

ONGOING OIG RISK ADJUSTMENT SCRUTINY: TOP 3 KEY INSIGHTS FOR PAYERS, RISK-BEARING PROVIDERS, CLINICALLY INTEGRATED NETWORKS & ACCOUNTABLE CARE ORGS

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ABOUT US

Founded in 2003, ATTAC Consulting Group is recognized as a premier national consulting and auditing firm serving insurers, managed care and provider organizations on issues related to:

- Medicare Advantage
- Medicare Part D
- Medicaid
- Duals Programs
- ACOs
- Health Exchange (ACA) products



We specialize in:

- Risk Adjustment for Medicare Advantage, ACA & Medicaid Plans
- Regulatory Compliance
- Program Development
- Provider Network Development
- Operational Excellence, Business Transformation, & Systems
- Medical & Pharmacy Management

SPEAKER INTRODUCTIONS

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AGENDA

- Common findings, trends & insights from OIG Medicare Advantage Risk Adjustment audits
- OIG audit implications for health plans
- OIG audit implications for providers in value-based & risk-sharing contracts
- Strategies to identify risks & audit threats, understand consequences & implement solutions to mitigate risk
- Key factors for robust Risk Adjustment programs that elevate member quality of care & improve outcomes

POLLING QUESTION #1

Which conditions were identified as targeted conditions for an OIG Dx code audit? (select all correct answers)

A – Acute heart attack

B – Vascular claudication

C – Chronic obstructive pulmonary disease

D – Diabetes with acute complications

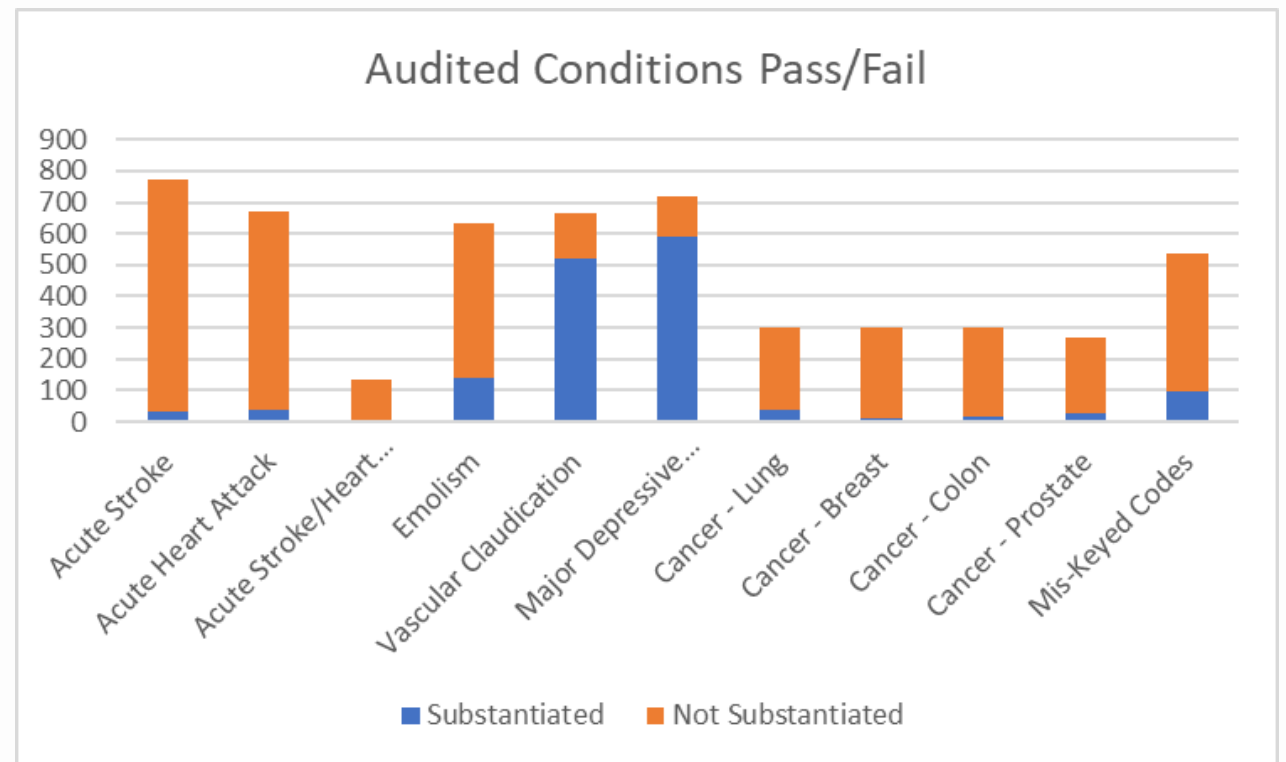
OFFICE OF INSPECTOR GENERAL AUDITS

- The OIG is actively auditing Medicare Advantage plans targeting Dx codes considered at high risk of being miscoded
- Between Feb. 2021 & May 2023, the OIG audited & issued reports for 25 health plans (*audits are continuing*)
 - Audits have covered contract years 2016 & 2017
 - Plans & providers need to review potential impact on all contract years through 2023
 - Overpayment for sampled data = \$8.3M covering 3,435 member years
 - Extrapolated overpayment estimate of more than \$427M

OIG audits analyze standard CMS Risk Adjustment files already in its possession to identify plans for audit based on observed data patterns

OFFICE OF INSPECTOR GENERAL AUDITS

- Reported an aggregate substantiation (pass) rate of 29.8%
 1. More than 70% of audited cases failed to be validated
 2. Factoring out major depressive disorder & vascular claudication, more than 90% of universe cases failed to be validated
 3. 1,420 out of 3,343 substantiated across the 10 condition scenarios (excluding mis-keyed codes)
 4. Samples were selected from a universe of more than 145,000 suspect cases



OFFICE OF INSPECTOR GENERAL AUDITS

OIG analytics *“Identify situations that do not make sense and could cause significant overpayments”* – OIG presentation at 2023 Risk Adjustment Innovations conference

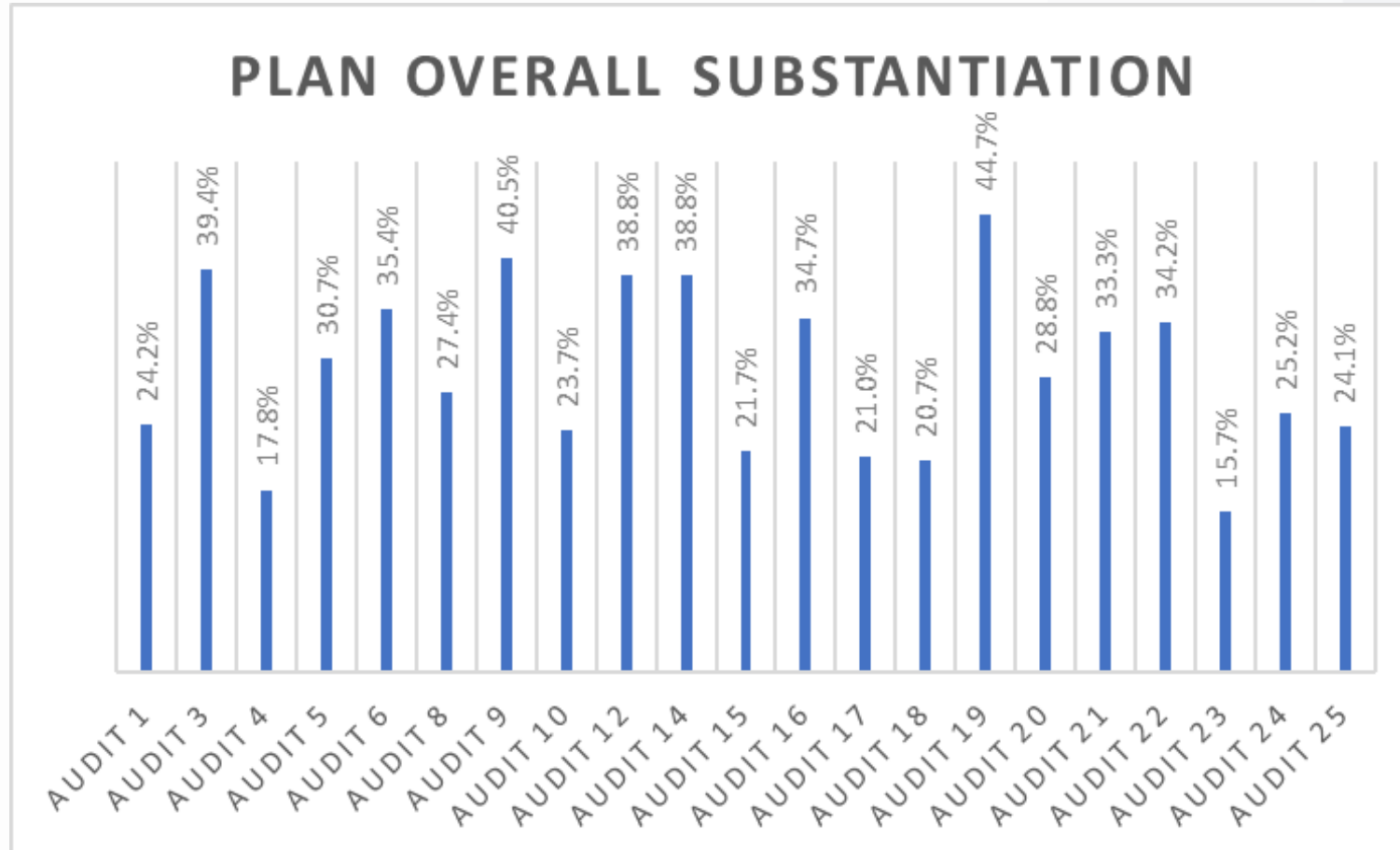
- What scenarios would be unlikely?
 - Acute stroke diagnosed in physician setting with no hospital claims
 - Acute lung cancer diagnosis with no recorded treatment
- What does this diagnosis look like in a normal situation?
- Additional information to research
 - Medications
 - Procedures

OIG AUDITS | TARGETED CONDITIONS

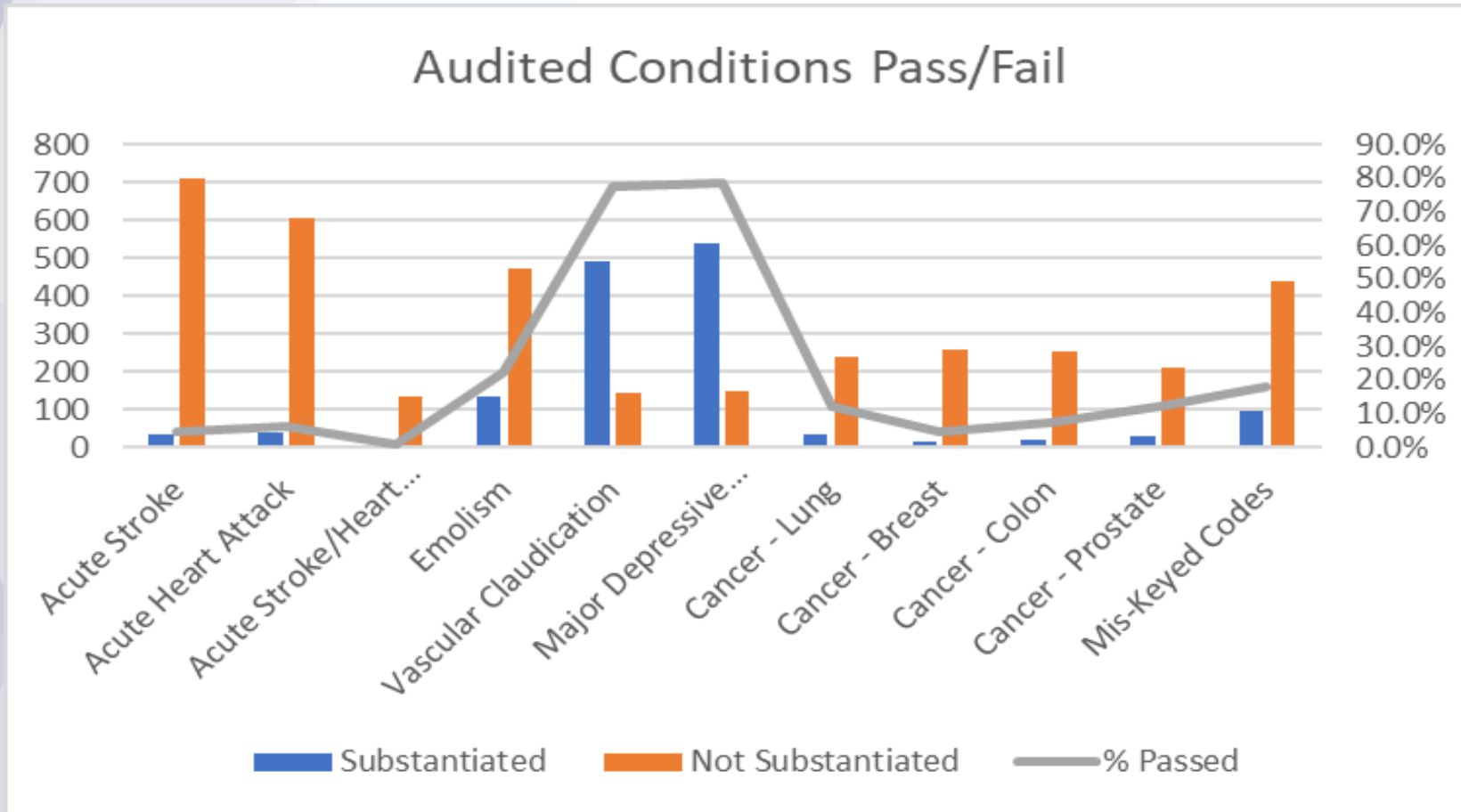
- Generally, the OIG is evaluating:
 1. Acute stroke and/or acute heart attack in single Dx in physician office setting and/or with no hospitalization
 2. Major depressive disorder, embolism – single Dx with no corresponding appropriate Rx therapy
 3. Vascular claudication – single Dx with no other in prior Dx (two years) & Rx for neurogenic claudication
 4. Cancers – single Dx with no treatment +/- 6-month window

OIG AUDIT FINDINGS

Plan level overall substantiation rates ranged from 15.7% to 44.7%



OIG AUDIT FINDINGS



- Acute stroke and/or heart attack 5% passed
- Cancers 8% passed

With OIG audits, the data triggers audit

THREE KEY INSIGHTS

1. **Data, data, data:** The OIG is analyzing plan-submitted data to determine the sample, and the selection is *objective*
 2. **Detectable, resolvable, defensible:** Scenarios can be proactively *detected* & processes can be enacted to *resolve* them, which puts plans in a position to *defend* remaining cases
 3. **Time, money & opportunity:** The OIG issued reports for PY2017 & prior. They'll start extrapolating payback with PY2018. Plans have opportunity to proactively identify & resolve issues
- ***Bonus insight:*** Affects more than health plans - at-risk providers can be severely impacted!

OIG AUDIT IMPLICATIONS FOR PROVIDERS IN VALUE-BASED & RISK-SHARING CONTRACTS

- Financial
 - Does your contract allow for refunds to CMS to flow down to provider?
 - If so, do you have reserves in place for 5-7 years to cover the impact?
- Administrative
 - Do you have methods in place to detect & address these & similar outlier cases?
 - Are you measuring patient compliance with care plans?
 - Are admin & clinical staff aware? Are they looking for them?
- Health plan collaboration
 - Review contracts for audit-related clauses
 - What recourse do plans have in event of audit findings?
 - What recourse do providers have?
 - Proactively collaborate with health plan to identify & address these cases
- Quality of care
 - Awareness of these & similar situations
 - Following up with members on care plans?
 - Medication adherence follow up?
 - Access or scheduling issues?
 - Other factors?

POLLING QUESTION #2

Has your organization evaluated claims & Risk Adjustment records & quantified your level of risk of an OIG diagnosis code audit?

A – Yes

B – Yes, but we have more work to do

C – No

STRATEGIES FOR PLANS AND RISK-BEARING ORGANIZATIONS: IDENTIFYING POTENTIAL OIG HIGH-RISK ISSUES

Develop or
Acquire Analytics

- Rules development: Data & clinical collaboration
- Establish governance

Quantify Impact

- Determine OIG high-risk universe
- Conduct coding where appropriate and estimate risk score & financial impact

Determine Root
Cause

- Conduct root cause analysis
- Identify trends at group, facility, specialty & geography level

Implement
Mitigation Plan

- Send deletions when applicable
- Education & ongoing monitoring

STRATEGIES FOR PLANS AND RISK-BEARING ORGANIZATIONS: IDENTIFYING POTENTIAL OIG HIGH-RISK ISSUES

- Develop or acquire analytic services that identify high-risk Dx cases
 - Requires collaboration between clinical & data experts
 - Identification criteria: Dx codes & therapy codes
 - Pharmaceutical, surgery, radiation, etc.
 - Diagnosis + therapeutic scenarios for each high-risk Dx case type
- Establish internal governance structure
 - Sets cadence for code set review & actions to take on each high-risk Dx case type
 - Define procedural steps for each high-risk Dx case type (e.g., automatic deletion vs medical record review)
- Stay abreast of industry, CMS & OIG developments & ensure analytics are updated; pivot rapidly when things change

STRATEGIES FOR RISK-BEARING ORGANIZATIONS: QUANTIFY POTENTIAL IMPACT

- Determine high-risk universe error rate:
 - Quantity impact across each contract
 - 100% medical record review OR statistically significant sampling
- Determine risk score impact (extrapolated if sampling was used)
- Estimate financial impact
 - Coordination of prior year(s) clean-up and/or reserve setting
 - Internal & external
 - Risk adjusted premiums going forward
 - Contracting/value-based arrangements

STRATEGIES FOR RISK-BEARING ORGANIZATIONS: DETERMINE ROOT CAUSE

- Conduct root-cause analysis on data universe
 - Primary care v. specialty
- Trends based on
 - Geography
 - Provider group
 - Provider specialty
 - Rendering provider
 - Care delivery modality
- Typical encounters vs. intervention/vendor-driven
 - In-office/in-home/telehealth assessment
 - Medical record review

STRATEGIES FOR RISK-BEARING ORGANIZATIONS: MITIGATION PLAN

- Submit deletions to CMS
- Education
 - Staff, providers & vendors
- Going forward
 - Adopt internal checks once claim is received & before EDS/EDGE submission
 - Medical record review project inclusion
 - Accepted encounter review & clean up
 - Pressure test efficacy of mitigation actions with an external review

POLLING QUESTION #3

Does your organization have a policy, procedure & method to detect outliers for high-risk diagnosis codes, quantify the impact & resolve them?

A – Yes

B – Yes, but it's informal

C – No

KEY FACTORS FOR ROBUST RISK ADJUSTMENT PROGRAM

- Look at each element through lens of Dx code accuracy
 - Internal & vendor resources
- Application to all lines of business
- End-to-end best practices
 - Prospective interventions
 - Retrospective chart review
 - Data submissions
 - Provider engagement

ROBUST RISK ADJUSTMENT PROGRAM

PROSPECTIVE INTERVENTIONS

- Objective: Accurately document & capture member's active conditions resulting in a face-to-face encounter
- Passive:
 - Member engagement
 - Outreach conducted by plan or by provider
 - Goal: Member has face-to-face visit eligible for Risk Adjustment
- Active:
 - In-Home/Telehealth/In-Office Assessments
- Quality controls
 - >95% coding accuracy
 - Dx codes appropriate for setting
 - Diagnostic testing/imaging
- Place of service, e.g., acute stroke/acute heart attack without emergent referral

ROBUST RISK ADJUSTMENT PROGRAM

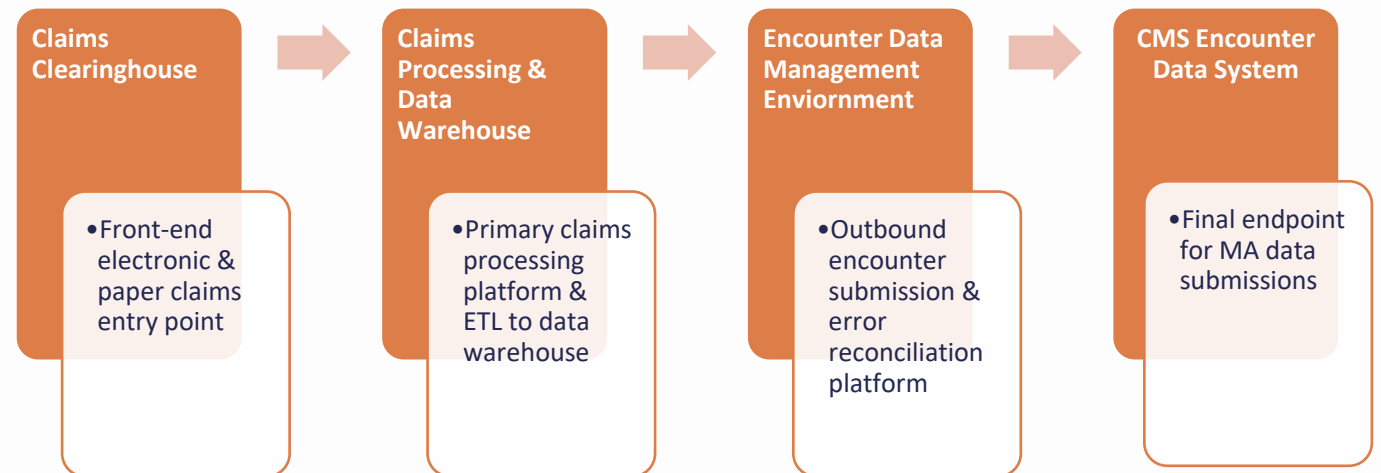
RETROSPECTIVE INTERVENTIONS

- Objective: Ensure diagnosis codes submitted to CMS are accurate based on clinical documentation
- Retrospective chart review
 - Targeting
 - Missing Dx's & high-probability erroneous codes
 - Single instance high-risk Dx codes
 - Upside & downside coding
 - Both adds & deletes
 - Coding accuracy SLAs
 - Vendor & internal staff >95% coding accuracy
- Supplemental record reconciliation

ROBUST RISK ADJUSTMENT PROGRAM

DATA SUBMISSIONS

- Data submission reconciliation & error remediation
 - Encounter data
 - Claim & Dx level
 - Supplemental data
 - Linked vs unlinked
 - Adds vs deletes
- Review upstream processes for Dx code impacts
 - Truncation, partial extraction, work queues, OCR & manually keyed claim errors



ROBUST RISK ADJUSTMENT PROGRAM

PROVIDER ENGAGEMENT

- Objective: Equip providers with tools, resources & support for accurate diagnosis coding
- Leverage advanced analytics
- Meet provider where they are
 - Communication & technology
- Collaborate with provider-facing functional groups to reduce provider abrasion
- Provide personalized feedback & training through chart review to aid adoption of coding & documentation best practices

ATTAC'S SUPPORT FOR HEALTH PLANS

Detect the Problem

- ATTAC offers a Summary Risk Assessment based on the 10 OIG criteria. The summary will quantify the number of member years by high-risk condition that meet OIG criteria
- For the first 20 health plans that sign up before August 31, 2023, ATTAC will run the summary for one H contract for one year, **free of charge**

Quantify the Problem

- ATTAC offers a Full Risk Assessment report which provides a detailed listing of cases that meet the criteria, quantify the value of those cases, & measure the potential impact to plan if audited
- ACG recommends this be run for PY 2018-2022

Address the Problem

- Using the Full Risk Assessment report, ACG will work with plans to remediate cases identified through deleting codes, supporting additional chart review & verification, or other activities as needed. Coding & chart retrieval can be completed by plan staff, existing vendors, or ACG can arrange through a 3rd party

Prevent the Problem

- ACG works with plan to conduct a root-cause review of cases identified & establish & execute a plan to prevent cases as appropriate
- Establish ongoing monitoring for these & similar cases to stay proactive
- Establish governance, policies & procedures, & plan decision-making protocols to guide the program going forward

QUESTIONS

Please send questions via webinar control box or contact us directly

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