RADV: Manageable for MA Plans, VBC Providers

No FFS Adjuster, Fair Extrapolation & No HRA, Marketing Policy Change

Today, the Centers for Medicare & Medicaid Services (CMS) finalized the risk adjustment data validation regulations (here). The highly anticipated rules cap over a decade of courtroom and regulatory drama.

- **The rules are likely a clearing event for Medicare Advantage (MA) plans as well as VBC providers (HUM, UNH, CVS, CNC, ELV, OSH, AGL, others)**. Our take on the three major policies is below. Overall the audits apply to a very small % of MA payments and appear reasonable overall. However, It's a confusing rule and may take some time to digest.

- **FFS ADJUSTER**. **CMS will *not* apply the FFSA (as CMS had proposed) which means that the plan community may engage in litigation**. MA plans argued against the FFSA being removed and wanted a double-digit adjuster. Previously CMS performed a study on the topic & subsequently announced it believes no need for FFSA. The adjuster would have allowed a permissible level of payment error. The CMS-HCC model allows and includes coding errors, but RADV audit standards hold each code to 100% accuracy.

- **EXTRAPOLATION & TIMEFRAME. CMS will extrapolate RADV findings in payment years 2018+.** CMS will not adopt specific sampling or extrapolated audit methodology, but will rely on any statistically valid method that is determined to be suited to a particular audit.

  - **No extrapolation for 2011-17 audits**. CMS will not extrapolate RADV audit findings for 2011 through 2017 and will begin with the 2018 RADV audit. CMS will only collect the *non-extrapolated* overpayments identified in the RADV audits and HHS-OIG audits between 2011 and 2017.
  - **Collection of extrapolated overpayments 2018+.** CMS states that its duty is to protect taxpayer dollars from overpayments, and preserves the ability to collect on potentially significant amounts of overpayments made to plans beginning in 2018 using an extrapolation methodology.

- **OUR TAKE GOING IN.** We said that the best case would be that extrapolation occurs at the contract level, rather than a small sliver of error rates being applied to an entire book of business. We said it is very possible that CMS recoups prior years, but likely not beyond 5 years back. We also said that FFS Adjuster would be small, as a concession to plans, but CMS decided to finalize the rules as proposed (*without* an adjuster).

- **HEALTH RISK ASSESSMENTS.** No changes, as expected, but look to MA '24 rate notice for potential policies. HRAs (in office or at home) are used to collect information from beneficiaries about status, health risks, and daily activities. HRAs remain a concern due to the disproportionate share of diagnoses coming solely from HRAs and no other service record. HRAs could be addressed in the pending 2024 MA advanced notice. CMS is unlikely to scrap them but given concerns about upcoding, the agency may rein them in.

- **MARKETING.** Aggressive MA plan tactics are not addressed here, but were a big part of the 2024 MA & Part D rules from December. Note that CMS may go further in MA 2024 proposed rates.

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Marketing practices, including television ads, have been a longstanding concern. CMS proposes adding bans and guardrails for MA plans and third-party marketing organizations.

- **OUR TAKE/NEXT UP**:

  - **CMS notes this evening in a stakeholder call that final RADV rules should not impact premiums or benefits for enrollees**. The rule seeks <$5 B from MA plans, a small % of MA plan pay (well under 1% of plan payments). The rules are manageable overall and now all eyes are on ‘24 proposed pay rates
  - **Litigation may ensue over the FFS adjuster policy**, but the rule overall appears to be better than expected for plans. We look at AHIP and BCBSA letters as to areas where the litigation would focus. Issuers specifically asked for (1) an FFS adjuster (FFSA) and (2) No retroactive nature for audits. (3) Minimal extrapolation.
  - **How does Congress weigh in, if at all?** RADV represents program integrity measures which all members of Congress can agree: combating fraud & abuse is important, as payments represent taxpayer dollars. MA members are a large voting base and bipartisan members of Congress support MA.
  - **50% of Medicare beneficiaries are enrolled in MA plans.** This is significant. MedPAC finds that MA plans are reimbursed at ~104% of FFS payment (here). MA ‘24 proposed pay rates should be out in the next week or so.

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BACKGROUND

RADV TIMELINE: As a reminder, here are some key past events shaping the RADV rules.

- Nov 21, 2022 – 90 audits spanning from 2011 and 2013 uncovered $12 M in net overpayments for 18,090 patients (Read here).
- By Nov 1, 2022 – HHS was scheduled to put out RADV final rules, punted to by Feb 2023.
- Jun 21, 2022 – Supreme Court declines to hear UnitedHealth appeal on Overpayment Rule litigation (Read here).
- Oct 21, 2021 – Announcement of one-year timeline extension due to exceptional circumstances (1) publication of FFS Adjuster Study and time for public comment, as well as (2) the COVID-19 PHE (Read here).
- Aug 13, 2021 – Federal appeals court reversed 2018 District Court rulings that sided against CMS on Overpayment Rule (Read here).
- Jan 10, 2020 – CMS issues Version 2 - Contract-level RADV: Medical Record Reviewer Guidance (Read here).
- July 3, 2019 - KHN sued CMS under Freedom of Information Act (FOIA) to seek 90 copies of audits from 2011, 2012, and 2013 (Read here). CMS claims that audits are not done yet.
- March 20, 2019 – CMS issues Contract-level RADV: Medical Record Reviewer Guidance (Read here).
- March 6, 2019 – Release of data underlying FFSA Study (Read here).
- Nov 9, 2018 – DC District Court agrees with UnitedHealthcare suit and vacates CMS's 60-day Overpayment Rule. (Read here).
- Nov 1, 2018 – CMS released proposed RADV rule (Read here). Agency announced plans of (1) extrapolating data in RADV contract-level audits in RADV contract-level audits going back to 2011 and (2) FFS adjuster to offset error rate would not be applied to audit findings. Since release of the proposed rule, there have been two extensions and HHS has issued provisional data (see above).
- Oct 26, 2018 – FFS Adjuster Study released by CMS
- July 19, 2017 – GAO report (Read here) found that (1) the government made $16 billion in improper payments to private MA plans and that (2) RADV audits did not target contracts with the highest likelihood of improper payments. This sparked CMS's reevaluation of RADV rules.
- May 27, 2014 – Center for Public Integrity sued CMS under FOIA to disclose RADV audit findings. They won the case, forcing release of RADV audits for the first time by CMS in 2016 (Read case here).
- Feb 24, 2012 – CMS issues Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Read here). Notice ***proposes extrapolation calculation***, sampling framework, and FFS Adjuster to reduce extrapolation amounts and set a permissible level of payment error.
- 2012 – CMS gives up on recouping overpayments from 2008 to 2010, although estimated improper payments were more than $32 billion.
- April 15, 2010 – CMS issues Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule (Read here). Effective date - June 7, 2010. Methodology for selecting "a statistically-valid sample of enrollees from each audited MA contract and extrapolating from the results of that sample audit to calculate a contract-level payment adjustment" proposed.
- 2008 - 2012 – First RADV Audits checked 32 plan contract payments from 2007, CMS recouped $13.7 million in overpayments (Read Fact Sheet here).

We participated in the 41st Annual J.P. Morgan Healthcare Conference in San Francisco, CA. We wanted to highlight our take and commentary made by insurers & value-based companies on Medicare

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Advantage – both MA rates & RADV expectations. Companies in attendance included CI, CNC, HUM, CVS, PRVA, AGL and others.

- **Value-based care providers also chime in on RADV, noting less concern given airtight practices.** Companies across the board expressed similar sentiment to one another, holding out hope that the government considers the changes they submitted during the 1-month comment period (2019). Physician enablement companies are confident that the industry overall has done a good job making sure that they have sound practices. agilon, Oak Street, Privia, aledade and others are participating in the conference this week.

- **Major payers – Centene, Humana, CVS, Cigna – are on the same RADV page and HUM indicates Congressional fixes & litigation if not satisfied**. Humana indicates that if industry asks are not satisfied, they may resort to Congressional legislation in response, or litigation as a last resort. Litigation may take several years. It is unknown if there would be a legal 'stay' placed on the audits until litigation is resolved.

- **Issuers would take the hit instead of physician enablement companies.** Both agilon and Privia indicate that they would likely not feel direct impact of the audit results. agilon notes that the claw back does not pose a significant risk. They are responsible for the codes submitted, but since the government is working its way back from 2015, things will take a long time to play out. Privia states that it has faith that the federal government will not "rip the rug out from under" the industry overall yet noting that government programs morph over time.

- **Health insurers expect pressure from the 2024 MA rate environment, and we certainly do not expect a negative rate update but more like +2-4% (versus +4-7% in prior years).** Cigna and Centene were hesitant to speculate on the 2024 MA rate environment. However, Humana and CVS Health indicated that while they have benefited in the past from favorable rate notices, they do not anticipate a 4%+ rate environment, as in past years. They acknowledged added complexities such as inflationary pressures and COVID costs as potential influences on 2024 rates.

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