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Why Actuarial Equivalence Matters For Medicare Advantage

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The phrase "actuarial equivalence" denotes a concept that is potentially complicated, maybe even intimidating, and certainly a mouthful to articulate. But a requirement that health insurance companies participating in the Medicare Advantage program be paid in a manner that "ensures actuarial equivalence" to traditional fee-for-service Medicare poses important implications for any stakeholder interested in an accurate and fair Medicare Advantage payment process. It is the centerpiece of a litigation challenge to a federal "overpayment" rule requiring Medicare Advantage organizations to return unsupported payments to the government or be exposed to treble damages, fines or other penalties. This article explains the concept of actuarial equivalence within the Medicare Advantage payment model and why it matters, particularly at this time when there is an increased focus by enforcement authorities, whistleblowers and politicians on the recovery of potential "overpayments" received by health insurers under the Medicare Advantage program.

Medicare Advantage and Risk Adjustment

Medicare Advantage presents an alternative to traditional fee-for-service Medicare by allowing enrollees to receive their Medicare benefits through private health plans. In 2016, 31 percent of the 57 million people on Medicare were enrolled in a Medicare Advantage ("MA") plan.[1] The participating health insurance companies, known as Medicare Advantage organizations (or "MAOs"), are compensated by the federal government under a capitated model whereby the MAO receives per member per month payments according to the number of enrollees covered by each MAO. This differs from traditional fee-for-service Medicare where healthcare providers are directly compensated by the federal government according to the services provided to enrollees.

Since the MA capitated model requires the MAOs to bear risk, there are incentives for MAOs to seek to attract healthier enrollees or to avoid unhealthy enrollees — a process known as risk selection. In order to discourage risk selection, and instead incentivize competition based on quality and efficiency, the U.S. Department of Health and Human Services ("HHS"), through its Centers for Medicare and Medicaid Services ("CMS"), implemented a risk adjustment program. Under the risk adjustment program, capitated payments to MAOs are adjusted to account for risk factors, such as age or health status, that affect expected healthcare expenditures. Diagnosis coding is used to determine if an enrollee possesses certain health conditions. Larger capitated payments are then made to MAOs that enroll beneficiaries who are expected to have higher healthcare costs. The risk adjustment model, including the

methodology for capturing and reporting diagnosis coding, is integral to ensuring that MAOs are paid according to the risk presented by their enrollees.

The Requirement of "Actuarial Equivalence" and the 2014 Overpayment Rule

Federal law requires CMS to pay MAOs in a manner that "ensures actuarial equivalence" between traditional Medicare plans and MAOs.[2] The amounts paid to MAOs for particular conditions as part of the Medicare risk adjustment methodology are determined by an analysis of the frequency and cost of those same conditions within traditional fee-for-service Medicare. This analysis includes a human element, however, and, thus, there is a propensity for error. Specifically, whether an enrollee possesses a particular condition for purposes of risk adjustment is generally determined by a multistep process: (i) an encounter between the enrollee and his or her healthcare provider; (ii) yielding physician notes or other medical records; (iii) which are then interpreted by a trained coder; (iv) and translated into numerical figures according to an expansive and evolving catalog of numerical diagnosis codes known as the International Statistical Classification of Diseases and Related Health Problems, 9th or 10th revision ("ICD" codes). Qualifying ICD codes are then assigned a risk score, which translates into a risk adjusted rate for the enrollee and his or her plan. Error at any step in this process may affect the amounts attributed to particular diagnoses under the risk adjustment methodology. Once the risk adjustment model is finalized, the propensity for human error also exists within the medical record documentation and coding that is used to determine whether an enrollee possesses a condition entitling the MAO to a risk adjustment payment.

A 2014 rule by CMS (the "overpayment rule") potentially violates the requirement of "actuarial equivalence."[3] The purpose of the overpayment rule was to clarify an Affordable Care Act ("ACA") requirement that insurers report and return overpayments received from the federal government that the insurers discover on their own.[4] The ACA requires an insurer to report and return that overpayment to the secretary of HHS or other government entity or contractor within 60 days after the overpayment is "identified." [5] If an insurer fails to return the overpayment within 60 days of identification, the MAO's claim for payment may be a violation of the False Claims Act (the "FCA"), which carries the potential for treble damages and civil penalties and can result in disbarment from Medicare.[6] The 2014 overpayment rule supplemented CMS' definition of an identified overpayment to state that a MAO must return as overpayments, or be subject to liability for, risk adjustment payments if and when the MAO "has determined, or should have determined though the exercise of *reasonable diligence*" that the risk adjustment is not properly supported by the requisite medical record documentation.[7] CMS did not define "reasonable diligence" in all factual scenarios but clarified that, "at a minimum, reasonable diligence would include *proactive compliance activities* conducted in good faith by qualified individuals to monitor for the receipt of overpayments."[8]

The overpayment rule undermines the requirement of "actuarial equivalence" because it addresses only one side of the MA risk adjustment analysis. While it imposes on MAOs an obligation to exercise reasonable diligence in determining whether the diagnosis codes giving rise to expected health expenditures are adequately supported by medical record documentation, the calculation of the risk adjustment amounts that are paid for particular conditions — and the amounts required to be returned as overpayments — are not similarly subjected to a document verification process.

The following example illustrates how the overpayment rule may run afoul of the requirement of "actuarial equivalence": Assume that the population of traditional Medicare beneficiaries includes 10 beneficiaries with a diagnostic code for depressive disorder, but there is no medical record documentation supporting the diagnostic code for one of those 10 beneficiaries. Assume also that the

annual expected healthcare expenditures for a beneficiary with depressive disorder are $1,000 per beneficiary. When CMS calculates the expected cost associated with depressive disorder it will observe and calculate a total expenditure of $9,000 for expenditures related to depressive disorder ($1,000 multiplied by nine beneficiaries). But it will calculate a per-beneficiary cost of $900 by dividing $9,000 in total expenditures by 10 beneficiaries (the number of beneficiaries with a diagnostic code for depressive disorder), rather than by 9 beneficiaries, as CMS does not attempt to account for the likelihood of unsupported medical record documentation when devising the risk adjustment model. Had CMS attempted to verify the supporting medical record documentation, it would have calculated a per-beneficiary cost of $1,000 because it would have divided the total expenditures for depressive disorder ($9,000) by the total verified beneficiaries (only 9). Thus, the fact that CMS does not verify whether there is underlying medical record documentation results in a calculated per-beneficiary costs of $900 versus $1,000.

If an MAO likewise has 10 beneficiaries with a diagnostic code for depressive disorder, CMS will pay $9,000 to the MAO ($900 times 10 beneficiaries). However, if only nine of the 9 beneficiaries have medical record documentation to support the diagnosis code then the MAO may be required to return $900 if it determines, or "should have determined based on reasonable diligence," that one of the beneficiaries did not have the condition adequately documented in the medical chart after the MAO submitted its risk adjustment data for the year. This would result in a total risk adjustment payment to the MAO for depressive disorder of only $8,100 (nine times $900). Had CMS undertaken a similar verification when creating the risk adjustment model, it would have calculated a higher total initial payment to the MAO ($10,000 versus $9,000). Thus, after returning the overpayment, the MAO ends up with only $8,100 versus $9,000. The MAO is underpaid by $900 because the methodology for calculating risk adjustment payment amounts using fee-for-service Medicare data is not subject to the same medical record documentation process that is required of the MAOs under the CMS overpayment rule. Although this illustration provides a simplistic example, the effects are amplified across entire populations and plans.

Importantly, CMS has acknowledged the propensity for error in the data used to calculate the risk adjustment payment amounts. In particular, unlike the overpayment rule, a retrospective audit process performed by CMS on MAOs, known as the risk adjustment data validation audit process or the RADV audits, incorporates an adjustment to account for this propensity for error within the claims data for traditional fee-for-service Medicare.[9] CMS conducts RADV audits annually on a subset of Medicare Advantage plans by comparing a sample of the diagnostic codes submitted by an MAO to its enrollees' underlying medical charts and determining a contract-level error rate.[10] When developing the RADV process, the American Academy of Actuaries pointed out that the requirement of actuarial equivalence would not be met to the extent that a medical record documentation requirement is imposed on an MAO as part of the RADV audit process because such a process is not applied to the Medicare data that is used to develop the risk adjustment model (based on claims data).[11] CMS agreed, and the final RADV methodology requires CMS to calibrate an MAO's observed error rate (determined in part by the percentage of codes not adequately supported by underlying medical charts) against an industry-average error rate (known as a fee-for-service adjuster or "FFS adjuster").[12] CMS calculates the FFS adjuster after auditing a sample of its own claims data and comparing that data to its members' underlying medical charts.[13] Under the final RADV methodology, CMS seeks to recover a contract-level payment from the plan only if the plan's error rate exceeds CMS' own error rate, and the MAO will only be found to have been overpaid by the amount that exceeds CMS' error rate. Despite the inclusion of a FFS adjuster within the RADV process, CMS rejected proposals to incorporate a similar FFS adjuster into its overpayment rule.[14]

False Claims Act Liability for Risk Adjustment Overpayments

The repercussions for failing to return risk adjustment "overpayments" are significant. Specifically, MAOs risk treble damages as well as penalties (between $5,500 and $11,000 per obligation) under the FCA. A defendant that is found liable under the FCA, or that settles an alleged liability, may also be subject to exclusion from participation in federal healthcare programs such as Medicare. Under the FCA, lawsuits may be brought by "whistleblowers" or "relators," often former employees or other insiders, on behalf of the government.[15] To date, at least eight whistleblower lawsuits alleging FCA liability with respect to Medicare Advantage risk adjustment have been unsealed.[16] Most notably, the Ninth Circuit held in United States ex rel. Swoben v. UnitedHealthcare Insurance Co., 848 F.3d 1167, that a whistleblower may bring claims against an MAO under the FCA when the MAO is alleged to have designed a "one-sided" retrospective review of enrollees' medical records, i.e., a review that is designed to find a missed diagnosis (entitling the MAO to additional payment), while deliberately avoiding the identification of erroneously submitted diagnosis.[17] The Ninth Circuit's decision is noteworthy given previous agency guidance and rulemaking. Specifically, CMS had previously confirmed that MAOs may conduct retrospective reviews of their enrollees' medical records to ensure the accuracy of the diagnosis codes they provide to CMS, and, as part of its final rulemaking, CMS expressly rejected a proposal that would have prohibited "one-sided" reviews.[18]

The U.S. Department of Justice ("DOJ") initially declined to intervene in the Swoben litigation. However, after the case was remanded to the trial court, the DOJ filed a complaint-in-intervention against UnitedHealth Group Inc. ("UHG").[19] The DOJ also recently filed a complaint-in-intervention in a separate but similar lawsuit by a former employee of UnitedHealthcare Inc., a subsidiary of UHG that provides healthcare coverage, alleging that UHG violated the False Claim Act by submitting exaggerated or "upcoded" risk adjustment claims as part of a national "one-sided" chart review process, U.S. ex rel. Benjamin Poehling v. UnitedHealth Group Inc. et. al., No. 16-cv-8697 (C.D. Cal.) (the "Poehling action"). Although the DOJ has only intervened in the Poehling action against UHG and UnitedHealthcare, it announced that it intends to continue investigations of other MAO defendants. These enforcement efforts coincide with a recent political focus on potential overpayment within Medicare risk adjustment, including questions raised by the chairman of the Senate Judiciary Committee following RADV audit results.[20] Together, the recent uptick in unsealed complaints concerning risk adjustment practices and the enforcement activities of the DOJ suggest that risk adjustment may be the new frontier for FCA liability.

Enforcing the Requirement of "Actuarial Equivalence" Through Affirmative Litigation

The FCA lawsuits by whistleblowers are not the only judicial forum within which the scope of MAOs' risk adjustment obligations is being disputed. In January of 2016, UnitedHealthcare initiated affirmative litigation against the federal government challenging the overpayment rule under the Administrative Procedures Act, 5 U.S.C. Section 551 et seq., UnitedHealthcare Insurance Company v. Price, No. 16-cv-157 (D.D.C.). UnitedHealthcare alleges that the overpayment rule violates CMS's statutory mandate to ensure actuarial equivalence between Medicare and Medicare Advantage plans by requiring MAOs to exercise "reasonable diligence" to identify and delete codes that are unsupported by underlying medical charts, without accounting for the fact that CMS does not exercise such diligence to identify and delete codes from the fee-for-service Medicare claims data.[21] UnitedHealthcare also alleges that the overpayment rule improperly imposes a negligence standard on MAOs in identifying and returning overpayments, while the ACA statute requires the MAO to have actual knowledge of the overpayments. UnitedHealthcare has requested that the overpayment rule be set aside, and that the court grant a declaratory judgment that it is not required to undertake "reasonable diligence" efforts unless CMS

imposes the same validation standard on itself.

Preliminary rulings have already been made in favor of the MAO in UnitedHealthcare v. Price. In ruling that UnitedHealthcare possesses standing to pursue its claims, the court rejected the argument that the overpayment rule merely repeated pre-existing obligations found within the Medicare Act and instead found that the rule imposes a novel legal obligation on the plaintiffs.[22] Judge Rosemary Collyer reasoned that the "insistence on 'proactive compliance activities,' under pain of a FCA suit provable by negligence alone" is not meaningless, but rather "imposes (for good reason or not) new obligations."[23] In addition, Judge Collyer rejected an attempt by the DOJ to stay UnitedHealthcare v. Price pending resolution of the FCA cases even though the litigations present similar issues. The court reasoned in part that the 2014 overpayment rule "has industry-wide implications, which, clearly, the FCA cases do not."[24] This means that the UnitedHealthcare lawsuit challenging the overpayment rule will likely be heard ahead of the FCA litigations since it will hinge on the review of an administrative record, while the FCA cases will "require considerable discovery" and a "highly fact-specific analysis of United's actions."[25]

Thus, the court will proceed with the merits of the MAO's claims in UnitedHealthcare v. Price. A ruling favorable to MAOs would result in a higher standard of knowledge necessary in order to trigger an obligation on behalf of MAOs to report and return risk adjusted overpayments. A favorable ruling would also obviate FCA liability for unsupported risk adjusted payments that are arguably attributable to mere human error or negligence.

Conclusion

The requirement of "actuarial equivalence" presents interesting and important implications for MAOs, CMS and other stakeholders keen on ensuring the fairness and equity of the Medicare Advantage payment process given the propensity for error in the multiple-layered steps that are required to identify and report diagnosis coding. This propensity for error exists within both the calibration and design of the risk adjustment model using traditional Medicare claims data, as well as the reporting that supports MAOs' entitlement to risk adjusted payments. The fact that the RADV audit process includes an adjustment to account for industry-wide error in the calculation of risk adjustment payments suggests that there should be a similar adjustment before an MAO may be subjected to FCA liability for failing to return any overpayments. Such an adjustment has not been incorporated into the requirements of the overpayment rule but will likely be a point of dispute in any damage calculation for any FCA liability. Thus, a central question presented by both the FCA litigations and the affirmative litigation under the Administrative Procedures Act is whether, and to what extent, MAOs are required to ferret out and pay for "overpayments" that are the result of human error or negligence. This issue matters because it impacts the integrity of the Medicare Advantage risk adjustment model, the objective of deterring risk selection, and the ability to achieve a fair and equitable model for compensating MAOs for the risk undertaken in providing health insurance coverage to Medicare advantage enrollees.

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[1] The Henry J. Kaiser Family Foundation, Medicare Advantage Fact Sheet (May 2016), available at http://kff.org/medicare/fact-sheet/medicare-advantage/.

[2] See 42 U.S.C. § 1395w-23(a)(1)(C)(i) (2016).

[3] See 42 C.F.R. § 422.326 (2014) entitled "Reporting and Returning of Overpayments."

[4] 42 U.S.C. §§ 1320a-7k(d)(1), 1320a-7k(d)(4)(B) (2010).

[5] Or, for providers, 60 days after repayment is identified or the date any corresponding cost report is due, whichever is later.

[6] 42 U.S.C. § 1320a-7k(d)(3) (2010) ("Any overpayment retained by a person after the deadline for reporting and returning the overpayment . . . is an obligation (as defined in section 3729 (b)(3) of title 31) for purposes of section 3729 of such title."); see False Claims Act, 31 U.S.C. § 3729 et seq. (2012)

[7] See 42 C.F.R. § 422.326(c) (emphasis added); 79 Fed. Reg. 29,843, 29,921, 29,923 (May 23, 2014).

[8] 79 Fed. Reg. 29,843, 29,923 (May 23, 2014) (emphasis added).

[9] See 42 C.F.R. § 422.311; CMS, Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits, at 4 (Feb. 24, 2012), available at http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/radvmethodology.zip.

[10] 74 Fed. Reg. 54,634, 54,673-74 (Oct. 22, 2009). The RADV process began with the 2007 payment year, but CMS only sought recoupment with respect to the sampled beneficiaries. More recently, CMS has implemented a procedure through which the payment error rate is extrapolated to the contract population as a whole. See Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits, available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2012-Fact-sheets-items/2012-02-24.html.

[11] Letter from Thomas F. Wildsmith, Vice President, Health Practice Council, American Academy of Actuaries, to Cheri Rice, Acting Director, Medicare Plan Payment Group, at 2 (Jan. 21, 2011), available at http://www.actuary.org/pdf/health/RADV_comment_letter_012111_final.pdf.

[12] See CMS, Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits, supra n.9, at 4.

[13] See id.

[14] 79 Fed. Reg. 29,844, 29,921 (May 23, 2014).

[15] See 31 U.S.C. § 3730.

[16] United States v. Janke, 2:09-cv-14044-KMM (S.D. Fla); United States ex rel. Swoben v. Scan Health Plan et al., 2:09-cv-05013-JFW-JEM (C.D. Cal.); United States ex rel. Graves v. Plaza Med. Ctrs., 1:10-cv-

23382 (S.D. Fla.); United States ex rel. Conte v. Blue Cross Blue Shield of S. Carolina, 3:13-cv-02251 (D. S. Car.); United States ex rel. Silingo v. Mobile Med. Exam. Servs., Inc., 8:13-cv-01348 (C.D. Cal.); United States ex rel. Ramsey-Ledesma v. ConseoHealth, LLC, 3:14-cv-00118-M (N.D. Tex.); United States ex rel. Valdez v. Aveta Inc., 2:11-cv-03343 (D.P.R.); United States ex rel. Poehling v. UnitedHealth Group Inc., 2:16-cv-08697-MWF-SS (C.D. Cal.).

[17] See United States ex rel. Swoben v. UnitedHealthcare Co., 848 F.3d 1161, 1167 (9th Cir. 2016).

[18] CMS, 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide Section 7.7; 79 Fed. Reg. 1918, 2000 (Jan. 10, 2014); 79 Fed. Reg. 29,843, 29,926 (May 23, 2014).

[19] Dkt. No. 296, United States ex rel. Swoben v. Scan Health Plan et al., No. 2:09-cv-05013-JFW-JEM (C.D. Cal. May 16, 2017).

[20] See Fred Schultz, Medicare Advantage Money Grab, Sen. Grassley Demands New Scrutiny of Medicare Advantage Plans, Center for Public Integrity and Kaiser Health News (April 18, 2017), available at https://www.publicintegrity.org/2017/04/18/20823/sen-grassley-demands-new-scrutiny-medicare-advantage-plans.

[21] Dkt. No. 1, Compl. ¶ 4, UnitedHealthcare Insurance Co. v. Price, No. 16-cv-157 (D.D.C. Jan. 29, 2016).

[22] Dkt. No. 25 at 13, UnitedHealthcare Insurance Co. v. Price, No. 16-cv-157 (RMC) (D.D.C. Mar. 31, 2017).

[23] Id.

[24] Dkt. No. 38 at 5, UnitedHealthcare Insurance Co. v. Price, No. 16-cv-157 (RMC) (D.D.C. June 14, 2017) (citing Dkt No. 35, Amicus Curiae Br. of America's Health Insurance Plans)).

[25] Dkt No. 38 at 4,6, UnitedHealthcare Insurance Co. v. Price, No. 16-cv-00157 (RMC) (D.D.C. June 14, 2017). However, UnitedHealthcare may seek to transfer and consolidate the Poehling action with the UnitedHealthcare v. Price litigation pending in the District of Columbia, which, if successfully consolidated, may delay resolution of UnitedHealthcare v. Price. See Dkt No. 295 at 9, United States ex rel. Swoben v. Scan Health Plan et al., 2:09-cv-05013-JFW-JEM (C.D. Cal. April 27, 2017).
