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White Paper

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Compliance in Medicare Advantage Risk Adjustment

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Introduction

The Balanced Budget Act of 1997 established the Part C program for Medicare, known then as Medicare+Choice. Since the 1970s Medicare beneficiaries have the option to choose to receive medical care through this program as an alternative to the traditional Medicare Parts A & B. In 2003 the Medicare Modernization Act renamed it "Medicare Advantage" (MA). The CMS (Centers for Medicare and Medicaid Services) administers risk adjusted payments to MA organizations using the CMS-HCC (Hierarchical Condition Category) risk adjustment model and patient demographics.

The CMS HCC Model calculates and ranks the ICD-10-CM (*International Classification of Diseases, (ICD) Clinical Modification*) diagnosis found in the CMS-HCC model into categories that represent conditions with similar cost patterns (different diagnosis same HCC). The more HCC categories submitted per patient predict higher healthcare cost, resulting in higher risk scores and higher payments, generally. The patient's risk score is used to adjust capitated payments for those patients enrolled in a MA plan. Patient's risk scores vary. This allows CMS to reimburse the MA plan based on the marginal cost of care for each individual patient.

The biggest contributor to the risk score is the patient's HCC diagnosis. It is vital that the capture or submission of these conditions to CMS is accurate and the medical documentation backs up the treatment or management of these conditions. Plans submitting HCC conditions that overstate the disease burden of the patient, result in the receipt of inappropriate reimbursement. Risk scores triggered nearly $70 billion in "improper" payments to MA plans from 2008-2013 according to government estimates.

Purpose

The MA program relies on accurate risk adjustment diagnosis data or ICD-10-CM codes to ensure payments made to the MA organization reflect the true healthcare risk of its beneficiaries. CMS audits this data to ensure the accuracy of the payments made to the organization.

The purpose of this white paper is to assist Medicare Advantage Plans participating in Medicare Parts C & D in understanding the compliance requirements outlined in the Federal Register and the Medicare Managed Care Manual and to provide alternative solutions to help organizations remain or become more compliant.

Background

In order to qualify as a MA organization under CMS, the organization must enter into a contract with CMS. There are many conditions the organization must meet in order to enter into a contract with CMS. This whitepaper will discuss the Federal regulations at 42 C.F.R. §§422.503 and 423.504 found in the Federal Register and specify the requirements for Medicare Advantage Plans to implement an effective Compliance Program. The guidelines correlate with Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

In 2012 CMS implemented what is known as the RADV (Risk Adjustment Data Validation) audit. CMS performs this audit to determine if the HCC risk adjustment code(s) the plan submitted to CMS for payment are supported in the beneficiary's medical record, or encounter. The goal is to identify and recover improper payments and to estimate the national MA improper payment rate.

- CMS selects thirty MA contracts for each RADV cycle
- CMS target criteria for RADV include:
    - Problematic past data findings
    - Plans with significant increase in risk scores
- CMS validates the beneficiary has at least one diagnosis code that resulted in the assignment of an HCC for that payment year and the HCC condition is supported in documentation
- CMS RADV audit is a mandatory requirement for MA health plans
- CMS may impose a financial penalty on findings

The Federal Register and the Office of Inspector General are just a few of the agencies interested in the compliance obligations and fraudulent billing in the MA plan. Diagnosis coding and documentation requirements are the resources used to support their investigations. MA Plan coders, clinicians and management are responsible to comply with regulatory requirements.

Compliance Requirements

The Federal Register:

MA organizations are responsible for establishing and executing an effective compliance program according to the CMS regulations and program guidelines. In the Federal Register under 422.503 General provisions(b) (vi) states the organization must "*Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum, include the following core requirements (a) Written policies and procedures, and standards of conduct that-*"

1. Articulate the organization's commitment to comply with all applicable Federal and State Standards;
2. Describe compliance expectations as embodied in the standards of conduct;

3. Implement the operation of the compliance program;
4. Provide guidance to employees and others on dealing with compliance issues;
5. Identify how to communicate compliance issues to appropriate personnel;
6. Describe how potential compliance issues are investigated and resolved by the organization; and
7. Include policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

- **Federal Register expands on the need to have internal and external auditing and monitoring systems in place**

  "*The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MA organization, including **first tier entities'**, compliance with CMS requirements and the overall effectiveness of the compliance program"*

  First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with a MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. (See, 42 C.F.R. § 423.501).

- **Procedures for responding to compliance issues**

  "Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements."

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual ("IOM"), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9

https://www.federalregister.gov/documents/search?conditions%5Bterm%5D=42+C.F.R.+%C2%A7%C2%A7422.503+

Medicare Managed Care Manual:

The Medicare Managed Care Manual outlines compliance guidelines using Chapter 42 of the Code of Federal Regulations, Parts 422 and 423. This chapter is designed to assist organizations to establish and maintain an effective compliance program. CMS requires Medicare Advantage Plans to implement an effective compliance program that prevents noncompliance, detects noncompliance and corrects noncompliance in the same way as the Federal Register articulates.

CMS, in their compliance training program as outlined in the Medicare Managed Care Manual requires a compliance program to include at the minimum, 7 core elements:

1. Written Policies, Procedures and Standards of Conduct;
2. Compliance Officer, Compliance Committee and High-Level Oversight;
3. Effective Training and Education;
4. Effective Lines of Communication;

5. Well Publicized Disciplinary Standards;
6. Effective System for Routine Monitoring and Identification of Compliance Risks; and
7. Procedures and System for Prompt Response to Compliance

Chapter 7 of the Medicare Managed Care Manual provides a high-level Risk Adjustment Data Submission checklist:

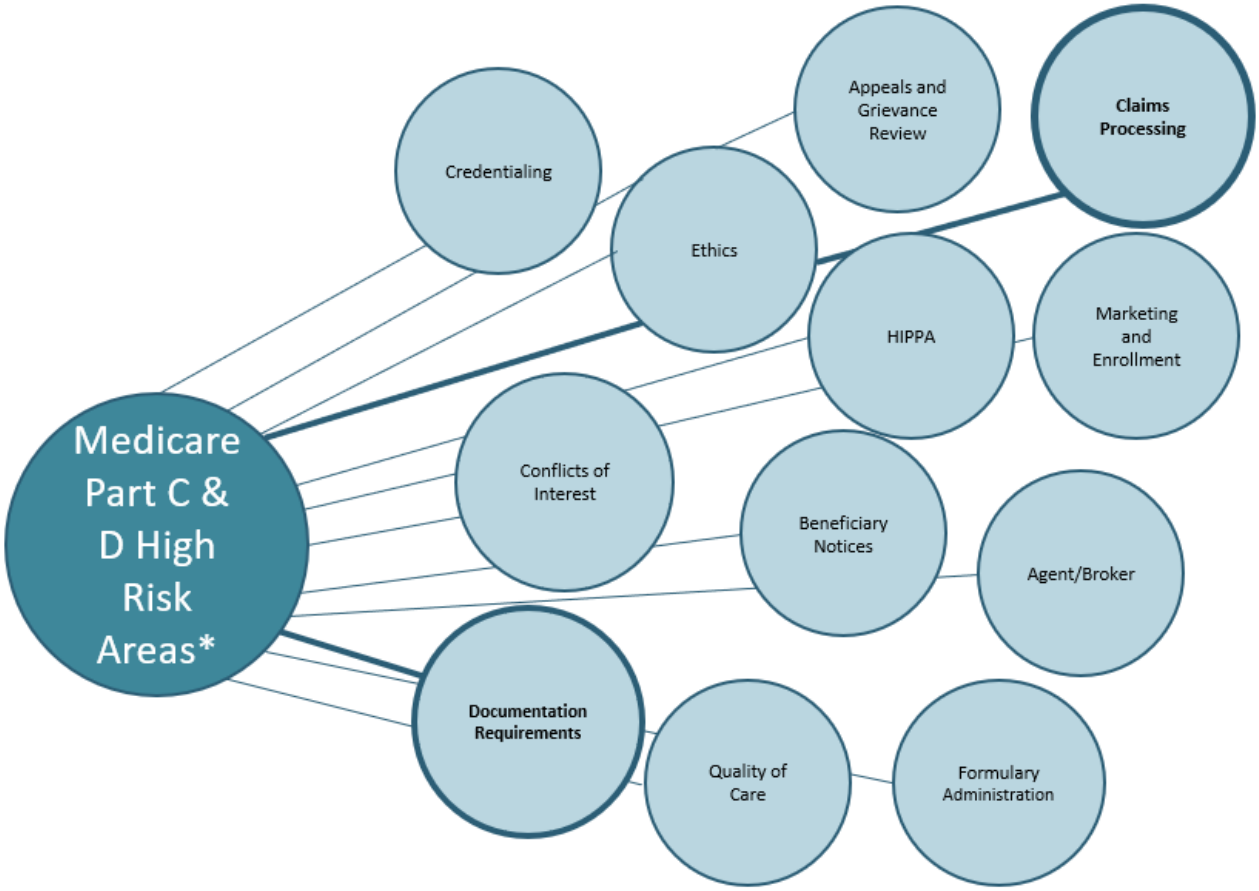
- **Ensure the accuracy and integrity of risk adjustment data submitted to CMS**. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*.
- **Implement procedures** to ensure that diagnoses are from acceptable data sources. The only acceptable data sources are hospital inpatient facilities, hospital outpatient facilities, and physicians. Plan sponsors are responsible for determining provider type based on the source of the data. (CMS has established rules regarding which inpatient and outpatient facilities, and which professional encounters, are acceptable for risk adjustment)
- Submit the required data elements from acceptable data sources **according to the coding guidelines.**
- Submit all required diagnosis codes for each beneficiary and submit unique diagnoses **at least once during the risk adjustment data-reporting period**. Submitters must filter diagnosis data to eliminate the submission of duplicate diagnosis clusters.
    - For Part B-only beneficiaries enrolled in a plan, the plan sponsor must submit diagnosis codes under the same rules as for a beneficiary with both Parts A and B. The plan should also submit diagnosis codes for Part A services provided under a non-Medicare contract.

If upon conducting an internal review of submitted diagnosis codes, the plan sponsor determines that any diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible.

- Receive and reconcile CMS Risk Adjustment Reports in a timely manner. Plan sponsors must track their submission and **deletion of diagnosis codes on an ongoing basis**.
    - The Affordable Care Act (ACA) requires MA organizations to report and return any overpayment that they have identified within 60 days. Failure to return an overpayment within this timeframe can lead to False Claims Act liability.
- Once CMS calculates the final risk scores for a payment year, plan sponsors may request a recalculation of payment upon discovering the submission of inaccurate diagnosis codes that CMS used to calculate a final risk score for a previous payment year and that had an impact on the final payment. **Plan sponsors must inform CMS immediately upon such a finding.**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R118MCM.pdf

Noncompliance is any conduct that does not conform to the law, to the Federal health care program requirements, or to an organization's ethical and business policies.



*For more information, see the Medicare Managed Care Manual and the Medicare Prescription Drug Benefit Manual

Medicare Advantage Compliance Program Effectiveness Self-Assessment Questionnaire

The Medicare Advantage Compliance Self-Assessment questionnaire includes 78 questions relating to various elements of the effective compliance program. This questionnaire is used by organizations to evaluate the effectiveness of their compliance program. MA organizations must ensure structures and procedures are in place that successfully implement all required elements of a compliance program.

https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/Compliance-Program-Effectiveness-Self-Assessment-Questionnaire.pdf

Actions that Support Compliance in the MA Organization

Coding compliance is essential to the MA organizations. Organizations should ensure that their coding professionals are certified and have relevant experience in risk adjustment coding.

MA organizations should have policies and procedures that outline their compliance activity from point of service to claim generation. Policies should identify the encounter and medical documentation for review. The procedures and policies should be reviewed for effectiveness and accuracy at least yearly.

Establishing a coding compliance focus and goals:

Organizations should adopt a standard method to measure coding accuracy. An audit will serve as a baseline indicator. A baseline audit will ensure your organization is compliant in coding and documentation supports the HCC risk adjustment codes submitted to CMS. Baseline audits help to identify the root cause of errors and identify your organization's strengths and weaknesses of coders and clinicians. Once a baseline is achieved you can use this as a measuring stick for improvement in compliance.

- **Baseline Audit for Coders**
  The audit of your coders should be performed by a seasoned coding manager, lead coder or compliance department. The individual performing the internal audit should be a certified coder with significant experience in risk adjustment coding policies and guidelines. (Remember, Fee-for-Service coders are not the same as risk adjustment coders.) If your organization does not have a person qualified to perform these audits, consider engaging a consultant and/or company with expertise in risk adjustment auditing. It is recommended by the OIG (Office of Inspector General) that a coder maintain a 95% or better accuracy rate. Perform a baseline audit of your coders and continue to audit at least yearly using a random sample of records they have audited.

- **Baseline Audit for Clinicians**
  Begin with a baseline audit. Decide on the number of encounters and time frame as well as an expected accuracy rate.
  Example: 10 encounters per clinician, per quarter. Clinicians not reaching 95% accuracy will be audited every quarter until the desired accuracy rate is reached. Communicate specific audit results to the clinicians and work with coders or risk adjustment trainers to help educate these providers on correct documentation and coding. From this baseline audit result you will learn valuable information and can develop targeted trainings and education.
    - Most commonly under documented conditions
    - Most commonly over coded conditions

- **Focus Audit for Specific HCC Condition**
  The results of the clinician baseline audit may indicate the need for a focus audit. When tracking and trending the result of a completed baseline audit for your organization you may have identified a significant error rate for a specific diagnosis.
    - Example 75% of the clinicians have inappropriately submitted the diagnosis of cancer. This may be a flag to your compliance officer who may recommend that your coding team perform an audit only on cancer.

Clinicians should consider coder feedback and organizations should use the results of audits for targeted training and education. qrcAnalytics coding software allows coders to flag instances where diagnoses are not supported in encounter documentation and flag encounters when diagnoses aren't submitted but documentation indicates the patient likely has the condition. Upon completion of the audit qrcAnalytics can identify specific clinicians that under-document and/or specific conditions that are most frequently under-documented. qrcAnalytics also has the capability to extract encounters for a specific year and a specific HCC as required for the focus audit. Utilizing this type of software and feedback ensures that clinicians are encouraged to document, and code accurately.

Audit definitions:

Baseline audits: An audit looking only at the randomly selected encounter to validate that this encounter only has supporting documentation for the HCC diagnoses that was submitted under this encounter or claim. This audit does NOT necessarily indicate a refund as this HCC may have been validated on a different claim during the same calendar year.

Focus audit: An audit of a specific diagnosis or HCC captured or submitted for a specific patient during the entire calendar year. A failed focus audit result is an indication of a refund as the entire year of encounters will be audited, unlike a baseline audit.

Who can help your organization design and implement a compliant risk adjustment auditing, training and education program?	qrcAnalytics has the experience and know-how to assist your organization in developing a compliant, effective and efficient risk adjustment program. We pride ourselves on our ability to translate complicated and sometimes confusing rules and regulations into practical straightforward strategies.
Who are the qrcAnalytics subject matter experts?	Our integrated delivery team includes experienced certified auditors and trainers, a regulatory subject matter expert specialist, data analysts, process improvement professionals, and IT specialists in medical informatics.
What specific compliance services does qrcAnalytics provide?	Our services include: MA Plan development ROI analysis Gap analysis Clinicians & coder training Workflow design Coding & auditing tools Supportive technologies Coding processes Compliance reviews Training plans And more …

qrcAnalytics is a niche healthcare IT company laser focused on assisting provider organizations with finding the strategic value in their ambulatory clinical data. We are acutely aware that healthcare reform has made basic compliance confusing and sustainability challenging. We have built our business assisting provider organizations with optimizing incentive and capitation payments, minimizing penalties, and assuring compliance through leveraging our extensive experience with CMS quality programs.

A Healthcare Analytics Company |*Bringing Clarity to the Complexity of Quality, Risk and Cost*

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