Session 701
The Compliance Challenges Inherent in Risk Adjustment's Continued Evolution and Expansion

Presented By
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## RELEVANT BIO FOR RICHARD LIEBERMAN

- Actively involved in the development of risk adjustment systems for 25 years
  - Johns Hopkins ACG Development Team, 1991-2005
  - Implemented the risk-adjusted payment system for Maryland Medicaid
  - Designed the clinical model for the first-to-market revenue management "suspecting" engine
- Developer of integrated decision-support platforms coalescing quality measurement, risk adjustment, and population health metrics
- Disseminator of risk adjustment and quality measurement technology and intellectual property to health plans, services vendors, and consultants

## TODAY'S AGENDA

- Understand the different ways risk adjustment operates in Medicare-Advantage, Medicaid, and Marketplace products
- Review critical court cases and administrative actions that target risk adjusted health plans and provider groups
- How to design the necessary oversight policies and procedures for delegated physician-groups, revenue management vendors, and in-house risk adjustment teams

## BENEFICIARY PREFERENCE FOR MEDICARE-ADVANTAGE

**Total Medicare Enrollment: Total, Original Medicare, and Medicare Advantage and Other Health Plan Enrollment, Calendar Years 2008-2013**

| Year | Total Enrollment | Total Enrollment Percentage Increase from Prior Year (%) | Total Original Medicare Enrollment | Total Original Medicare Enrollment Percentage Increase from Prior Year (%) | Total Original Medicare Percent of Total Enrollment (%) | Total Medicare Advantage and Other Health Plan Enrollment | Total Medicare Advantage and Other Health Plan Enrollment Percentage Increase from Prior Year (%) | Total Medicare Advantage and Other Health Plan Enrollment Percent of Total Enrollment (%) |
|---|---|---|---|---|---|---|---|---|
| 2008 | 45,472,051 | 2.53 | 35,405,507 | -0.69 | 77.86 | 10,066,544 | 15.73 | 22.14 |
| 2009 | 46,573,201 | 2.42 | 35,395,361 | -0.03 | 76.00 | 11,177,840 | 11.04 | 24.00 |
| 2010 | 47,702,632 | 2.43 | 35,921,747 | 1.49 | 75.30 | 11,780,885 | 5.40 | 24.70 |
| 2011 | 48,944,303 | 2.60 | 36,466,909 | 1.52 | 74.51 | 12,477,395 | 5.91 | 25.49 |
| 2012 | 50,828,094 | 3.85 | 37,125,843 | 1.81 | 73.04 | 13,702,251 | 9.82 | 26.96 |
| 2013 | 52,506,598 | 3.30 | 37,531,896 | 1.09 | 71.48 | 14,974,702 | 9.29 | 28.52 |

NOTES: The enrollment counts are determined using a person-year methodology. Numbers and percentages may not add to totals because of rounding.

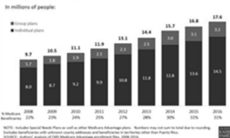
SOURCE: Centers for Medicare & Medicaid Services, Office of Enterprise Data and Analytics, CMS Chronic Conditions Data Warehouse.

## MEDICARE-ADVANTAGE CONTINUES TO GROW

- As of January 2017, there are now 19.4 Medicare beneficiaries enrolled in a managed Medicare plan (including Medicare-Medicaid plans, cost contracts, and PACE)
  - This represents year-over-year growth of 8.4 percent. From 2008 to 2016, annual enrollment growth has been 7.5%

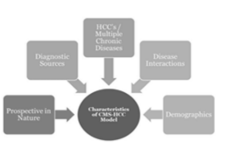
**Total Medicare Private Health Plan Enrollment, Among the Individual and Group Markets, 2008-2016**

In millions of people:



## COMPREHENSIVE RISK ADJUSTMENT FOR MEDICARE-ADVANTAGE

- The Medicare Modernization Act of 2003 (MMA) ushered in comprehensive risk adjustment for Medicare-Advantage plans
  - 4-year phase-in began in 2004
  - Medicare was not "first to the party" with risk adjustment (Medicaid was in several states)
- From 2004 - 2011, many plans did not pay that much attention to risk adjustment
  - Many other "bigger fish to fry:" competitive bidding, Part D rollout, new plans entering the market, private-fee-for-service, etc.
  - There was more than enough money flowing into plans by way of regular increases to the county level



## AND THEN THERE WAS THE AFFORDABLE CARE ACT…

- Despite the partisan rhetoric to the contrary, the ACA has not destroyed Medicare-Advantage nor has it hastened the depletion of the Part A Trust Fund
  - Medical Loss Ratio (MLR) standards were implemented at 85 percent, although most MA plans were already at or above the 85 percent threshold
  - Beneficiaries got enhanced benefits- preventive services with 0 copay, caps on chemotherapy costs
- ACA tied annual growth in the rate setting benchmarks to same growth rate as FFS Medicare
  - Phased in over 6-years (some counties were completely phased-in at 2 and 4 years
    - Some counties experienced a reduction in their benchmarks, while others remained stable
  - Linking growth rates in managed care to fee-for-service Medicare eliminated many of the distortions created by decades of rate increases largely determined by

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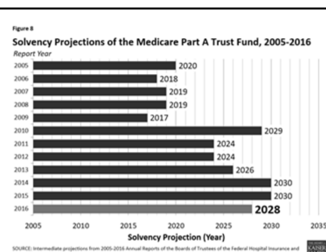
## ACA CREATES WINNERS AND LOSERS

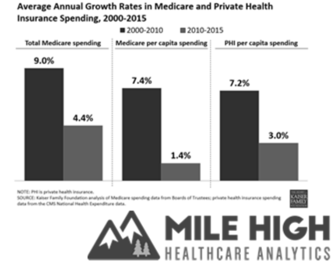
- It is impossible to move from a system in which people with preexisting conditions can be denied health coverage or charged much higher premiums to a system where people pay the same premium regardless of their health without some who have previously benefited having to pay more
  - Some of the winners might perceive themselves as losers
- The ACA's funding stream represents a wealth transfer from younger, healthier Americans to older, less healthy Americans
  - Wealth transfers are commonly used in the US: Medicare Part A and Social Security are the two best examples

## ACA HAS EXTENDED THE LIFE OF THE PART A TRUST FUND



## ACA HAS RESTRAINED THE GROWTH OF SPENDING

- There are likely to be many factors driving the reduction of spending growth:
  - The Great Recession
  - Provisions of the Affordable Care Act

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## HOW DOES FINANCIAL PERFORMANCE IMPACT COMPLIANCE?

- Restrained growth in baseline Medicare-Advantage rates means that most of the opportunities for plans to maintain or increase their margins lies in how they manage quality and risk adjustment programs
- And herein lies the compliance challenge……

| | Determination of the benchmark | |
|---|---|---|
| A | County-specific unadjusted rate (1.0 risk score, no bonus) | $1,000.00 |
| B | Star rating bonus (4.0 star rating)[2] | 5.0% |
| C | Plan risk factor (HCC model) | 0.90 |
| **D = A * (1+ B) * C** | **Plan-specific risk-adjusted benchmark** | **$945.00** |

## HOW DO PLANS RUN THEIR RISK ADJUSTMENT PROGRAMS

- Most MA plans view risk adjustment in very narrow financial context: filling a budget gap
- The majority of plans outsource much of the risk adjustment data collection and even some clinical interventions
  - Retrospective medical record reviews
  - In-home assessments
  - Efforts to increase member engagement with network providers
- Oversight of these outsourced functions has improved, but is still lacking

## DOESN'T CMS OVERSEE PLAN BEHAVIOR?

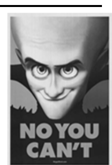
- CMS conducts risk adjustment data validation (RADV) audits of MA contracts intended to facilitate the recovery of improper payments from MA organizations that submitted beneficiary diagnoses for payment adjustment purposes that were unsupported by medical records
  - With a separate national audit, CMS estimated that it improperly paid $14.1 billion in 2013 to MA organizations, primarily because of these unsupported diagnoses
- Each year CMS selects 30 Medicare-Advantage contracts (about 5 percent of the total) to audit

## THE RADV PROCESS IS FRAUGHT WITH PROBLEMS

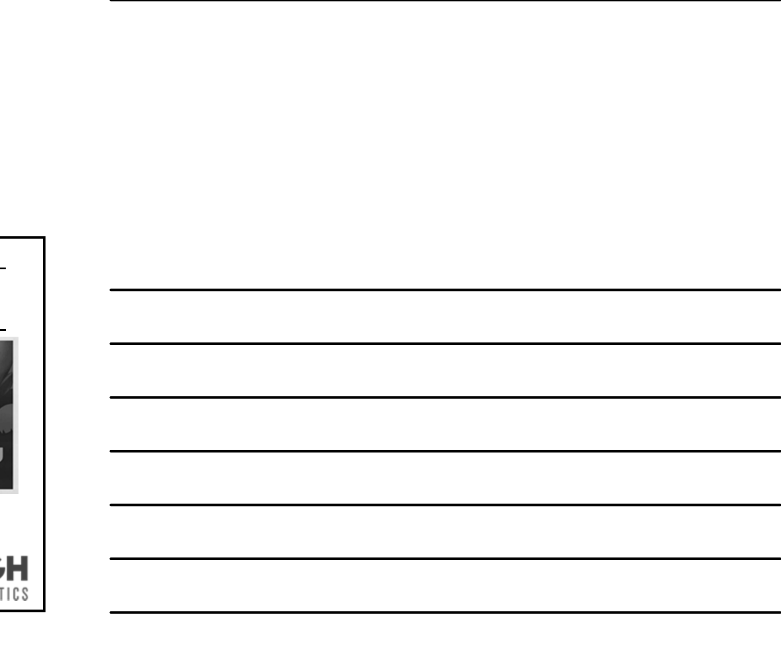
- RADV audits of 2007 and 2011 payments have taken multiple years and are still ongoing for several reasons.
  - First, CMS's RADV audits rely on a system for transferring medical records from MA organizations that has often been inoperable.
  - Second, CMS audit procedures have lacked specified time requirements for completing medical record reviews and for other steps in the RADV audit process.
  - CMS has not established timeframes for appeal decisions at the first-level of the MA appeal process, as it has done in other contexts
- The potential improper payment penalties are so large as to render them inadequate as deterrents against "bad behavior"

Source: Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments. GAO-16-76: Published: Apr 8, 2016. Publicly Released: May 9, 2016. http://www.gao.gov/products/GAO-16-76.

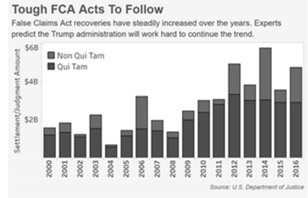
## FALSE CLAIMS ACT




- The False Claims Act, which has been dramatically expanded under the ACA
  - Overpayments now have to be reported to HHS within sixty days of detection
- Elements of a False Claims Act violation:
  - defendant makes a false statement or engages in a fraudulent course of conduct
  - do so with the required scienter (intent or knowledge of wrongdoing)
  - the statement or course of conduct is material
  - the statement or course of conduct caused the government to pay out money of forfeit moneys due



## HUGE INCREASES IN FALSE CLAIMS ACT RECOVERIES



## WHAT'S A FALSE CLAIMS ACT LITIGATION WORTH?

- False Claims Act suits recouped $4.7 billion in fiscal year 2016
  - The Obama administration has clawed back $31 billion for federal coffers since January 2009 — almost 60 percent of all FCA proceeds since the law was strengthened in 1986
  - The majority of the $31 billion reflects improper billing of government health programs, such as Medicare and Medicaid. And that remained true in 2016, when $2.5 billion of the $4.7 billion involved health care programs
  - There were 845 new FCA suits in 2016, one of the largest totals in history. Of those, 143 were initiated by the government and 702 were brought by whistleblowers

## DEPARTMENT OF JUSTICE TRIED OUT A FRAUD THEORY AGAINST RISK ADJUSTMENT VIOLATIONS

Home • Miami • Press Releases • 2015 • Delray Beach Doctor Charged with Health Care Fraud

**Delray Beach Doctor Charged with Health Care Fraud**

U.S. Attorney's Office — Southern District of Florida
February 04, 2015 — (305) 226-9100

A Delray Beach doctor has been charged with eight counts of health care fraud.

## ACTIVE FALSE CLAIMS ACT COURT CASES

- Olivia Graves, on behalf of herself and the U.S.
  - Humana is defendant in this case
  - U.S. District Court for the Southern District of Florida (10-23382-CIV-MORENO)
- Seemingly perpetual case in California (Swoben v. United Healthcare, et. al.
- Recently filed case against two coding and in-home assessment vendors in Texas
- Not every FCA complaint will have merit, but the allegations provide increased fodder for partisan exploitation

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## TRY TYPING "MEDICARE ADVANTAGE WHISTLEBLOWER" INTO GOOGLE

More Whistleblowers Say Health Plans Are Gouging Medicare

Medicare Advantage Risk Adjustment Fraud | whistleblower ...

Medicare Advantage risk scores the next whistleblower gold ...

Another whistleblower suit alleges Medicare Advantage fraud

More whistleblower lawsuits target Medicare Advantage plans

Medicare Advantage plans accused of inflating diagnoses ...

More whistleblowers allege health plan overcharges ...

Humana Stuck With FCA Suit Over Medicare Advantage ...

Fraud case puts spotlight on Medicare Advantage plans ...

How to report Medicare Advantage fraud against Medicare ...

## OFFICE OF THE INSPECTOR GENERAL WORKPLAN: 2017

- Medicare-Advantage: Risk Adjustment Data- Sufficiency of Documentation Supporting Diagnoses
- Marketplace Issuers: CMS Oversight and Issuer Compliance in Ensuring Data Integrity for the ACA Risk Adjustment Program

**Risk Adjustment Data – Sufficiency of Documentation Supporting Diagnoses**

Payments to MA organizations are risk adjusted on the basis of the health status of each beneficiary. MA organizations are required to submit risk adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts (SSA §§ 1853(a)(1)(C) and (a)(3)). In general, MA organizations receive higher payments for sicker patients. CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations. Prior OIG reviews have shown that medical record documentation does not always support the diagnoses submitted to CMS by MA organizations. We will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS's risk score calculations and determine whether the diagnoses submitted complied with Federal requirements.

OAS: W-00-16-35078; various reviews • Expected Issue Date: FY 2018

## WHAT SHOULD MA PLANS DO?

- Many of the alleged whistleblower lawsuits will be bogus. But not all of them!
- Get Your Head Out of "the Sand"
  - Providers need real training on optimal clinical documentation
    - Not coding! Documentation!
  - Providers need oversight
    - Just because the contract transfers risk, doesn't mean it transfers responsibility
- Risk adjustment is hard and has lots of nuances
- Medicaid and exchange risk adjustment are not just like Medicare!

## AREAS OF RISK FOR MA PLANS

- Most vendor-supplied services are black-box
  - MA Plans typically accept this arrangement
  - Most vendors have very limited analytical capabilities
- Inside of health plans, there is very limited knowledge of the nuances of risk adjustment
  - Most risk adjustment managers have segued from finance positions and have learned risk adjustment "on the job."
    - You don't know what you don't know!
  - Vendors typically know very little about risk adjustment process and its complex calculations

# Medicaid Risk Adjustment

## RISK ADJUSTMENT TOOLS IN CURRENT USE FOR MEDICAID

- The Chronic Illness and Disability Payment System (CDPS) and the MedicaidRx system –developed by Richard Kronick and Todd Gilmer at the UC-SD
- Adjusted Clinical Groups (ACGs) – developed by Jonathan Weiner and Barbara Starfield and other researchers at the Johns Hopkins University.
- Diagnostic Cost Groups (DxCG) – developed by Arlene Ash and Randall Ellis of Boston University
- Clinical Risk Groups – developed by DRG team at 3M
- Episode Risk Groups (ERGs) – developed by Symmetry, now owned by Optum



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## HOW CAN I FIND OUT WHAT A PARTICULAR STATE IS USING?

- There is no single source or location to look at that is guaranteed to be up to date!
- There are State Medicaid & CHIP Profiles at: https://www.medicaid.gov/medicaid/index.html
  - But many of these are outdated!
- To understand what is happening in most states requires exhaustive, state-by-state research
  - MCO contracts have to be reviewed
  - EQRO reports must be read
  - Multiple state web pages must be perused
- Mile High Healthcare Analytics has compiled a comprehensive database

## MODEL TYPOLOGY #1

Additive Models

- CDPS (Chronic Illness and Disability Payment System)
- MedicaidRx
- CDPS + MedicaidRx
- DxCG (Diagnostic Cost Groups)

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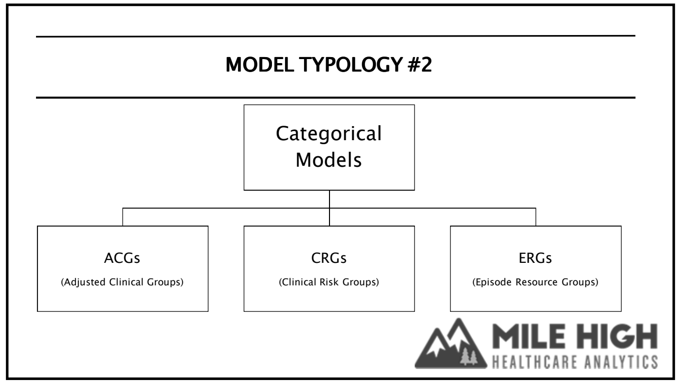
MODEL TYPOLOGY #2
Categorical Models
ACGs
(Adjusted Clinical Groups)
CRGs
(Clinical Risk Groups)
ERGs
(Episode Resource Groups)
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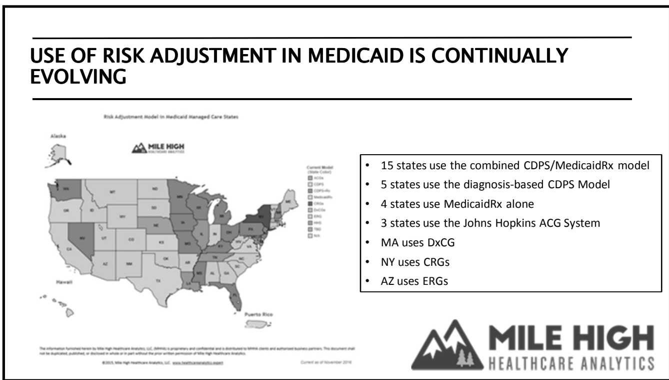
USE OF RISK ADJUSTMENT IN MEDICAID IS CONTINUALLY EVOLVING
15 states use the combined CDPS/MedicaidRx model
5 states use the diagnosis-based CDPS Model
4 states use MedicaidRx alone
3 states use the Johns Hopkins ACG System
MA uses DxCG
NY uses CRGs
AZ uses ERGs
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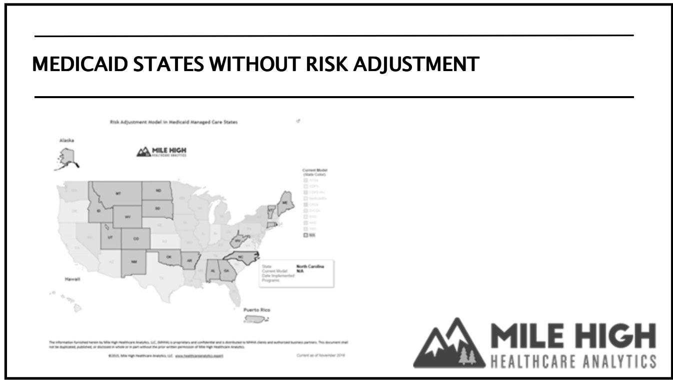
MEDICAID STATES WITHOUT RISK ADJUSTMENT
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## HOW MEDICAID RISK ADJUSTMENT WORKS

- "Plan-level" risk scores are then applied to a future population of enrollees in the same risk score strata
- The historical health plan risk score DOES NOT determine the payment to the plan
  - The group-level average risk score from the prior period is applied to a different group of enrollees in some future fiscal year
    - For example, risk scores determined in 2012 using 2011 claims history will be used to set health plan rates in 2014
- Actuaries typically set future rates by age/sex cell, eligibility category, and geography

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## THE HISTORICAL HEALTH PLAN RISK SCORE

0.95 0.89 1.07 1.40 1.80 1.01 1.35

1.21

2014

2016

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## Medicaid Risk Adjustment: Value Proposition

- Medicaid Premium Risk Adjustment is a Zero-Sum Game
  - Risk scores are calculated for each MCO and compared to the overall risk score for all MCOs within the same aid category (e.g., TANF, ABD)
  - CMS requires states to ensure budget-neutrality
  - MCOs "win" by submitting complete and accurate encounter data
- Return on Investment has Two Components:
  - What the MCO prevents in redistribution to its competitors
  - Truly incremental premium, obtained by closing diagnosis coding gaps, capturing withholds/bonuses tied to quality improvement, managing MLR

$100 in Premium From State to Cover Medical Costs across 3 MCOs

If Relative Risk Scores Differ Across the MCOs, then the $100 is Divided Proportionately

All-MCO average risk score by aid category

MCO takes no action

Total Return from Risk Adjustment

Prevented Payment to other MCOs (unobserved)

Received Payment (Incremental Premium)

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## COMPLETE AND ACCURATE ENCOUNTER DATA DRIVES MEDICAID MCO SUCCESS

- Historically states have struggled to collect complete and accurate encounter data from managed care plans and to manage that data in legacy systems designed for FFS
- The most important change is that federal payment for Medicaid managed care is tied to the submission of accurate, complete, and timely encounter data to CMS in a CMS-specified format, likely TMSIS.
- Accurate and comprehensive coding is required on all encounters
  - States are increasingly assessing money penalties for inaccurate encounter data
  - In risk adjustment, MCOs often only get one bite at the apple!
    - Few states have authorized supplemental diagnosis code submission
    - Many states only use a subset of diagnosis codes from encounter record

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## STATES ARE UNDER PRESSURE AND MCOS WILL BE UNDER PRESSURE

- The new Medicaid rules requires states and plans to meet stronger data submission and reporting requirements
  - Good data must support program oversight, program integrity, and increased transparency.
  - To meet these requirements, states and plans must have adequate IT systems to ensure accurate and timely data delivery and reporting.
  - Some states and managed care plans will likely need to increase their data collection and analytics capabilities to comply with the new rule
- Some states are already applying financial sanctions to MCOs for incomplete or inaccurate encounter data

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## EXAMPLE FROM WASHINGTON STATE MCO CONTRACT

- "The Contractor's encounter data submitted and accepted…will be validated against submitted and accepted data captured…and must be within one percent (1%) of what HCA captured"
- The Withhold Factor is intended to hold back one percent (1%) of the capitation payments excluding any SNAF, PAP, or Trauma funding…The amount withheld from the monthly premium payment will be released upon successful reconciliation of the Contractor's encounter data per subsection 5.11.6 of

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## MISSOURI ALSO HAS ELABORATE ENCOUNTER DATA REQUIREMENTS AND POTENTIAL SANCTIONS

| Encounter Data Completeness/Accuracy Specific Performance Metrics | Frequency of Metric Evaluation | Statewide vs. Regional Application | Original Contract Period Withhold Amount | Metrics Applicable during the following Contract Periods: | | |
|---|---|---|---|---|---|---|
| | | | | Original Contract Period | 1st Renewal Period | 2nd Renewal Period |
| 1. Monthly encounter submissions must meet a ninety-eight percent (98%) acceptance rate. If the health plan is new to the MO HealthNet Managed Care Program, the health plan must transmit their first encounter data submission to the state agency by October 31, 2015 and meet a submission acceptance rate of at least eighty percent (80%) for claims incurred from July 1, 2015 to September 30, 2015. Beginning January 1, 2016, if the health plan is new to the MO HealthNet Managed Care Program, the health plan must transmit monthly encounter data submissions and meet the ninety-eight percent (98%) acceptance rate consistent with the measure for all other health plans. | Quarterly | Regional | 0.50% (prorated by region) for the Original Contract Period and .17% for the 1st and 2nd Renewal Periods | Yes | Yes | Yes |
| 2. Monthly health plan encounter volumes must be within a certain percentage of historical average volumes or regional averages if the health plan is new to the MO HealthNet Managed Care Program. | TBD | Regional | .17% | No | Yes | Yes |

## WHAT DOES RISK ADJUSTMENT COMPLIANCE LOOK LIKE?

- Failing to “do right” by risk adjustment will cause adverse financial performance and expose managed care plans to whistleblower allegations
- Key elements of program oversight:
  - Education, education, education!
    - Education of physicians without incentives is a waste of time!
    - Training materials must be very carefully drafted and edited
  - Data, data, data!
    - Most of the money “left on the table” comes from suboptimal data systems and data handling
  - Engage, engage, engage
    - Rely on vendors that can perform and supply relevant analytics documenting their performance

## CONTACT INFORMATION

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