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As 'Originator' of Codes for HCCs, Providers Face Their Own Risk From Crackdown on MA Plans

By Nina Youngstrom

As the government turns up the heat on Medicare Advantage (MA) plans, they're expected to do the same to providers—with lawsuits, audits and new contract terms, experts say.

Some of the dollars MA plans may lose in False Claims Act (FCA) settlements and/or risk adjustment data validation (RADV) audits will be recovered, one way or another, from providers because they're the ones who diagnose patients and code and document their conditions—all of which drives CMS payments to MA plans, said attorney Barak Bassman, with Blank Rome in Philadelphia. Providers are required to sign standard contract language promising they will submit true, accurate and complete risk assessment data, making them vulnerable to recoupment if it's not perfect, he noted.

"It's the quake that may be coming," Bassman said.

Providers should brace for Targeted Probe and Educate, MA style, said attorney Stephen Bittinger, with K&L Gates in Charleston, South Carolina. "Plans will go back to the provider, who is the originator."

CMS is nudging MA plans in this direction, said Amy Bailey, a principal with HBE Advisors LLC in Idaho. When CMS finalized the MA RADV audit rule in the Feb. 1 *Federal Register*, "it said the biggest goal of this rule was to incentivize managed care organizations to take meaningful steps to reduce improper risk adjustment payments in the future," she said.[1] "What they mean by that is we have known a lot of these improper payments are occurring because managed care organizations accept ICD-10 codes providers have submitted and they report them to CMS without doing validation or auditing and monitoring and improper payments flow back through. CMS wants that to stop. They want MA plans to actively and aggressively audit their providers to make certain the ICD-10 codes reported up to CMS are accurate."

The rule gives CMS the authority to extrapolate overpayments to MA plans going back to 2018 and recover actual overpayments back to 2011.

"Medicare wants to incentivize these MA plans to start coming after the providers, which they feel are the root of the issue," Bailey said at an Oct. 24 webinar sponsored by the HCCA.

CMS pays MA plans under a risk-adjustment system, which relies on them to get ICD-10 diagnosis codes from providers. Certain ICD-10 codes are considered hierarchical condition categories (HCCs) conditions and may yield higher risk adjustment payments, she said. MA plans are generally paid more for beneficiaries with more severe diagnoses, and providers are paid more for more complex encounters.