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# Taking the risk out of risk adjustment: Managing exposure for ACOs

By Andrea D. Kelly, JD, CHC, CHPC, and Heidi Lopez, RN, CPC, CPC-I, CHC, CHPC

**Andrea D. Kelly** (adkelly@houstonmethodist.org) is Compliance Manager and **Heidi Lopez** (hlopez@houstonmethodist.org) is Director, Business Practices, at Houston Methodist in Houston, TX.

The Medicare Shared Savings Program (MSSP) has provided increased opportunity for providers opting into accountable care organizations (ACOs) to derive additional income for closely monitoring and coordinating the care of Medicare beneficiaries. In maintaining high-quality standards while controlling and reducing costs, ACOs and their member providers are in a position to share in any savings realized by the Medicare program.

But beyond meeting quality standards and reducing the Centers for Medicare & Medicaid Services' (CMS) cost per beneficiary, ACOs can also maximize their earnings under the MSSP by ensuring their providers thoroughly detail each beneficiary's medical conditions and diagnoses with coding and documentation in order to affect the individual patient's risk adjustment factor (RAF). An increased RAF results in a corresponding increase in the amount CMS will anticipate allocating for the beneficiary in the following program year. By widening the gap between CMS' anticipated spend and actual spend per beneficiary, ACOs stand to gain additional savings for their participation in this alternative payment model.

Given this incentive to build up the RAF score for each patient, compliance professionals should take note of recent enforcement actions and recognize the need for diligence in this emerging risk area.

## Risk adjustment 101

To really understand the risk around RAF, it is essential to first understand how these scores are calculated and why a financial incentive could lead to liability under the federal False Claims Act (FCA).

### RAF calculation

The Balanced Budget Act of 1997 required CMS to adopt a risk adjustment methodology for Medicare Advantage (at the time, Medicare+Choice).[1] CMS first outlined the specifics of calculating risk in a 1999 *Report to Congress*,[2] and changes to the methodology have been made over time.[3] In establishing the MSSP, CMS elected to use the same risk adjustment model that it uses for Medicare Advantage (MA).

In its current state, the RAF score is calculated by taking into account ICD-10-CM codes that are assigned to the beneficiary over the duration of a calendar year.[4] Thousands of ICD-10-CM codes roll up into 79 Hierarchical Condition Categories (HCCs), and each HCC has a corresponding RAF score.[5] The RAF score is cumulative and aids CMS in determining the severity and complexity of a beneficiary's medical conditions.[6]

Ultimately, the more complex a beneficiary's care needs are, the higher the RAF score will be. For instance, a beneficiary with a diagnosis of type 2 diabetes mellitus without complications would receive a RAF score of 0.105, whereas a patient with type 2 diabetes mellitus with other specified complications would see a RAF of 0.302, and if that same beneficiary suffers from additional acute and/or chronic conditions, the score will increase

accordingly.

## The financial incentive

For ACOs participating in the MSSP, shared savings or losses are determined based on a simple concept: maintaining and evidencing high-quality care while simultaneously lowering costs to the Medicare program.

ACOs joining the MSSP enter into a three-year agreement with CMS.[7] For each new agreement period, CMS considers claims data for the ACO's attributed beneficiaries from the three years preceding the start of the agreement period, called the benchmark period. So, if the agreement period begins in 2020, CMS will review data from 2017–2019. CMS tallies up expenditures per beneficiary during the benchmark period and also factors in RAF scores. Based on these two elements, CMS derives a minimum savings rate, which is the target number an ACO will need to achieve to receive shared savings.

Importantly, while CMS calculates new RAF scores for beneficiaries each year, it does not adjust for score shifts in the MSSP in the same way the agency does for MA. If an MSSP-attributed beneficiary's RAF score increases during the agreement period, CMS will not make a concordant change in the minimum savings rate. However, if a beneficiary's RAF score decreases during the agreement period, the minimum savings rate will be adjusted upward, effectively making an ACO's job of achieving savings more challenging.

The result of this facet of the program is that ACOs have a financial incentive to maintain RAF scores during their agreement period and, further, to ramp up efforts to increase RAF scores prior to entering into a new agreement period. If CMS believes an ACO's beneficiaries have a higher acuity of conditions, target thresholds may become more achievable and the potential shared savings become greater. Herein lies the risk.

## From RAF to false claims

Given an inherent incentive to maintain or raise a beneficiary's RAF score to gain shared savings, compliance professionals should be mindful of the potential for violation of the FCA.[8] The federal statute subjects anyone who knowingly submits, or causes someone else to submit, illegal claims for payment of government funds to fines and penalties ranging from $11,000 to more than $23,000 per claim, with the possibility of treble damages in certain cases.

If providers add inaccurate or unsupported diagnosis codes, resulting in an increase to a beneficiary's RAF score, the outcome could be an overpayment when the MSSP program year concludes and CMS distributes shared savings.

The MSSP was instituted with the 2010 Patient Protection and Affordable Care Act[9] and has only been operational since 2012. The program's relative recent emergence means that significant enforcement actions against participating ACOs have not yet made it to the forefront. However, over the last decade, a number of enforcement actions have been undertaken around unsupported coding and inflated RAF scores in the MA sphere.