Legal, Regulatory and Compliance Summit on

Medicare Advantage

FORECASTING FUTURE ENFORCEMENT:
IMPLICATIONS FOR LEGAL AND COMPLIANCE

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THE HEADLINES

WHAT IS RISK ADJUSTMENT FRAUD?

Risk-adjustment fraud occurs when Medicare Advantage plans report to CMS that their members are sicker than they truly are, causing CMS to overpay the Medicare Advantage plans for the members. The Medicare Advantage plan – or a physician, contractor, or consultant hired by the plan – knows that the diagnosis submitted to CMS is unsupported.

Los Angeles Times

Column: The government lawsuit against Kaiser points to a massive fraud problem in Medicare

DOJ accuses Anthem of fraud in risk adjustment payments for its Medicare Advantage plans

PROVIDER NETWORK PAYS $270 MILLION FOR MEDICARE ADVANTAGE FRAUD

QUI TAM / WHISTLEBLOWER

Medicare Advantage Fraud Lawyers

AGENDA

- Enforcement History Overview
- Current Enforcement Trend Implications
- Legal and Compliance Oversight Considerations and Best Practices

ENFORCEMENT HISTORY OVERVIEW

- **CMS Risk Adjustment Data Validation (RADV) Audits**
  - 1999 – 2003: Focus on education, intended to improve the accuracy of RA data
  - 2004 – 2006: Pilot years for payments based on current HCC RA model
  - 2009 – 2018: Traditional RADV; 2010 finalized rule
  - 2019 – current: Co-hort based methodology based on 2018 proposed rule

CURRENT ENFORCEMENT TREND IMPLICATIONS

- **CMS Risk Adjustment Data Validation (RADV) Audits**
  - Proposed Rule in November of 2018 Key Issues
    - Extrapolation of overpayment amount
    - Elimination of a fee-for-service risk adjustor
    - Targeted co-hort methodology
  - Implications - DISRUPTION
    - Litigation, litigation, litigation
    - Plan Challenges: Recoveries, bids, participation / survival
    - Beneficiary: benefit design / co-pays
    - Government: costs rise

ENFORCEMENT HISTORY OVERVIEW

- **OIG Reports**
  - *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments*, September 2021, OEI-03-17-00474
  - *Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns*, December 2019, OEI-03-17-00470
- **OIG Auditing**
  - Oversight authority of agencies
  - 2012 audits on 2007 dates of service
  - 2020 – current: targeted and general audits on 2014 – 2017 dates of service

CURRENT ENFORCEMENT TREND IMPLICATIONS

- **OIG Auditing**
  - Plans with Current Audits
    - Engaging risk adjustment team and legal
    - Refunding of overpayment
    - CMS – extrapolation
    - Compliance review
    - Future monitoring and auditing
  - Plans without Current Audits

ENFORCEMENT HISTORY OVERVIEW

- **DOJ / Qui Tam Actions**
  - Initial concerns in MA - underutilization
  - Response to political pressure of MA plans being overpaid (CMS / OIG audits)
  - Enforcement Mechanisms:
    - Overpayment Rule
    - False Claims Act
    - Anti-Kickback Statute

ENFORCEMENT HISTORY OVERVIEW

- **DOJ / Qui Tam Actions**
  - Retrospective Reviews
  - In-Home Assessments
  - Prospective Reviews
  - Coding Guidance
  - Provider Engagement
  - Monitoring and Auditing

CURRENT ENFORCEMENT TREND IMPLICATIONS

- **Retrospective Reviews**
  - Review of medical records to identify any missing diagnosis codes not previously submitted to CMS
    - One-way versus two-way coding
    - Often blind coding
  - Cases often explore the knowledge element of the FCA
  - Cases include:
    - *United States of America ex rel. Swoben v. Secure Horizons, et al.*, 09-5013 (Central District of California)
    - *United States of America ex rel. Benjamin Poehling v. UnitedHealth Group, et al.*, 2:16-cv-08697-MWF-SS (Central District of California)
    - *United States of America v. Anthem, Inc.*, 1:20-cv-02593 (Southern District of New York)
    - *United States ex rel. Ross v. Independent Health Association et al.*, 12-CV-0299(S) (Western District of New York)
  - Implications

CURRENT ENFORCEMENT TREND IMPLICATIONS

- **In Home Assessments**
  - Plan initiated activity to engage with member in the home
  - Often target those beneficiaries who have not had an encounter in the year of service to close both quality and risk adjustment gaps
  - CMS originally not a fan; issued best practices
  - DOJ focus: reasonableness of diagnosis, oversight, telehealth
  - Cases include:
    - *United States ex rel. Silingo vs. Mobile Medical Examination Services, Inc.* Case No. SA CV 13-1348 FMO (JCx) (Central District of California)
    - *United States ex rel. Ramsey-Ledesma v. Censeo Health, LLC* Civil Action No. 3:14-CV-00118-M (Northern District of Texas)
  - Implications

CURRENT ENFORCEMENT TREND IMPLICATIONS

- **Coding Guidance**
  - Internally developed coding methodology for plan, downstream entities to adopt
  - Varies in content (from risk adjustment overview to how to diagnose) and audience (coders and/or providers)
  - DOJ focus: clinical accuracy, focus on revenue capture, communications
  - Cases include:
    - *DaVita case*
  - Implications

CURRENT ENFORCEMENT TREND IMPLICATIONS

- **Prospective Assessments**
  - Engagement with providers pre, during or shortly after encounter
  - Attempt to ensure accurate diagnosis and documentation is captured during visit
  - DOJ Focus: use of algorithms to identify chronic/ suspect conditions codes, queries, addenda, provider communications
  - Cases include:
    - *United States ex rel. Ross v. Independent Health Association et al.,* 12-CV-0299(S) (Western District of New York)
  - Implications

CURRENT ENFORCEMENT TREND IMPLICATIONS

- **Provider Engagement**
  - Takes many forms – emails, training, education, queries, performance tracking, electronic medical record, etc.
  - Focus and delivery may differ if FFS v risk sharing arrangement
  - DOJ Focus: is communications driving accuracy or risk score lift only
  - Cases include:
    - *United States ex rel. Osinek v. Kaiser Permanente*, 3:13-cv-03891 (Northern District of California)
    - *United States ex rel. Ormsby v. Sutter Health, et al.*, No. 15-CV-01062-LB (Northern District of California)
  - Implications

CURRENT ENFORCEMENT TREND IMPLICATIONS

- **Monitoring and Auditing**
  - Always trying to find right balance – internal and outside vendor oversight
  - Monitoring done by SMEs with compliance oversight DOJ
  - Focus: what did organization know, did they do enough
  - Cases include:
    - *United States of America ex rel. Benjamin Poehling v. UnitedHealth Group, et al.*, 2:16-cv-08697-MWF-SS (Central District of California)
    - *United States of America v. Anthem, Inc.*, 1:20-cv-02593 (Southern District of New York)
    - *United States ex rel. Ormsby v. Sutter Health, et al.*, No. 15-CV-01062-LB (Northern District of California)
  - Implications

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **Compliance Programs and Risk Adjustment**
  - CMS guidance on compliance program oversight of risk adjustment is **minimal and out-of-date**
    - MMCM Chapter 7 (Risk Adjustment) Updated 9/19/2014
    - MMCM Chapter 21 (Compliance Program Guidelines)
      - Updated 1/11/2013
      - No mention of risk adjustment
  - Plans need to design compliance programs for risk adjustment using:
    - Available guidance
    - Information gleaned from litigation

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **2014 MMCM Ch 7, §40 – Plan Responsibilities**
  - Ensure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record as the result of a face-to-face visit and be coded according to International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting.
  - Implement procedures to ensure that diagnoses are from acceptable data sources.
  - Submit the required data elements according to the ICD coding guidelines.
  - Delete codes that do not meet risk adjustment submission requirements.
  - Inform CMS if the MAO discovers that diagnosis codes used by CMS to calculate a final risk score for a previous payment year were inaccurate and had an impact on the final payment.

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **Litigation Insights – Compliance Oversight and Monitoring**
  - Graves v. Plaza Medical Center
    - Family physician in Florida alleged a practice of inflating patient diagnoses to enhance MA risk adjustment scores at a clinic Humana acquired during her employment
    - Contended that the clinic terminated her employment after she began to question the accuracy of diagnoses being submitted to CMS
    - Argued that Humana failed to make a good faith effort to verify accuracy of coding submissions, ignored red flags that its codes were inaccurate, **and failed to operate an effective compliance program with respect to oversight of risk adjustment**
  - Silingo vs. Mobile Medical Examination Services, Inc.
    - Former compliance officer for a IHA vendor = whistleblower
    - Alleged MAO customers "turned a blind eye to the truth"
  - Key Takeaways for MAOs and Vendors
    - Capture complaints from employees and vendor employees
    - Oversee HR decisions and non-retaliation policy

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **Compliance Program Recommendations**
  - Prioritize risk adjustment in annual risk assessment
    - CMS/OIG are not your biggest threat
    - Deploy compliance resources to address whistleblower litigation risk
  - Build risk adjustment expertise in compliance and in-house legal departments
  - Negotiate vendor and provider contracts to:
    - Ensure rights to conduct monitoring and oversight
    - Flow down legal risk for their conduct
  - Risk Adjustment program materials
    - Conduct compliance review of all external materials on risk adjustment
    - Provider-facing
    - Vendor materials
    - Theme should be "complete and accurate coding"
  - Publicize MAO compliance hotline to employees as well as vendors/providers and their employees

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **Tone from the Top**
  - What are your executives saying about risk adjustment?
  - Compliance message needs to come from business leaders
  - **Communicate the WHY OF RISK ADJUSTMENT**
    - Coding **completeness** is essential to have the financial resources we need to provide the care our members need
    - Coding **accuracy** is essential to ensure we are not overpaid by the government

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **Compliance Program – Pivot**
  - Beyond check-the-box audit readiness
  - Culture of compliance in risk adjustment
  - Monitor all risk adjustment messaging
    - Internal and external
  - Oversee risk adjustment program with emphasis on providers and vendors
    - Routine quality assurance monitoring of coding
    - Periodic audits
    - Respond to complaints

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **Retrospective Reviews**
  - One-way vs. two-way reviews
  - Target list and algorithm development
  - Use of natural language processing
  - Coding guidelines development and deployment
  - Coding validation reviews/audits
    - Internal coders
    - Vendors

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **In-Home Assessments / Prospective Programs**
  - Suspect condition list development
  - Clinical and coding coordination on condition prompts
  - Coding (who is doing what)
  - Guidance for in-home assessments
  - Provider incentives

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **Monitoring and Auditing / Provider Engagement**
  - Data validation audit processes and procedures
  - Informed provider education initiatives
  - Contract clarity – providers and vendors
  - Review of vendor processes and procedures
  - Corrective action plans

LEGAL AND COMPLIANCE OVERSIGHT CONSIDERATIONS AND BEST PRACTICES

- **Coding Guidance**
  - Coding guidelines development and maintenance
  - Uniform training and use across internal coders and vendors
  - Documented rules/interpretations and coding or clinical support