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Compliance Today - August 2023

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The risks of risk adjustment coding

by Amy Bailey, CHC, CPC, COC, CPC-I, CCS-P, Kimberly Lansford, RN, BSN, MHL, CHC, and Sarah Spry, CHC, CPC, COC, CPC-I

As you have likely seen by now, there is heightened scrutiny surrounding the Medicare Advantage (MA) risk adjustment reimbursement program. Oversight is coming from several entities, including the U.S. Department of Justice (DOJ), U.S. Department of Health & Human Services Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS). In fact, OIG just added hierarchical condition coding (HCC) to their Work Plan for June, announcing they will be conducting nationwide audits. The buzz surrounding risk adjustment coding—also known as HCC—is nothing to take lightly.

Historically, the healthcare provider community viewed this largely as a "payer" problem. However, providers are not immune to risk adjustment enforcement actions. Providers have been subject to the False Claims Act (FCA) settlements related to their submission of HCC conditions, with one of the largest providers' FCA settlements coming in at $90 million, coupled with a stringent corporate integrity agreement (CIA). Inspector General Christi Grimm delivered comments regarding the OIG's interest in risk adjustment reimbursement at the 2023 Health Care Compliance Association Compliance Institute. During her address, she announced that risk adjustment coding is one of OIG's top two priorities. She also emphasized the significant dollars at stake in managed care and indicated OIG had identified more than $6.5 billion in improper risk-adjusted payments in just one year.

Given the current government focus surrounding risk adjustment reimbursement and proper reporting of HCC conditions, the time for providers to closely examine their own process and compliance is now. In this article, we will discuss the fundamentals of risk adjustment reimbursement, explore operational considerations, examine recent settlements and enforcement actions, and provide recommendations to achieve success and mitigate compliance risk associated with your HCC program.

Fundamentals of risk adjustment reimbursement

Under the MA program, CMS makes monthly payments to MA organizations based on the anticipated cost of providing Medicare benefits to an enrollee while accounting for differences in demographics, as well as certain characteristics for each beneficiary and risk factors such as age, gender, and health status.[1] This risk adjustment system relies, in part, on MA organizations collecting diagnosis codes (ICD–10) from their providers and submitting them to CMS. This is known as risk adjustment coding or HCC reporting. As shown in Figure 1, certain ICD–10 diagnosis codes are categorized as HCC conditions and are eligible for increased risk adjustment payments based on their payment group assignment.

Simply put, MA plans receive larger payments for beneficiaries with more severe diagnoses and, in turn, providers receive increased reimbursement for managing more complex patients. Each year, the risk adjustment payment rates are reset and established based on the conditions reported the prior year. This means there may be fluctuations in risk adjustment payments from year to year based on the conditions addressed and captured for reporting.

The two keys for accurate risk adjustment reimbursement are (1) correct and complete provider documentation and (2) exact and complete ICD–10 reporting. As you can imagine, incomplete and nonspecific medical record documentation, as well as improper, suboptimal, and missed reporting of ICD–10 codes, can result in lost reimbursement or, conversely, overpayments and, most assuredly, increased compliance risk.

In review of recent risk adjustment audit reports, there are recurring themes in virtually every case:

1. Inadequate auditing, monitoring, and oversight of providers by the MA plans, and
2. Improper provider reporting of HCCs.

On January 30, CMS issued the Medicare Advantage Risk Adjustment Data Validation Final Rule. The rule was issued in response to the growing concerns surrounding improper risk adjustment reimbursement. CMS stated the rule was designed to incentivize MA plans to conduct more effective auditing of providers to identify improperly reported HCC conditions and thereby improve the accuracy of the data they report to CMS—which will reduce improper risk adjustment payments in the future. The rule also gives CMS the authority to extrapolate overpayments made to the MA plan back to 2018 and recoup actual overpayments for 2011–2017. It is expected that providers will start seeing the effects of the new rule as MA plans implement measures to reduce their own risk and financial liability. It is almost certain that MA plans will begin ramping up auditing of provider HCC coding and recouping identified overpayments.