FAST BREAK: RISK ADJUSTMENT AND LIABILITY

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TODAY'S PRESENTERS

Tesch Leigh West

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Agenda

- Understanding Risk Adjustment
  - Federal Agencies
  - Risk Adjustment Overview
  - Medicare Advantage & Affordable Care Act
  - Mechanics of Risk Adjustment
- Enforcement Mechanisms
  - False Claims Act
  - Civil Monetary Penalties Law
  - Exclusion
  - Other Tools
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- Risky Risk Adjustment

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UNDERSTANDING RISK ADJUSTMENT

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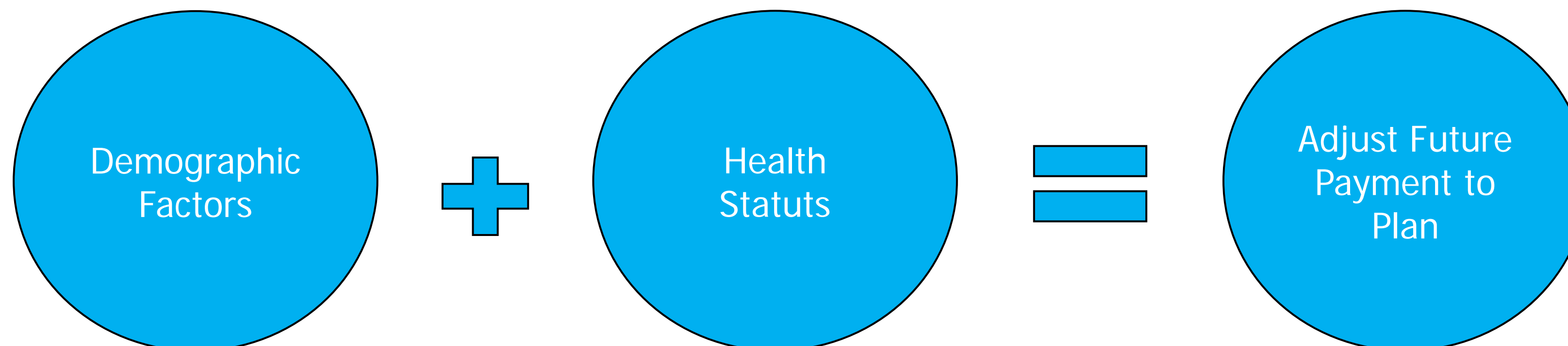
Federal Agencies

- The Department of Justice ("DOJ")
  - Main Justice (Criminal and Civil Enforcement)
  - US Attorney's Offices (Criminal and Civil Divisions)
- The Centers for Medicare and Medicaid Services ("CMS")
- Health and Human Services, Office of the Inspector General ("HHS-OIG")

Risk Adjustment Overview

- Under managed care programs, health plans contract with the government to provide services to beneficiaries and receive capitated payments (per member per month).
  - Managed care is a healthcare delivery system that improves patient outcomes and reduces costs by aligning incentives towards quality rather than quantity of care.
- Risk adjustment is the method by which CMS adjusts the capitation payments to account for the differences in expected health costs. CMS bases risk adjustment payments on beneficiaries' demographic information and any diagnosis codes submitted for the prior year.
  - Risk adjustment is paramount to ensuring each beneficiary's health status is fully captured and resources are appropriately allocated to treat and manage beneficiary care.

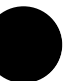


Medicare Advantage

- CMS contracts with Medicare Advantage Organizations (MAOs) to provide healthcare coverage to qualifying beneficiaries.

- Capitated payments to MAOs are intended to reflect the anticipated cost of providing care to that beneficiary. Medicare beneficiaries vary greatly in terms of their health status. Capitation payments are adjusted to ensure that MAOs are paid more for beneficiaries that have higher expected healthcare costs.
  - The goal is to neutralize any incentive MAOs may have to avoid sicker, and therefore, more costly beneficiaries.
  - Beneficiaries are assigned a risk adjustment factor ("RAF") score that acts as a multiplier on the capitated payment base rate.

The higher the risk score, the greater the expected cost of the beneficiary, and the greater reimbursement an MAO draws down from the federal government



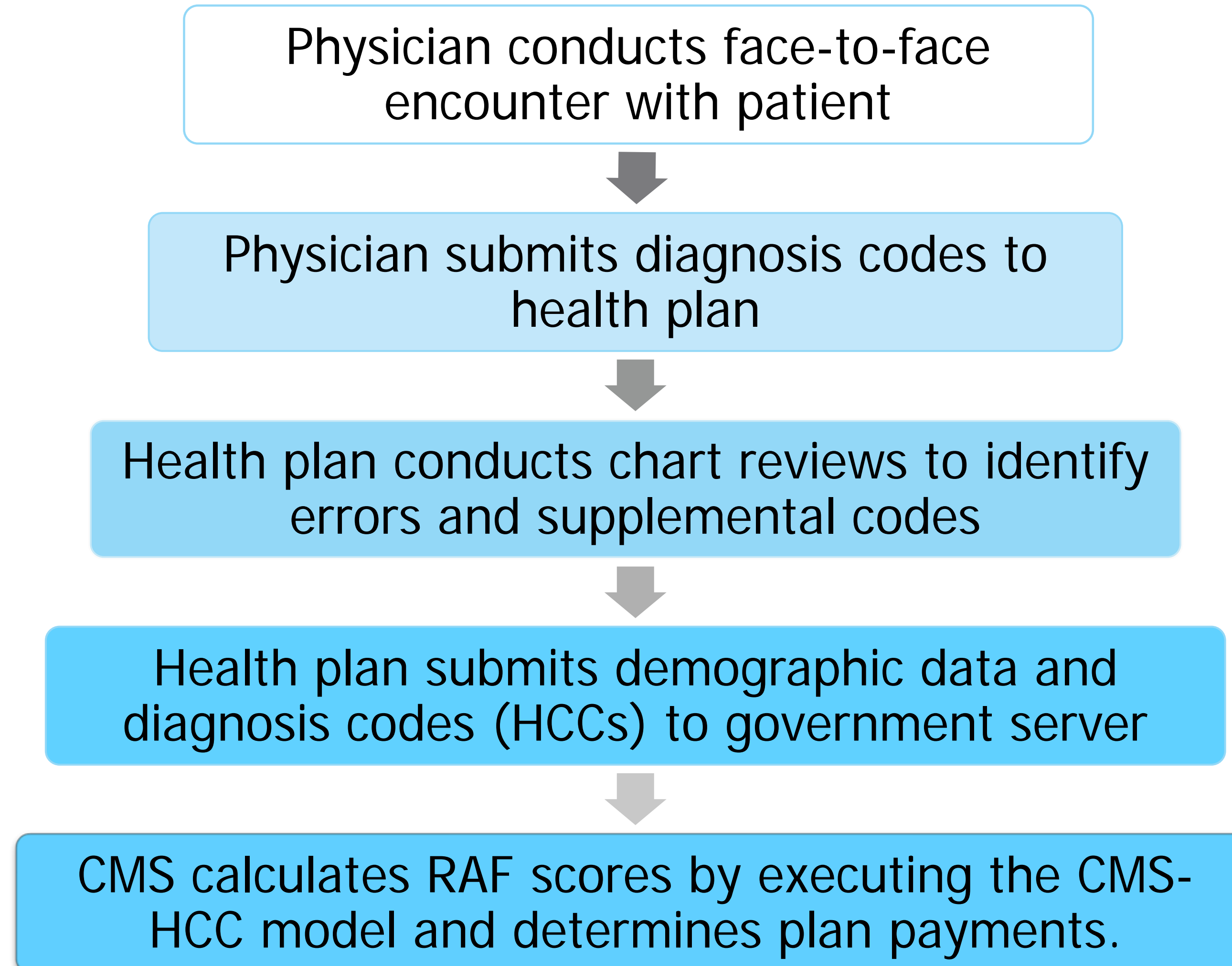
Affordable Care Act

- Congress incorporated risk adjustment into the ACA in 2014 with the intention of:
  - Stabilizing health insurance premiums;
  - Encouraging health plans to participate in health exchanges; and
  - Discouraging health plans from eluding enrollment of sicker individuals.

- ACA risk adjustment payments are referred to as "transfers" because health plans with low-risk enrollees are **assessed a charge** and health plans with high-risk enrollees **receive a payment**.

This is one of the biggest differences between MA risk adjustment and ACA risk adjustment.

The Mechanics of Risk Adjustment



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ENFORCEMENT

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Enforcement Mechanisms: False Claims Act

- The False Claims Act is the primary enforcement tool that DOJ utilizes for Risk Adjustment.
- FCA prohibits:
  - Knowingly presenting or causing to be presented a false or fraudulent claim for approval
  - Knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim
  - Having possession of property or money of the government and knowingly delivering or causing to be delivered, less than all of that money or property
  - Knowingly avoiding or decreasing an obligation to the government
- The "knowingly" standard is not met if a party acts on an objectively reasonable interpretation of relevant statutes and has not been warned away by guidance.
  - *United States ex rel. Sheldon v. Allergan Sales, LLC*, 24 F.4th 340 (4th Cir. 2022).
- Government has an expansive view of this statute.

Enforcement Mechanisms: Civil Monetary Penalties Law

- The Civil Monetary Penalties Law ("CMPL") authorizes the HHS Secretary to impose civil money penalties, an assessment, and program exclusion for various forms of fraud and abuse involving the Medicare and Medicaid programs.
- Penalties between $2,000 and $100,000 for each violation depending on the specific misconduct.
- The Inspector General is required to prove liability only by a "preponderance of the evidence."
- A health care provider can be held liable based on its own negligence and the negligence of its employees.
- There is no requirement that intent to defraud be proved.

Enforcement Mechanisms: OIG Exclusion

OIG has the authority to exclude individuals and entities from Federally funded health care programs. OIG maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities ("LEIE").

Mandatory Exclusion: OIG must exclude individuals/entities that are convicted of:

- Medicare or Medicaid fraud;
- Patient abuse or neglect;
- Felony convictions for other health care-related fraud, theft, or financial misconduct; and
- Felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Permissive Exclusion: OIG may exclude individuals/entities for many other reasons including:

- Misdemeanor convictions related to health care fraud;
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; or
- Engaging in unlawful kickback arrangements.

To avoid CMP liability, OIG recommends that entities routinely check the LEIE to ensure that new hires/current employees are not on the excluded list.

Enforcement Mechanisms: Other Tools

- Risk Adjustment Data Validation ("RADV") audits
  - The RADV program was created to identify and correct past improper payments to Medicare providers and implement procedures to help CMS prevent future improper payments.
  - RADV is the process of verifying that diagnosis codes that MAOs submit for payment are supported by appropriate medical record documentation.
  - <u>Two Major RADV Activities</u>
    - Contract - Level Samples: Used to conduct payment recovery from MAOs
    - National Sample: Used for annual payment error reporting
- Criminal Enforcement

Enforcement in Action

- *United States ex rel. Ormsby v. Sutter Health, et al.*, **No. 15-CV-01062-LB (N.D. Cal.)**
  - DOJ alleged that Sutter Health knowingly submitted unsupported diagnosis codes for certain patient encounters for beneficiaries under its care, which caused inflated payments to be made to the plans and to Sutter Health.
  - $90 million settlement.

- *United States ex rel. Ross v. Independent Health Ass'n et al.*, **No. 12-CV-0299 (W.D.N.Y.)**
  - DOJ alleges that Independent Health submitted inaccurate information about the health status of beneficiaries enrolled in Medicare Advantage Plans, through chart reviews conducted by a wholly-owned subsidiary, DxID.
    - Allegedly, DxID asked health care providers to sign addenda and subsequently used them as substantiation for adding risk-adjusting diagnoses that were not documented during the patient encounter.
  - The case is currently ongoing and Independent Health filed a motion to dismiss.

Risky Risk Adjustment

- Upcoding (clinicians v. coders)
- High-risk groups of diagnoses
  - Acute stoke, acute heart attack, acute stroke and acute heart attack combination – must occur in the physician office to be accurately coded.
  - Lung cancer, breast cancer, colon cancer – must show surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis.
  - Potentially mis-keyed diagnosis codes (basically typos).
- Coding from Past Medical History and Problem Lists
- Retrospective chart reviews

Join us next month!

Please join us for next month's webinar:

Fast Break: **No Surprises Act**

Featuring

Jessica Totten and Jake Harper

- March 24th at 3pm

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QUESTIONS?

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Thanks and Be Well!

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With a dual focus on litigation and regulatory compliance, Tesch Leigh West represents providers in federal and state government investigations and litigation matters relating to criminal, civil, and administrative allegations, including violations of federal healthcare program fraud and abuse laws. Tesch also represents states, hospitals, clinics, nursing homes, physician groups, health plans and associations, with a focus on Medicare reimbursement, Medicaid supplemental payments and financing options, and analysis related to 1115 Demonstration Waivers.

Thanks and Be Well!

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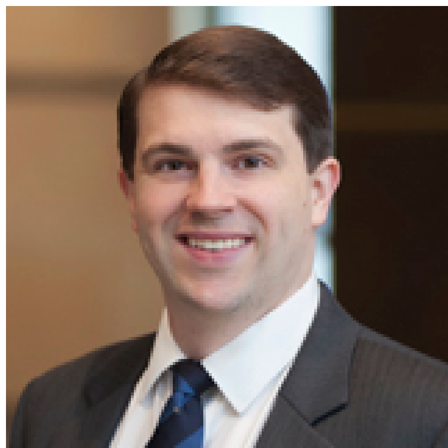
Michelle M. Arra handles a variety of litigation matters across all sectors. Prior to joining Morgan Lewis, she served as a judicial law clerk to Judge Ronald S.W. Lew of the US District Court for the Central District of California, and as a judicial extern to Judge Dolly M. Gee of the US District Court for the Central District of California. During law school, Michelle served on the Scott Moot Court Honors Board, and as executive editor of the Loyola of Los Angeles Entertainment Law Review. Due to her academic achievement, Michelle was admitted to Alpha Sigma Nu, Jesuit Honors Society, and the St. Thomas More Law Honor Society. Michelle is admitted in California only, and her practice is supervised by DC Bar members.

Thanks and Be Well!



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Jacob Harper advises stakeholders across the healthcare industry, including hospitals, health systems, large physician group practices, practice management companies, hospices, chain pharmacies, manufacturers, and private equity clients, on an array of healthcare regulatory, transactional, and litigation matters. His practice focuses on compliance, fraud and abuse, and reimbursement matters, self-disclosures to and negotiations with OIG and CMS, internal investigations, provider mergers and acquisitions, and appeals before the PRRB, OMHA, and the Medicare Appeals Council.

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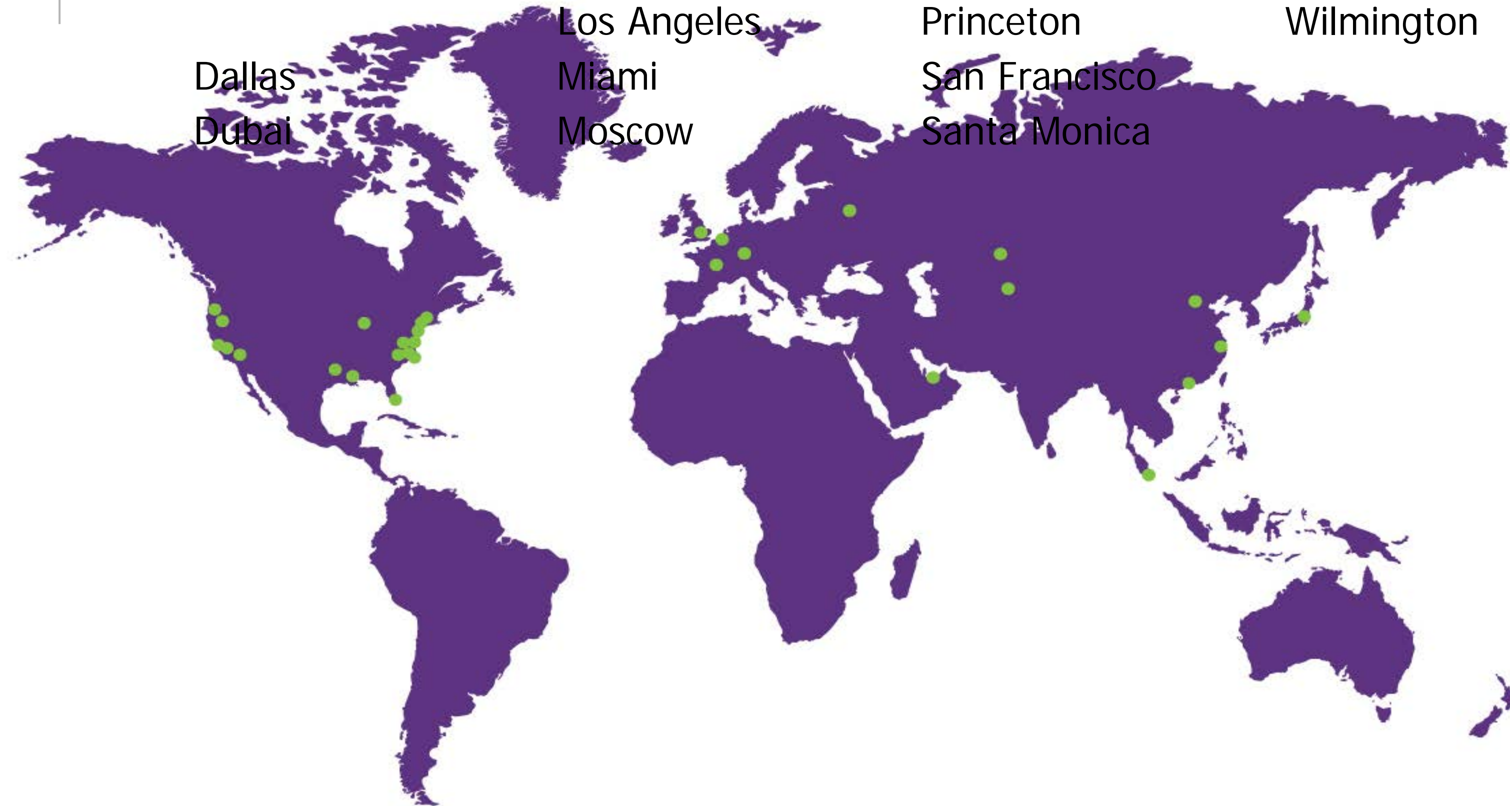

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