Minimizing the "Risk" In Risk Adjustment

Earlier this year we released a whitepaper, Risk Adjustment Programs Are Under Fire, to detail the noticeable uptick of claims against Medicare Advantage Organizations (MAOs) centering around initiatives that whistleblowers and the government have alleged were aggressive and focused on boosting risk scores. Since then, the enforcement activity has continued to increase, with the government most recently announcing its intervention in whistleblower cases against two different MAOs related to their risk adjustment practices.

Recent Cases

The first case is based on allegations that the MAO implemented a comprehensive and systemic scheme to boost its risk adjustment scores by improperly adding high value diagnosis codes. According to the complaint, the scheme involved pressuring providers to add diagnosis codes to the member records retroactively – many times up to a year after the face-to-face encounter. This was done in various ways, including prompting physicians to addend or amend medical records to add or change diagnoses to capture a high(er) value HCC, regardless of whether there was evidence or documentation to show such condition was present during the encounter. If a physician declined to add or change the diagnoses, the MAO would force the physician to move through a burdensome, time-consuming escalation process to resolve the disagreement. The MAO also allegedly hosted "coding parties," gathering several physicians together with computers and requiring them to review past progress notes and look for opportunities to update the medical records with new or updated diagnoses. These events were used to focus on specific diagnoses, with the expectation that each physician would addend approximately 30-40 progress notes during the 3-hour party, Finally, the MAO allegedly created provider bonus programs and competitions that were based on the percentage of chronic conditions captured and refreshed by the provider, which the complaint alleges incentivized the providers to capture and/or refresh as many codes as possible, even those that were unsupported.

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In the second case, the MAO, through an affiliated third party, is alleged to have implemented a retrospective chart review program that impermissibly captured diagnosis codes that were not accurate or adequately documented in the medical records. CMS allows retrospective chart reviews to afford MAOs an opportunity to ensure the accuracy of the risk adjustment scores by adding missed diagnoses and deleting unsupported diagnoses or diagnoses that are not risk adjustment eligible. In this case, the government has alleged that the MAO improperly utilized retrospective chart reviews by disregarding the requirement that the condition must be documented as relevant to patient care, treatment or management during an encounter in the date of service (DOS) year, instead adding diagnoses based on records from prior years, or impermissible sources such as

problem lists, past medical history, labs and DME orders. To further this alleged scheme to capture high value diagnosis codes, the MAO implemented an addenda process intended to create the documentation necessary to support the additional diagnosis codes captured during the chart reviews. According to the government, this process involved sending providers leading (or misleading) and suggestive forms – often times many months and up to a year after the encounter – pressuring the provider to sign off on a diagnosis that was purportedly missed during the encounter, even when there was no basis or appropriate documentation to support such diagnosis.

New OIG Report

In addition to the government's intervention in these recent whistleblower actions, the Office of Inspector General (OIG) issued a new report in September 2021 citing concerns, for a third time in the last couple of years, with the use of chart reviews and health risk assessments (HRAs) to inappropriately increase risk adjustment payments by capturing codes with no underlying service records to support the conditions. The September 2021 report built on two prior reports issued by the OIG which identified potential compliance issues related to the completeness of encounter data, the validity of diagnoses submitted on chart reviews or HRAs, and the quality of care provided to beneficiaries. The reports point to the billions of dollars in risk-adjusted payments made to MAOs based solely on chart reviews or HRAs. According to the OIG, the findings of these reports call into question whether MAOs are misusing chart reviews and HRAs as a mechanism to collect diagnoses that inappropriately increase risk adjustment payments and do not result in improved care for the beneficiaries.

How to Minimize Risk With A Physician-Centric Approach

A common theme running through these whistleblower cases and OIG reports is the government's concern with the implementation of risk adjustment processes that work around the primary care providers (PCPs) instead of with them. In fact, the September 2021 OIG report specifically calls out the common HRA process employed by MAOs as flawed, making the point that the legacy approach of not working alongside primary care providers raises particular concerns about the quality-of-care coordination for these beneficiaries and the validity of diagnoses. As the pioneer in physician-centric risk adjustment processes, Vatica has been making the same point for nearly a decade. Instead of using third parties with no pre-existing relationship to the patient and no access to the underlying medical record, Vatica's solution puts the PCP at the center of the risk adjustment process, empowering them to complete HCC coding with the greatest level of accuracy and completeness. The PCP is in the best position to perform this coding work given their direct knowledge of the patient's history and real-time access to applicable medical records. Vatica provides the PCP with its advanced, proprietary technology and expertly trained clinicians at the point of care to ensure the PCP is able to accurately and confidently complete the diagnostic coding. After the PCP has completed the HCC coding, Vatica reviews and clinically validates all HCC codes prior to submitting the codes to the health plan as part of its standard QI review process.

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In all likelihood, this increased scrutiny by the government into risk adjustment programs will continue for the foreseeable future. While the first reaction to this increased enforcement activity might be take a more conservative approach, limiting the codes submitted to CMS in an effort to reduce risk, that is not the ideal approach. The better course of action is to implement a comprehensive and PCP-centric solution that includes clinical support and easy to use technology to produce more accurate and compliant coding. Perhaps paradoxically, this more compliant approach actually enables MAOs to improve performance as

a result of higher confidence in the accuracy of the coding and documentation submitted for risk adjustment payments and by reducing the MAOs' legal exposure which is undoubtedly mounting.

As a compliance-first organization, Vatica's focus has always been to address the ever-increasing compliance issues that MAOs are facing by providing solutions to limit potential audit exposure, enforcement actions and high-cost lawsuits, while simultaneously improving clinical and financial performance. It is now more important than ever for MAOs to carefully evaluate their risk adjustment programs, reducing their reliance on traditional chart reviews and in-home HRAs that the government has continued to point to as problematic and ineffective at improving outcomes, and instead focusing on PCP-centric solutions like Vatica's that are geared towards enhancing the quality of patient care, closing care gaps, and improving the quality of coding and documentation.

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