30% of any recovery

- The FCA also provides for counsel’s recovery of fees and costs
Qui Tam FCA Actions on the Rise*

Government Allegations

- Defendants submitted false or fraudulent claims to cause overpayments to an MA Plan (the Jankes were the sole owners of the MA Plan)

- Defendants, working through their clinic, improperly assigned diagnosis codes that were not documented by medical records or supported by the actual medical conditions of beneficiaries

- Defendants knowingly failed to review claims for erroneous data before submitting them to CMS

- Defendants failed to delete incorrect diagnoses from CMS’s database after they learned of the inaccuracies

Settlement

- $22.6 million in November 2010
3. Risk Adjustment Data Submission Process: Areas Impacting Legal Exposure
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Retrospective Chart Reviews
MA Plan/Provider Relationships

**Compensation**
- Percentage of premium capitation arrangements
- Per-chart payments

**Health Plan Reports to Providers**
- Member-specific reporting of potential missed codes (i.e., suspect reporting)
- Reporting of risk adjustment scores

**Education & Training**
- Proper documentation
- Proper coding

**Quality of Care**
- HEDIS & STAR Ratings
- Mis-diagnosing
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Retrospective Chart Reviews
Encounter Processing and Filtering

Health Plan Processing Systems
- Payment systems
- Risk adjustment processing and submissions systems

Filtering
- Correct member, DOS, and diagnosis codes
- Face-to-face (CPT codes, revenue codes, bill types)
- Specialty (specialty codes)

Deletions
- Open period deletes
- Closed period deletes
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Retrospective Chart Reviews
Retrospective Chart Reviews

Chart Selection and Scope of Review
- Outlier audits
- Mock RADV
- Random
- Every member/every visit
- Based on suspect reporting
- Quality Measurement

Coding Standards
- Official coding guidelines
- QA/QC to ensure consistency and accuracy
- Handwritten vs. electronic medical records (EMR)
4. Additional Risk Adjustment Trends
CMS Regulatory Trends

Risk Adjustment Data Validation ("RADV") audits
- Extrapolation
- Fee-For-Service Adjuster
- Other RADV audit protocol changes

Coding intensity adjustment to premiums
- Adjusts premiums for MA coding patterns above and beyond fee-for-service program
- Arguably penalizes plans who have taken seriously CMS’s call to educate providers

2014 Medicare Advantage Advance Notice and Call Letter
- HCC model revisions
  - Conditions removed (e.g., lower-severity kidney diseases)
  - Conditions added (e.g., morbid obesity)
- In-Home assessments

CMS Medicare Managed Care Manual
- “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.”
OIG FY 2013 Work Plan

- Review diagnoses submitted to CMS for compliance with federal rules
- Ensure documentation supports diagnoses submitted to CMS
- Determine if CMS properly adjusted payments to MA plans based on the results of its CY 2007 data validation reviews (see recent reports on RADV audits of MA plans)
Risk Adjustment Expanding Beyond Medicare Advantage

- Policies issued under the Affordable Care Act

- Medicaid managed care programs
Contact Information
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