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Insurers profit from Medicare Advantage's incentive to add coding that boosts reimbursement

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Health insurers have perfected a way to wring billions more in revenue from the Medicare program by combing patient medical charts for additional diagnosis codes to submit to the federal government for payment.

The latest example of the massive returns that insurers reap from the practice known as a retrospective chart review was outlined in legal documents filed in a case against Indianapolis-based health insurer Anthem. The documents show Anthem pocketed more

than $112 million in additional Medicare Advantage risk-adjustment payments in 2015 and $102 million in 2014 while spending little over $18 million each year to carry out the review program.

Identifying and documenting additional diagnosis codes to send to the CMS for risk-adjustment payment is perfectly legal if the patient's medical record supports it. In fact, the way Medicare pays Advantage organizations encourages them to code all diagnoses possible. Traditional Medicare providers do not have that incentive.

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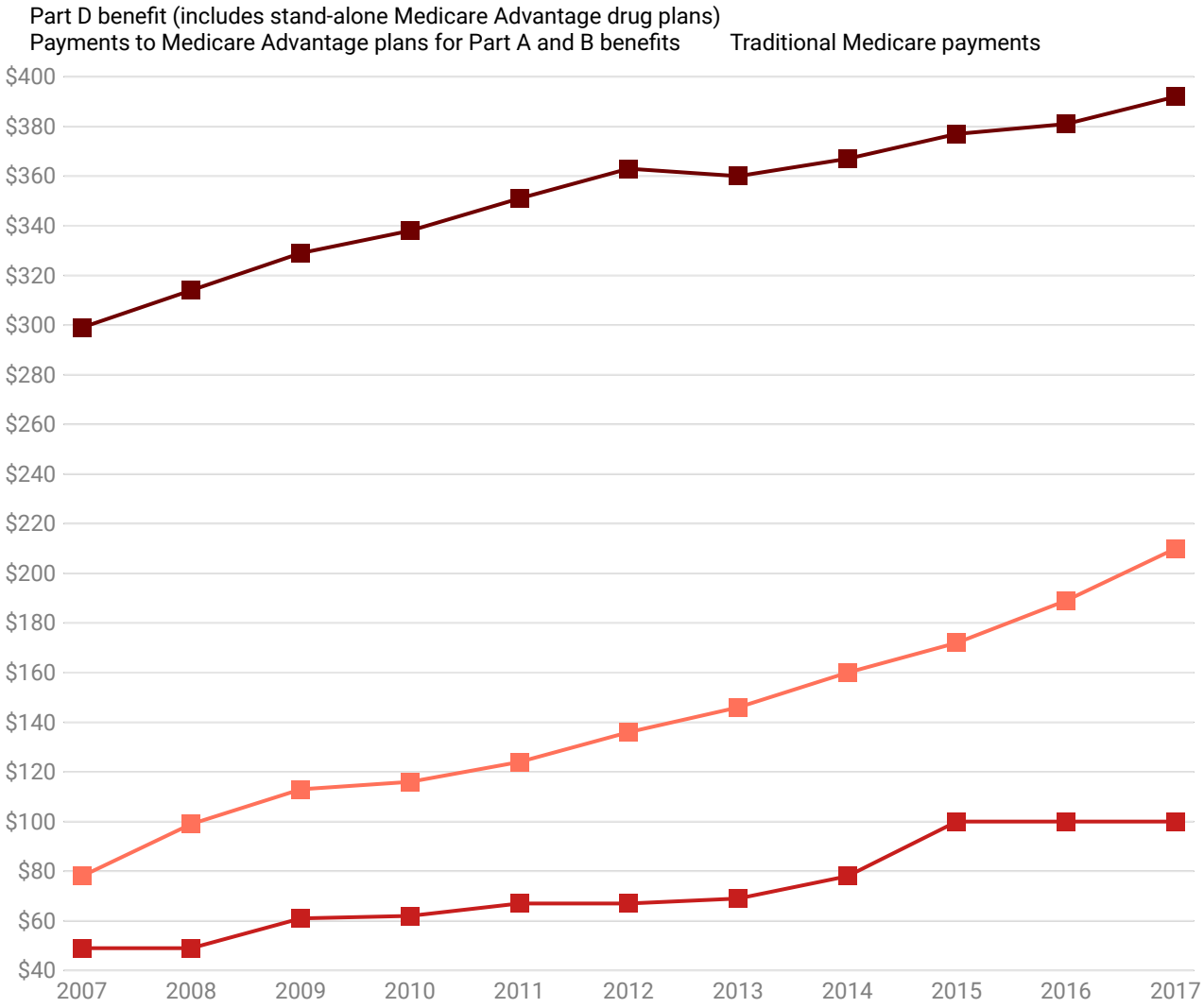
But as enrollment in Medicare Advantage grows and health insurers invest more in that lucrative market, it is likely they will continue to partner with third-party vendors to perform medical chart reviews to find thousands of extra diagnostic codes that translate to millions in taxpayer-funded Medicare dollars, putting the cash-strapped program at risk.

“Medicare will pay Medicare Advantage plans $200 billion more over the next 10 years than those plans should receive,” said Richard Kronick, a professor at the University of California at San Diego and former director of the Agency for Healthcare Research and Quality during the Obama administration, citing his own research published in Health Affairs in 2017. That's unless the CMS opts to tweak the payment system so Advantage plans are not paid more than traditional Medicare fee-for-service providers when they submit additional diagnostic codes.

Contrasting growth

Federal outlays to Medicare Advantage plans nearly doubled over the past 10 years. In 2007, payments to Medicare Advantage plans accounted for 18% of Medicare spending, rising to 30% in 2017. ($ in billions)



Source: Kaiser Family Foundation • Created with Datawrapper

Health insurers aren't keen to advertise the extra revenue they obtain from chart review programs and other practices aimed at increasing risk-adjustment payments. But their returns-on-investment are sometimes included in whistle-blower and Justice Department lawsuits against the insurers. Third-party vendors that help insurers carry out retrospective reviews also like to tout the big ROI they purport to deliver.

Anthem's alleged benefit from the practice pales in comparison with UnitedHealth Group's. The Justice Department alleged in a whistle-blower lawsuit it joined last year that UnitedHealth obtained $882 million for the 2014 payment year, $758 million for 2013 and $455 million for 2012 in additional Medicare Advantage risk-adjustment payments as a result of its medical record reviews. In all, the feds claimed that UnitedHealth took in over

$3 billion in additional risk-adjustment payments from the CMS from 2010 to 2015 by combing medical records.

Both Anthem and UnitedHealth have argued their practices are by-the-book. But the feds say the insurers' returns may be high because of fraudulent practices that include knowingly neglecting to delete inaccurate codes. The Justice Department is also investigating the risk-adjustment and chart review programs at Aetna, Cigna and Humana but hasn't alleged any wrongdoing against them, according to the companies' documents filed with the Securities and Exchange Commission.

Risk-adjustment coding is critical to the success of a Medicare Advantage plan and relying on the diagnostic codes that providers submit won't cut it, insurers argue. “Doctors are terrible at this. Doctors see patients, and coding is complicated and esoteric,” said Dr. Mario Molina, former CEO of Advantage insurer Molina Healthcare who now heads up Golden Shore Medical, a chain of California clinics. “Theoretically you should be able to get all the info from the claims data, but health plans hire coders or nurses to look at the chart and find things they can take credit for and get paid more.”

Creating incentives

The CMS pays Medicare Advantage organizations a per member, per month fee to care for seniors enrolled in the plans. Since the 1980s, that payment has been adjusted based on demographic information such as age and sex. But in 2004, the government implemented a new risk-adjustment model that tweaked payment based on demographic information and the health conditions of each member.

Each Medicare Advantage beneficiary is assigned a risk score based in part on their health diagnoses. Insurers are supposed to be paid more for sicker members with higher risk scores because they use more resources to care for them, while plans receive a lower payment for healthier-than-average members with lower risk scores. The payment system is designed to prevent health insurers from cherry-picking only healthy members and it has worked to that effect.

At the same time the system created strong incentives for health insurers to report as many diagnosis codes as possible because that can lead to higher risk scores and higher payments from the CMS. The annual payment to an Advantage plan for an 84-year-old male patient with diabetes without complications who is not eligible for Medicaid would be $6,765, according to the Medicare Payment Advisory Commission. But tack on a diagnostic code for vascular disease and that same diabetic patient's Medicare payment would jump to $9,796.

It's important to note that the CMS requires diagnosis codes to be backed up by the patient's medical record and result from a hospital stay or face-to-face clinician visit. There have been allegations that some health insurers haven't followed this rule.

The traditional Medicare fee-for-service program is paid differently, and there is no incentive for providers in that program to code all possible diagnoses. Because that incentive is present in Advantage plans, the average risk score for Advantage enrollees is about 8% higher than the scores for similar Medicare fee-for-service beneficiaries, according to MedPAC's latest report, despite strong evidence that Advantage members are not sicker than fee-for-service patients.

The result is that payments to Medicare Advantage were 2% to 3% higher in 2016 than they would have been if those same patients were treated under fee-for-service Medicare, according to MedPAC. With that extra money, Advantage plans can offer benefits to their patients that fee-for-service beneficiaries don't have access to, such as vision care and health club memberships. Payments to Medicare Advantage plans totaled $210 billion in 2017 to manage the care for 19 million seniors.

The CMS has taken steps to adjust for the higher rate of coding in Advantage to create more parity in payment with traditional Medicare, but experts like Kronick argue the adjustment isn't enough. Powerful insurance industry lobbies and voter reaction to Medicare payment cuts are one reason the CMS has not done more, he said.

The promise of big ROI

When the CMS began risk-adjusting Medicare Advantage payments, a cottage industry of third-party vendors formed to help insurers rake in more Medicare dollars by reviewing patient medical charts to find diagnoses that physicians didn't code. Some also send clinicians to patients' homes to perform health risk assessments to find additional diagnoses they can submit to the CMS to increase their payments.

Vendors with advanced analytics platforms that can comb through patient data and identify missing codes in claims often promise insurers high returns for using their risk-adjustment products. Verscend Technologies says on its website it helped Advantage plans secure $279 million in risk-adjustment payments in 2015 by deploying its “best-in-class” medical coders to find undocumented patient conditions. Thirty health plans, including Anthem, contract with Verscend for risk-adjustment. And business is good: Verscend closed last week on a $4.9 billion deal to acquire analytics company Cotiviti.

A case study published by Optum, which is owned by UnitedHealth Group, said it helped one payer identify a single provider whose patient medical records showed $1 million worth of medical codes for a year, but who didn't send a claim for them. It also helped the payer identify a capitated provider with $250,000 in claims, but who did not submit the diagnosis data. Optum and Verscend declined to be interviewed for this story.

Another vendor called SCIO Health Analytics said its clients see an average increase to their patients' risk scores of 18% in the first year of using its risk-adjustment services and 56% in the second year, translating to higher Medicare payments for the health plan. In one case study, SCIO said it helped a Texas-based Advantage plan with more than 65,000 enrollees increase its revenue potential by $24 million.

SCIO said its goal is to increase the accuracy of its clients' diagnostic data through prospective and retrospective chart reviews and provider education. It analyzes patient data to look for gaps in documentation or diagnostic coding patterns that don't make sense, and it fixes mistakes.

Donna DuLong, a senior consultant with SCIO, said the team often subtracts as many diagnostic codes from the claims as it adds. The CMS requires diagnosis codes submitted for risk-adjustment to be present in the patient's medical record.

“Our focus is accuracy of documentation. The coding team is looking at the documentation and for this service, you either have the support (in the medical record) or you don't,” DuLong said. Accurate documentation of patients' medical conditions also helps ensure they are benefiting from care-management programs and other services that the payers provide, she said.

Most insurers are probably not out to inflate patient illnesses through their chart review programs, sources said. But DuLong acknowledged there is potential that plans will game the system by fraudulently making patients look sicker on paper to increase risk-adjustment revenue, though she said those bad actors are few and far between (and not her clients).

Reviewing the reviewers

The Justice Department has some possible suspects. Last month it told a federal court that Anthem wasn't fully complying with a civil investigative demand to offer testimony about its chart-review program and asked the court to force the insurer to comply. In one document filed with the court, Assistant U.S. Attorney Li Yu said Anthem has already

admitted in response to the investigation that it does not attempt to identify which medical codes that providers submit on claims are not supported in the medical record.

“Instead of using the chart review process to identify both additional codes to submit and corrections to be made, Anthem executed its chart review program solely to generate additional diagnosis codes to report so that it could receive more payments from CMS,” the court filing stated.

The federal government similarly argued that UnitedHealthcare for many years used its chart review program to find additional codes to send to the CMS for payment but didn't bother to delete codes it knew were false and that would have saved Medicare a lot of money. One of the whistle-blower lawsuits against UnitedHealth was dismissed; the other case was pared down but is still alive.

Mary Inman, an attorney at law firm Constantine Cannon who brought one of the whistle-blower cases against UnitedHealthcare, said that the False Claims Act cases against Advantage insurers are the tip of the iceberg.

“This is clearly an industrywide practice that lots of managed-care organizations are involved in,” Inman said.

She also noted there have yet to be Medicare Advantage fraud lawsuits against the vendors that orchestrate the chart-review programs. Yet Verscend is mentioned throughout the Justice Department's case against Anthem, as Ingenix—now named Optum—is in the whistle-blower lawsuit against UnitedHealthcare.

“That may be the common thread: Vendors will often work for multiple plans and be unscrupulous and encourage them to do this kind of risk-adjustment work; to go out and comb the records. There will be cases against the vendors,” she predicted.