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Contents

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

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."

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OIG: Compliance Committee's 'Inputs' and 'Outputs' Should Be Clear; CCO Runs the Show

When compliance officers plan to bring up a compliance issue at a compliance committee meeting, they should consider letting the operational manager of the affected department know beforehand, an HHS Office of Inspector General (OIG) official said. Surprises won't go over well at compliance committee meetings.

"The goal of the compliance committee is to frankly discuss organizational risks and what the response needs to be to address those risks," said OIG Senior Counsel Adam Ribner. "One of the ways to do that is by avoiding potential surprises. You don't want to call someone out at a meeting. You want people to be candid and forthcoming and avoid finger pointing and blaming."

Establishing the compliance committee "as a safe space" will contribute to the effectiveness of your compliance program, he said Oct. 26 at an HCCAwebinar.

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Compliance committees are there to support compliance officers in the implementation, operation and monitoring of the compliance program, said Tamar Terzian, OIG senior counsel. That should be articulated in a charter because it helps compliance "understand the functional responsibility of the compliance committee in the organization" and "ensure it doesn't inadvertently overlap with existing committees," Ribner added.

Once you have the charter, it may be challenging to put your finger on how the compliance committee helps implement an effective compliance program. He finds it helpful to think about the process flow of a compliance committee and its "inputs" and "outputs." The inputs include identification of departmental risks; discussion of mitigation plans to address those risks; and the latest regulatory developments in their respective departments so the organization can determine if they're a risk. The charter also should spell out the expectations of the compliance committee, such as providing recommendations to a higher-level oversight committee (e.g., board's audit committee) or empowering the compliance committee to make determinations.

Whatever decisions come out of the compliance committee, it's important to present a united front, Ribner said. "Everything that arises out of the committee should be substantive, not simply a dress rehearsal, or the compliance committee will become form over function."

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CCO Should Chair the Committee

The chief compliance officer (CCO) should run the compliance committee show. "It should be his or her meeting," Terzian said. "When looking at the compliance committee structure and membership, we want it to be chaired by the chief compliance officer," as OIG requires in corporate integrity agreements (CIAs).

Terzian often looks to CIA requirements for compliance committees. "We want it at a high level," with people from different departments, such as billing/coding, quality, operations, registration, legal and risk management, she said. "We want different voices heard in the compliance committee."

As chair, CCOs should encourage active participation by all committee members, Terzian said. "You need to make sure you're not just getting in a room and staring blankly at each other." Compliance officers should give regulatory updates on risk areas relevant to the departments in the meetings, monitor enforcement actions and ask members whether the organization faces risks in these areas.

"You also need to set precise and substantive agendas for each meeting," Terzian said. "If your agenda doesn't change from meeting to meeting, you're not accomplishing your goal for an active and engaged meeting." Agendas should be set in advance and include the risk areas previously considered by the compliance committee. "In this way, your agenda can serve as an informal corrective action plan tracking system," she said.

Terzian noted that committee members can be held accountable for their attendance in performance evaluations and she is "seeing it more frequently."

Over time, different people will serve on the compliance committee, "and one of the key things compliance officers should keep in mind is, as you have people coming to the compliance committee, train them. What are you expected to bring to the committee and take out of the committee? It's important to guide the new members as they join the committee at the macro level and something as little as being on the distribution list for the agenda."

CCO Is 'Key Member of Senior Leadership'

Terzian suggested monitoring and reporting on the compliance committee's progress toward its goals, including a periodic review of compliance program effectiveness.

"This is a lot for a person to do and that's why we want the role of the chief compliance officer to be elevated in an organization," she said. "In our CIAs, we have them reporting directly to the CEO because we understand how vast a role they have in so many areas while being

approachable and available. We see the chief compliance officer as a key member of senior leadership."

In terms of compliance committee size, it can be challenging when they're large but "if you don't have voices from major departments, you will struggle with buy-in," Ribner said. "If a major division doesn't feel like it has a say in determining risk factors, they will feel disenfranchised." One option is to use subcommittees, added Steve Forman, managing senior consultant at Strategic Management Services, at the webinar. "I have seen organizations with subcommittees and they can be very effective," said Forman, former CCO at New York Presbyterian Hospital. He worked at one organization with 23 people on the committee and it divided into six subcommittees with a separate charter for each. "I attended meetings of all the subcommittees," he said. "It was important to make sure they were carrying out their functions."

The functions of the compliance committee somewhat track the seven elements of a compliance program. That includes developing and evaluating policies and procedures; promoting compliance reporting; developing a system to solicit and respond to complaints; doing risk assessments; and developing the compliance work plan, among other things. The compliance committee also is responsible for analyzing legal and regulatory issues and evaluating the effectiveness of the compliance program. "That's one of the roles of the compliance committee, not just the compliance officer," Terzian said.

'Boards Should Provide Guidance and Direction'

Whether the compliance committee itself is getting the job done is another question. There are indicators of success, according to the speakers. They include:

- substantive compliance committee discussions;
- engaged members;
- resources allocated based on compliance committee decisions;
- actions by the committee "indicate authority and autonomy" and are "taken seriously and completed within a reasonable time;"
- committee determinations bring about accountability and follow-up; and
- mitigated risks.

"It's always important to evaluate how you're doing," Terzian said. She advises routinely reviewing the charter, the outputs and the people at the table. Does reality align with expectations? Maybe the charter and members are due for change. For example, if your organization merges with another, "you may want to make sure people from the new place are part of compliance committee meetings." Also confirm there was follow through on committee decisions.

Finally, it's important to understand the board's oversight role of the compliance committee. In CIAs, OIG requires boards to review compliance committee relationships and operations and endorse compliance committee determinations, Ribner said.

More broadly, "boards should provide guidance and direction to the compliance committee and chief compliance officer," Ribner said. A main role is to ensure the compliance program and compliance officer have enough resources. Otherwise, it won't have the staff or buy-in for effectiveness, he noted. "Without commitment from the top, you might struggle to get executives and management to participate in these processes."

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CMS: 'Content Was Correct' in QIO Publication on Short Hospital Stays

CMS for the most part is standing by a July publication on compliance with the two-midnight rule from the Medicare contractor, Livanta, that conducts short hospital stays.[1]

"The content was correct, but it needed to be written more clearly to avoid confusion," a CMS spokesperson told *RMC* Oct. 25. "The publication will be re-released after Livanta has updated for clarity." The spokesperson noted that "CMS informed Livanta that all communications and newsletters need to be written clearly and align with CMS policy to avoid confusion among stakeholders." It had been retracted in September.

CMS closely reviewed the publication, Livanta Claims Review Advisor for July 2023, after questions were raised about it. But other than issues around its clarity, apparently CMS is OK with it.

Livanta, the Beneficiary and Family Centered Care-Quality Improvement Organization (QIO), took people in the utilization review, case management and compliance community by surprise when it put out the publication. The QIO opened the door to greater use of the case-by-case exception and seemed to have a more generous view of inpatient admissions than in its audits, including for appendectomies and gallbladder removals.

"It is surprising that CMS states that they stand by all the case information Livanta presented in their memo, especially indicating that emergent appendectomies and cholecystectomies are appropriate for inpatient admission," said Ronald Hirsch, M.D., vice president of R1 RCM. "I am anxious to see the revised version of the memo to see if Livanta continues to include those."

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Sample of Compliance Committee Meeting Minutes

Here's an example of meeting minutes for a compliance committee (see story, p. 1). It appears in the HCCA's *Healthcare Compliance Forms and Tools* and was developed by Cornelia Dorfschmid.[1]

Sample Compliance Committee Meeting Minutes

[NAME] Health System
Regular Meeting of the Corporate Compliance Committee (CCC)

Time: [TIME] [A.M./P.M.]–[TIME] [A.M./P.M.] [TIME ZONE]	**Date:** [MM/DD/YYYY]
Location: [ROOM NAME], [BUILDING NAME]]	**Remote Access:** via [TEAMS, ZOOM, or Webex]

Members	Guests
• [NAME], [JOB TITLE] • [NAME], [JOB TITLE] • [NAME], [JOB TITLE] • [NAME], [JOB TITLE] • [NAME], [JOB TITLE] • [NAME], [JOB TITLE]	• [NAME], [JOB TITLE] • [NAME], [JOB TITLE] • [NAME], [JOB TITLE]

MINUTES			
#	**Agenda Item**	**Meeting Note**	**Action Item**
1.	**Record of Attendance/Start Time**: *Compliance officer (CO) [NAME]*		
		[Response examples follow] All but one member attended in person. [NAME] was excused and out of town. Quorum.	
2.	**Approval of Minutes**: *CO [NAME]*		
		Upon review, members approved minutes of the [XX/XX/XXXX] meeting	
3.	**Compliance Program Update**: *CO [NAME]*		
	New hire, hybrid work	• Human Resource (HR) director reported an update on candidates for new compliance manager position. • Several department heads reported challenges their staffs had with timely completion of the specialized compliance training in the LMS due to technical issues and network access for remote workers. • A lengthy discussion ensued on hybrid work environments and efficiencies in compliance training. CIO wanted to follow up with senior system admin on access issues.	
4.	**Policies, Procedures, and Code of Conduct Update**: *Presenter(s) [NAMES]*		
	Code of Conduct: revisions status	• Code of Conduct draft version 2/2022 was presented by CO and discussed members' requested edits to intro letter and Attestation Statement. • CO brought back Exclusion Screening Policy, draft version 2a, after incorporating requested edits in prior meeting. Members approved the revised version. • To ensure procedure matches process, CO emphasized importance of getting the COI policy revised and finalized prior to the upcoming annual COI survey.	CO to revisit policy comments, edit suggestions with policy committee and compliance team, then bring back to next meeting.
	Exclusion Screening Policy: update		
	Conflict of Interest (COI) Policy: draft		
	Arrangements with Providers Policy: update		
	Billing Monitoring Policy: draft		
	Corporate Compliance Committee Charter: update		
	False Claims Act Policy: revision		
5.	**Risk Areas, Auditing, and Monitoring**: *CO, Presenter(s) [NAMES]*		
	HHS OIG Work Plan: risk areas follow-up		
	Annual Risk Assessment: status		
	Annual Compliance Work Plan: progress report		
	Compliance score review/metrics: update		
	Regulatory update: • Sunshine Act reporting requirements • 21st Century Cures Act final rule (information blocking) • COVID-19 blanket waivers • Telemedicine		
	External government audits update: • RAC • ZPIC • TPE • OIG		
	Annual Compliance Program Assessment: schedule and planning status		
	External audit: outsourced coding-audit status		
	Regulatory update: • Sunshine Act reporting requirements • 21st Century Cures Act Final Rule (information blocking) • COVID-19 blanket waivers		

MINUTES			
#	Agenda Item	Meeting Note	Action Item
6.	**Compliance Training and Education Update**: *Presenter(s) [NAMES]*		
	Board compliance training presentation: schedule and content		
	New employee orientation/HR meeting		
	General compliance training [YEAR]: vendor proposal for LMS/content		
	General compliance training: statistics		
	Coding compliance training: schedule and content		
7.	**Exclusion Screening/Enforcement**: *Presenter(s) [NAMES]*		
	LEIE screening: update on monthly [YEAR] results		
	Screening vendor: contract status		
8.	**Effective Communication (Hotline/Disclosures)**: Presenter(s) [NAMES]		
	Hotline summary report: Q3/[YEAR]		
	Quarterly Compliance Newsletter: Q4/[YEAR] draft		
9.	**HIPAA**: Presenter(s) (e.g., Privacy Officer [PO]), Security Officer [SO]) [NAMES]		
	OCR disclosure/incident		
	Upcoming HIPAA security assessment		
10.	**Open Forum**: All		
11.	**Adjournment/End Time** [TIME] [A.M./P.M.] [TIME ZONE]	Meeting concluded at [TIME] [AM/PM] [TIME ZONE]	Next meeting scheduled [MM/DD/YYYY]

[Confidential]

Endnotes

1. Cornelia Dorfschmid, "Sample Compliance Committee Meeting Agenda," *Healthcare Compliance Forms and Tools* (Eden Prairie: Health Care Compliance Association, 2023), https://bit.ly/492amXQ.

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After concerns were expressed about the publication, CMS instructed Livanta to retract it pending an internal review. The CMS spokesperson said, "We received confirmation from Livanta that the publication was retracted from their website Sept. 11 and CMS confirmed that the article had been removed Sept. 14" and verified it Oct. 19.

In the publication, Livanta explained it relies on CMS's two-midnight guidelines "to identify cases where resource utilization best justifies inpatient payment" and makes decisions based on the documentation available when the inpatient order was written. Under step four of the guidelines, Livanta assesses whether it was reasonable for the admitting physician to expect the patient to require medically necessary hospital services for two midnights or more, including all outpatient/observation and inpatient time. Under step six, the QIO evaluates whether claims for patients who stayed fewer than two midnights (i.e., one night in the hospital) support the physician's determination that inpatient care was necessary based on complex medical factors (e.g., risk of an adverse event, severity of signs and symptoms).

Livanta cited these examples of adverse events:

- metabolic abnormalities (e.g., diabetic ketoacidosis, symptomatic hyperkalemia or hypercalcemia);
- acute medical conditions (e.g., crescendo angina or life-threatening arrythmia requiring urgent intervention or high-risk medication);
- pulmonary embolism with right ventricular strain;
- acute surgical conditions (e.g., cholecystitis or appendicitis where early intervention may be associated with next-day discharge); and
- "other use of high-risk medication that can only be given on an inpatient basis."

This is "much more liberal in allowing inpatient admissions on one-day stay patients" than previous Livanta statements, Hirsch said when the publication was released. Surprised by the development, in August he asked Livanta about its statement that emergency appendectomies and gallbladder surgeries are always eligible for inpatient admissions under the case-by-case exception. In response, Livanta's medical directors clarified that they're talking about "emergent or urgent operations, not any admission from the emergency room for non-urgent conditions," according to an email Hirsch received. But he said people generally don't show up at the emergency department for nonemergency appendectomies and cholecystectomies. Other statements in the publication also raised eyebrows.

Contact Hirsch at rhirsch@r1rcm.com. ✧

Endnotes

1. Nina Youngstrom, "QIO Views Short Stays More Favorably in New Publication, Experts Say; CMS Reviewed It," *Report on Medicare Compliance* 32, no. 29 (Augst 14, 2023), https://bit.ly/48hm68p.

Providers Face Risk from MA Crackdown

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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 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.

Risk adjustment is at the heart of OIG audits of MA plans and U.S. Department of Justice (DOJ) enforcement actions, which have already led to multiple high-dollar FCA settlements. The latest: Cigna Group and its MA organizations agreed to pay $172 million to settle false claims allegations they submitted false and invalid patient diagnosis codes to inflate payments.[2] The HHS Office of Inspector General (OIG) has identified certain HCCs as high risk for reporting errors, including embolism, acute stroke, major depressive disorder and vascular claudication.

"If the health plan is audited by the government and it comes from information received from the providers, they will certainly file claims against the providers," said attorney Daron Tooch, with King & Spalding in Los Angeles.

It May Be a Difficult Strategy

But it may be a difficult strategy, said attorney Max Voldman, with Constantine Cannon in Washington, D.C. With exceptions, MA plan contracts with providers fall into three categories: fee-for-service (FFS), capitated and owned by the MA plan or its parent and capitated and outside of the MA plan's corporate family, he said. The contracts between providers and MA plans probably condition payment on accurate diagnostic data in the FFS world, "but the provider would have arguments about that being a material term," Voldman explained. In the scenario where a capitated provider is in the corporate family of the plan, an MA plan's lawsuit against the provider seems like "it would be a waste of resources." But it would make sense "in scenarios where capitated providers are outside of the plan's corporate family—and I bet some capitation agreements even have a provision that would adjust reimbursement retroactively in the case of CMS taking money back in a RADV."

The problem is, it's unclear how "the line of liability will run," Bittinger noted. A patient would see both a primary care physician and specialists for a high-risk diagnosis. "How do they quantify and divide this among multiple providers with direct-line financial responsibility for a capitated payment structure? I think they will ask for money back on incentive plans rather than attribute direct liability," he said. "The carrot will go away and turn into a stick because MA plans will get crunched financially." The stick could take the form of auditing for accuracy and completeness; threatening termination of a network contractor; and moving lives away from big medical groups or health systems that don't comply with their new standards. "In the next five years, we will see a lot of mandatory compliance tests added to MA network contracts," Bittinger predicted.

Bassman sees the potential for a "perverse situation." He said, "The more the payer does to ensure accuracy through audits and chart reviews, the less recourse they have against providers. The less they do, the bigger risk they run with CMS." He also noted that "diagnosis coding is not some sort of objective true north lodestar. It's incredibly variable. You have human error and different providers acting in good faith code the same patient differently."

Other Twists and Turns

Other pieces are moving on the chessboard. RADV audits will set in motion an MA version of the appeal backlog and outcry that happened on the FFS side of the house with the Office of Medicare Hearings and Appeals, Bittinger said. "RADV audits will throw big ugly numbers at these plans, they'll all appeal, and it will get backlogged," he said. The hearing officers will explain they don't have enough people or money to move faster and the MA plans will sue in federal court because they're being denied due process and eventually they will get more money to expedite the administrative appeals process. In the meantime, CMS will recoup these funds and pass along the costs to providers—"by auditing and driving down reimbursement rates," Bittinger said.

He also expects litigation on where the buck stops in terms of adequate documentation of risk adjustment in the contractual relationship. "There are certain duties a provider has for adequate documentation and then the MA plan takes over and does their calculation, so we will have litigation about the sufficiency of performance," Bittinger said. "Where it will get really messy is with provider-owned plans and plans that own providers." For example, Optum is now the largest owner of physician

practices and is itself a subsidiary of UnitedHealth Group, he noted.

Meanwhile, Humana on Sept. 1 sued CMS under the Administrative Procedure Act, arguing the RADV rule violated notice and comment rulemaking, Bittinger said.[3] Humana is primarily arguing that CMS's new audit methodology for MA plans is an improper application of the law.

An even more consequential fight may be looming, Bittinger said. The RADV rule allows MA plans to appeal audit findings to hearing officers and the CMS administrator, not federal courts. He thinks that's ripe for a challenge because of an April 14, 2023, decision from the U.S. Supreme Court in *Axon Enterprise, Inc. v. Federal Trade Commission et al*.[4] In a case about two companies challenging administrative law judge reviews at the Federal Trade Commission and Securities and Exchange Commission, the Supremes ruled that "The question presented is whether the district courts have jurisdiction to hear those suits—and so to resolve the parties' constitutional challenges to the Commissions' structure. The answer is yes. The ordinary statutory review scheme does not preclude a district court from entertaining these extraordinary claims."

Understanding the ICD-10, HCC Risks

Tying together the MA plans and the providers are CMS and OIG, which have identified risk adjustment as a "compliance risk and fraud focus," Bailey said. She cited two themes running through the audits and FCA cases: inadequate oversight of providers by MA plans and provider reporting of ICD-10 codes that weren't supported by the MEAT criteria.

To ensure they've addressed HCCs, providers must document they've done one or more of the following (this is known as MEAT because it's an acronym):

- **M**onitoring the condition.
- **E**valuation of the condition.
- **A**ssessment of the condition.
- **T**reatment of the condition.

"If you don't meet one of those, you may not report a diagnosis code categorized as an HCC," Bailey said.

Calling risk adjustment "arguably the highest risk area out there right now in terms of compliance," Bailey said providers should be thinking about "where the points of failure may be and how we might reduce that on a go-forward basis." Here are some of them:

A patient's medical conditions are typically included in an active problem list. Many electronic health record (EHR) systems read active problem lists and flag conditions tied to HCC categories, she said. In many organizations, providers may be prompted by the EHR or the staff to address HCC conditions at every encounter and claims may be submitted to the payer without coder review. The problem lists are often inaccurate and the clinical staff may not do a great job reviewing or updating them in detail. They often contain conditions the patient no longer has and that should be classified as past medical history or removed, Bailey said. "We are hearing on an increasingly frequent basis" that providers are pushed to pull in conditions from the problem list to their assessment even if the provider is not managing the conditions. Suppose a patient visits the physician for a sore throat and runny nose. Although the patient also has congestive heart failure, that's not what he's there for. "What we're hearing is the primary care physician is being pressured to pull congestive heart failure into their assessment even though they're not managing the patient for congestive heart failure because cardiology is," Bailey said. If the physician is pressed to make it look like they're managing, treating or assessing the condition to allow capture of the HCC, "that's a problem."

Bailey added that it amplifies the risk to rely on physicians to assign their own ICD-10 codes when they're not coders and there are 70,000 possible codes and code combinations. "Even if you have certified coders, they may not have HCC expertise and while a lot of basic guidelines for ICD-10 assignment apply to HCCs, they have their own unique set of nuances and rules that the coder needs to be attuned to," she said. Even with

CMS Transmittals and *Federal Register* Regulations, October 20-26

Transmittals

Pub. 100-04, Medicare Claims Processing

- Internet-Only Manual Update, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 50.6, Trans. 12,326 (Oct. 26, 2023)
- Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 18 Section 50.3-50.4, To Remove 0359U Per The International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--October 2023 Update Change Request (CR) 13166, Trans. 12,325 (Oct. 26, 2023)

Pub. 100-08, Medicare Program Integrity

- Updates of Chapter 4 and Chapter 8 in Publication (Pub.) 100-08, Including Adding Guidance Regarding Handling of Freedom Information Act (FOIA) Requests, Trans. 12,333 (Oct. 26, 2023)

Pub. 100-20, One-Time Notification

- Report of Hospice Election for Part D (Response File), Trans. 12m331 (Oct, 26, 2023)
- Implement Edits on Hospice Claims, Trans. 12,330 (Oct. 26, 2023)

Federal Register

Notice

- Medicare and Medicaid Programs; Quarterly Listing of Program Issuances-July Through September 2023, 88 Fed. Reg. 73,591 (Oct. 26, 2023)

certified coders, encounter volumes—especially in clinic settings—may exceed coding resources, and coders are unable to review all codes assigned at encounters before they're sent to payers.

There also are competing priorities and risks inside organizations. For example, if you're asking physicians to pull HCCs into their assessments and address conditions they aren't managing, you're creating quality of care and malpractice concerns for them, she said. "We have to balance that with the risk of underreporting our HCCs and not capturing all the work the providers are doing and then trying to make sure we are also limiting our risk and exposure to overpayments."

Here are some of Bailey's auditing tips:

- Do routine audits of risk adjustment. "We have to be looking at documentation and coding specific for our MA beneficiary encounters," she said.
- Conduct documentation and coding reviews of beneficiary encounters with at least one reportable HCC.
- Consider larger, more focused audits of conditions identified as high risk by OIG (e.g., acute strokes, acute heart attacks, major depressive disorders).
- Review whether ICD-10 codes were assigned to the highest level of specificity and whether MEAT criteria support the ICD-10 (HCC) reported.
- Determine whether all conditions were managed/treated during the encounter captured.
- Decide how to define an error and how to communicate results to providers.

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Endnotes

1. Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 88 Fed. Reg. 6,643 (Feb. 1, 2023), https://bit.ly/46NhKow.
2. U.S. Department of Justice, U.S. Attorney's Office for the Southern District of New York, "United States Reaches $37 Million Settlement Of Fraud Lawsuit Against Cigna For Submitting False And Invalid Diagnosis Codes To Artificially Inflate Its Medicare Advantage Payments," news release, September 30, 2023, https://bit.ly/3tjsxI9.
3. Complaint For Declaratory & Injunctive Relief, Humana Inc. et. al. v. Becerra et. al., No. 4:23-cv-00909-O, (N.D. Tex., 2023), https://bit.ly/40bGLas.
4. Axon Enterprise, Inc. v. Federal Trade Commission et. al., https://bit.ly/3FDTcSN.

NEWS BRIEFS

◆ **In an Oct. 24 memo, CMS said that in January it will start auditing Medicare Advantage (MA) plan compliance with the utilization management requirements in the 2024 MA final rule published in the April 12 *Federal Register*.**[1] The rule, which was warmly greeted by the provider community, requires MA plans to follow the two-midnight rule, its case-by-case exception and the inpatient-only (IPO) list, among other requirements. The scope of the rule is broad. It states that "MA organizations may not limit coverage through the adoption of policies and procedures—whether those policies and procedures are called utilization management and prior authorization or the standards and criteria that the MA organization uses to assess and evaluate medical necessity—when those policies and procedures result in denials of coverage or payment where the Traditional Medicare program would cover and pay for the item." According to the new memo, CMS's Medicare Parts C and D Oversight and Enforcement Group "will begin conducting both routine and focused audits of organizations to assess compliance with the UM requirements finalized in CMS-4201-F. Routine program audits will be conducted as we have conducted them in the past. Focused audits will be limited in scope and duration." CMS will give feedback to MA plans chosen for a focused audit. "It is somewhat reassuring that CMS has heard provider concerns and is not only working with MA plans to ensure they interpret the regulations properly but also plan to perform audits as the regulations become effective and not wait for complaints to accrue," said Ronald Hirsch, M.D., vice president of R1 RCM.

◆ **The U.S. Department of Justice (DOJ) said Oct. 26 it has charged Kenia Valle Boza, a former executive of HealthSun Health Plans Inc., a Medicare Advantage (MA) plan in South Florida, in connection with a Medicare fraud scheme.**[2] But DOJ declined to prosecute HealthSun after considering the factors in the Principles of Federal Prosecution of Business Organizations and Corporate Enforcement and Voluntary Self-Disclosure Policy, including "HealthSun's prompt voluntary self-disclosure, cooperation, and remediation," as well as its agreement to refund to CMS $53 million in overpayments. DOJ alleges that Valle, the former director of Medicare risk adjustment analytics, orchestrated a scheme to submit false information to CMS to increase the amount HealthSun got for some MA enrollees. She was charged with conspiracy to commit health care fraud and wire fraud.

Endnotes

1. Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120 (April 12, 2023), https://bit.ly/3CH7TmX.
2. U.S. Department of Justice, Office of Public Affairs, "Former Executive at Medicare Advantage Organization Charged for Multimillion-Dollar Medicare Fraud Scheme," news release, October 26, 2023, https://bit.ly/40fAJFF.