

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

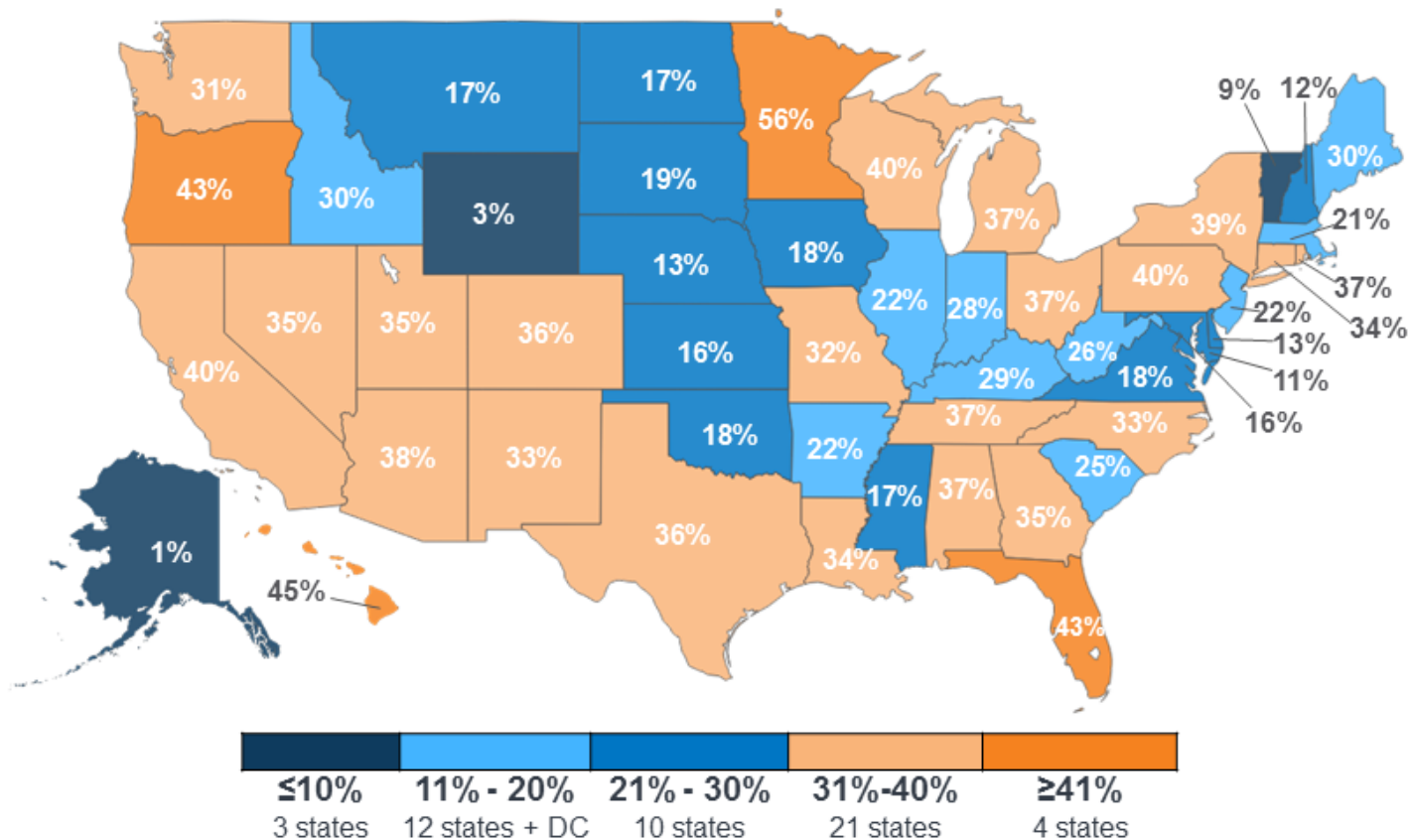
Compared with 2004

- 13% of beneficiaries
- 5.3 million beneficiaries

Figure 3

Medicare Advantage Penetration, by State, 2018

National Average, 2018 = 34%



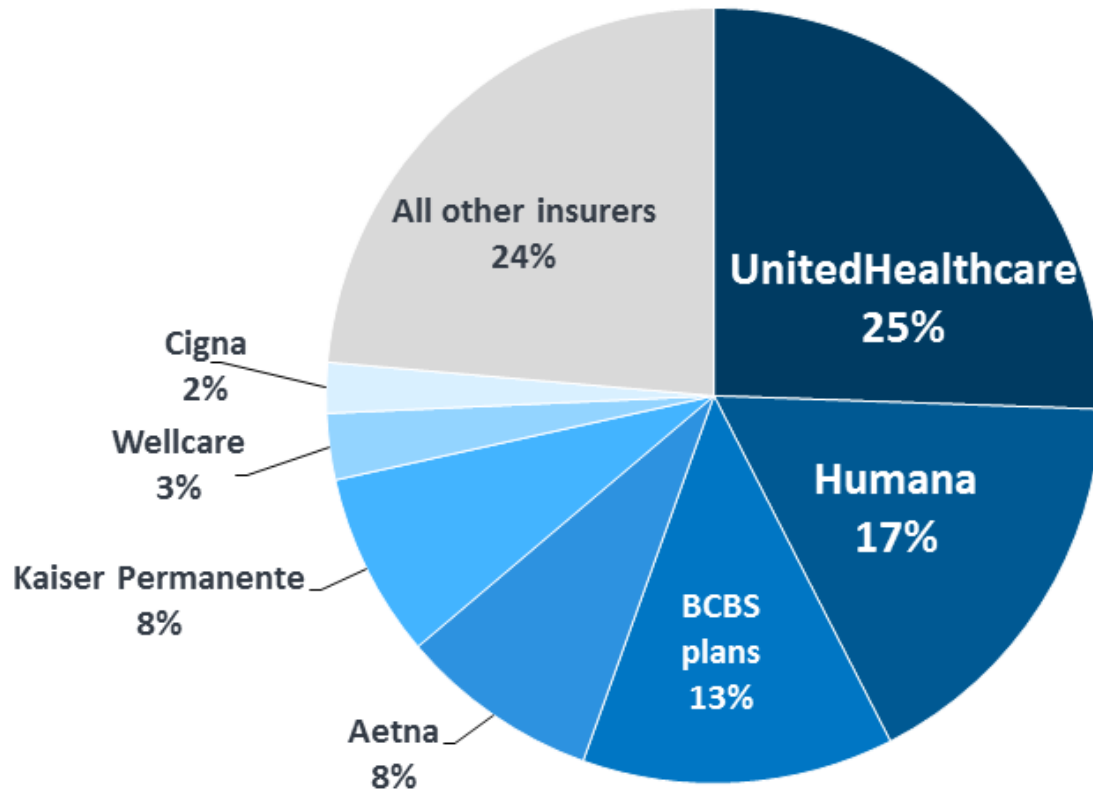
NOTE: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.

SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2018.



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.

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

Market Capitalization in billions as March 11, 2019

\$1,670.62



amazon

\$1,179.26



Alphabet

\$337.85



ExxonMobil

\$243.15



UnitedHealthcare®

\$208.58



NOVARTIS

Venture Capital Backed Health Plans

OSCAR



Founded:
2012



Total funding amount:
\$1.3B

Clover



Founded:
2013



Total funding amount:
\$925M

brightSM
HEALTH



Founded:
2015



Total funding amount:
\$440M

 **Devoted**Health



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

The screenshot shows a web browser window with the URL www.phillipsandcohen.com/Health-Care-Fraud/Medicare-Advantage-Risk-Adjustment-Fraud.shtml. The page header for Phillips & Cohen LLP includes the tagline "FIGHTING FOR WHISTLEBLOWERS FOR NEARLY 30 YEARS" and lists offices in Washington, London, San Francisco, and Miami. A navigation menu contains links for "WHO WE ARE", "INTERNATIONAL WHISTLEBLOWERS", "SUCCESS FOR OUR CLIENTS", "QUI TAM WHISTLEBLOWERS", "TAX WHISTLEBLOWERS", and "SEC/CFTC WHISTLEBLOWERS". A prominent orange button reads "CONTACT US FOR A FREE, CONFIDENTIAL CONSULTATION". Below this is a link to "Read our whistleblower blog". A featured article from "THE NATIONAL LAW JOURNAL" is titled "2015 THE PLAINTIFFS' HOT LIST" and includes the quote: "Qui tam case looked like a winner - and was it ever." The main content area is titled "Medicare Advantage Risk-Adjustment Fraud" and includes a breadcrumb trail: Home » Common Types of Qui Tam Cases » Health Care Fraud » Medicare Advantage Risk-Adjustment Fraud. The sub-header reads "Upcoding, chart review, chart mining and other ways Medicare risk scores are fraudulently increased". The text explains that Medicare Advantage and PACE plans commit fraud by knowingly submitting inaccurate or ineligible risk-adjustment data to CMS. It notes that whistleblowers can receive a reward if they file a "qui tam" lawsuit. A sidebar on the left lists "Qui Tam Whistleblowers" with links to a contact form, FAQs, and other resources. The bottom of the page features a list of "Upcoding members' diagnoses to exaggerate the severity of the members' condition" as a form of fraud.

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 adjuster).
- **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



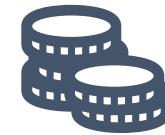
Traditional risks:

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:

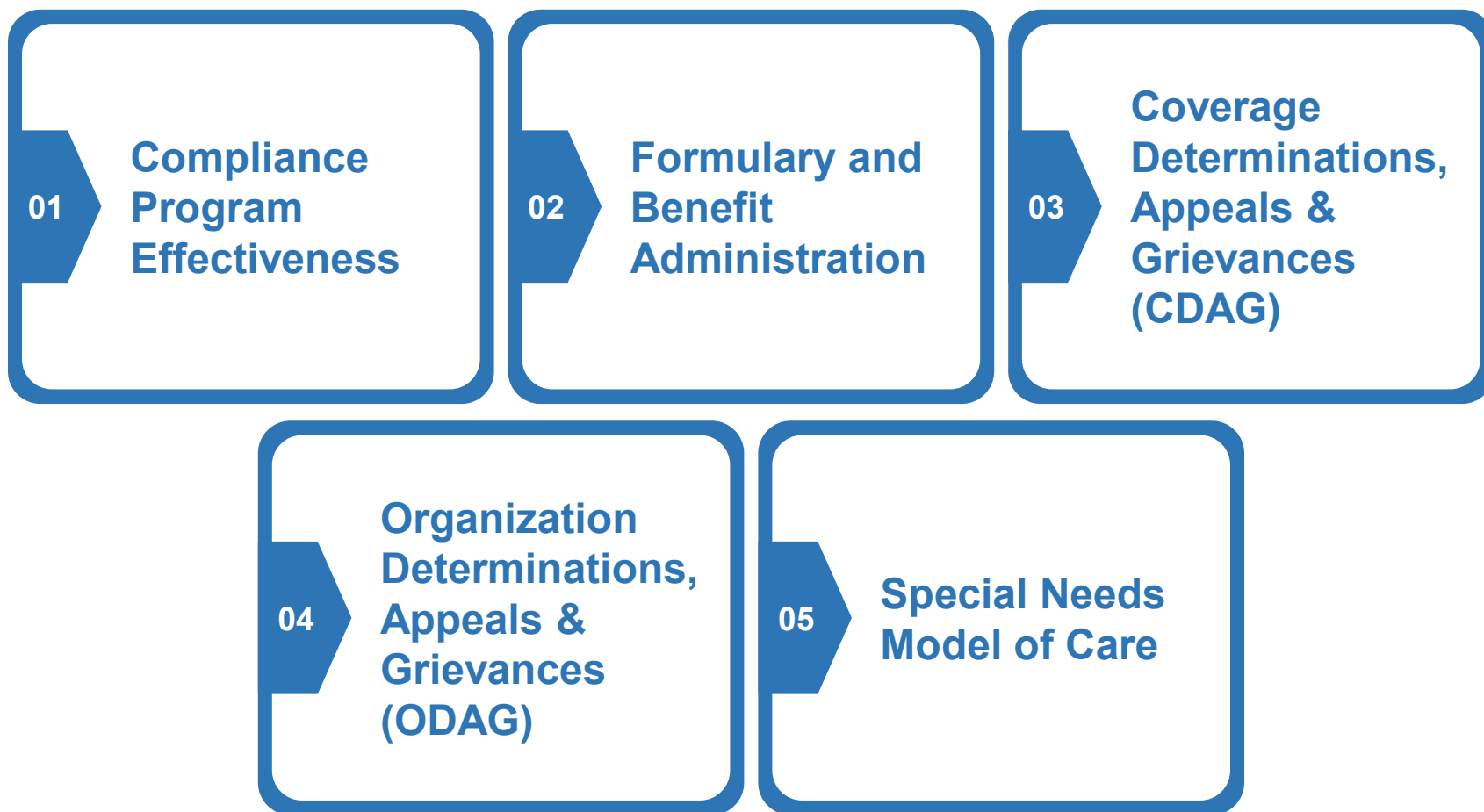
Rebates for preferred formulary placement
Inflated capitated payment to providers and vendors
Payment of incentive payments for unmet performance metrics
Shared savings



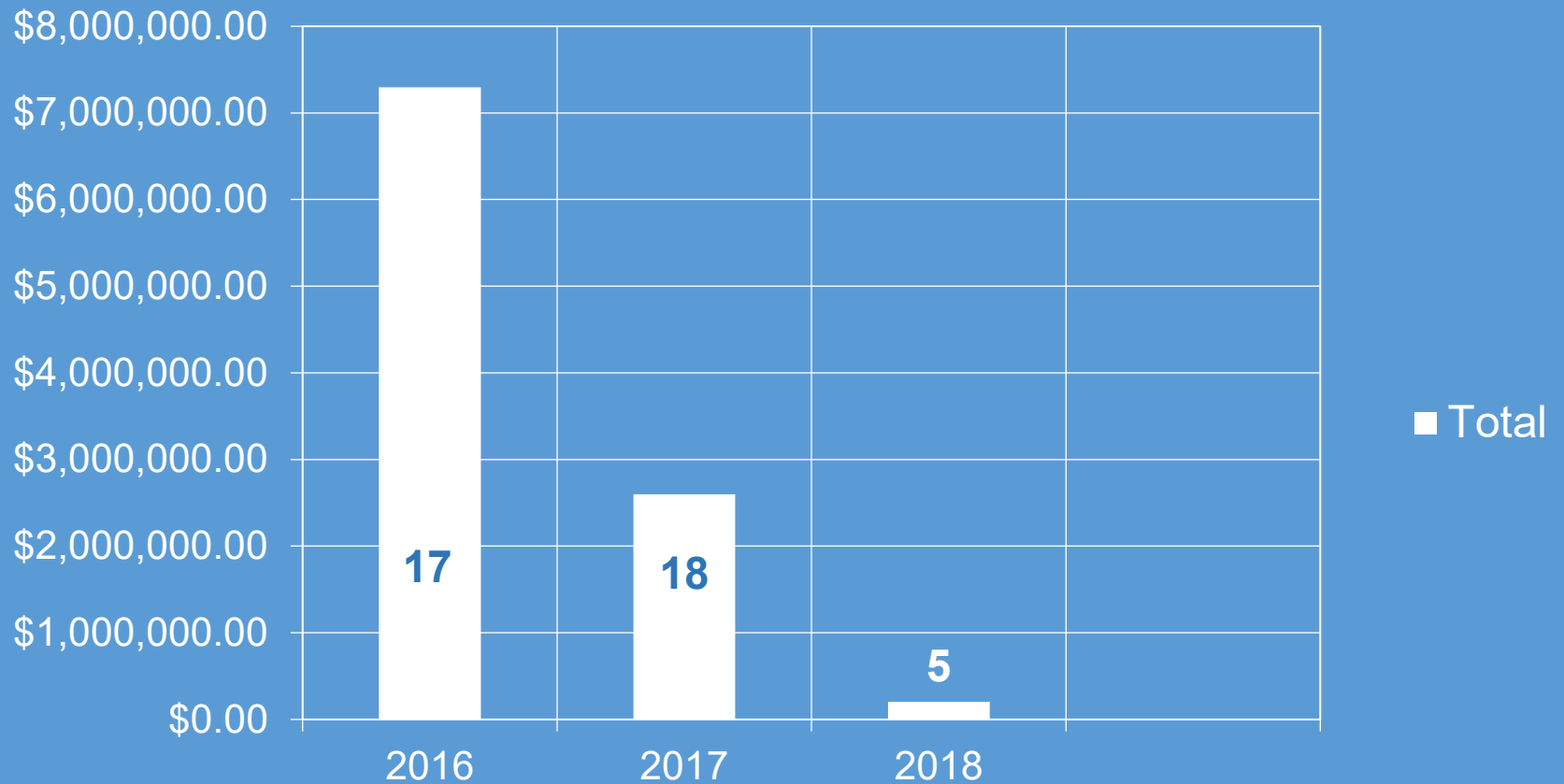
Non-traditional plan functions:

Charitable donations
Plan investment in start ups with providers

CMS Program Audits



Enforcement Action Comparison 2016 to 2018



CMS Enforcement Mechanisms

Compliance Actions

Notices of Non-Compliance and Warning Letters

Corrective Action Notices

Enforcement Actions

Civil Monetary Penalties

Intermediate Sanctions

Contract Actions

Non-renewal

Termination

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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