STRATEGIC HEALTH LAW

Medicare Advantage:
Supporting Profitability While Managing Legal Risk

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2019 Medicare Advantage Market Overview

MA Enrollees in 2019

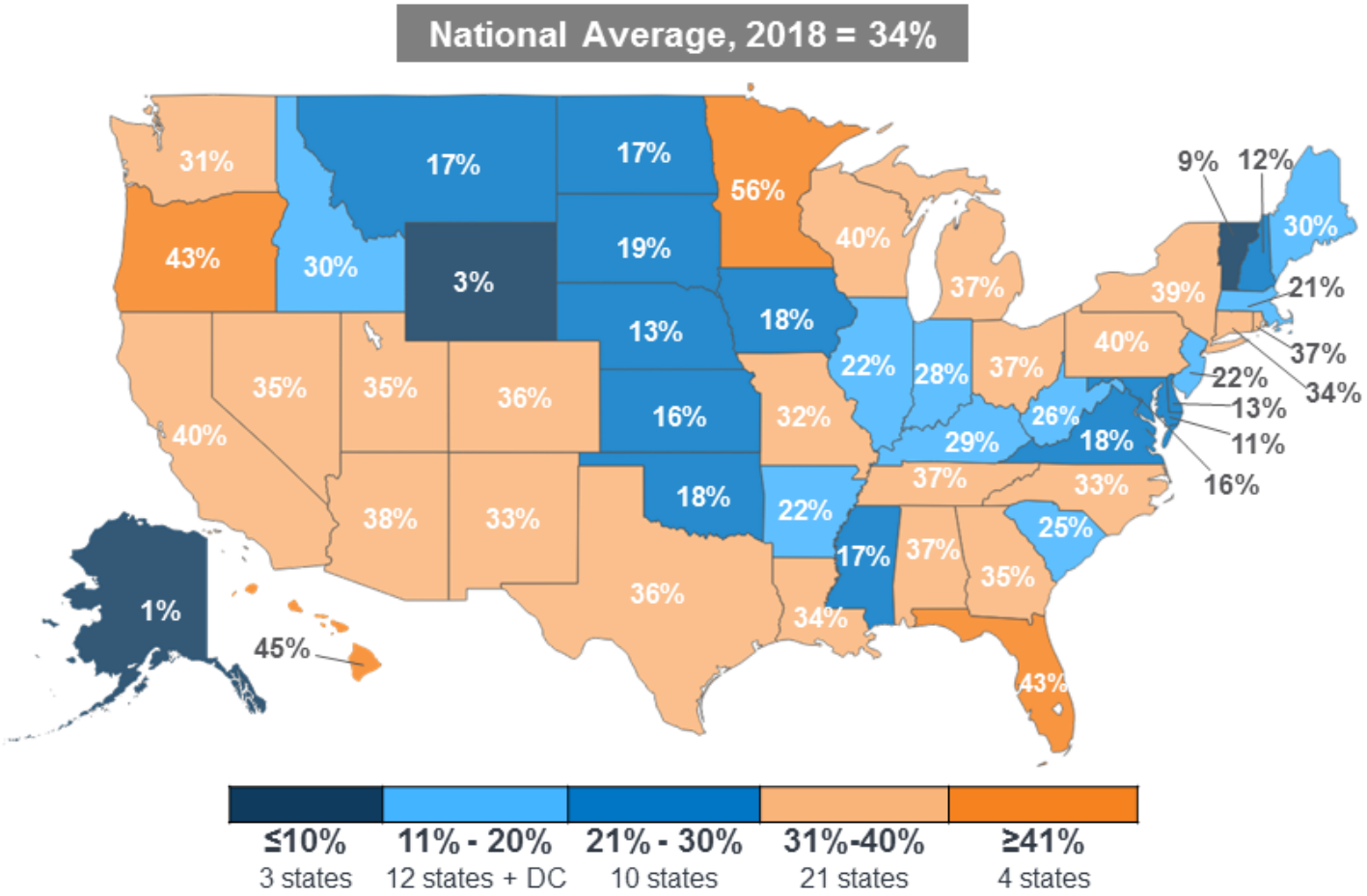
- 34% of Medicare beneficiaries
- 20 million beneficiaries

Compared with 2004

- 13% of beneficiaries
- 5.3 million beneficiaries

Figure 3

Medicare Advantage Penetration, by State, 2018



NOTE: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2018.

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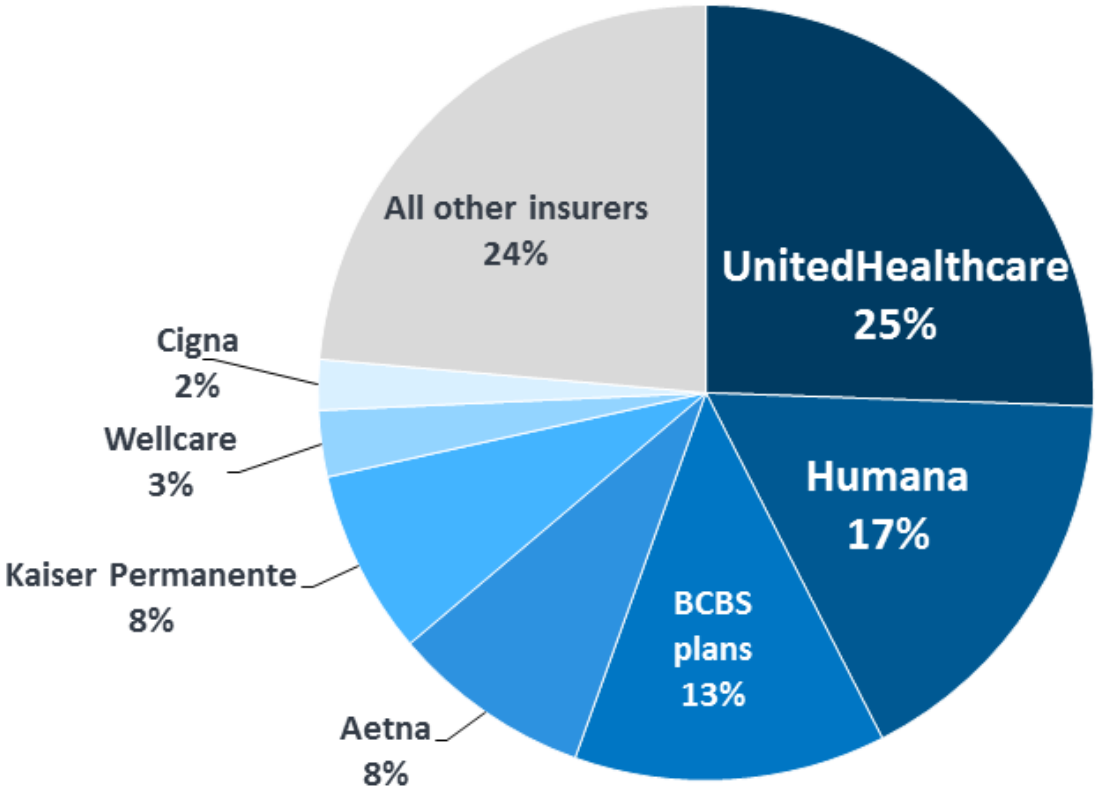
Figure 5

Medicare Advantage Enrollment by Firm or Affiliate, 2018



Total Medicare Advantage Enrollment, 2018 = 20.4 Million

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and excludes Anthem BCBS plans. Anthem includes BCBS plans (3% of total enrollment) and other plans (1% of total enrollment). Percentages may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of CMS Enrollment files, 2018.

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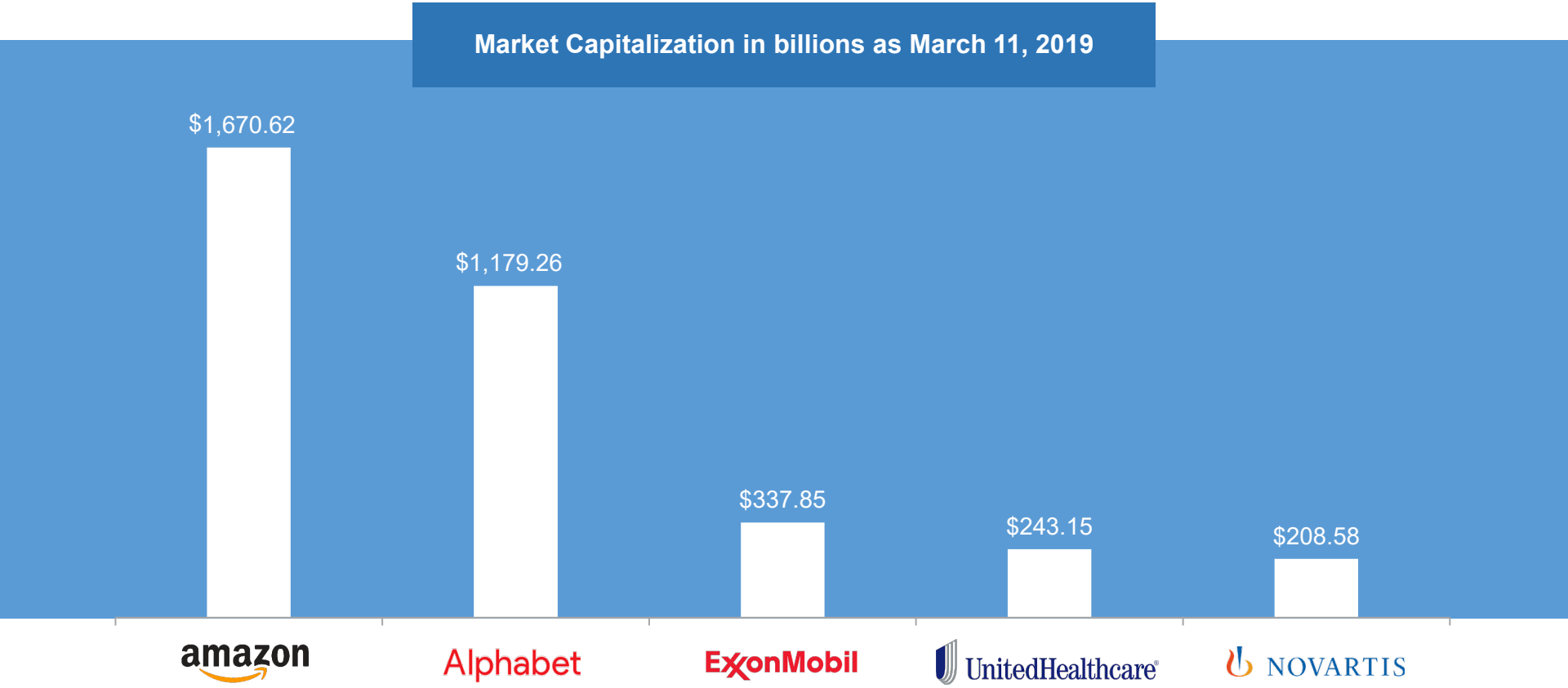
Tech Companies: They're big, and they are moving into healthcare.



Venture Capital Backed Health Plans

oscar

Founded: **2012**

Total funding amount: **$1.3B**

Clover

Founded: **2013**

Total funding amount: **$925M**

bright HEALTH

Founded: **2015**

Total funding amount: **$440M**

DevotedHealth

Founded: **2017**

Total funding amount: **$362M**

Source: www.crunchbase.com (accessed 3/11/2019)

Key Profitability Drivers Counsel Can Support

New MA Plans

Informed, up-front financial analysis: Are the numbers going to work?

Needed:

Vendor contracts

Provider contracts

When?

Before preparing CMS Application

February pre-plan year

Before submitting bid

June pre-plan year

Before entering into CMS contract **September** pre-plan year, factoring in provider contract rates

Worst case scenario – moving forward into an area of high legal risk without foundation for profitability

Provider Agreements Make or Break Plan Success

Rates and payment methodology

Alignment with STARs Measures

Quality of Care

Accuracy of coding

Alignment with CMS expectations

Ability to gather information for prior authorization and appeal

Right to review charts

Vendor Contracts – The Right Terms in Place with the Right Vendors

Vendors

- Pharmacy Benefit Manager (PBM)
- Operations
  - Claims
  - Utilization Management
  - Behavioral Health Management
- Risk Adjustment
- Sales & Marketing

Key Contract Terms

- Performance Standards and Penalties
- Flowing down legal risk and monetary penalties
- Ability to perform oversight expected by CMS
- Negotiation: Use your leverage!

Medicare Advantage Risk Adjustment

- Adjustment to capitated payments to account for member demographics and the relative health of members
- Relative health compared to average beneficiary: The HCC Model

Medical conditions from a given year are used to predict expenditures in the next year	Disease groups are referred to as Hierarchical Condition Categories (HCCs)	Disease groups contain major diseases and are broadly organized into body systems
HCC assigned to a disease is determined by the diagnosis codes submitted	Only selected diagnoses are included in the risk adjustment models	Risk factors are additive when the diseases are not closely related

Risk Score Calculation (Simplified)

All conditions coded appropriately		Some conditions coded with poor specificity		No conditions coded	
76 year female	0.468	76 year female	0.468	76 year female	0.468
Medicaid eligible	0.177	Medicaid eligible	0.177	Medicaid eligible	0.177
DM w/ vascular CC (HCC 15)	0.608	DM w/o CC (HCC 19)	0.181	DM not coded	
Vascular disease w/CC (HCC 104)	0.645	Vascular disease w/o CC (HCC 105)	0.324	Vascular disease not coded	
CHF (HCC 80)	0.395	CHF not coded		CHF not coded	
Disease Interaction*	0.204	No Disease Interaction		No Disease Interaction	
Total RAF	2.497	Total RAF	1.15	Total RAF	0.645
PMPM Payment	**$1,873**	**PMPM Payment**	**$863**	**PMPM Payment**	**$484**
Annual Payment	**$22,473**	**Annual Payment**	**$10,350**	**Annual Payment**	**$5,805**

Jonathan Hendrickson, Principal, Consulting Actuary, Milliman, "Medicare Advantage Risk Adjustment and False Claims Liability," October 16, 2015. Used with permission. For illustration only. Dollar amounts are not current.

Accuracy

Overcoding	Creates potentially devastating legal risk
Accuracy	The goal
Undercoding	Plan will not be financially viable

MA Supplemental Benefits

Expanded Flexibility & Opportunity		
Expanded Supplemental Benefits	**Uniformity Requirements**	**Targeted Supplemental Benefits for Chronically Ill Members**
Diminish impact of injuries or health conditions	Reduce/eliminate cost-sharing	Additional supplemental benefits tailored to individual member's medical condition and needs
Reduce avoidable emergency and healthcare utilization	Benefit flexibility, with targeted supplemental benefits	Must have reasonable expectation of improving or maintaining health or overall function
Focused on member's healthcare needs and recommended by HCP	Must be tied to health status or disease state and based on objective	Starting in 2020, due to Bipartisan Budget Act of 2018
Not solely for comfort, general use, or social determinant purposes	Similarly situated members with same health condition must be treated the same	

Identification and Management of High Risk Legal Areas

MA Risk Adjustment Legal Risk Environment

False Claims Act (FCA) risk for exaggerated or unsubstantiated diagnoses that lead to overpayments to MA plans

Active area for qui tam whistleblower litigation

Proposed Rule would intensify Risk Adjustment Data Validation (RADV) Audit program

Ongoing OIG interest and criticism of CMS RADV Audit program

Key Issues in Risk Adjustment Litigation

Failure to Oversee/Monitor

Failure to oversee and to monitor risk adjustment programs and vendors

Compliance and oversight not proportionate to risk adjustment score-improvement activities

Ignored “red flags” from audits

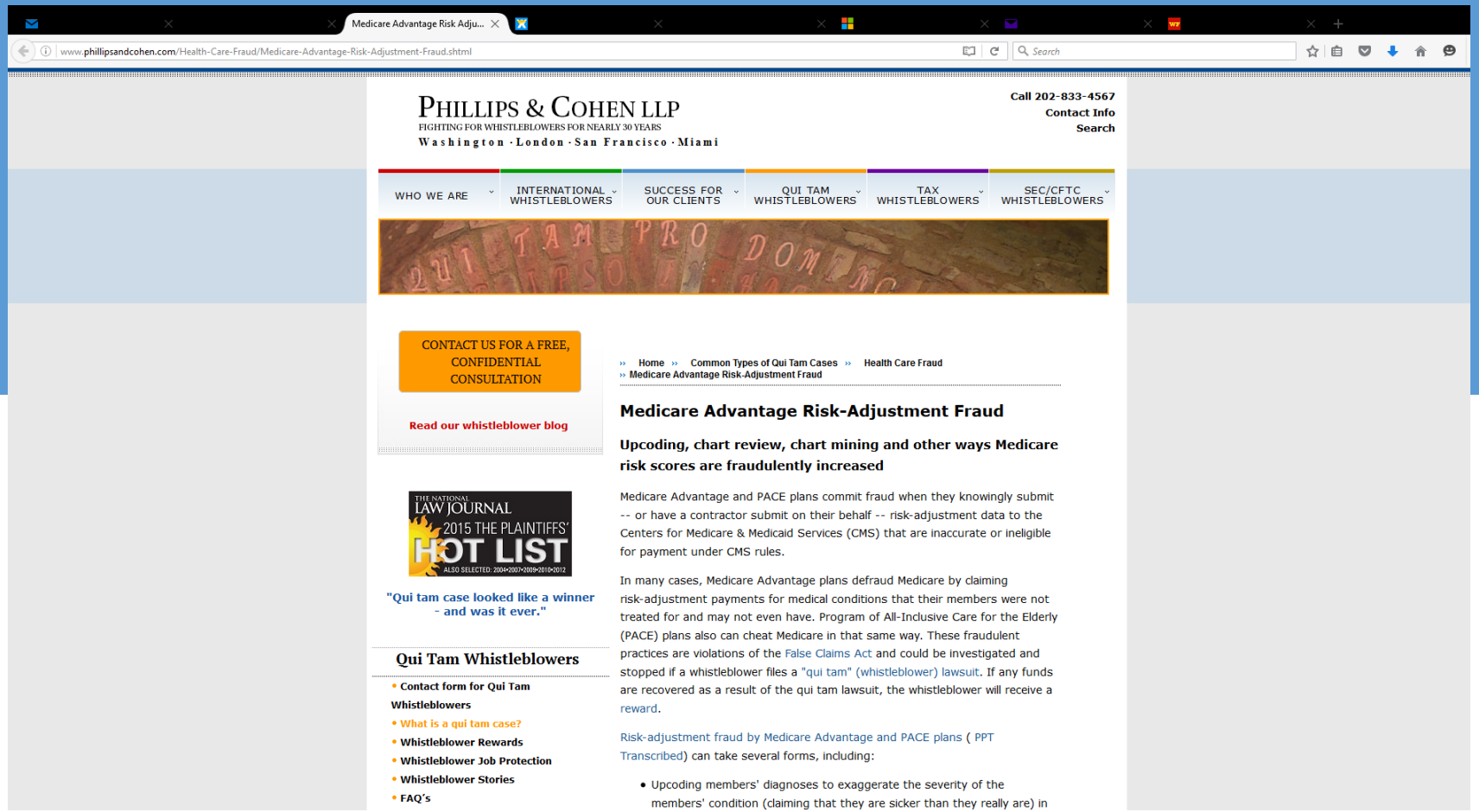
Failure to effectively monitor coding, review for coding accuracy, and consider broader implications of fraud, waste, and abuse.

One-Sided Retro Reviews

One-sided chart reviews designed to find missing diagnosis but not identify unsupported diagnosis

- Chart review that failed to “look both ways”
- Risk adjustment programs focused solely on revenue generation

High Risk Environment



Risk Adjustment Recent Developments

United v. Azar

- **Overpayment regulation struck down (Sept. 2018).**
  - "Reasonable diligence" incorrectly applies a negligence standard to what essentially gives rise to a claim for fraud.
  - It is arbitrary for CMS to treat any incorrect diagnosis code as an overpayment, when for RADV audits only errors above a certain threshold are penalized (the FFS adjustor).
- **CMS moves for reconsideration based on new data underlying the November 1, 2018 proposed rule, then appeals. Appeal now held in abeyance.**

CMS Proposed Rule

- **CMS Proposed Rule**
  - 83 Fed. Reg. 54982 (Nov. 1, 2018)
  - CMS intends to extrapolate RADV audit results to calculate overpayments.
  - Rule would eliminate FFS adjuster from RADV.
  - Extended comment period.

Ongoing OIG Scrutiny of Risk Adjustment

- OIG Work Plan
  - Financial Impact of Health Risk Assessments and Chart Reviews on Risk Scores
  - Review of CMS Systems Used to Pay MAOs
  - Risk Adjustment Data – Sufficiency of Documentation Supporting Diagnosis
  - Integrity of Medicare Advantage Encounter Data
- 2007 risk adjustment data audit reports
- Authority independent of CMS

The Anti-Kickback Statute

Makes it a crime to **offer, pay, solicit, or receive anything of value** to induce referrals of items or services reimbursable by Medicare, Medicaid, or other federal healthcare programs

The idea behind the law is that providers and contractors should make decisions based on the patient's health interests, not financial incentives

Amended by the ACA so that the government does not have to prove actual knowledge of the AKS or intent to violate the law to state a claim under the False Claims Act.

42 U.S.C. § 1320a-7b(b); 42 CFR § 1001.951

Plan Kickback Risks

Traditional risks:

Offer of value to a provider to reward steering patients to the plan

Transfer of value to a payer for referral of patients to the provider

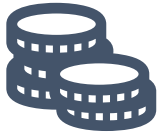
More complex payment arrangements:

Rebates for preferred formulary placement

Inflated capitated payment to providers and vendors

Payment of incentive payments for unmet performance metrics

Shared savings

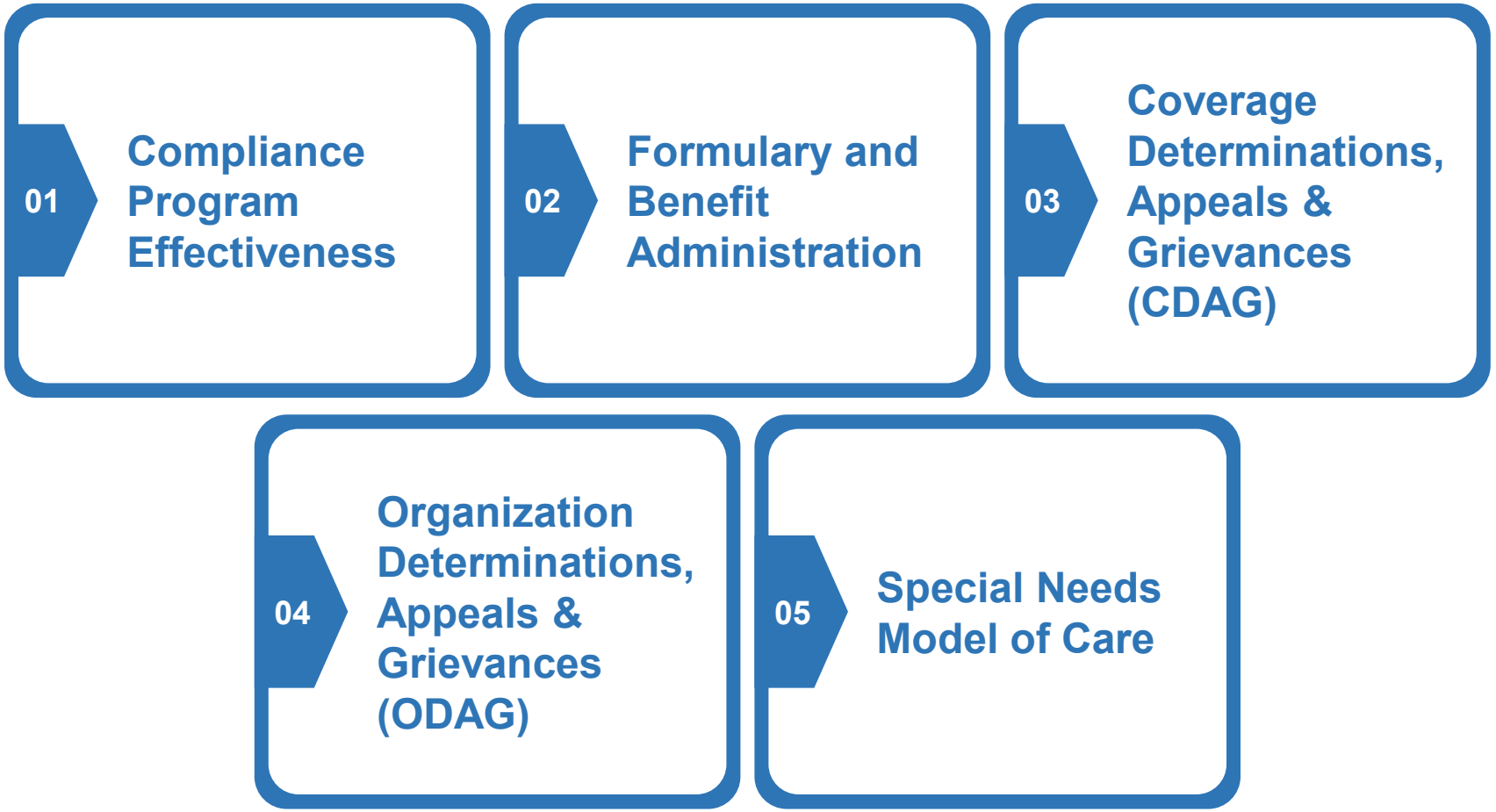


Non-traditional plan functions:

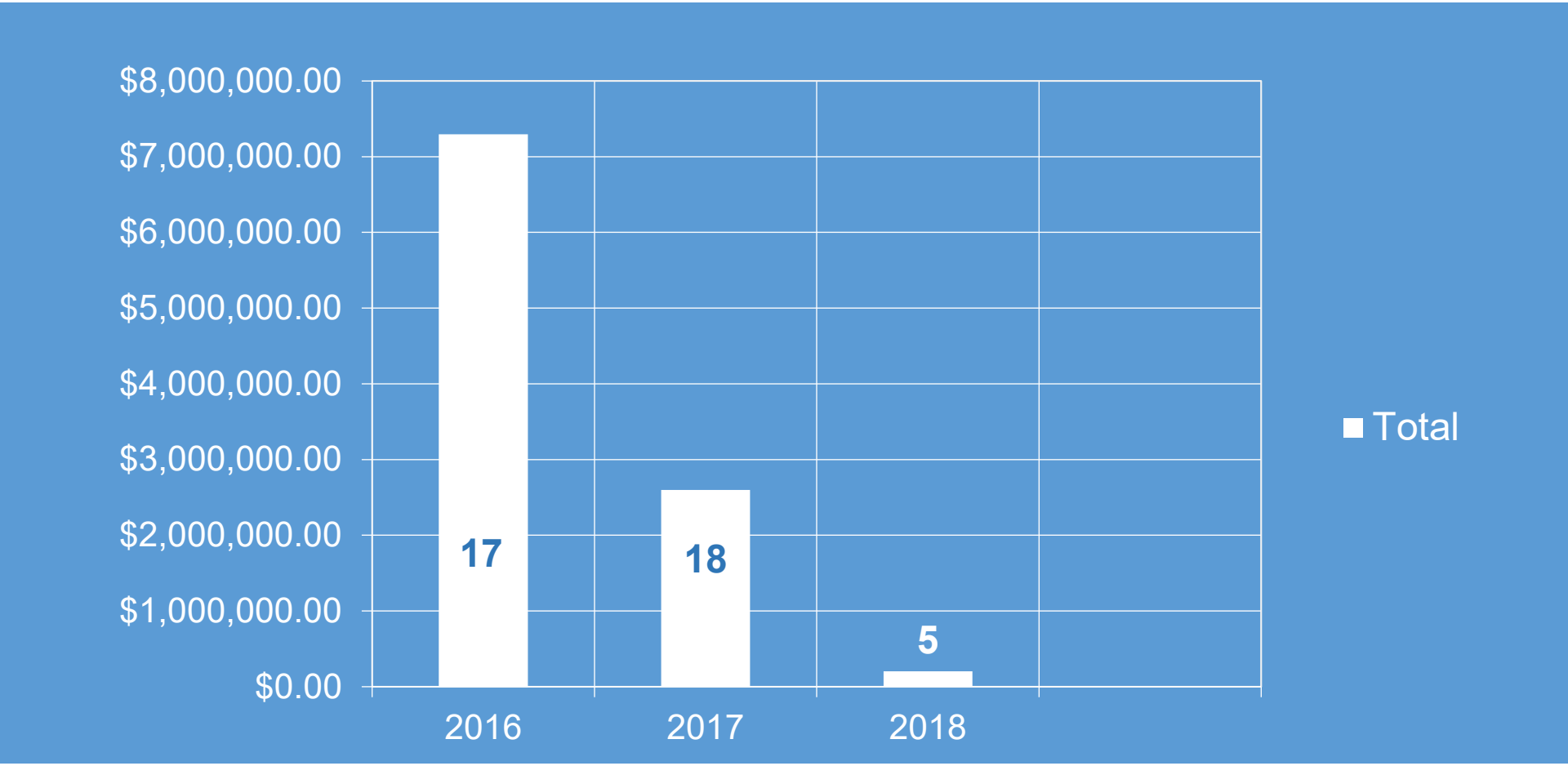
Charitable donations

Plan investment in start ups with providers

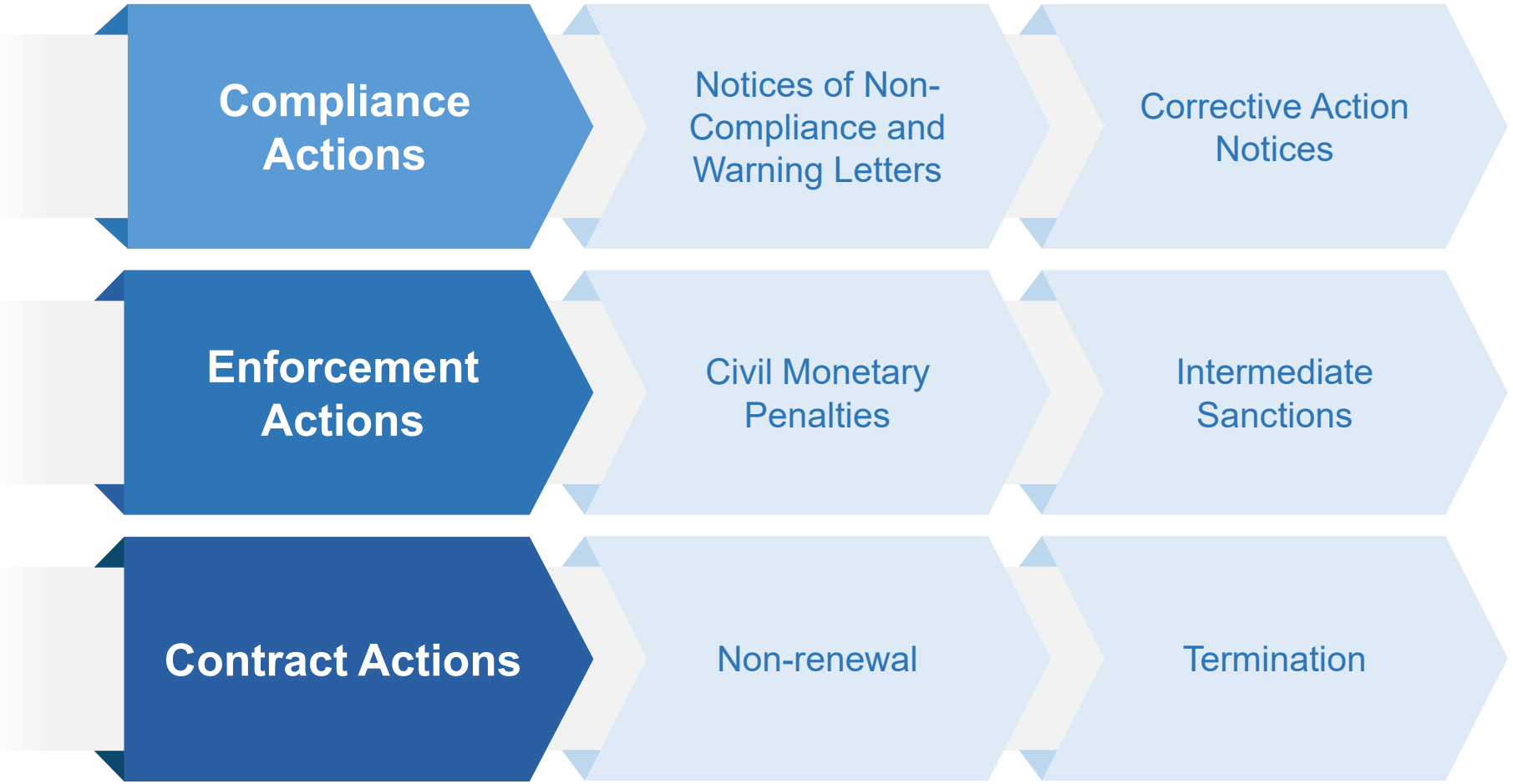
CMS Program Audits



Enforcement Action Comparison 2016 to 2018



CMS Enforcement Mechanisms



Checklist of Takeaways

- ❑ Is organization aware of **changing Medicare marketplace**?
- ❑ Are **provider contracts and vendor contracts**
  - ❑ Aligned with STAR ratings?
  - ❑ Aligned with legal risk mitigation strategies?
- ❑ Is **risk adjustment program** focused on coding accuracy?
- ❑ Is organization tailoring **benefit design** to quality of care goals?
- ❑ Is organization managing **FCA and AKS risks**?
- ❑ Will you be prepared if CMS changes the **intensity of its oversight**?

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