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SESSION 3

Medicare Advantage –

Compliance Issues and Enforcement

January 19, 2024

Presented by:

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Speaker Introduction

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Mike Tuteur has spent nearly 40 years successfully trying cases and arguing appeals in both civil and criminal courts around the country. He is sought after for his seasoned judgment, trial experience, and litigation victories. Mike served as chair of the firm's national Litigation Department from 2009 to 2015, as well as chair of its Business Litigation & Dispute Resolution Practice. He is a partner in the Government Enforcement Defense & Investigation Practice and a former member of the firm's national Management Committee.

Mike represents a broad range of clients, with a particular focus on health care litigation, False Claims Act defense, government and internal investigations, and scientific and research misconduct. He has recently been involved in FCA matters involving Medicare Advantage as well as assisting various health care entities, including "High Impact Target" hospitals, avoiding FCA liability in connection with the CARES Act, the Paycheck Protection Program, and the Health Care Enhancement Act.

Speaker Introduction

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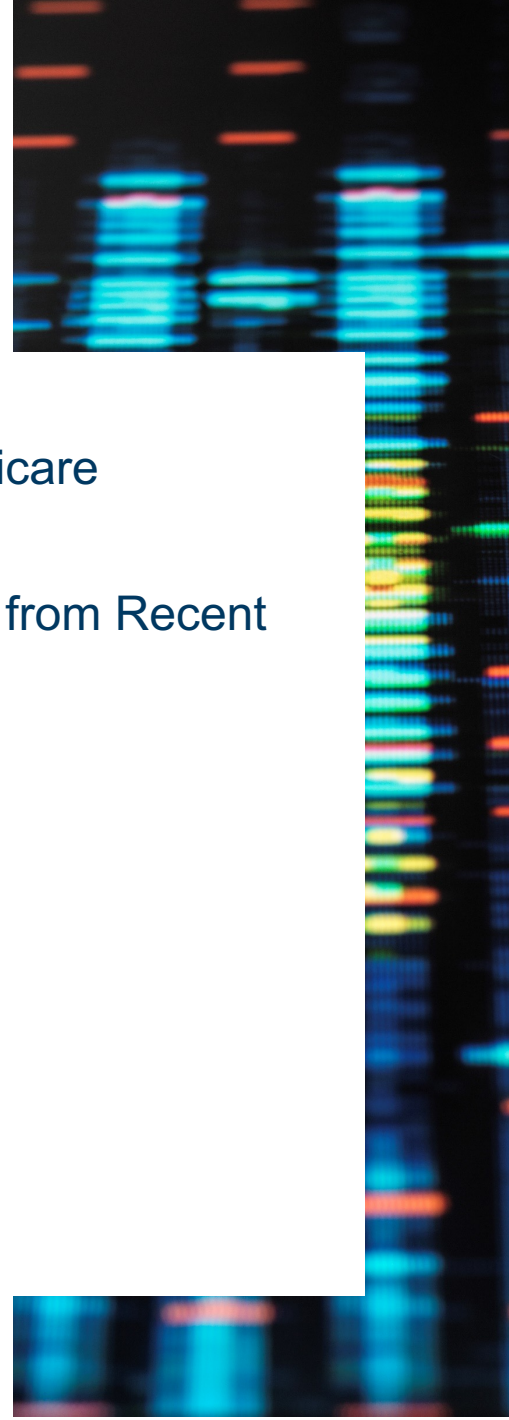
Valerie Rock serves as a Principal on PYA's Revenue and Compliance Advisory Services team and manages the Revenue Integrity service line. She specializes in physician coding, reimbursement, and regulatory compliance.

With over 20 years of experience in healthcare consulting, and holding Certified Professional Coder (CPC) and Certified in Healthcare Compliance (CHC) credentials, Valerie has assisted numerous PYA clients with hospital-employed physician compliance and audit program development; physician and laboratory compliance program advisory support; statistically valid, sample-based refunds; physician and non-physician practitioner compliance; Medicare and Medicaid regulatory compliance and reimbursement methodologies; and practice establishments and operational consultations.

Agenda

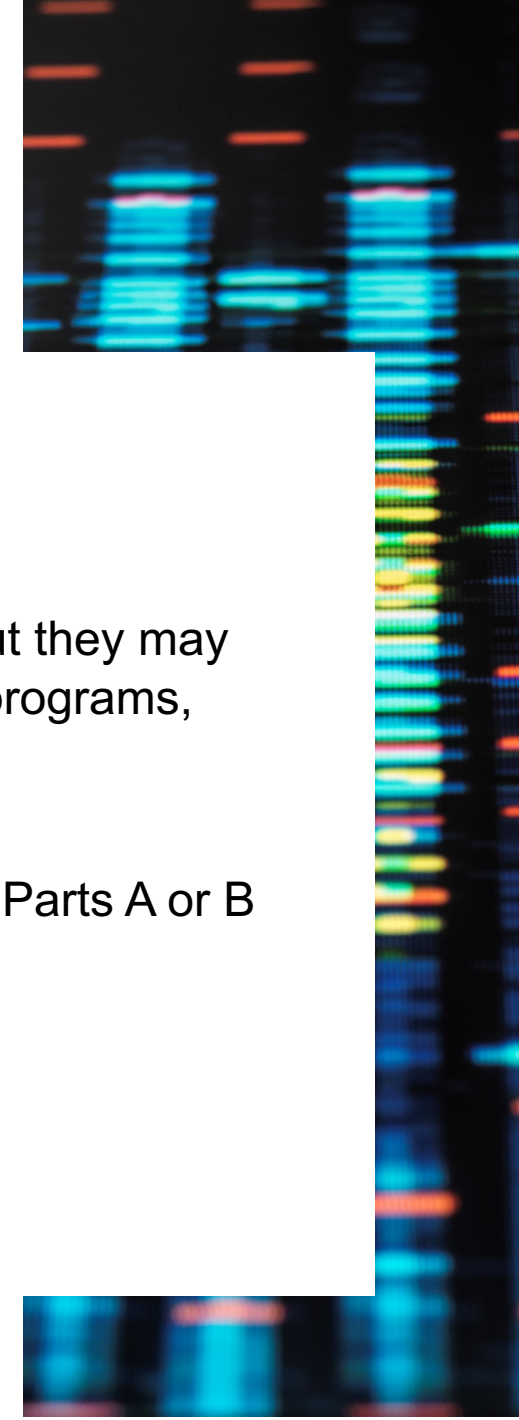
1. Medicare Advantage Overview
2. Differences Between Medicare Advantage and Fee-for-Service Medicare
3. Reimbursement Considerations
4. The Changing Landscape
5. OIG Areas of Focus for Medicare Advantage
6. Compliance Program Focus from Recent Government Activity
7. Questions



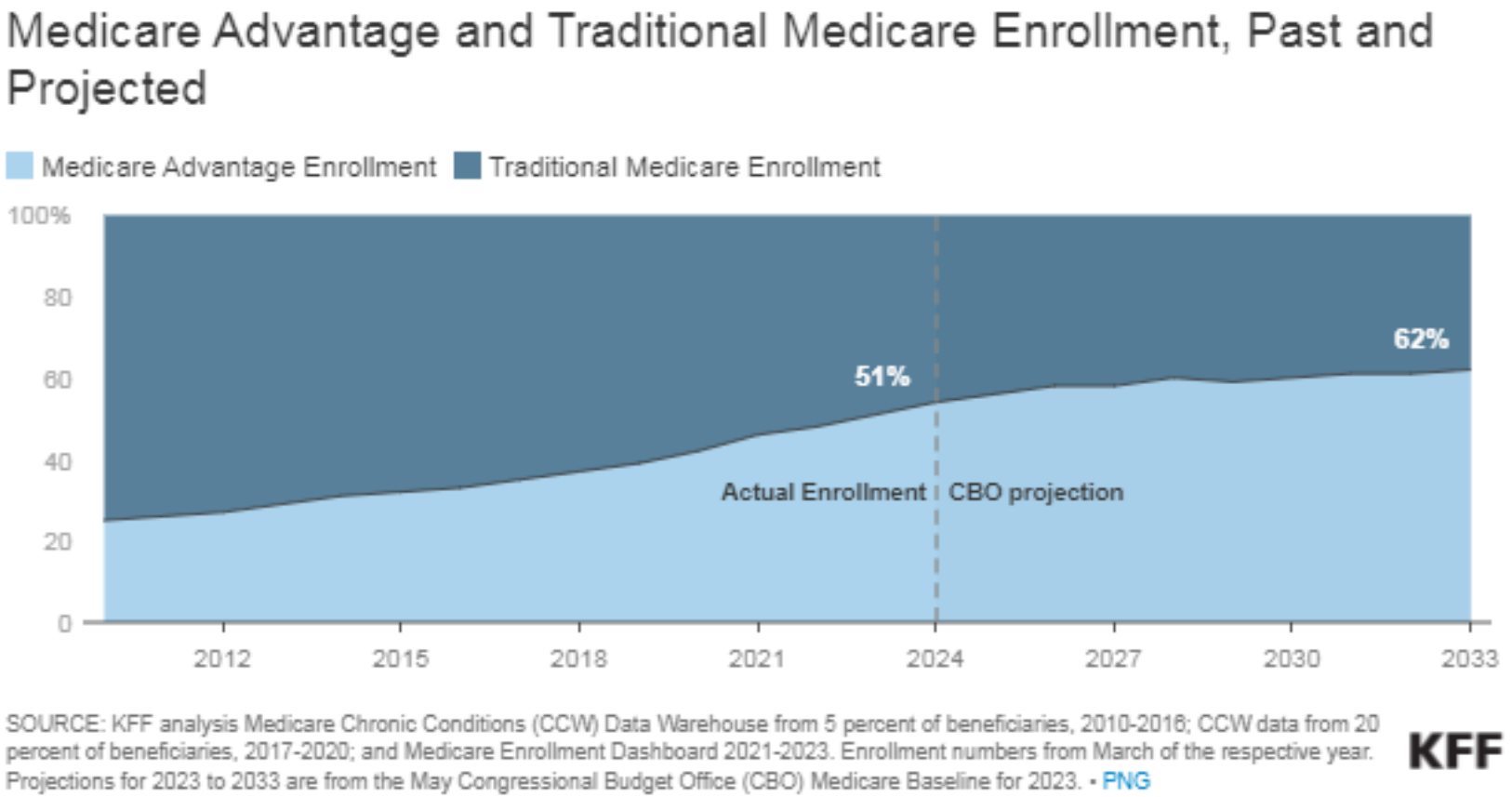
Medicare Advantage (MA) Overview

MA Background – Definition

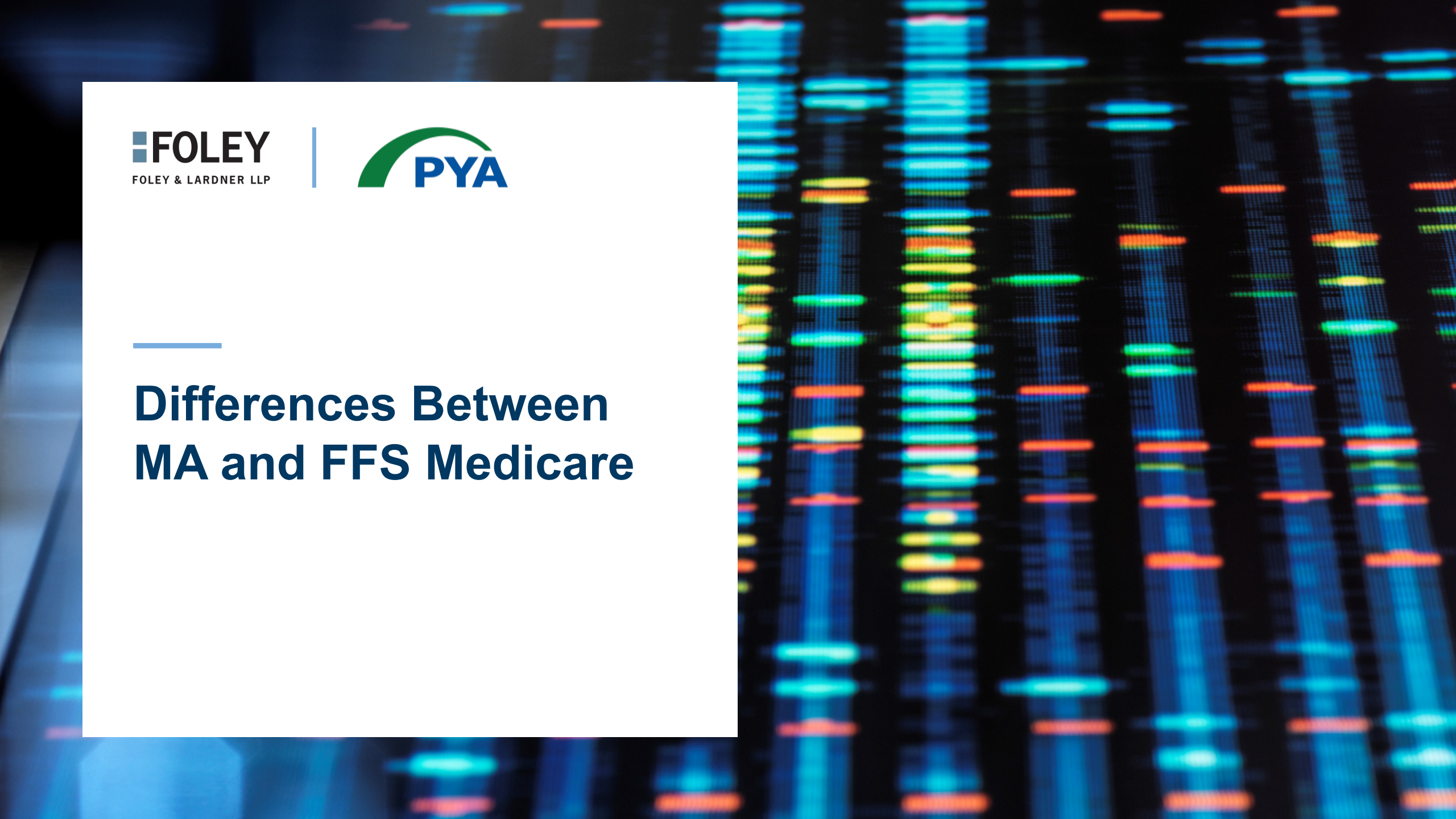
- **MA**
  - Insurance plans offered by private insurance companies to Medicare beneficiaries
  - Provide the same benefits as the original Medicare plan (Medicare Parts A and B), but they may offer additional benefits, such as vision, hearing, dental, and/or health and wellness programs, and/or include varying restrictions
  - Beneficiaries elect to join a MA plan or stay with traditional Fee-for-Service (FFS)
  - Medicare services are covered through the plan and are not paid for under Medicare Parts A or B
  - Managed care with a health plan network
  - May offer prescription drug coverage (Part D)



What Is MA and Why Is It Important to Discuss?



Source:
https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/



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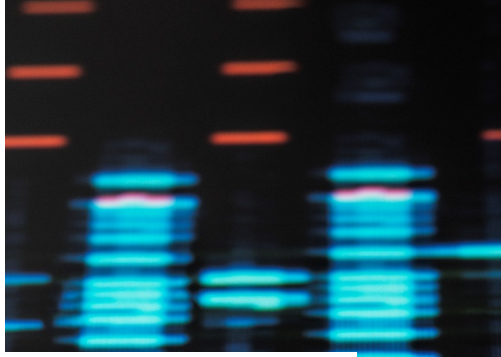
Differences Between MA and FFS Medicare

What are the differences in MA vs. Medicare FFS (i.e., “Traditional” Medicare)?



Provider Payments

- **FFS:** Providers are paid by CMS based on procedures performed.
- **MA:** Providers are paid by the MA plan:
  - Based on procedures performed, ***or***
  - Based on a risk adjusted capitated model

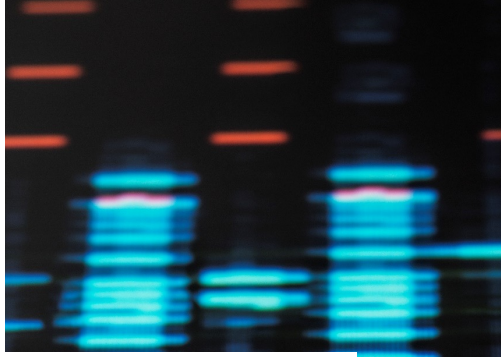
Payer Funding

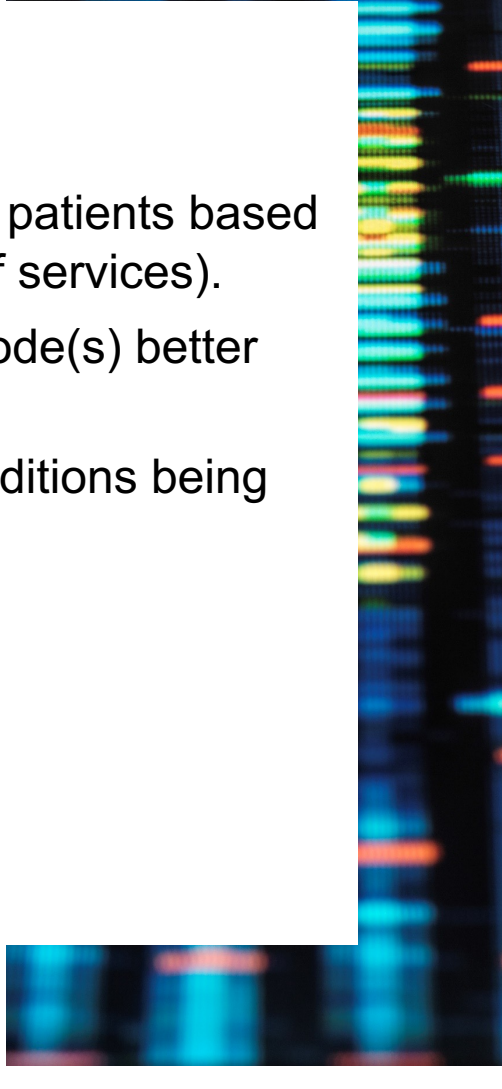
- **FFS:** Medicare Trust Fund and beneficiaries pay premiums, deductibles, and co-pays
- **MA:** CMS pays MA Plan a capitated amount (adjusted for risk adjustments); beneficiaries only pay co-pays or co-insurance if chosen plan requires them.
  - MA Plan receives additional sums directly based on risk adjustment scores.

FFS vs. Risk Coding for Reimbursement

- **FFS**
  - Physicians paid on FFS; bill services based on CPT/HCPCS procedure codes.
  - Diagnosis codes minimally used for payment policies, only to match procedures.

- **Risk Adjustment**
  - CMS assigns plan payments for patients based on risk (not as reimbursement of services).
  - Higher specificity of diagnosis code(s) better defines financial risk.
  - CMS will only pay for health conditions being currently managed.



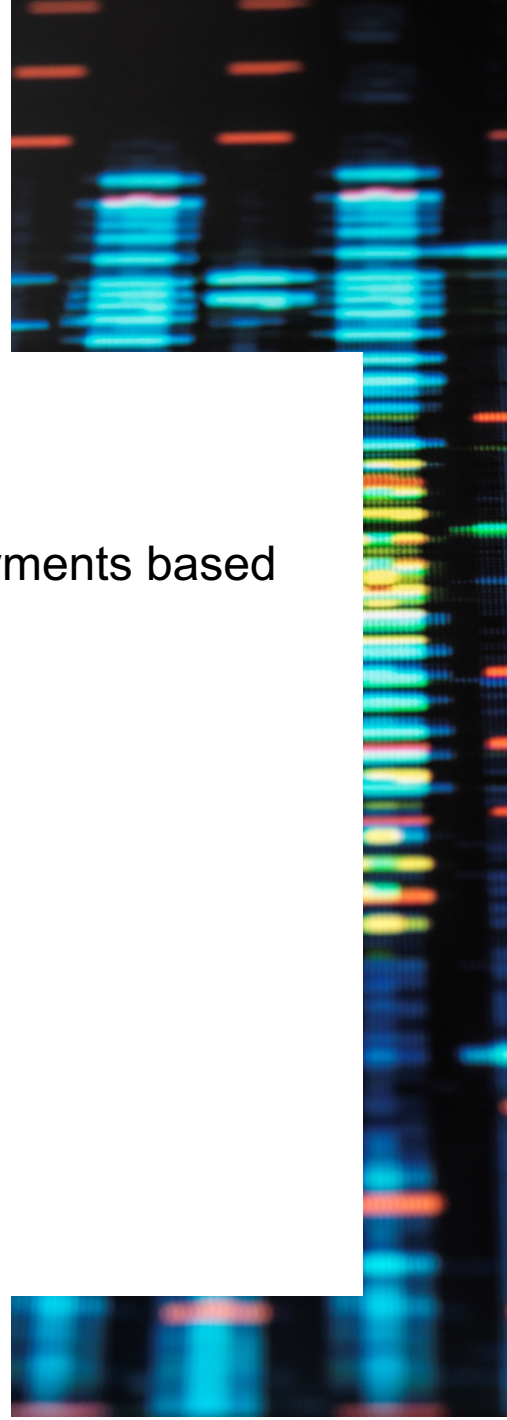


Reimbursement Considerations

Payment to MA Plans

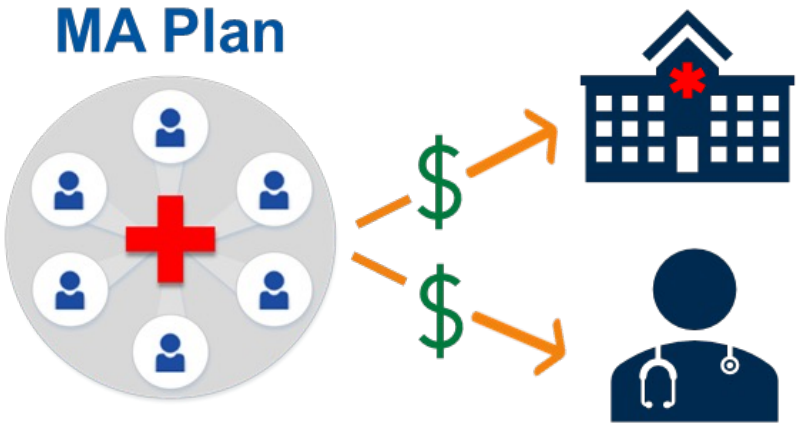
- **CMS Payments**
  - Submit an annual bid to CMS
  - Receive a fixed (or capitated) monthly payment from CMS per enrollee (beneficiary)
  - Monthly payments are based upon the following factors:
    - Geographic benchmarks as determined during the annual bid process
    - MA plan's Star rating
    - Enrollee's Risk Adjustment Factor (RAF) scores

- **Enrollee Payments**
  - Fixed monthly premium payments based on benefit plan selected



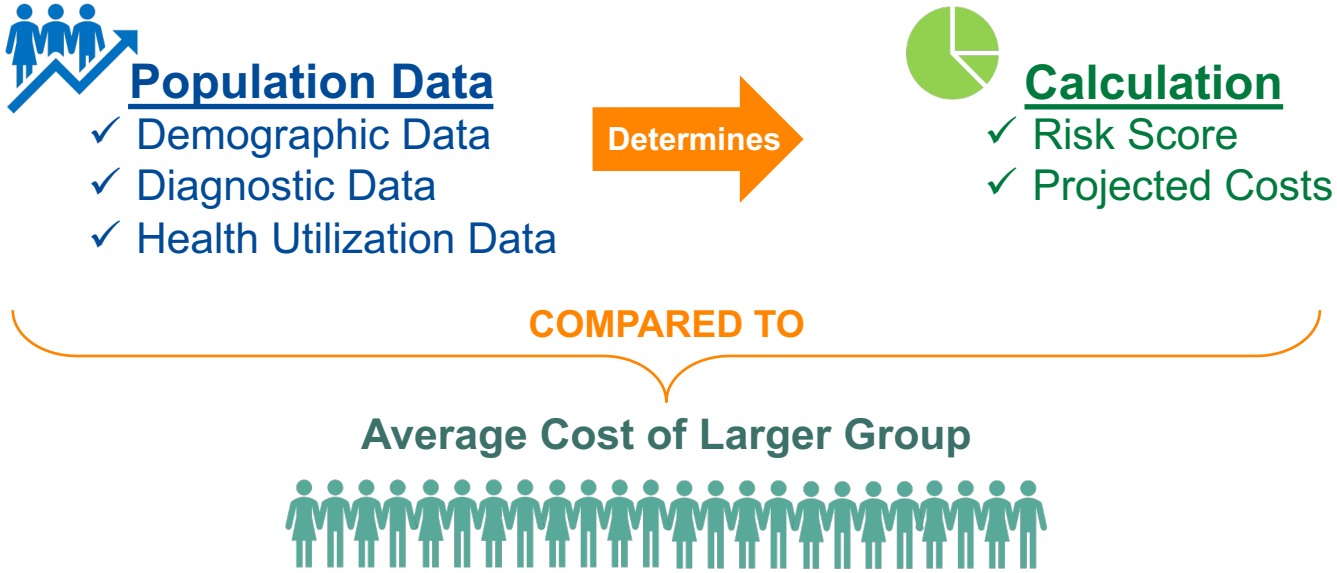
Payment to Providers

- **How do MA Plans pay for medical services on behalf of their enrollees?**
  - MA Plan directly contracts with Providers in their network to provide covered services for their enrollees.
  - MA Plans can pay for such services under various methods:
    - FFS
    - Capitation
    - Other payments (quality, shared savings)

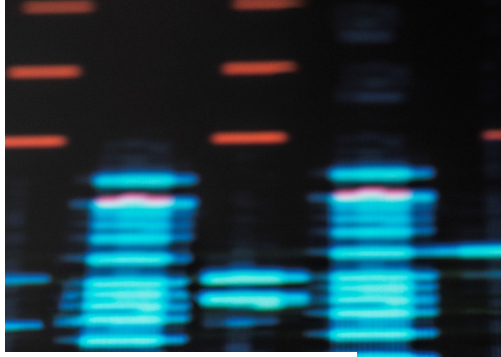


Risk Adjustment Methodology

- Risk adjustment is an **actuarial tool**
  - Measures morbidity and/or health service utilization to assess the relative risk of a population
- **Risk factors = health status or health spending**
  - Age, gender, diagnostic information, and healthcare utilization

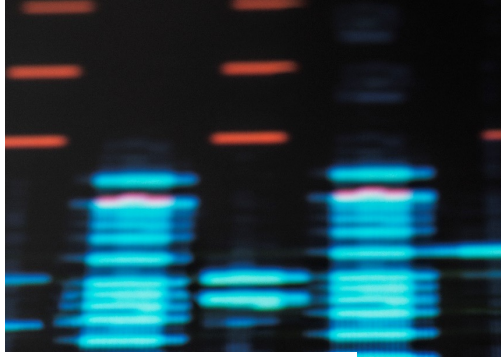


Traditional/FFS vs. Medicare and MA Reimbursement Differences and Compliance



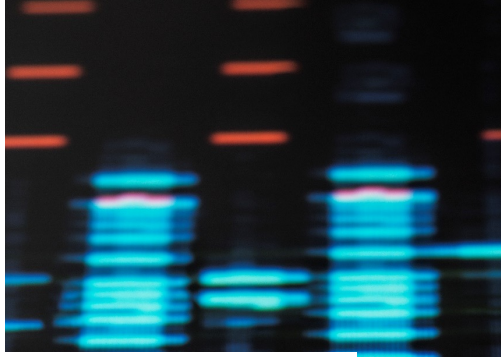
- **How do the reimbursement differences between FFS Medicare and MA affect the analysis of compliance?**
  - ***Example***: Who is responsible for the false claim?
    - Plan differences:
      1. **FFS:** Claim is submitted by the provider to CMS (e.g., direct false claim)
      2. **MA:** Claim is submitted by the provider to the MA Plan (e.g., possible false claim to federal contractor)
  - **Key legal issue #1:**
    - The looming split in the Circuits concerning the causation standard for AKS/FCA cases (3rd vs. 6th and 8th; and USDC split in D. Mass. that's being heard in the 1st Cir.)

Traditional/FFS vs. Medicare and MA Reimbursement Differences and Compliance



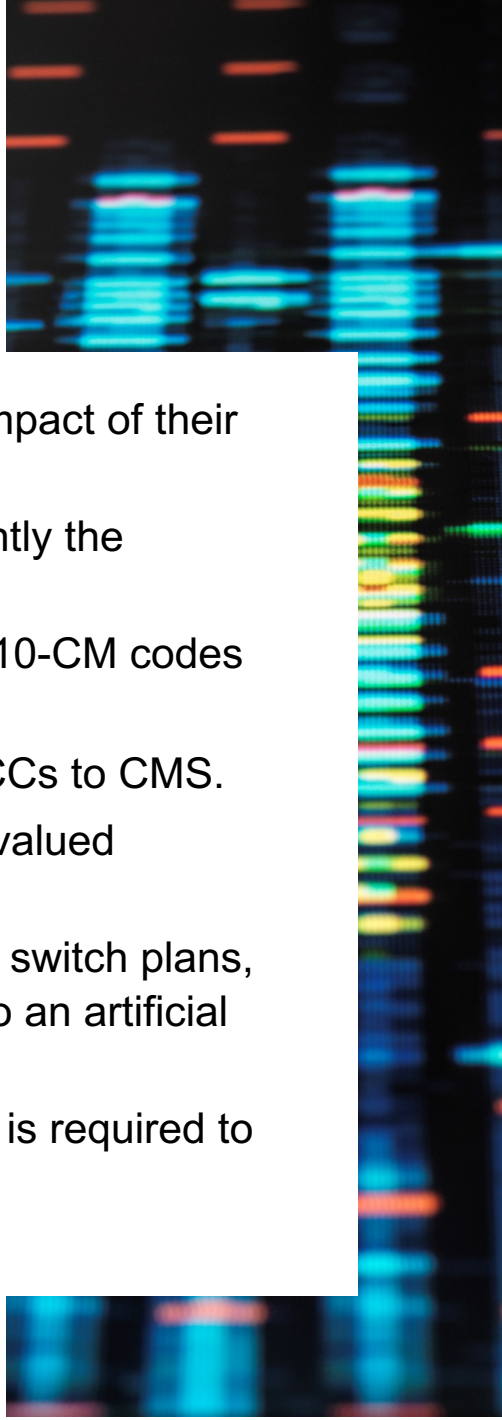
- **Reimbursement differences (*cont.*)**
  - **Key legal issue #2:**
    - **Diagnosis codes drive reimbursement**
      - Providers submit diagnoses to the MA plan
        - Providers do not submit records to validate the diagnoses.
        - This results in prospective and retrospective reviews by MA plans of data and records to ensure accuracy.
          - Health Risk Assessments
          - Substantial Govt interest/litigation involving retrospective chart reviews

MA Plan's Risk Adjustment Programs



- **MA plans typically administer two risk adjustment programs to identify supported HCCs:**
  - **Prospective Risk Adjustment Program**
    - The purpose is predominately for case management of high-risk members who have co-morbid conditions and/or may be suspect to incur a major clinical event.
    - MA Plan may send their own clinical staff or third-party to conduct a health risk assessment in the enrollee's home
      - Designed to capture missed diagnoses/chronic illnesses
  - **Retrospective Risk Adjustment Program**
    - The purpose is to validate suspected diagnoses for members in the current year based on complex algorithms driven from past and current claims

Risk Factors and Potential Scenarios That Impact Data Accuracy



- MA plans are reporting based on the data submitted by providers who may not understand the impact of their coding accuracy.
- Diagnoses unsupported by documentation can artificially increase the RAF score and subsequently the reimbursement received by the MA plans from CMS.
- MA plans that provide education regarding the importance of claim submission with correct ICD-10-CM codes could inadvertently steer the coding to a higher specificity when not warranted.
- MA plans that do not perform routine audits to identify coding inaccuracies risk over reporting HCCs to CMS.
- MA plans that perform retrospective audits may be incentivized to only identify additional/higher valued diagnoses-HCCs.
- MA Plans are not incentivized to apply techniques to identify supportable HCCs of enrollees who switch plans, since the revenue from those HCCs would accrue to the subsequent MA Plan. This could lead to an artificial decrease in RAF scores for those.
- CMS can utilize the data to identify abnormal or outlier patterns; however, documentation review is required to confirm aberrant behavior.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The Changing Landscape

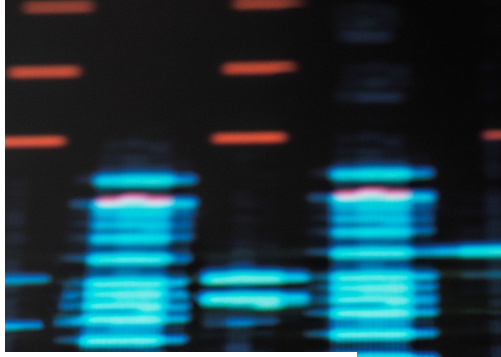
New Scrutiny of Coverage and Access to Care for Beneficiaries

- **OIG study released April 27, 2022**[1]
  - Concern that capitated payment model is incentive to deny access to services and deny payments to increase profits.
  - Found that 13% of services were denied that met Medicare coverage rules and MAO billing rules.

- **Contract Year 2024 Key Changes to the Medicare Advantage Program**[2]
  - Strengthen translation requirements for marketing and communication
  - Health Equity in MA
  - Utilization Management (UM) requirements:
    - Prior authorizations, continuity of care, annual review of UM tools
  - Marketing changes to protect beneficiaries
  - Behavioral Health in MA
  - Enrollee notifications requirements for MA provider contract terminations

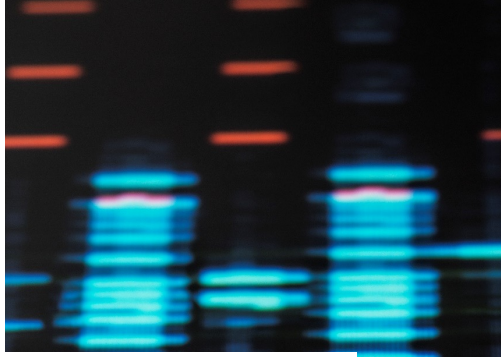
1. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp
2. https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

Increasing Interest/Visibility of MA in Congress, OIG, and CMS



- **Enrollment/Marketing**
  - New scrutiny of Medicare Advantage plan relationships with third party organizations from the **Senate Finance Committee**:
    - https://democrats-energycommerce.house.gov/sites/evo-subsites/democrats-energycommerce.house.gov/files/evo-media-document/centene-corporation.2023.9.28-letter-re-mco-prior-auth.he_.pdf; and
  - **House Democrats**:
    - Letter from Pallone & Neal

CMS Rulemaking – Contract Year 2025 Key Changes Proposed



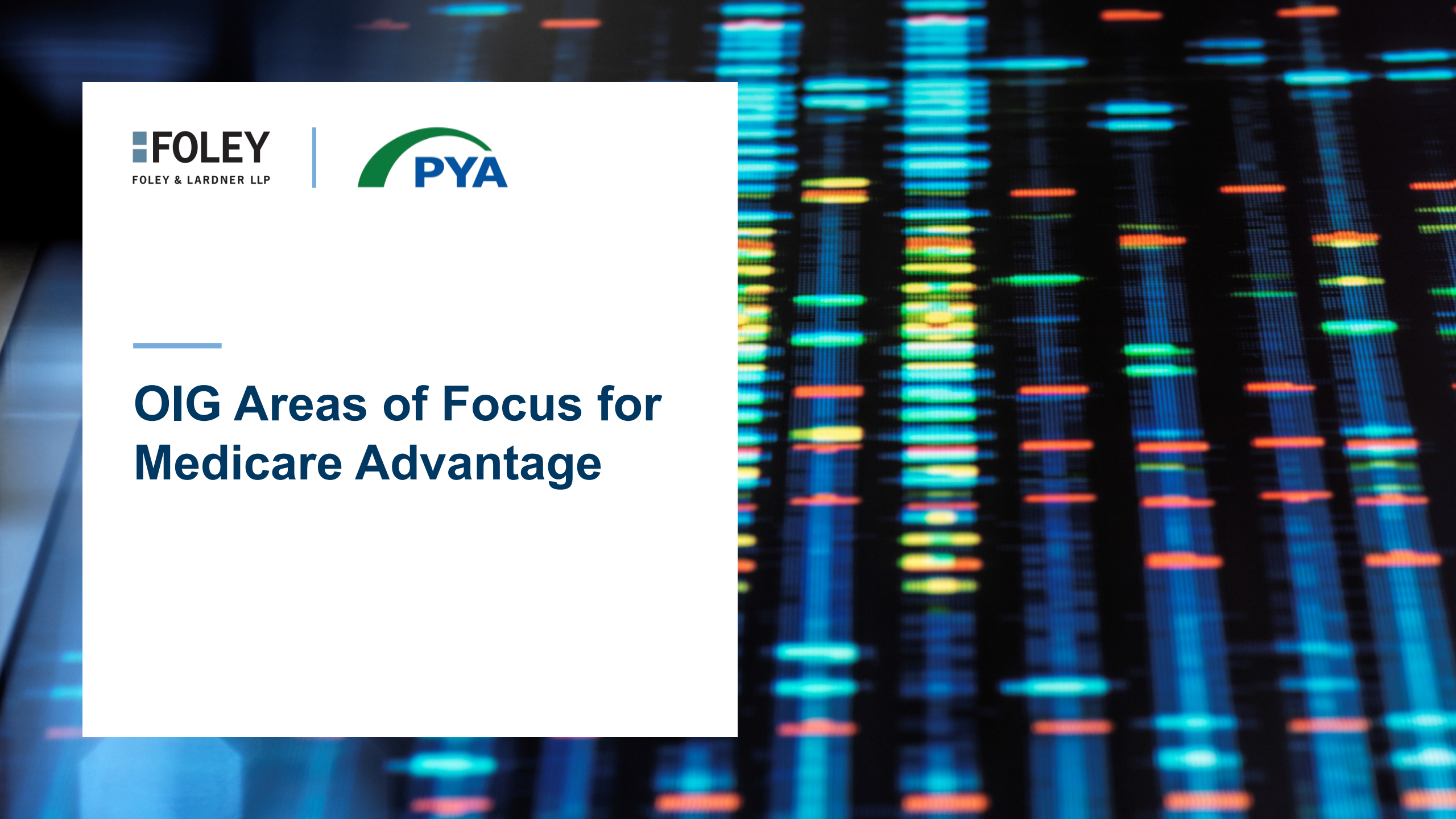
- **CMS Rulemaking – Contract Year 2025 Key Changes Proposed**

  - New marketing and communications policies relating to plan oversight of third-party marketing organizations for Contract Year 2025 (starting Sept. 30, 2024):
    - Proposing to generally prohibit contract terms between MA organizations and agents, brokers or other third-party marketing organizations (TPMOs) that may interfere with the agent's or broker's ability to objectively assess and recommend the plan that best fits a beneficiary's health care needs;
    - Set a single compensation rate for all plans;
    - Revise the scope of items and services included within agent and broker compensation; and
    - Eliminate the regulatory framework which currently allows for separate payment to agents and brokers for administrative services.

CMS Rulemaking – Contract Year 2025 Key Changes Proposed (cont.)

- **Standardizing RADV audit appeals process, effective 60 days after publication of the final rule.**
  - Medical review process will complete adjudication prior to payment error appeal process can start.

- **New annual assessments:**
  - Requiring annual health equity analysis of UM policies and procedures, including requiring the UM committee have expertise in health equity, and conduct an annual health equity assessment of the use of prior authorizations with certain social risk factors
    - Source: https://www.federalregister.gov/documents/2023/11/15/2023-24118/medicare-program-contract-year-2025-policy-and-technical-changes-to-the-medicare-advantage-program



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OIG Areas of Focus for Medicare Advantage

What Are Current Areas of Focus of the HHS OIG in the MA Space?

Artificial Intelligence

SCOTUS

"Reasonable Interpretation" ruling in SuperValu – and possible responses

COVID-19

Increased DOJ Resources

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Compliance Focus from Recent Government Activity

Compliance Focus Now…

- **Regarding recent government activity, what should the compliance focus of plans and providers be?**
  - Ensure compliance with finalized Medicare rules
  - Data Analysis: OIG Toolkit[1]
  - Mock RADV audit
  - Provider ICD-10 training

1. Source: https://oig.hhs.gov/oas/reports/region7/72301213.asp#:~:text=What%20Is%20the%20Toolkit%3F,provide%20better%20care%20for%20enrollees

TOOLKIT

To Help Decrease Improper Payments in Medicare Advantage Through the Identification of High-Risk Diagnosis Codes

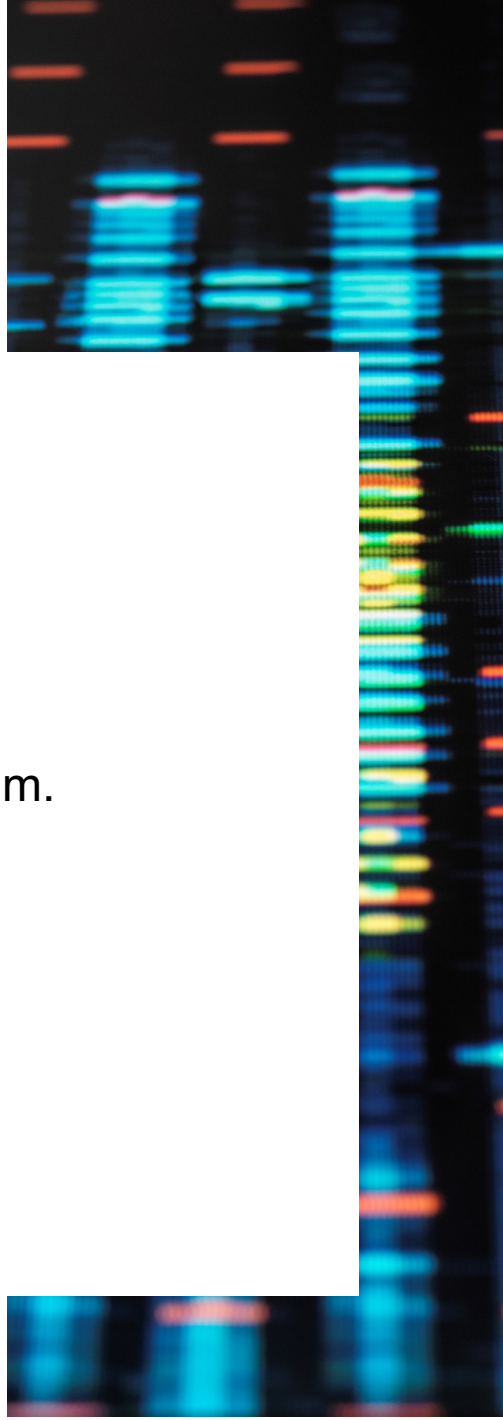
December 2023 | A-07-23-01213

Figure: Errors in High-Risk Groups as of November 2023

High-Risk Group	Total	Errors	Error %
Acute stroke	945	908	96%
Acute heart attack	791	751	95%
Embolism	754	593	79%
Lung cancer	391	345	88%
Breast cancer	390	373	96%
Colon cancer	390	368	94%
Prostate cancer	360	322	89%
Potentially mis-keyed diagnosis codes	522	421	81%
Totals	**4,543**	**4,081**	**90%**

Documentation and Coding Guidance

- **Health Risk Assessment**
  - All chronic conditions must be assessed and reported no less than once a year.
  - All conditions should be documented in the medical record.
  - Provider should document and code to the highest level of specificity.
  - Medical record must support ICD-10-CM codes reported on the encounter form or claim.

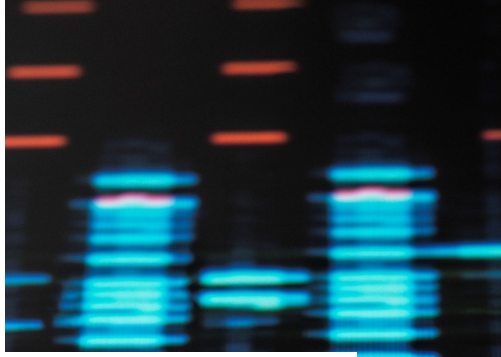


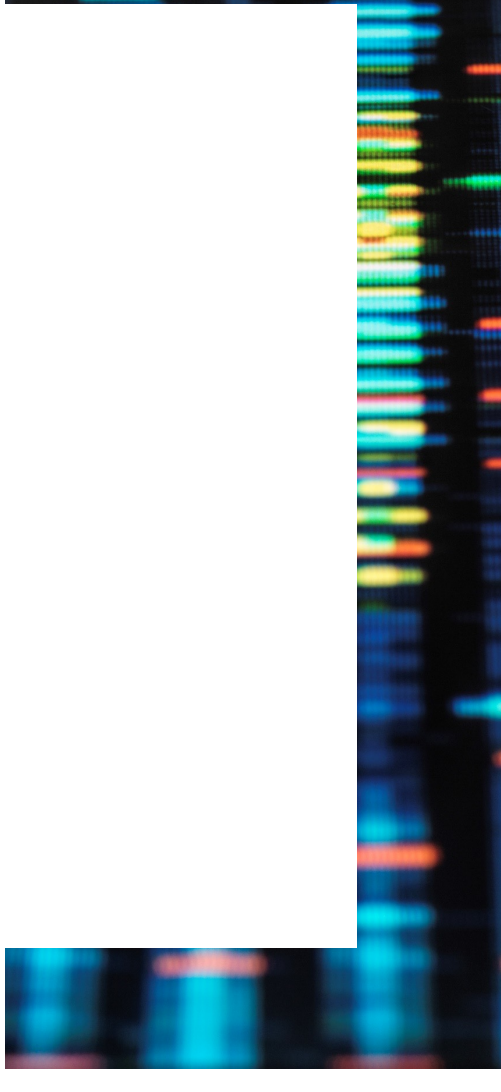
Health Risk Assessment

Affordable Care Act Section 4103(b)[1] states that an HRA is to be completed before, or as part of, an annual wellness visit with a health professional who may be a physician, medical practitioner, medical professional (e.g., health educator, registered dietician, nutrition professional) or a team of medical professionals. The law specifies that the HRA:

1) must identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of an individual (Element 1)
2) may be furnished through an interactive telephonic or web-based program (Element 2)
3) may be offered during the encounter with a health care professional or through community-based prevention programs (Element 3)
4) may be provided through any other means appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of beneficiaries (Element 4)

Source: CDC Interim Guidance for Health Risk Assessments and their Modes of Provision for Medicare Beneficiaries
https://www.cms.gov/files/document/healthriskassessmentscdcfinalpdf

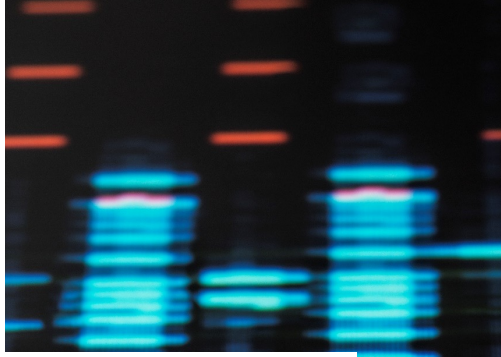




HCC Documentation Requirements

- Patient name and date of service must appear on all pages of the record.
- Encounter must be based on a face-to-face visit.
- Condition(s) must be documented in the medical record and be clear, concise, consistent, complete and legible.
- Acceptable provider's signature, credentials and date of authentication must be appended.

ICD-10 Documentation and Coding Guidance



- **ICD-10-CM and CMS Manual Guidance**
  - Chronic diseases can continue to be reported on an on-going basis as long as receiving treatment and care for the condition.
  - Diagnoses that receive care and management during the encounter can be reported.
  - Diagnoses that have resolved or are no longer treated should not be listed.
  - Malignancy can be reported as long as receiving active treatment.
  - Be careful using problem list diagnoses that have been resolved.
  - Do not code conditions that were previously treated and no longer exist.
  - History codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Questions?

Image Source: Shutterstock

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About Foley

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About PYA

For 40 years, PYA, a national professional services firm providing healthcare management consulting and accounting, has helped its clients navigate regulatory compliance. PYA's suite of compliance services includes developing and evaluating compliance programs and performing risk assessments, serving as an Independent Review Organization, supporting providers undergoing investigations/payer audits, advising on reimbursement and revenue management, and providing fair market value compensation opinions. Serving clients in all 50 states from offices in seven cities, PYA is consistently ranked by Modern Healthcare as one of the Top 20 healthcare consulting firms in the U.S. and by INSIDE Public Accounting as one of the nation's “Top 100” Largest Accounting Firms.

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