WAKE UP CALL FOR HEALTH PLANS

Risk Adjustment Programs Are Under Fire

Over the past year, there has been a noticeable uptick of claims against Medicare Advantage Organizations (MAOs) centering around what the government states are aggressive initiatives allegedly focused on boosting risk scores.

Most recently, a whistleblower filed a lawsuit against a national health plan for $1.4 billion, claiming that one of the health plan's risk adjustment programs was designed to intentionally over-code diagnoses and fraudulently inflate its risk adjustment scores to increase the capitated payments it received from the Centers for Medicare & Medicaid Services (CMS). While the government has thus far declined to intervene in the case, the whistleblower is alleging that the health plan intentionally and fraudulently submitted risk adjustment claims for payment using improper diagnosis codes that referred to health conditions of Medicare beneficiaries that: (i) did not exist; (ii) were not recorded in any medical records; and (iii) were not based on clinically reliable information. From the whistleblower's point of view, this is a story of intentional deception and greed. From the health plan's perspective, it is a story of confusion and misinterpretation.

The lawsuit is based on a number of allegations regarding how the visits were conducted and the diagnosis codes captured, including: that diagnosis codes were submitted to CMS for risk adjustment without obtaining clinical validation, including review and approval from the appropriate provider; that the health plan was encouraging inappropriate and fraudulent coding by evaluating its risk adjustment vendors based on their rates of re-validating high value chronic conditions and risk score increases as opposed to accuracy; and providing training to providers focused on how to render high value diagnoses based on anecdotal evidence rather than appropriate clinical validation.

In reality, this is a story of two sides of the same coin — compliance. For health plans, a lot can be gleaned from these increasing claims of MAO wrongdoing.

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The American healthcare system is under scrutiny, as costs rise without much improvement in outcomes, and the challenges in patient care are further exacerbated by the Covid-19 pandemic. As the government looks for cost savings, it is likely to continue to find and home in on potential Medicare Advantage over-payments, particularly among MAOs. At the end of 2019, the Office of Inspector General (OIG) released a report raising serious concerns about the potential improper inflation

of risk adjustment payments made to MAOs and calling on CMS to take more aggressive steps to monitor MAO activities. The OIG's report specifically addresses MAO chart review activities. The OIG points out that, because CMS does not require diagnoses identified in chart reviews to be linked to a specific service, the current chart review process creates an opportunity for MAOs to potentially circumvent the face-to-face encounter requirement for a diagnosis to be risk adjustment eligible. The OIG's report concluded that an estimated $6.7 billion in risk adjusted payments were made in 2017 based on diagnoses that MAOs reported only on chart reviews, not on service records, and that an estimated $2.7 billion of that did not link to any specific service provided to the beneficiary. The OIG report concluded by recommending that CMS undertake more rigorous monitoring and oversight activities to address these potential vulnerabilities associated with MAOs using chart reviews, and CMS agreed.

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Then, in September 2020, the OIG issued another report, this time pointing to concerns that MAOs may be using health risk assessments (HRAs) as a tool to improperly increase risk adjustment payments instead of improving patient care. Upon completing a review of 2016 MA encounter data, the OIG determined that an estimated $2.6 billion in risk adjustment payments were made in 2017 based on diagnoses that were reported by MAOs only on HRAs and not reflected in any other service records. Significantly, the report points out that 80% of the $2.6 billion in risk adjusted payments the OIG is questioning were generated from in-home HRAs. Most often, in-home HRAs are conducted by third party vendors that are engaged by the MAOs, not by the beneficiary's primary care provider (PCP). While the OIG acknowledged that in-home HRAs have the potential to address the health care needs of beneficiaries with serious conditions, the report calls out the concern that some MAOs may be initiating and using HRAs – many times by hiring a third party to conduct in-home HRAs - merely as a vehicle to collect diagnoses and increase risk adjustment payments, with no attempt to improve beneficiary care. The OIG specifically points to the lack of additional service records reflecting the diagnoses reported on the HRAs, and questioning whether the HRAs are being properly administered as part of a care plan that includes care coordination with the PCP to ensure proper treatment is provided to the beneficiary. The OIG further states that when diagnoses are represented only on HRAs, particularly those conducted in-home by a health care professional other than the beneficiary's PCP, and not documented in any additional service records, questions are raised of whether the beneficiary's PCP was made aware of the HRA results and also if the diagnoses reported on the HRAs were accurate. As a result of its findings, the OIG has recommended to CMS that it take additional steps related to the oversight of HRAs, with particular focus on those HRAs completed in a beneficiary's home.

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A New Trend of Greater Scrutiny

The health plan subject to the whistleblower lawsuit discussed above is not the only health plan that has been recently impacted by the increased litigation against MAOs. A few months after the OIG report was released, the DOJ brought a case against a different national health plan, alleging that the health plan disregarded its duty to ensure the accuracy of the risk adjustment data it submitted to CMS for payment, including its duty to delete thousands of inaccurate diagnoses, resulting in millions of dollars in additional risk adjustment payments from CMS. According to the government, this health plan intentionally designed a retrospective chart review program that was focused solely on finding additional diagnosis codes to increase their risk scores, while turning "a blind eye" to inaccurate or unsupported codes that should have been deleted. The health plan engaged third-party vendors to conduct retrospective chart reviews and utilized internal software processes to help identify new diagnosis codes that could be submitted for risk adjustment purposes. However, the government alleges that the health plan failed to meet its contractual and regulatory obligations to CMS when it did not instruct its chart review vendors to look for diagnoses codes that were unsupported by the medical record documentation and should be deleted. The government further alleges that, although the health plan had the ability and resources necessary to create a computer algorithm to detect diagnosis codes that should be reviewed for possible deletion, it instead intentionally focused its efforts only on ways to identify diagnosis codes that could be added, which would lead to enhanced risk adjustment revenue.

From our vantage point, in the vast majority of cases, national health plans like these, as well as other companies in the Medicare Advantage world, do not intentionally misrepresent their population risk. But the practical reality is that risk adjustment is predicated upon a complex process which, if not handled by true risk adjustment experts, can lead to poor program design and inadvertent errors. It is a challenge for MAOs and provider risk adjustment programs to deploy the resources necessary to constantly monitor changing rules and apply more stringent standards like clinically validating the existence of codes. They may also lack the technology and processes to delete (as opposed to just add) HCC codes. These two compliance measures alone can significantly mitigate potential compliance risks.

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Sometimes misrepresented population risk is a result of inadvertent loopholes in policies and procedures outlined by CMS. For example, to be eligible for risk adjustment, CMS requires that a diagnosis be documented in a medical record as the result of a face-to-face encounter. However, CMS also allows MAOs to submit diagnoses from chart reviews without linking them to a specific service or treatment related to the diagnosis.

These inconsistencies and uncertainties in guidance create situations in which MAOs may unintentionally bypass CMS requirements related to risk adjustment payments, including a face-to-face encounter and related medical record documentation to support the diagnoses, leading to potentially inflated risk-adjusted payments. In other words, the risk information can be wrong, without any intentional wrongdoing. This speaks to the importance of implementing an effective fail-safe and compliant program that encompasses multiple checks and balances.

The Value of Clinically Reviewed and Validated Risk Adjustment

Part of the problem, according to Dr. Averel Snyder, co-founder and Chief Medical Officer of Vatica Health, is the absence of a PCP focused approach. He points out that in the pending cases against the national health

plans discussed above, the health plans utilized (in part) third parties with no pre-existing relationship to the patient and the underlying medical record. A better approach would be to empower the PCP to perform HCC coding, since they have an existing relationship with the patient and direct knowledge of the patient's history and real-time access to their medical records. In addition, the PCP is in the best position to identify and close gaps in care to improve outcomes. Dr. Snyder remarked that "Health plans should review their risk adjustment solutions to ensure they do not separate the coding and the care of the patient —the two go hand-in-hand."

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According to Dr. Snyder, who is a 25-year cardiothoracic surgeon and holds several medical coding certifications, "A face-to-face encounter with a patient and their provider is an invaluable opportunity for the PCP to appropriately document and code each active medical condition for that patient."

To reduce the risk of becoming a target, it is imperative for health plans and providers to collaborate on risk adjustment programs in the context of improving health, quality, and outcomes. Getting members in the office each year for an annual wellness visit (AWV), preventive service, or other face-to-face encounter helps ensure active conditions are accurately captured and treated. This approach also mitigates the risk of MAOs being penalized for carrying forward diagnoses that should be updated or deleted because the providers are clinically validating each diagnosis on at least an annual basis.

"There is the potential for massive fines if health plans and providers don't cross all their t's or dot all their i's," said Dr. Snyder. He added, "A better approach is to give PCPs smart, intuitive technology and experienced clinical support directly at the point of care."

How Vatica Reduces Health Plan Risk by Driving Compliance

As a compliance-first organization, addressing the compliance issues that MAOs are facing has been a primary focus for Vatica since its inception. We work diligently with health plans and providers to improve the quality of care for patients, and thwart potential exposure from audits, enforcement actions and lawsuits. Our solution puts PCPs at the center of the risk adjustment process to enhance quality of care and improve quality of coding. This is accomplished by a unique combination of advanced technology, expertly trained clinicians embedded at the point of care, provider training, and an extensive QI process in which all HCC codes are reviewed and clinically validated prior to Vatica submitting the codes to the health plan.

Dr. Snyder remarked "By implementing a comprehensive risk adjustment program, health plans and providers shouldn't lose risk-adjusted revenue, but actually improve overall performance by submitting accurate diagnosis codes, reducing audit risk, while still submitting valid codes supported by the documentation in the provider's medical record." This compliance-focused approach—preferred by health plans and providers—drives comprehensive visits, closes care gaps, and improves quality of care and quality of coding.

It should be noted that these legal cases are ongoing and the courts will ultimately determine whether the claims against the companies have merit. What these cases demonstrate, however, is that whistleblowers and the federal government remain focused on bringing False Claims Act suits to target Medicare Advantage risk adjustment practices. Regardless of the sentiment surrounding it, the recent uptick in enforcement activity and litigation involving MAOs serve as an important wakeup call to the MAO community. One potential reaction to this increased scrutiny for some MAOs may be to take a more conservative approach and reduce the number of codes submitted to CMS, thereby (hopefully) reducing the risk. But a better approach may be to utilize a PCP-centric solution

to drive accurate and compliant coding, leading to reduced audit risk and, ultimately, better performance for the MAO. Though it may seem overwhelming to overhaul risk adjustment programs, most health plans and providers are already on the right track to reducing their reliance on traditional chart reviews and in-home assessments – and moving toward PCP-centric risk adjustment and quality of care initiatives. Now is the time for MAOs to review and tighten their risk adjustment processes to strengthen their compliance in an effort to minimize the likelihood of enforcement actions and high-cost lawsuits.

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