

Risk Adjustment Compliance & Operations: Building Meaningful Communications

HCCA Managed Care Conference

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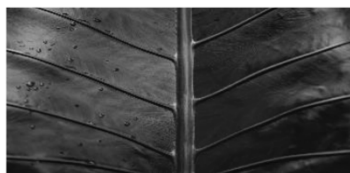


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Agenda

Discussion Points

- ❖ What is Risk Adjustment?
- ❖ Overview of the landscape (regulatory and legal)
- ❖ Considerations for structural models in Compliance, Legal, and the Risk Adjustment team
- ❖ The cost of ineffective communication channels
- ❖ Deep dive into proper communication channels and examples



Key Aspects of Medicare Risk Adjustment

Documentation and Coding Guidelines

- ❖ Conditions must be documented in a face to face visit with an allowable provider
- ❖ Claims coded in accordance with ICD-10 CM guidelines
- ❖ Condition must be coded at least one time in the calendar year

Data - submission and accuracy

- ❖ Previous year claims used to calculate risk scores, thus payment to plans
- ❖ Three data submission deadlines for plan payment year:
 - ❖ Initial – sets plan payment for the first 6 months of the year
 - ❖ Mid-year – sets plan payment for the last 6 months of the year and makes adjustments (+/-) to the initial
 - ❖ Final – adjustments (+/-) to the plan payment not processed previously
- ❖ Plans **must** submit deletions for identified errors (special process if the final submission has passed)
- ❖ Reconcile submission reports to correct and reduce errors
- ❖ Data accuracy attestation required annually

Medicare Risk Adjustment History

Balanced Budget Act (1997)

Risk Adjustment payments based on Inpatient Hospital claims

Benefits and Improvements Protection Act (2000)

Established an implementation schedule to achieve 100% risk adjustment payment in 2007
Expanded to outpatient services

Medicare Modernization Act (2003)

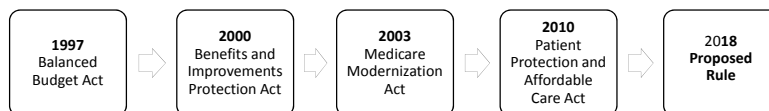
Established bidding methodology for MA organizations and drug plans in 2006

Patient Protection and Affordable Care Act (2010)

CMS required to evaluate the risk adjustment system

Proposed Rule at Federal Register/Vol. 83, No. 212/ Thursday, November 1, 2018

CMS states that a FFS Adjuster is not required due to its "non-systemic" impact on payment



Regulatory Authorities

42 C.F.R. § 422.308

- Clarifies that CMS will adjust payment amounts to account for health status

42 U.S.C. § 1395w-23(a)(1)(C)(i)

- Requires that CMS pay Medicare Advantage plans in a manner to “ensure actuarial equivalence” to Fee-for-Service Medicare.
- The Medicare Advantage payment methodology developed by CMS relies on three components all derived from Medicare Fee-for-Service claims data.
- Benchmark Rate Development relies on:
 - **The Medical Expenditures per beneficiary** – derived from FFS claims data
 - **The Risk Scores for each beneficiary** - derived from diagnosis codes submitted by providers in the FFS data
 - **Development of the Risk Adjustment Model** – The risk adjustment model relies on FFS claims data to weight medical costs by various conditions as reported by diagnosis codes.
- The implicit assumption in the design of the MA payment system is that the same member would have the same risk score in MA and FFS. This assumption requires that the inputs for both the Fee-for-Service aspects (benchmark setting and model development) and Medicare Advantage payment (bid setting and risk adjustment payments) are consistent.

42 C.F.R. § 422.310

- Governs Risk Adjustment Data. Allowable Sources: provider, supplier, physician, or other practitioner that had a face to face encounter with the beneficiary
- MAOs can assess financial penalties in contracts for failure to provide complete risk adjustment data
- RADV Audit Authority

42 C.F.R. § 422.311

- RADV audit dispute and appeals processes including payment error calculation

42 C.F.R. §422.504 (1)(2)

- MAOs must certify that data submitted to support payment is accurate, complete and truthful

False Claims Act

The False Claim Act is a federal law that makes it a crime for any person or organization to **knowingly** make a false record or file a false claim regarding any federal health care program. This includes those monies funded, in whole or in part by the US or state healthcare systems.

Knowingly is defined as having either direct knowledge or reckless disregard concerning the validity of the claim.

Liability includes fines, penalties and treble damages (permitting a court to impose up to three times the amount of actual or compensatory damages as a form of punishment).

The Act permits Whistleblowers to file law suits on behalf of the government and offers protections to these individuals from discrimination, harassment, suspension or termination of employment and backlash as a result of reporting possible fraud.

Lawsuits are initially sealed to the public and there is always a possibility that the Department of Justice may seek to intervene and pursue further action.

Key Aspects of Medicare Risk Adjustment

Risk Adjustment Data Validation (RADV) audits

- ❖ National RADV – small member samples (5 – 30) from a larger number of plans
- ❖ Pilot and Targeted RADV – 201 members from a smaller number of plans
- ❖ Pilot PY 2007 audited 5 contracts
- ❖ Targeted PY 2007 audited 32 contracts
- ❖ Targeted PY 2011 – 2013 audited 30 contracts
- ❖ Extrapolation of error rate – Fee for Service Adjustor
 - ❖ CMS had not formally announced or applied an adjustor
 - ❖ FFS adjustor of 8.1% noted in a CMS meeting (*Exhibit 16, Declaration of David Schindler US ex rel Poehling v UHC et al*)
- ❖ One best medical record to up to five medical records can be submitted
- ❖ CMS Attestation allowed for technical issues such as a missing signature
- ❖ CMS under fire to intensify RADV audit program (GAO April 2016 report)
- ❖ CMS encourages plans to conduct mock RADV audits
- ❖ On 11/1/18, CMS shocked the industry with the proposed rule which indicated that a FFS Adjuster was not needed and would not be employed; however, extrapolation would be employed.

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

Key Aspects of Medicare Risk Adjustment

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Risk Adjustment Data Validation (RADV) audits

- ❖ Pilot PY 2007 audited 5 contracts; Targeted PY 2007 audited 32 contracts
- ❖ Target PY 2011 – 2013 audited 30 contracts
- ❖ Extrapolation of error rate – exact formula not defined to date
- ❖ CMS under fire to intensify RADV audit program (GAO April 2016 report)
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See Chapter 7 (Risk Adjustment) of Medicare Managed Care Manual (last updated 9/19/14)

Risk Adjustment Litigation – Key Issues

<p>Associate education and training</p> <ul style="list-style-type: none"> • Identify a possible issue (hotlines, CS, internal and external communication) • Route to the appropriate area • Complete review of the concern with assistance from SMEs as needed <p><i>See, United States ex rel. Olivia Graves v. Plaza Medical Centers Corp., et al.</i></p>
<p>Audits – provider and/or mock RADV to identify risk of inaccurate coding</p> <ul style="list-style-type: none"> • Lack of programs • Developed but not fully implemented <p><i>See, United States ex rel. Sewell v. Freedom Health, Inc., et al.</i></p>
<p>Certification of data accuracy submitted to CMS for payment</p> <p><i>See, United States of America ex rel Benjamin Poehling v. Unitedhealth Group Inc.</i></p>
<p>Compliance Programs - ineffective in oversight and monitoring of risk adjustment processes</p> <p><i>See, United States v. Janke</i></p>
<p>One-sided or blind chart reviews - designed to find missing diagnoses but not identify unsupported diagnoses</p> <p><i>See, United States ex rel. Swoben v. SCAN Health Plan</i></p>
<p>Ordered that the 2014 Overpayment Rule, 79 Fed. Reg. 29,844, 29,918-25 (May 23, 2014), is Vacated.</p> <p><i>See, United Healthcare Insurance Company, v. Alex M. Azar II, Secretary of the Department of Health and Human Services</i></p>

Poehling v. UnitedHealth Group, Inc., No. 16-0869

Poehling v. UnitedHealth Group, Inc., DOJ took the position that MA plans who use external chart review vendors to add diagnoses to beneficiaries' medical records should also be using these chart review vendors to "look both ways" for diagnoses that should be deleted.

- Alleging that United's program was "strictly a one-sided revenue generating program"
- CMS proposed a "look both ways" rule in 2014 but did not finalize it

DOJ claims damages are the difference between what was paid and what would have been paid in a "but-for" world where improper diagnoses were removed from patient's medical records.

- DOJ has pursued this theory throughout the MA industry through civil investigative demands

Applying this theory through settlements could impact historic and future risk scores which serve as the basis for aspects of MRA Payment, including:

- MA Plan Bids
- The Coding Intensity Adjusters

DaVita Medical Holdings, LLC

In September 2018, the U.S. Department of Justice released information pertaining to the settlement of HealthCare Partners Holdings LLC, doing business as DaVita Medical Holdings LLC (DaVita), whereby inaccurate reporting by Medicare Advantage Plans resulted in the improper inflation and receipt of Medicare payments. DaVita in a signed settlement to pay \$270 million dollars in to settle its False Claims Act liabilities.

Case Summary: This case stems concerns reimbursements submitted by DaVita's contracted Medicare Advantage Organizations, who reported incorrect diagnosis codes for patients that resulted in inflated payments by the US government. Medicare Advantage Organizations operate at a flat monthly rate of reimbursement and provider for higher payments for those patients that are diagnosed with conditions requiring heightened care.

Conclusion:

- In DaVita, both in-home evaluation and coding vendors collected and submitted inflated diagnosis codes to CMS, in which DaVita received a percentage of the payments attributed to the reimbursement of said codes. DaVita failed to corroborate the validity and accuracy of information submitted by both types of vendors and therefore was held accountable.
- In addition, the Department of Justice also penalized DaVita for its failure to take corrective action when notified of a clinically unsupported and inappropriately documented codes.
- Finally, DaVita's use of providers who improperly mapped electronic health record conditions that effected its risk score, when such condition was not supported by the corresponding diagnosis code compromised the honor and reliability of the Medicare system.

Assistant U.S. Attorney General Joseph H. Hunt, emphasized "federal health care programs rely on the accuracy of information submitted by health care providers to ensure that managed care plans receive the appropriate compensation." Therefore, incorrect information submitted by either vendor or insurance provider undermines the integrity of the entire Medicare system and can hold both parties legally responsible.

Sutter Health

- In December of 2018, DOJ decided to intervene in an MRA case against Sutter Health.
- DOJ claims that Sutter Health and an affiliate, Palo Alto Medical Foundation failed to submit accurate diagnosis codes and to take corrective action on unsupported codes.
- This represents an interesting shift in DOJ taking the False Claims Act case action against a provider organization.
- There are important implications for FDR oversight, payer/provider communications, and coding education to watch out for as the case unfolds.

Assessing Current Risk Adjustment Structure

Risk Adjustment Health Plan Operations & Departmental Compliance Champions

- Promotes a “dotted line” to the organizational compliance department on a variety risk adjustment compliance areas
- Reduces gaps in risk adjustment compliance issue identification and management
- Ensures subject matter expert (SME) opinion in those risk adjustment operation areas with unique nuances and CMS/HHS program compliance requirements
- Complimentary to existing organizational compliance committee

Risk Adjustment Health Plan Operations & Departmental Compliance Champions (Cont'd)

Risk adjustment operational areas to consider:

- Risk Adjustment Program Documentation and Coding Provider Education
- Retrospective & Prospective ICD-10/HCC chart review
- Data Analytics
- Network Management
- Member Engagement
- RAPS, EDPS, & EDGE Submissions Team
- Medicare Advantage Product Sales
- Government Program Medical Director
- STARS/HEDIS

Physician Education Internal Discussions vs External Sharing; Where do we draw the line?

Internal Strategy & Internal Discussion

- Performance Data Analytics & Strategy
 - Condition Specific likely added value (LAV)
 - Risk adjustable ICD-10 code individual risk factors
 - Risk score to dollar conversions
 - Prioritizing data by condition prevalence


External discussions & strategy on the above sample of topics should not be shared externally unless:

- The discussion is to provide an overview of Medical Loss Ratio (MLR) status and movement on physician group performance
 - Physician group performance and status on PMPM (capitation per member per month)
 - Risk score to PMPM impacts for the purpose of education
 - Network Directors & Actuary

Risk Adjustment Compliance Physician Education Example

Should the below illustration be presented externally to a Provider organization by a health plan provider educator?

Less Specific Coding			VS	More Specific Coding			Difference	
ICD-10 Code	Risk Factor	Annual Revenue		ICD-10 Code	Risk Factor	Annual Revenue	Risk Score	Annual Revenue
C18.9 Colon Cancer	0.325	\$2,730		C78.7, C18.9 2ndary Colon Cancer, Liver	2.560	\$21,504	2.235	\$18,774
E11.9 Diabetes	0.121	\$1,016		E11.49 Diabetes w/neuro manifestations	0.378	\$3,175	0.257	\$2,159
J45.909 Asthma Unspecified	-	\$0.00		J44.9, J45.909 Asthma w/ COPD	0.356	\$2,990	0.356	\$2,990
Total	0.446	\$3,746	Total	3.294	\$27,670	2.848	\$23,923	

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Risk Adjustment Compliance Submissions Example

- Date Span Billing & Place of service 11
 - Date Span Billing occurs when patient services are conducted in a provider’s office over a period of time and are billed with multiple dates of service in a range on one claim form.
- Risk adjustment compliance submission (RAPS, EDPS, EDGE) impacts include:
 - ICD-10 codes associated with the 1st date of service in the span duplicate across all dates of service in the span when consumed by CMS & HHS
 - Creates invalid diagnosis codes for additional dates of service in the date span
 - Visit one in the span could have been for a cold where visit three in the span could have been for COPD, RA, & hemiparesis.
 - Creates a situation where the associated clinical documentation for additional dates of service in the span do not correlate to the ICD-10 codes CMS & HHS has consumed due to duplication of the diagnosis codes associated with the 1st visit in the span.

Controls and Monitoring

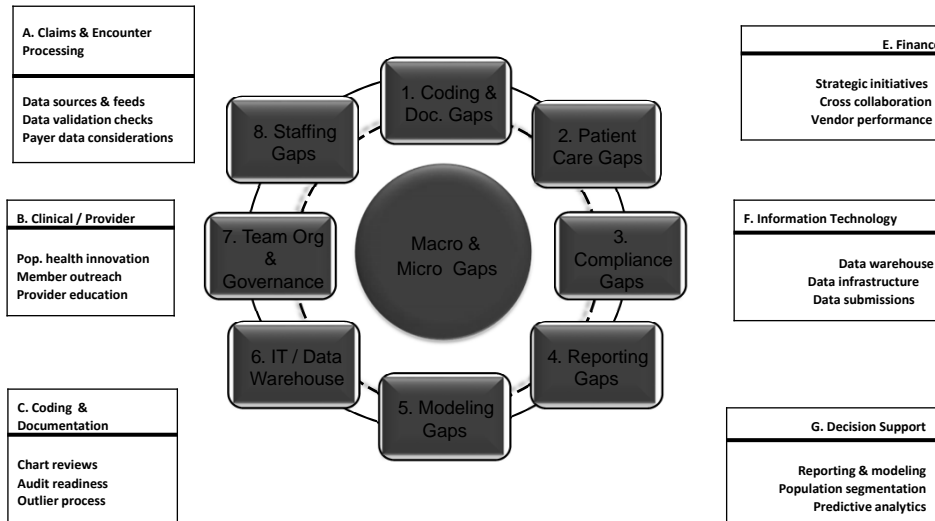
- ❖ **Internal Identification of Risks:**
 - ❖ Education of associates
 - ❖ Identification of a potential issue
 - ❖ Routing and research of potential issues
- ❖ **Clinical Care Management:**
 - ❖ Identification of members that may be appropriate for case or disease management
- ❖ **Documentation and Coding Quality Audits:**
 - ❖ Drive improvement in the programs through internal and external education
 - ❖ Identify and review providers who may represent a risk of inaccurate coding
 - ❖ Mock RADV audits to identify HCCs for further education efforts
- ❖ **Vendor Management:**
 - ❖ Effective oversight and management by the plan
 - ❖ Data provided by vendors must meet plan standards and be capable of augmenting plan quality and education programs

Alignment of Processes

Risk adjustment processes and data should align with clinical programs designed to manage population health.

Documentation & Coding	Population Health	Compliance
<ul style="list-style-type: none"> • Drive best practices in documentation • Provider outreach and education opportunities • Coding guidelines and annual updates • Vendor management – quality audits and remediation 	<ul style="list-style-type: none"> • Population segmentation for tailored outreach • Member outreach and education opportunities • Gaps in care (follow-up visit scheduled, outreach w/in 2 days of discharge, medication reconciliation, etc.) 	<ul style="list-style-type: none"> • Controls and policies & procedures in place • Data – accuracy and timeliness • Chart reviews (random or targeted sample) • Education of staff to recognize and investigate risk adjustment issues (hotlines, communication from internal or external sources)

Multiple Areas Involved in Mitigating Risk



Assessment and Control Examples

- Risk Assessment
 - Appropriate Identification of Financial, Compliance, Strategic and Operational Risk
 - Escalation of Issues
- Process and Controls Review and Testing
 - Effective committees and structure (risk adjustment activities, coding compliance) with reporting up to Senior Leadership
 - Review of Market Operations to ensure consistency with Corporate Oversight expectations
 - Validation of the Oversight functionality and Operations
 - Validation of Accuracy of Data Submission
 - Audit of Vendors and supporting activity
 - Validation of QA Methodology
 - Baseline and Accuracy of Reporting/ Analytics
- Internal Investigatory Support

Fraud Waste and Abuse (FWA)

- ❖ In Risk Adjustment - collaborative effort among Special Investigations, Legal, Clinical Leadership, and Provider Risk Assessment/Auditing
- ❖ Proper Data Governance – data analysis of chart reviews, quality results, operational metrics to identifying outliers and data driven risk assessment around accuracy
- ❖ Provider Audit results - clinical knowledge and market based knowledge necessary to understand outliers
- ❖ The standard plan FWA reporting methods must be appropriately informed to ensure Risk Adjustment issues can be identified, routed to the appropriate parties for research.

Network – Value Based, Joint Venture & Owned Arrangements

- ❖ Incentive to improve documentation and coding practices which tends to improve risk scores
- ❖ Groups - staff who educate and other efforts focused on risk adjustment
 - ❖ Skills and education varies
 - ❖ not always certified coders or
 - ❖ subject matter experts on Clinical Documentation Improvement (CDI)
- ❖ Use of outside consultants or billing companies (on and off shore)
 - ❖ Lack of controls and monitoring to ensure accuracy
- ❖ Tools such as superbills, problem lists, and data analytics to code and/or trigger documentation efforts which may not result in accuracy
- ❖ Routine additional testing pattern for members with no symptoms such as:
 - ❖ Spirometry for Chronic Obstructive Pulmonary Disease
 - ❖ Ankle Brachial Index (ABI) for vascular disease

MRA FWA Warning Signs

These warning signs are not a definitive indicators of FWA. They are meant to show areas of a higher risk for FWA rather than a definitive examples of FWA.

- **Numerous coding errors where the code has no basis in the chart:** This is different from making many mistakes, in these instances there is nothing in the documentation that would support even a mistaken version of the condition.
- **Conditions that contradict the charting:** This can be seen when a condition is coded but lab values or other test results contradict the conditions.
- **Non-Responsive Risk Sharing Providers:** Providers who share risk with a plan have a vested interest in working with the plan. Resistance to collaboration with the plan is an indicator of risk.
- **Resistance to Training Efforts:** Providers that aren't willing to accept further training in this area may be indicative of further risk.
- **Failure to Make Changes/Follow Plan Guidance:** Providers who have been provided with coding issue examples, follow up training, and are either resistant to work with the plan around process changes or to change their coding direction are a high risk indicator.
- **Contracts with ROI related to Risk Score changes:** Most of these contracts have been sunset, but where they still exist this is a high risk indicator. These may show up downstream from the plan.



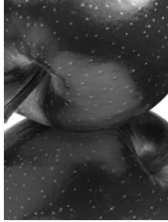
MRA FWA Evidence Examples

Providers

- Training and/or reference book provided by MSO or IPA with questionable documentation and coding guidance
- Documentation by other practitioners in the practice that is questionable (e.g. spinal enthesopathy)
- Inappropriate use of health plan HCC detail reports (late entries and/or adding diagnoses to progress notes of conditions dropping off)
- New members to the practice with HCC diagnoses on first visit with no testing and previous charts to support
- Diagnoses documented with no testing, imaging, or corroboration (specialist) to support
- Addendums and/or entries in the medical record by someone who did not see the member on that date
- Entries made in response to health plan request for medical records (HEDIS, audit, CMS RADV, plan RADV)
- Carrying over all diagnoses in an EMR without review and removal of diagnoses no longer present.
- Treatment plans that are inappropriate for the diagnosis but continue to copy over each on each progress note.
- Problem lists that are not updated and/or incomplete.



Wrap Up



- ❖ A comprehensive compliance plan must include oversight on risk adjustment processes
- ❖ Value Based, Joint Venture, and Owned Provider Network arrangements present unique risks to the plan
- ❖ Risk adjustment is a rich source of clinical data – align with medical management to drive improved member outcomes
- ❖ Education of associates to identify and refer potential risk adjustment issues to the appropriate area for of potential risk adjustment issues is critical (hotlines, communication from internal or external sources)
- ❖ Plan must be able to fully investigate risk adjustment issues
- ❖ Litigation outcomes impact – audits, overpayment, compliance programs, and vendor oversight



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