Bipartisan Spotlight on Medicare Advantage Risk Adjustment Fraud Likely to Spur Audits

By Thomas C. Hill and Kristi V. Kung

Potential fraud and abuse in the Medicare Advantage Program ("MA Program") has become the focus of two senior-ranking Senators on each side of the aisle—Chuck Grassley (R-Iowa) and Claire McCaskill (D-Mo.)—and this attention is likely to serve as a catalyst for increased governmental audit activity as well as opportunist whistleblowers. While health care fraud recoveries have been on the rise for both federal and state agencies over the past several years, the MA Program has managed to largely fly under the radar despite agency knowledge that plans may be inflating beneficiary risk scores.

Risk Scoring Inflation Costs Taxpayers Billions

The MA Program (or Medicare Part C) was created by Congress in 2003 pursuant to the Medicare Modernization Act to help stabilize health care spending on seniors. Under this program, Medicare beneficiaries are provided the option of receiving their benefits through private health insurance plans rather than through the traditional Medicare Program (Medicare Parts A and B). Private health insurance companies enter into contracts with the federal government to coordinate the care of eligible Medicare enrollees and are paid a fixed or capitated rate per enrollee, per month as compared to the Fee-for-Service ("FFS") model of traditional Medicare. Many seniors choose the MA Program option because it provides for comparable coverage while also providing certain extra benefits such as prescription drug coverage and dental care. Additionally, the MA Program can cost Medicare beneficiaries less in out-of-pocket costs than the traditional Medicare Program. Currently, over 15 million individuals are covered under Medicare Advantage, or about 30 percent of all Medicare beneficiaries, and enrollment numbers are expected to continue to climb. According to the Government Accountability Office (GAO), Medicare payments to Medicare Advantage plans ("MA plans") totaled approximately $154 billion in 2014 alone, and approximately $12 billion was estimated to have been paid improperly.

Under the MA Program, MA plans are paid by the federal government based on the health status of the MA plan's enrollees. To discourage cherry-picking of healthy patients by the MA plans, the government pays the MA plan a higher capitated payment for a sicker enrollee than a healthier one. Specifically, the

Centers for Medicare and Medicaid Services (CMS) groups diagnosis codes into separate disease categories known as Hierarchical Condition Categories (HCCs) and calculates a risk score for each enrollee based on his or her HCCs. The risk score in turn determines the risk adjustment payment to be made to a MA plan by the government on behalf of each enrollee.

According to a 2014 report by the Center for Public Integrity (CPI), risk scores for MA patients rose sharply in at least 1,000 counties nationwide between 2007 and 2011, increasing taxpayer costs by more than $36 billion over the estimated costs of caring for patients under traditional Medicare. CPI further alleged that in more than 200 of these counties, the cost of providing care under the MA plan was 25 percent higher than the cost of providing traditional Medicare coverage. CMS officials have conceded that, indeed, risk scores rose much faster for MA patients than for those in traditional Medicare and that the rise could not be explained by asserting that the MA patients were sicker. CMS further estimates that approximately $70 billion in improper MA payments were made between 2008 and 2013 as a result of risk score inflation.

Whistleblowers Cite Abusive Gaming of Risk Scores

Recent whistleblower lawsuits filed against MA plans under the *qui tam* provisions of the Federal False Claims Act (FCA) have alleged that the MA plans are engaging in abusive billing practices by altering patient records in order to claim that enrollees are sicker than they actually are (a practice known as "upcoding"). The June 4, 2014 CPI report cites government investigations of Humana, Inc. as well as two Puerto Rican MA plans—MMM Healthcare and Preferred Medical Choice—subsidiaries of the New Jersey-based Aveta, Inc., for allegedly inflating patient risk scores. Additionally, Humana disclosed in its February 2015 annual report that it had received a voluntary request for information from the DOJ regarding an ongoing review of risk adjustment scores. Humana further asserted that it believed that the DOJ request was made "in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Risk Adjustment plans, providers and vendors."

Responding to recent publicity regarding the potential inflation of risk scores by MA plans and the filing of whistleblower lawsuits alleging MA plan fraud and abuse, Senator Grassley sent letters on May 19, 2015 to both the Acting CMS Administrator, Andrew Slavitt, and Attorney General Loretta Lynch, requesting reports regarding the steps that CMS and the Department of Justice (DOJ) have taken to ensure that MA plans are not fraudulently altering risk scores, and further encouraging CMS to increase its auditing practices in this area. One week later, Senator McCaskill, the top-ranking Democrat on the Senate Special Committee on Aging, also sent a letter to Slavitt, requesting a report by June 12, 2015 detailing CMS' efforts to address the issue of risk score inflation.

Increased MA Plan Audit Activity and Litigation on the Horizon

This increase in media coverage, the filing of whistleblower lawsuits, and the bipartisan focus of lawmakers are expected to incite activity by both CMS and the DOJ on the issue of risk scoring inflation. MA plans should be prepared for increased audit activity as well as qui tam FCA whistleblowers in this area as well as be cognizant of the extrapolation tools that CMS has at its disposal to dramatically increase overpayment recoveries. Pillsbury attorneys reported in March 2012 on the change in CMS methodology for risk adjustment data validation ("RADV") payment error calculation and the resulting impact that this new methodology could have on overpayment recoveries from MA plans. Specifically, medical record reviews by CMS under a RADV audit used to calculate a payment error rate will be extrapolated over the entire MA plan population to determine overpayment amounts. This change in methodology would substantially increase payment recoveries by many multiples over historic overpayment determinations. If, for example, a MA plan had 15,000 RADV-eligible enrollees, the sample size utilized by CMS would

consist of three groups of 67, for a total of 201 enrollees, and each enrollee's sampling weight would be 74.627 (5,000 enrollees per group divided by 67). Assuming an average overpayment of just $500 for each sampled enrollee, the new extrapolated plan-level overpayment amount would total over $7.5 million ($500 average overpayment x 74.627 sampling weight x 201 enrollees), as compared to the result under the old methodology of an overpayment of just $100,500 based solely on the sample size.

As the MA Program continues to grow and risk score inflation remains a target on both the government and the public's radar, increased audit activity and litigation is likely to result. It will be critical for MA plans subject to RADV audits to position themselves for appeal and aggressively challenge any extrapolation determination. Pillsbury attorneys have a wealth of experience with respect to the representation of MA plans, including the successful settlement of one of the few—if not the only—FCA actions to date pursued by the DOJ against a MA plan as a result of an extrapolated RADV audit. Medicare Advantage Organizations are advised to prepare for what may be the next wave of fraud and abuse scrutiny.

If you have any questions about the content of this alert, please contact the Pillsbury attorney with whom you regularly work, or the authors below.

Thomas C. Hill (bio)
Washington, DC
+1.202.663.8073
thomas.hill@pillsburylaw.com

Kristi V. Kung (bio)
Washington, DC
+1.202.663.8037
kristi.kung@pillsburylaw.com

Michael W. Paddock (bio)
Washington, DC
+1.202.663.8026
michael.paddock@pillsburylaw.com

Gerry Hinkley (bio)
San Francisco
+1.415.983.1135
gerry.hinkley@pillsburylaw.com

About Pillsbury Winthrop Shaw Pittman LLP
Pillsbury is a full-service law firm with an industry focus on energy & natural resources, financial services including financial institutions, real estate & construction, and technology. Based in the world's major financial, technology and energy centers, Pillsbury counsels clients on global business, regulatory and litigation matters. We work in multidisciplinary teams that allow us to understand our clients' objectives, anticipate trends, and bring a 360-degree perspective to complex business and legal issues—helping clients to take greater advantage of new opportunities, meet and exceed their objectives, and better mitigate risk. This collaborative work style helps produce the results our clients seek.