HCCA
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# WHAT YOU DON'T KNOW WILL HURT YOU: MANAGED CARE ENFORCEMENT TRENDS AND KEY RISK AREAS


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# RISK ADJUSTMENT BACKGROUND

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# 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 |

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# 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

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# 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

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# 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** |

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# GOVERNMENT FOCUS

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## Medicare Advantage Enrollment Trends

- 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

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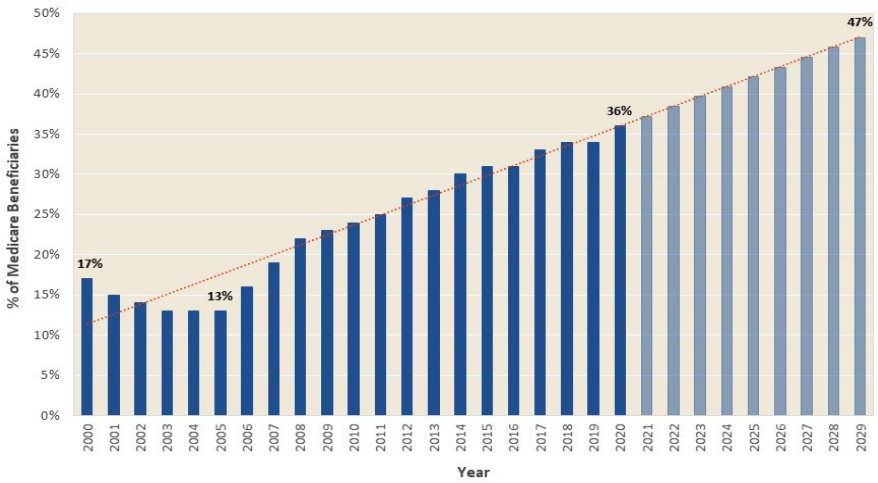
## Medicare Advantage Enrollment




**Source**: Kaiser Family Foundation (https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/

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## 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 December 2020, DAAG Michael Granston speaking on future priorities, stated that "another important priority for the Department has been investigating and litigating a **growing number** of matters related to Medicare Part C, which is Medicare's managed care program."
  - Ongoing enforcement activity

Deputy Assistant Attorney General Michael Granston

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## FALSE CLAIMS ACT AND LITIGATION BACKGROUND

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## 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

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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 (HHS-OIG)
  - OIG RADV Audits
  - 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

- 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.'"
  - DOJ appealed the ruling

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## 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."

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# ENFORCEMENT ACTIVITY

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## Enforcement Activity

| Provider Submissions | Chart Review | In-Home Assessments | Provider Assessments |
|---|---|---|---|
| Janke settlement | *Swoben* | *Silingo* | *Ormsby* |
| *Baez/Thompson* | *Poehling* | *Ramsey-Ledesma* | *Rasmussen* |
| *Graves* | *Sewell* | *Gray* | *Zafirov* |
| *Nutter* | *Ross* | *Cutler* | *Mansour* |
| DaVita settlement | Anthem | | |
| Sutter settlement | | | |

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## 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, settlement in progress)

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

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## Select Enforcement Activity (cont.)

*Poehling*, No. 11-0258 (C.D. Cal.) (unsealed *qui tam*, DOJ intervention, case proceeding)

- 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 May 2019

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

- 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

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## Select Enforcement Activity (cont.)

### DaVita Settlement

- DaVita acquired HealthCare Partners ("HCP"), a large independent physician association, in 2012. DaVita voluntarily disclosed practices instituted by HCP (also a defendant in the *Swoben qui tam* alleging unlawful one-way chart reviews) that caused MAOs to submit incorrect diagnosis codes to CMS and obtain inflated payments in which DaVita and HCP shared.
- In October 2018, DaVita entered into a $270M settlement with DOJ to resolve both the *Swoben* allegations and the diagnosis coding practices at the center of DaVita's voluntary disclosure.

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# Managed Care: Compliance and Enforcement – What You Don't Know Will Hurt You

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# Overview

- OIG – who we are, what we do
- Risk Areas
- OIG's Priorities
- OIG's Managed care reports and CIAs

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# Who we are:


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# What we do:

Audit Evaluate Investigate Counsel

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# Identifying Risk Areas


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# Managed Care Risk Areas

- Inappropriate denial of services
- Provider network issues
- MA Risk Adjustment Data
- Payments to ineligible providers
- Data quality and security problems

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# Why do we care?

- Beneficiary Harm
- Fraud in one program often means fraud in another program
- Fraud in Managed Care can increase taxpayer costs
- Federal Government has the enforcement tools: criminal, civil, administrative

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- Quality
- Federal $
- Data

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# Quality

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# OIG Report: Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care



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# Federal Funds

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# OIG Report: Essence Healthcare, Inc. – Targeted RADV

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# OIG Report: MA Payments from Health Risk Assessments

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# Data

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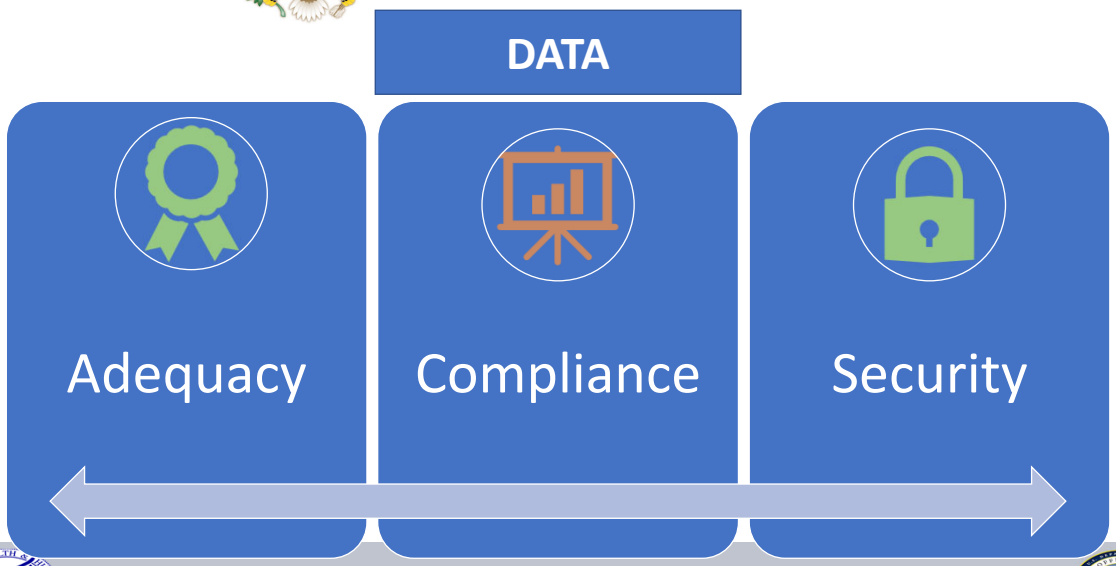




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# Freedom Health CIA (May 2017)

- Provider Network Review:
- Diagnosis Coding Review

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# Beaver Medical Group CIA (Dec. 2019)

- Annual Chart Review
- Review of diagnoses data and medical records

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# Conclusion

- ***Quality*** – more Americans than ever rely on Managed Care,
- ***Federal $*** – ensure the financial integrity of HHS programs,
- ***Data*** – leverage data to identify risk areas

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