Beyond RADV

Does Your Plan's Risk Adjustment Strategy Run Afoul of the False Claims Act

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Overview of Risk Adjustment Fraud

- Risk adjustment fraud is essentially "upcoding" for diagnosis codes
  - Traditional Upcoding: doctors and hospitals, paid by the procedure, claim payment for procedures they did not truly perform, or for a more complex version of the procedure they did perform
  - Risk Adjustment Upcoding: Medicare Advantage ("MA") HMOs, paid in large part by their members' health status, claim payment for diagnoses they do not have/were not treated for

Principles of Risk Adjustment

Principles of Risk Adjustment

- CMS pays Medicare Advantage HMOs on a capitated basis
  - Per-member-per-month
- CMS recognizes, however, the risk HMOs take by agreeing to insure beneficiaries for a flat monthly fee
  - A single hospitalization costs an average of $10,000 and can wipe out the Medicare premiums the HMO received that year

Principles of Risk Adjustment

- To help HMOs manage their risk, CMS created a system that increases its premium for beneficiaries who are receiving treatment for diseases that typically correspond to high costs
  - The additional money comes in the form of an increased capitation rate:
  - Member's Capitation Rate = (The HMO's Base Capitation Rate) x (The Member's Risk Adjustment Multiplier)

Example: 76-year-old female with diabetes and renal failure

Condition	HCC	Adjustment
Female, 76		0.468
Diabetes (no complications)	19	0.162
Renal failure	131	0.368
Total		0.998

Base PMPM	Multiplier	Adjusted PMPM
$800	0.998	$798.4

Requirements for Risk Adjustment Claims

- The patient must have been treated that year
- Face-to-face
- By a qualifying provider

Requirements for Risk Adjustment Claims

- CMS has rigid requirements about how plans qualify for increased risk adjustment payments
  - The diagnosis codes must be documented in the medical record, following standard industry guidelines (ICD-9-CM)
  - The diagnosis codes must stem from a face-to-face encounter between the physician and the patient

Requirements for Risk Adjustment Claims

- To ensure these goals are met, CMS requires HMOs to follow its guidance as to what diagnosis codes they submit
  - For example: HMOs cannot submit diagnosis codes taken from certain types of medical records, such as radiology and lab reports, because the records do not reflect a face-to-face physician encounter

Risk Adjustment Fraud and the False Claims Act

Risk Adjustment and the False Claims Act

- The False Claims Act prohibits:
  a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; and
  b) knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government.

31 U.S.C. § § 3729(a)(1).

Risk Adjustment and the False Claims Act

- Any person who violates the FCA is liable for a civil penalty of up to $11,000 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. § 3729(a)(1).

Each Diagnosis Submitted to CMS is a Claim for Payment

- With every diagnosis, HMOs submit information to CMS asserting the member has the diagnosed condition and received treatment for it:
  - The member's Health Insurance Claim ("HIC") number;
  - The ICD-9-CM diagnosis code
  - The "service from" date and "service through" date
  - The provider type

Risk Adjustment and the False Claims Act

- Each risk adjustment claim is itself a false statement, if the diagnosis is unsupported
- No separate certification is required to establish falsity
- That being said . . .

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO CMS PAYMENT TO A MEDICARE+CHOICE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF M+C ORGANIZATION), hereafter referred to as the M+C Organization, governing the operation of the following Medicare +Choice plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the M+C Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the M+C Organization. The M+C Organization acknowledges that the information described below directly affects the calculation of CMS payments to the M+C Organization or additional benefit obligations of the M+C Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The M+C Organization has reported to CMS for the period of (INDICATE DATES) all (INDICATE TYPE OF DATA – *INPATIENT HOSPITAL, OUTPATIENT HOSPITAL, OR PHYSICIAN*) risk adjustment data available to the M+C Organization with respect to the above-stated M+C plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

(INDICATE TITLE [CEO, CFO, or delegate]) on behalf of

(INDIC

DATE

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Medicare Advantage HMOs must attest to the accuracy of their risk adjustment data on an annual basis.

United States v. Janke

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA Plaintiff v. WALTER JANKE, M.D., LALITA JANKE and MEDICAL RESOURCES, L.L.C. Defendants.	**09-CV-14044-Moore-Lynch** CIVIL ACTION NO.: JURY TRIAL DEMANDED

COMPLAINT

The United States of America alleges as follows:

I. Introduction

1. This is an action brought by the United States of America against Walter Janke, M.D., Lalita Janke, and Medical Resources, L.L.C. (MR) for treble damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729-3733, and for damages under the common law theories of unjust enrichment and payment by mistake.

2. Defendants, Walter and Lalita Janke, and MR knowingly presented and made or

United States v. Janke, 09-CV-14044-Moore-Lynch (S.D. Fla. Feb. 10, 2009)

Settled for $22.6 million in November 2010

United States v. Janke

- MA plan used coding reviewers to submit diagnosis codes to CMS that were not documented in the medical record or supported by an actual medical condition
  - Data sweeps to find additional codes
- MA plan submitted codes via an automated system that could not delete unsupported or false claims
  - Example (Freedom): reviewers are unable to submit delete codes when they find erroneous data (there is an "add" function, though)

and truthfulness of the ICD-9-CM codes to obtain risk adjustment payments to which they were not entitled.

CMS's Audit

38. CMS conducted an audit of risk adjustment payments made to AHC for the 2006 calendar year based upon diagnoses codes submitted by the defendants for dates of service between January and December 2005. CMS chose a random sample of 193 beneficiaries from the AHC population of beneficiaries with diagnosis codes.

39. The 193 beneficiaries had a total of 550 assigned HCCs based upon the diagnoses codes submitted by AHC. (Some beneficiaries had multiple HCCs.) CMS requested that AHC provide medical records to substantiate the HCCs and a review of those medical records was conducted by an independent contractor. The results of the medical record review revealed that 61%, or 335 of the 550 HCCs, could not be substantiated by AHC's medical records.

40. For each beneficiary in the sample, CMS determined that AHC was paid an average of $3,015 as a result of unsubstantiated HCCs. It was able to extrapolate its results to the AHC population by multiplying this amount by the number of AHC beneficiaries with HCCs, i.e., 9,456 beneficiaries. The product of these two figures, $28,509,840 is the amount by which AHC was overpaid, i.e., the debt owed the United States.

41. In addition, statistics compiled by CMS s
scores were 33% higher than other Florida MAOs ar
Also, in 2006, AHC beneficiaries had 65% more HC
MAOs and 45% more HCCs that all other MAOs. In

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CMS Extrapolated Audit Results to Assess Damages from Risk Adjustment Fraud

Areas of Risk for the Submission of False Risk Adjustment Claims

Causes of False Claims: Affirmative Upcoding

1. Simple fraud – "making it up"
2. Exaggerating severity of patient's condition (e.g., depression, malnutrition)
3. Claiming current treatment of condition (e.g., stroke, cancer) instead of past history of treatment
4. Claims based on laboratory, radiology or other improper provider or service type
5. Improperly linking complications and conditions

Causes of False Claims: Business Practices and Systemic Causes of Falsity

1. Failure to coordinate w/ Fraud and Abuse Department
2. Conducting chart reviews or other audits that only look for new risk adjustment claims
3. Failure to properly filter data used to generate risk adjustment claims
4. Compliance risk due to incentives to providers and failure to monitor provider submissions
5. Compliance risk due to vendor business methods and incentives