Session 25, More Risk Score! Running a Compliant Medicare-Advantage Risk Adjustment Program That is Also Profitable

More Risk Score! Running a Compliant Medicare-Advantage Risk Adjustment Program That is Also Profitable

Presented by: Richard N. Lieberman

2019 SOA Health Meeting

Phoenix, AZ

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Relevant Bio for Richard Lieberman

- Actively involved in the development of risk adjustment systems for 25 years
  - Johns Hopkins ACG Development Team, 1991-2005
  - Implemented the risk-adjusted payment system for Maryland Medicaid
  - Designed the clinical model for the first-to-market revenue management “suspecting” engine
- Developer of integrated decision-support platforms coalescing quality measurement, risk adjustment, and population health metrics
- Disseminator of risk adjustment and quality measurement technology and intellectual property to health plans, services vendors, and consultants
- Frequently engaged by Medicare-Advantage Organizations, and ACOs and payers engaged in shared savings arrangements

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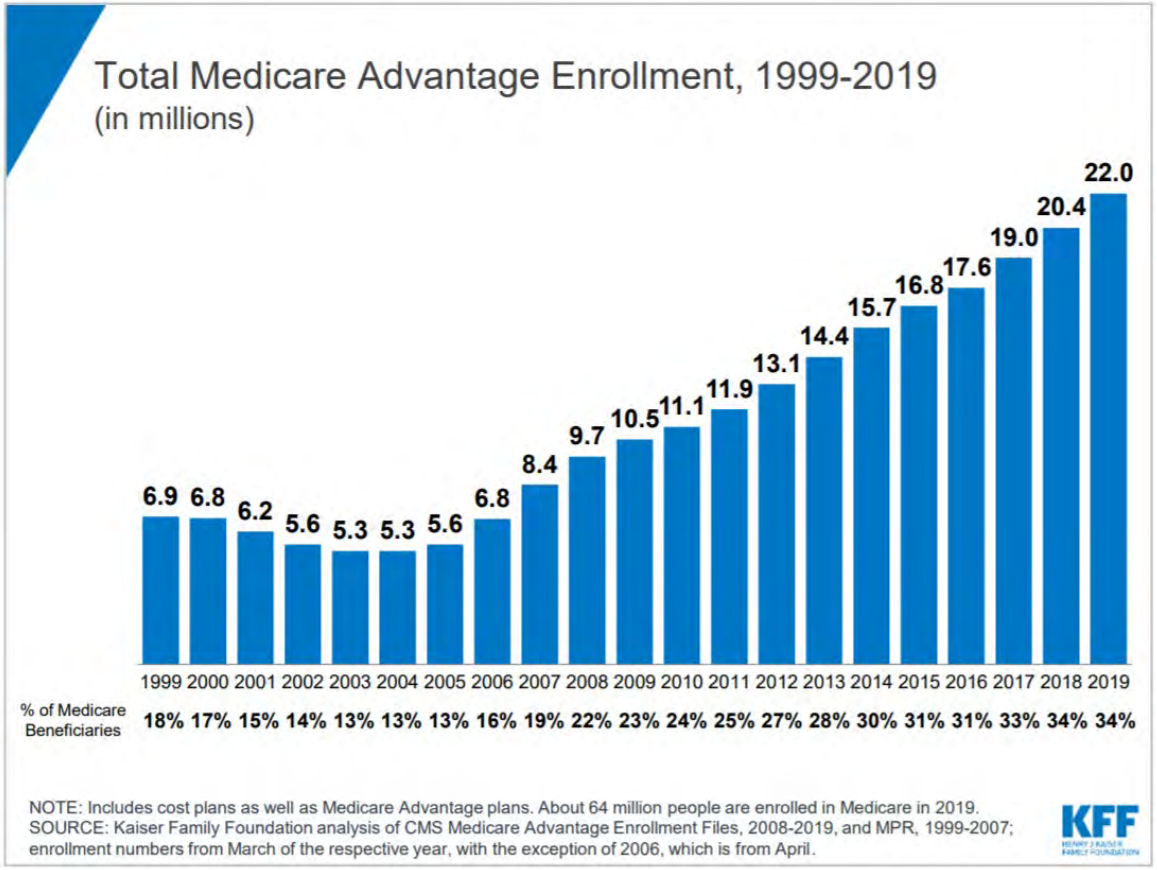
Enrollment in Medicare Advantage has Nearly Doubled Over the Past Decade



- In 2019, one-third (34%) of all Medicare beneficiaries – 22 million people – are enrolled in Medicare Advantage plans, similar to the rate in 2017 and 2018.
- Between 2018 and 2019, total Medicare Advantage enrollment grew by about 1.6 million beneficiaries, or 8 percent – nearly the same growth rate as the prior year.
- The Congressional Budget Office (CBO) projects that the share of beneficiaries enrolled in Medicare Advantage plans will rise to about 47 percent by 2029.

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What Is Changing in the Healthcare Financing and Delivery System

- The composition of the Medicare population is changing
- Value-based payments
- The increasing prevalence of multimorbidity
- CMS is pushing hard to implement interoperability requirements
- EMRs are ubiquitous but remain challenging
- Both CMS and DOJ are ramping up their oversight of perceived risk adjustment overpayments
- The ongoing and likely to be perpetual, political tug-o-war around healthcare reform

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Risk adjustment is Increasingly Prevalent in Value-Based Payments

- CMS recently began to increase pressure on Track 1 MSSP groups
  - “Pathways to Success” now requires taking downside risk after 1-2 years
    - Previously, ACOs could limit their participation to upside risk only for up to 6 years
- Risk adjustment is no longer a constant in MSSP
  - ACO groups now can increase CMS-HCC risk scores by up to 3 percent
- Private ACO initiatives
  - Risk adjustment is far more opaque in private VBP initiatives
  - Payers rarely know how to implement risk adjustment correctly
- Why is this relevant to Medicare-Advantage risk adjustment?

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To Be Or Not to Be, That is the RADV

- If CMS has been thinking all of these years that an effective RADV program would change the behavior of Medicare-Advantage Organizations, perhaps they should have implemented one!
- Well, they say they're serious this time! There are proposed regulations for which the comment period ends on August 31, 2019. Will they finalize them? And if so, when?
  - To establish that CMS would use extrapolation in RADV contract-level audits and that the extrapolation authority would apply to the payment year 2011 contract-level audits and all subsequent audits.
  - Not to apply a fee-for-service (FFS) Adjuster to audit findings

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Life expectancy at age 65 by Race/Ethnicity and Sex 2007 to 2016

- The oft-reported decreases in life expectancy have occurred primarily in the under-65 population
  - Largely the result of the opioid epidemic and the increase in intentional and unintentional injuries
- But life expectancy at age 65 continues to increase across all race, ethnicity, and sex cohorts.

	2007	2015	2016	Change 2007–2016	Change 2015–2016
All races and ethnicities, both sexes	18.8	19.3	19.4	0.6	0.1
White, not Hispanic, both sexes	18.8	19.3	19.3	0.5	0
African American, not Hispanic, both sexes	17.2	18.1	18.0	0.8	–0.1
Hispanic, both sexes	20.5	21.4	21.4	0.9	0
All races and ethnicities, female	20.0	20.5	20.6	0.6	0.1
White, not Hispanic, female	20.0	20.4	20.5	0.5	0.1
African American, not Hispanic, female	18.7	19.5	19.5	0.8	0
Hispanic, female	21.7	22.6	22.7	1.0	0.1
All races and ethnicities, male	17.4	18.0	18.0	0.6	0
White, not Hispanic, male	17.4	18.0	18.0	0.6	0
African American, not Hispanic, male	15.3	16.2	16.2	0.9	0
Hispanic, male	18.7	19.7	19.7	1.0	0

Source: National Center for Health Statistics 2018.

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The Changing Composition of Medicare Beneficiaries

- As the baby-boom generation ages, enrollment in the Medicare program will surge.
- In 15 years, Medicare is projected to have more than 80 million beneficiaries—up from 57 million beneficiaries today—almost 90 percent of whom will be of the baby-boom generation

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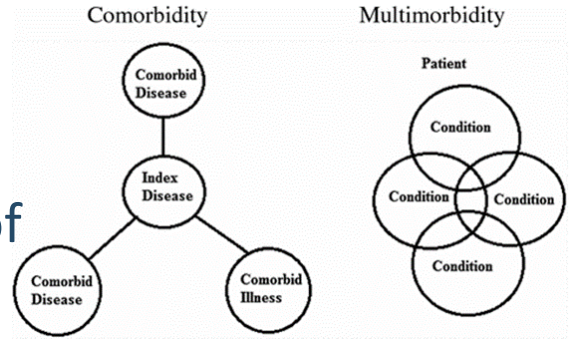
Increasing Prevalence of Multimorbidity

- What is multimorbidity?
  - Multimorbidity is defined by the presence of two or more long-term conditions (LTCs), which are those that cannot currently be cured but can be controlled through the use of medications or other treatments.[1]
  - A considerable overlap exists between frailty and multimorbidity.
- Life expectancy continues to increase, concomitantly increasing the number of people managing multiple chronic conditions
- Patients with multimorbidity:
  - Cost more to manage
  - Will benefit from primary care practice transformation efforts
  - Are precisely the patients that a risk-adjusted provider group needs to be paid accurately for



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EMRs are Ubiquitous but Remain Challenging

- “Many of the benefits of EHRs have been elusive. As implemented today, EHRs have too many of the drawbacks of paper records. The promise of being able to send them easily from one office to the next has been hampered by a lack of standards and perverse incentives in the health care marketplace to hoard information.”
- But there is hope!
  - The amount of training physicians get in their EMRs has a big impact on their own levels of satisfaction
    - Colorado Health
    - Northshore University Health System

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Why Does This Matter?

- Physician workload keeps increasing
- The clinical complexity of an increasing subset of the Medicare population is increasing
- There is broad consensus in the policy community that the Medicare Physician Fee Schedule currently pays relatively too much for tests and procedures and too little for evaluation and management services—including cognitive work performed by specialists in their office-based practices.
- Physician have always been prone to making diagnostic errors. That is likely to increase.
    - "In one classic study patients were allowed to finish their "opening statement of concerns" in only 23 percent of doctors' visits, and in another patients spoke for an average of only twelve seconds before being interrupted by resident physicians."

Source: Berenson, R., & Singh, H. (2018). Payment Innovations To Improve Diagnostic Accuracy And Reduce Diagnostic Error. *Health Aff (Millwood), 37*(11), 1828-1835. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/30395510. doi:10.1377/hlthaff.2018.0714

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The Push to Achieve Interoperability of Medical Records

- CMS is pushing hard to implement interoperability requirements
  - Several notices of proposed rule making will be finalized this year
  - New rules (if finalized as proposed) will apply to EMR vendors, Medicare-Advantage plans, Medicaid managed care organizations, health information exchanges, etc.
- Patients will have the right to authorize the transfer of their health information and details of medical care to other providers.
- The “doctor’s notes” are no longer just the “doctor’s notes”

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Wait, Which Is It?

- Are Medicare-Advantage Risk Scores Too High?
  - MedPAC thinks so:
    - “However, for several years, the Commission has expressed concern that enrollees in MA plans have higher risk scores than similar beneficiaries in FFS because of plans’ more intensive coding practices. Those higher risk scores inflate Medicare’s payments to plans by about 1 to 2 percent. The Commission previously recommended that CMS reduce excess payments stemming from plans’ intensive coding practices, which would improve equity across plans and produce savings for Medicare.”
  - We all need a bit of contradiction now and then:
    - Higher risk scores result in higher rebate amounts, resulting in more benefits or reduced financial exposure for Medicare beneficiaries

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CMS and DOJ are Ramping Up their "Oversight" of Perceived Risk Adjustment Overpayments

- Sutter Health in California has agreed to pay $30 million to resolve allegations that it and its affiliates inflated the severity of illness of Medicare Advantage patients to get higher risk scores and the resulting increase in financial benefits.
  - A related qui tam (whistleblower) complaint is still pending
- In October 2018, HealthCare Partners Holdings LLC, doing business as DaVita Medical Holdings LLC (DaVita), agreed to pay $270 million to resolve its False Claims Act liability for providing inaccurate information that caused Medicare Advantage Plans to receive inflated Medicare payments.
  - The whistle blower received a $10.2 million reward
- Another whistleblower complaint, United States ex rel. Benjamin Poehling v. UnitedHealth Group, Inc. et al., is scheduled to go to trial in 2020.

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What the Government Sees as Risk Adjustment Fraud is Evolving

- "the Government seeks to determine if Anthem knowingly disregarded its obligation to vet the validity of provider-submitted diagnosis codes "that were unsupported by the "retrospective review" and correct or withdraw the invalid codes" [8/1/2018 US Attorney Civil Information Demand Letter to Anthem, Inc.
- "…recognizing that FCA liability arises based on a Part C plan sponsor's failure to correct and withdraw the provider-submitted diagnosis codes that were unsupported by the retrospective reviews [U.S. v. Swoben, 848 F.3d 1161,] 1173-74 [9th Cir. 2016]

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What May (or May Not) Happen

- For the 2011, 2012, and 2013 contract years, CMS audited 30 contracts per payment year
  - 90 contracts in all
- Roughly half the contracts each year had no net findings of improper payments.
- The audits for payment years 2011, 2012, and 2013 suggest that audited MA contracts received $650 million in of improper payments in those 3 years
- The fully extrapolated payment recovery would average about $14-15 million per contract with any improper payments detected

THE LADIES' HOME JOURNAL

WHAT MAY HAPPEN IN THE NEXT HUNDRED YEARS

By JOHN ELFRETH WATKINS, JR.

HESE prophecies will seem strange, almost impossible. Yet they have come from the most learned and conservative minds in America. To the wisest and most careful men in our greatest institutions of science and learning I have gone, asking each in his turn to forecast for me what, in his opinion, will have been wrought in his own field of investigation before the dawn of 2001—a century from now. These opinions I have carefully transcribed.

Trains One Hundred and Fifty Miles an Hour. Trains will run two miles a minute, normally; express trains one hundred and fifty miles an hour. To go from New York to San Francisco will take a day and a night by fast express. There will be cigar-shaped electric locomotives hauling long trains of cars. Cars will, like houses, be artificially cooled. Along the railroads there will be no smoke, no cinders, because coal will neither be carried nor burned. There will be no stops for water. Passengers will travel through hot or dusty country regions with windows down.

Automobiles will be Cheaper than Horses are to-day.

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Compliantly Finding More Patients with HCCs

- There is increasing evidence from the literature that patient registries will yield more patients with chronic conditions than just looking at historical incidence of HCCs.
- From the risk adjustment researchers at the Bloomberg School of Public Health:
  - Laboratory tests that are frequently ordered by physicians in outpatient practices contain valuable data for individual risk assessment.
  - Ranges of blood chemistries and hematology results define a set of model markers that have clinical face validity and potential utility for care management.
  - Adding the laboratory-based markers to risk levels derived from claims, prescriptions, and enrollment data improves the prediction of individual cost, the prediction of inpatient admission, and the prospective identification of high-cost patients.
  - For practices, a simple model that includes demographics and laboratory information may provide a basic tool to evaluate patient panels.

Source: Klaus W. Lemke, P., Kimberly A. Gudzune, M. M., Hadi Kharrazi, M., PhD, MHI, & Jonathan P. Weiner, D. (2018). Assessing Markers From Ambulatory Laboratory Tests for Predicting High-Risk Patients. *Am J Manag Care, 24*(6), e190-e195.

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Rely on Rx Risk Adjustment for Case Finding

- Using the various Rx risk adjustment systems can be a good way to identify members with comorbidities that have not been adequately documented.

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One Choice: The Johns Hopkins ACG System

The ACG System has over 80 “pharmacy morbidity categories, derived from NDC codes:

- ALLx050 Allergy/Immunology / Transplant
- CARx060 Cardiovascular / Arrhythmia
- CARx080 Cardiovascular / Ischemic heart disease
- ENDx030 Endocrine/Metabolic / Diabetes with insulin
- ENDx040 Endocrine/Metabolic / Diabetes without insulin
- GASx012 Gastrointestinal/Hepatic / Irritable bowel syndrome
- GASx022 Gastrointestinal/Hepatic / Chronic hepatitis
- GASx050 Gastrointestinal/Hepatic / Pancreatic disorder
- HEMx010 Hematologic / Coagulation disorders
- INFx030 Infections / HIV/AIDS
- INFx030 Infections / HIV/AIDS
- MALx011 Malignancies / Moderate impact
- MALx012 Malignancies / High impact
- NURx010 Neurologic / Dementia
- NURx040 Neurologic / Movement disorder
- NURx050 Neurologic / Seizure disorder
- NURx060 Neurologic / Multiple sclerosis
- PSYx040 Psychiatric/Behavioral / Depression
- PSYx060 Psychiatric/Behavioral / Chronic major
- RENx020 Renal / Chronic kidney disease
- RESx020 Respiratory / Chronic obstructive pulmonary disease

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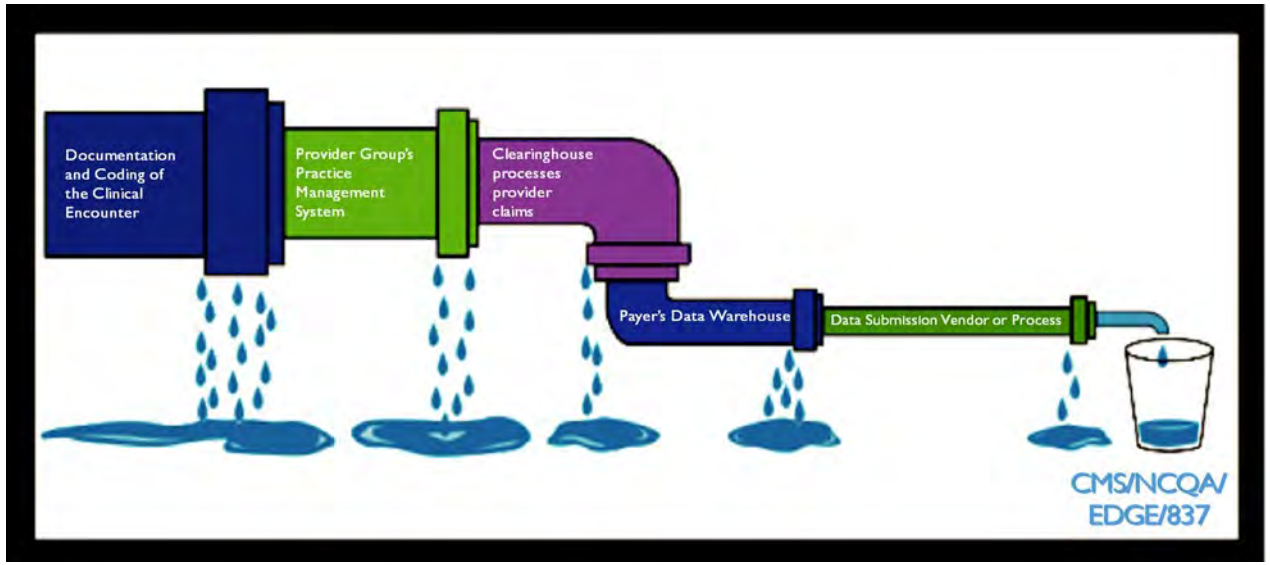
Data Loss Occurs Throughout the Pipeline

- Clearinghouse and/or practice management software
  - Is it compliant with HIPAA Transaction Standards?
- Are groups using the correct version of the CMS-1500 claim form?
- Some payers are not even HIPAA compliant!



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Tracking Risk Scores Along the Data Pipeline

Figure 1: Comparing Risk Scores: RAPS vs. EDPS at Varying Points Along the Data Pipeline

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Encouraging Clinician Buy-In: Distinguishing Between Upcoding and Right-Coding

Upcoding

- Means reporting a higher-level service or procedure or a more complex diagnosis, than is supported by medical necessity, medical facts, or the provider's documentation. Providers who upcode are violating documentation and coding compliance standards and may be engaging in fraud,

Right-coding

- The coding of all documented conditions, which coexist at the time of the visit that require or affect patient care or treatment. For accurate reporting of ICD-10-CM diagnosis codes, right-coded documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. Right-coding compliance standards should be encouraged of all clinicians and coders!

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Providing Feedback to Clinicians

- Feedback will be most effective when provided from a source that is a supervisor or senior colleague
- Is delivered at least monthly
- Is delivered in both a verbal and written format
- Offers instructions with 'both explicit goals and a specific action plan

Source: Ivers N, Jamtvedt G, Flottorp S, Young JM, Odgaard-Jensen J, French SD, O'Brien MA, Johansen M, Grimshaw J, Oxman AD. Audit and feedback: effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews 2012, Issue 6. Art. No.: CD000259. DOI: 10.1002/14651858.CD000259.pub3.

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Provider Groups and Physicians Need Performance Data

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Running a Compliant Risk Adjustment Program

- Accept and embrace “two-way” coding when performing chart reviews
- Federal law requires that MAOs have a fraud unit
  - But the MAO actually has to use the fraud unit!
  - Just having a Fraud Unit is not sufficient
- Improve clinical documentation, not just the coding.
  - Never talk about coding with physicians!
- Remember, what you do today may come back to haunt you in a decade or so (see, RADV)

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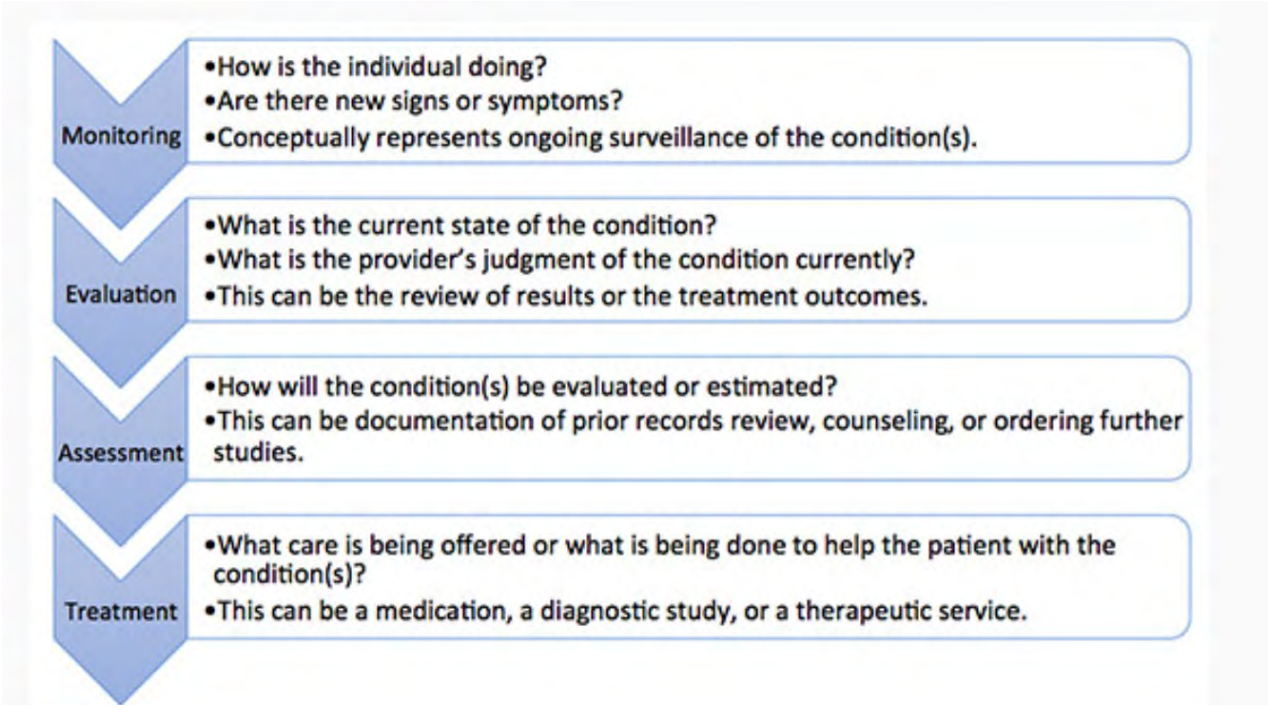
Monitor, Evaluate, Assess, Treat (MEAT)



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More Risk Score! Running a Compliant Medicare-Advantage Risk Adjustment Program That is Also Profitable

Presented by:

Richard Ferrans, MD

2019 SOA Health Meeting

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Relevant Bio for Richard Ferrans, MD ScM

- Former Medical Director for Provider Sponsored MA Plan
- Former CEO of Chicago based MSSP ACO
- Former Health System VP, Network CMO, CIO/CMIO
- Internist and Medical Informaticist
- MD Tulane, Residency GWU, Masters Health Care Management Harvard
- Consulting in Provider risk, compliance, MRA education, health system redesign for ACOs
- Co –author of “High Risk Beneficiary Identification” 2017 (NAACOS+AAMC publication)
- Founder Care Mirror: AI enabled provider performance feedback

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Core Elements of Compliance Program

1. Written Policies and 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
7. Procedures and System for Prompt Response to Compliance

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Running a Compliant Risk Adjustment Program

- Accept and embrace “two-way” coding when performing chart reviews
- Federal law requires that MAOs have a fraud unit
  - But the MAO actually has to use the fraud unit!
  - Just having a Fraud Unit is not sufficient
- Improve clinical documentation, not just the coding.
  - Coding education should revolve around SPECIFICITY without specific regards to MRA
- Remember, what you do today may come back to haunt you in a decade or so (see, RADV)

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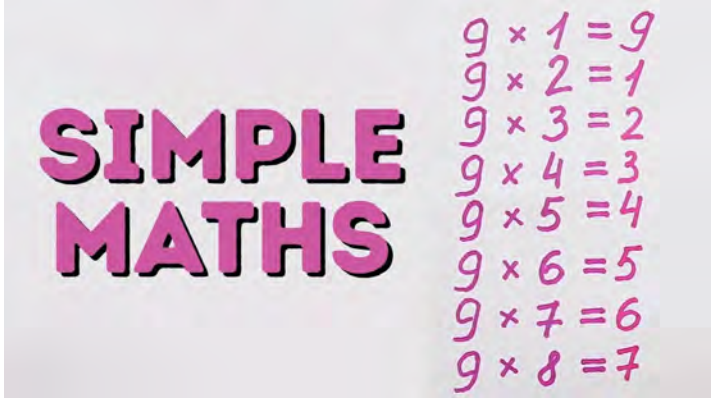
The Simple Mathematics of Compliant Risk Adjustment Improvement

- Number of opportunities identified x % acted upon= yield
- Barriers to improvement:
  - VOLUME of opportunity identification
    - Coding continuity (HIGH)
    - EMR data availability (LOW)
    - Indirect methodology (labs, Rx, other diagnostic tests) : (VARIABLE)
    - Inferential epidemiological methodology (LOW)
  - PERCENT of proactive and reactive provider action
    - Culture, Education and Motivation (LOW)
    - Workflow and Completeness of action (LOW)



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Coding Continuity

- Easy to identity
- High likelihood that is optimized
- High likelihood transmitted to providers
- The issue is response rates

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EMR Data Availability

- Increasing in frequency
- Enabled by FHIR APIs
- Hampered by distrust
  - Reciprocal claims element sharing to providers variable
  - Provider fear of information used against them to narrow network and pass judgement without transparency of methods a statistical significance
- Social determinant data high value in high risk beneficiary identification
- 3rd party infomediary concept has great potential
- Uses of data should be explicit and not limited to financial gain
- Shared governance is key to gaining provider buy in

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Indirect Methodology

- Use claims lab and other ancillaries and Pharmacy claims
- Useful sensitivity but hampered by variable specificity
- Three key opportunities
  - Use Rx orders reconciled against Pharmacy claims to identify non-adherence: solving non-adherence will achieve the Active Treatment threshold for risk adjustment.
  - Addressing non-adherence can lead to successful outcome and in cases of chronic conditions improve risk adjustment PMPM cost net increased pharmacy costs

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Indirect Methodology (cont'd)

- Economic analysis of increased screening for conditions in physicians office- select high return
  - Observed vs expected prevalence, number of screens to identify new case, claims cost of new screening tech
  - Cost of treating new case
  - Benefit of identifying case in risk adjusted payment
  - Benefit of treatment net cost of treatment

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Inferential Methodology

- Underused and conceptually powerful
- Represents true net new HCCs
- Measuring frequency in claims and EMR against well established epidemiological data
- Great potential for AI
- Example: Diabetic Gastroparesis

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Culture

- Culture is the unseen force that largely influences provider motivation to respond to queries.
- It is unappreciated and under-treated by payers
- Default= distrust of motives
- Default: “ You are making me do more work so YOU can make more money. This doesn’t benefit my patients. Or me.
- Starts at the top: lack of social interaction and personal relationships between payer and provider executives.
- In absence of interaction, provider leaders reinforce provider suspicions. That is “playing to the base. Base support keeps provider leaders in power, not contracts or titles.
- Culture reinforced by inadequate education

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Education

- Missed opportunity: Address the “why am I doing this”
    - Good for patients, my practice, my income= good.
- Lack of peer to peer education
- Too much coder focus: we miss discussing what was not written down and why
- Education by peers is best opportunity for plan to gain insight on ROOT CAUSES of poor risk score performance.

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Providing Feedback to Clinicians

- Feedback will be most effective when provided from a source that is a supervisor or senior colleague
- Is delivered at least monthly
- Is delivered in both a verbal and written format
- Offers instructions with 'both explicit goals and a specific action plan
- Is Bidirectional

Source: Ivers N, Jamtvedt G, Flottorp S, Young JM, Odgaard-Jensen J, French SD, O'Brien MA, Johansen M, Grimshaw J, Oxman AD. Audit and feedback: effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews 2012, Issue 6. Art. No.: CD000259. DOI: 10.1002/14651858.CD000259.pub3.

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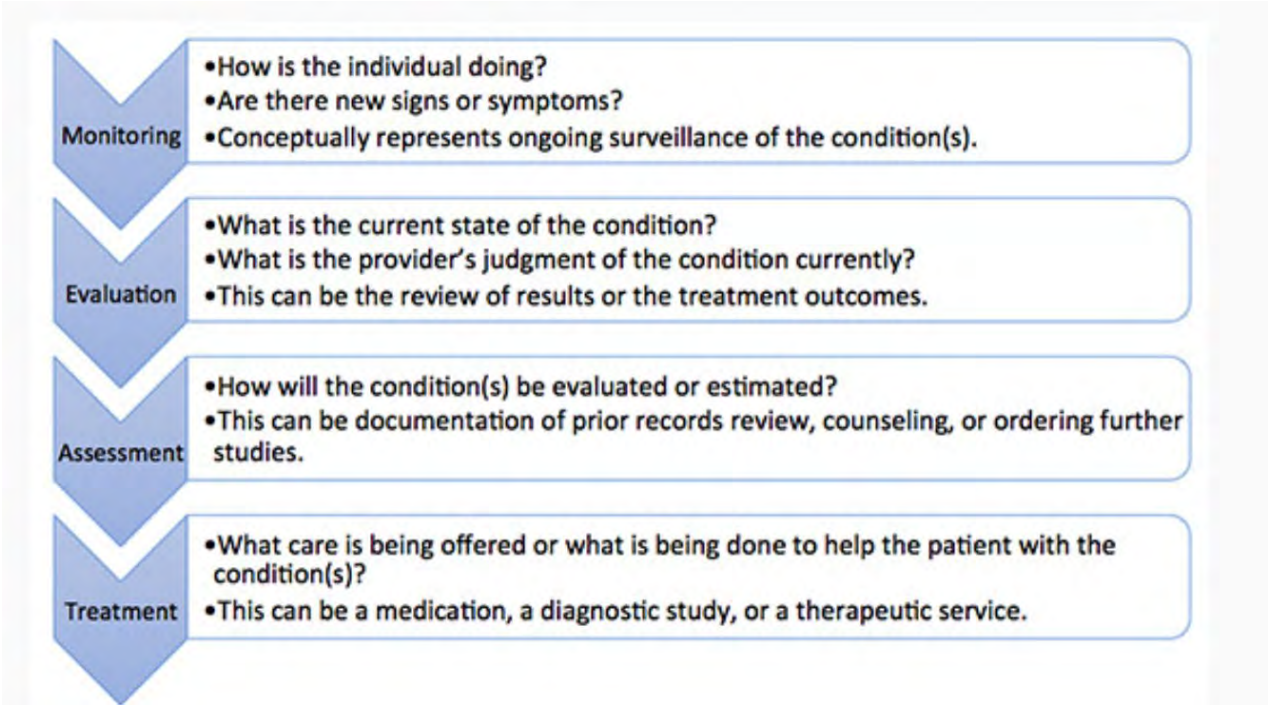

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Education (cont'd)

- Education can provide active encouragement of better documentation for improvement of scores
- Education can also provide the 2 way: actively discourage fraudulent activities.
- This balanced approach moves compliances from checkbox to culture.

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MOTIVATION: The New Calculus for Providers

- The provider burnout epidemic is driven by exponential increase in meaningless EMR tasks and a shared experience of depersonalization akin to being on a hamster-wheel.
- In this context provider performance reports and queries about UM, quality, and MRA are a few more gallons in the tsunami of “do this, do that”
- Providers are experiencing alert desensitization, task desensitization, and report desensitization because the few nuggets of gold are obscured by a torrent of mud.

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MOTIVATION: The New Calculus for Providers

- Provider employment has reduced motivation; most benefits go to the practice, not the provider.
- Providers used to say “ If it is important I will do it”
- Provider now say, “ If it is important, I will do it, but only if you remove less important task. I am maxed out.

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Motivation

- Culture: build human relationships, not just via provider relations rep.
- “The give and the get”
  - Providers will do ….
  - Payers will do…..
    - Invest in EMR customization designed to reduce tasks via automation
    - Provide integrated timely reports on quality, MRA and UM
    - Identify and address concerns especially quality of life issues
    - More than anything, address the hassle factor
  - Use professional neutral facilitators

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Workflow

- I recommend that payers literally pour money in FHIR standards, Blockchain, and other efforts and side with providers against EMR vendors to accelerate adoption of payer provider IT integration that
  - Automate and accelerate tasks (reduce staff and provider burden)
  - Reduce task complexity
  - Enhance all payer standards
- Advocate on behalf of providers. You will benefit in MRA via goodwill and more cognitive time for providers.
- Invest in EMR improvement projects that enhance quality and MRA. The two are tied together so this spend can theoretically be part of MLR if designed with that purpose in mind.

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Completeness of Action

- AI can help you identify more targeted conditions, but the real opportunity is to address completeness of action
- Summary, invest in relationship building, more relevant peer to peer education, and infrastructure and standards that reduces provider burden and provider-payer friction
- Uncertainty about ACA, provider burnout and ideological divisions in America are occurring precisely at inflection point of provider risk. Worst possible timing!! Therefore, abandon the status quo and
  - Invest in listening to provider concerns
  - Invest in helping them (we are at breaking point, not kidding)

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Compliance Strategies

- **CULTURE** and **EDUCATION** and **WORKFLOW**: The BIG 3!!
- Provide more ACTIONABLE information (especially timely)
- Make explicit RELEVANCY through TRANSPARENCY to build trust
- NARROW NETWORKS AND “FAIR PLAY”: Strike a transparent balance
- GUIDELINE ADHERENCE as legitimate tool for risk adjustment improvement
- NON_ADHERENCE and SOCIAL DETERMINANTS as rationale for gaining EMR data access

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Summary: The Importance of Culture

- Every organization has the seven elements in the provider manual for compliance
- Organizations and partnerships with the right culture will have fewer compliance issues.
- This is because of shared goals and shared values and transparency.
- Here is a cultural “rubber meets the road question for payers:

  “If you are willing to invest heavily in AI for MRA improvement , are you also willing to equally leverage that investment to prevent fraud and detect fraud?”

  - BERT Bidirectional Encoder Representations from Transformers (Google) enabled platforms are powerful enough to monitor cultures and workforce in REAL TIME for compliance. This is the future.

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