Medicare Advantage Risk Coding Update

Fall RADV Rule: 3 Policies to Watch, Litigation Likely If Finalized

Medicare Advantage (MA) is in a somewhat odd place. Some data points: 50% of Medicare beneficiaries are enrolled in MA plans. MedPAC finds that MA is ~104% of FFS payment. Critics contend that the program is creating paperwork and burden for hospitals and physicians to get approvals. There are agency questions on how Seniors are using supplemental benefits. CMS has also requested feedback from plans and stakeholders (due Aug 29) to be incorporated into the fall 2022 rule, or 2024 payment notices. Some at CMS believe that MA is on autopilot and things should change

- **Medicare Advantage (MA) risk adjustment data validation (RADV) final rules are currently scheduled to be issued in Sept/Oct 2022.** Last October, HHS announced (here) a new Nov 1, 2022 deadline for final rules. "The proposed rule discussed the Secretary's authority to: (1) extrapolate in the recovery of RADV overpayments, starting with payment year 2011 contract-level audits; and (2) not apply a fee-for-service (FFS) adjuster to the RADV overpayment determination," per the delay notice.

- **Headline risk for MA plans this fall is the long-standing risk adjustment audits that the agency started over a decade ago.** HHS must release final rules by Nov 1, 2022 or request an extension. In the Program Integrity Group, RADV has never been a popular issue among policymakers. RADV audits have taken place over the last decade but significant plan pay recoupments have not.

- **If finalized, we 100% expect industry litigation**. We look at AHIP and BCBSA letters as to areas where the litigation will focus. See here for a blog post on plan perspectives. Issuers want (1) no FFS adjuster (FFSA) and (2) No retroactive nature for these audits. (3) CMS should estimate a model based on audited data then determine what payment error is based on audited data then adjust for that. We note that program integrity / anti-fraud measures are bipartisan issues that combat fraud & abuse.

- **Three levers in the final rule to watch.** HHS is likely to lean on SCOTUS in the final rule. We will be watching for the following three main issues below:

    - FFS Adjuster. CMS has said that the application of the FFSA is not necessary. So, does CMS finalize what they proposed, with no FFSA? CMS performed a study on the topic & subsequently announced it believes there is no need for FFSA. CMS commissioned a study and looked for differences between its unaudited and audited model.

    - Retroactive (vs. Prospective) audits. There is regulatory text that allows CMS to extrapolate the results from the audits, going as far back as 2011. Some argue the agency has always had the authority to look back. The plan community would have a strong argument, in our view, to solely make RADV prospective, and/or go back only a handful of years.

    - Extrapolation. There is n=200 (sample size) for audits. Basically 200 persons are selected and the auditors will ask plans to provide up to 5 medical records to validate whether the Hierarchical Condition Category (HCC) is supported by any of the medical records. Medical records must be from medical providers i.e., from i/p, o/p and physician. A radiology claim, for

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instance , would not be allowed. The medical record has to be signed. CMS uses a medical record contractor to conduct reviews (not recovery audit contractors, or RACs).

- **FFSA Model that CMS uses to determine payment to health plans which used dx codes from FFS Medicare**. The CMS-HCC model allows and includes coding errors, but RADV audit standards hold each code to 100% accuracy. The FFSA accounts for differences in these documentation standards, between FFS data the risk adjustment model is calibrated on and RADV, creating a mismatch.

- **Medicare Advantage RFI (Request for Information) released, with industry comments that were due Aug 30.** CMS released a request for information quietly this summer. Agencies want to engage more and improve the program given how large the program now is. We expect CMS comments and/or policies in the Fall technical rule or in 2024 rulemaking.

- **<u>OUR TAKE/NEXT STEPS:</u> The proposed RADV rule could be finalized any day now.** We provide a RADV timeline in the text of this note, as the program goes back over a decade. Many of the audits have been completed. The last year audits were done were 2015. We do not know error rates. The rule will be from HHS, not DOJ. Much of the litigation has had to do with the FFSA and the Overpayment Rule, so whatever HHS decides here is likely that the DOJ would rely on. If finalized in an onerous manner, we do anticipate litigation and/or Congressional intervention. MA plans may in time increase bids, adding risk premiums to account for variable coverage recoupment. This may decrease funding for supplemental benefits (e.g., fitness classes, transportation, wellness offerings, etc.), leading to increased beneficiary and government costs.

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BACKGROUND

- **RADV TIMELINE:** As a reminder, here are some key past events shaping the RADV rules.
    - By Nov 1, 2022 – HHS scheduled to release RADV final rules
    - 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).
    - 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.
    - 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).

- **There was a MA Oversight hearing in June 2022.** We did not hear anything new regarding MA at the House oversight hearing this summer. We view this as headline noise for now, ahead of the election, with the pressure being placed on CMS to implement long standing recommendations from government watchdog groups to the Medicare agency.

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- **HHS Office of the Inspector General (OIG) Report reported that some MA plans use HRAs and Chart Reviews to "disproportionately drive payments."** Read findings here. CMS currently allows medical chart reviews, by plans or by third party-vendors, and health risk assessments (HRA), in office or in home, to be used as sources of diagnoses for risk adjustment. Concerns have been raised that MA plans are using them as tools to inappropriately conduct diagnoses and inflate risk payments. The HHS OIG recommends that CMS regulate the top 20 MA plans, which were not named. 20 of the 120 plans examined received $9.2 B in payments reported only through chart reviews.

- **We held an Insurance – MA, Medicaid, Commercial & Marketplace -- Policy Webinar this past summer.** Let us know if you need the June 29 Replay as it is available upon request. We will discuss recent rulemaking for MA, how it impacts value based care / physician enablement, and the overall outlook for RADV audits, star rankings, payment reforms and potential policies in 2023+.

- **The MA hearing major recommendations included prior auth legislation passage, RADV rules / coding intensity pay recoupment, better encounter data and HRA reforms.** The recommendations discussed in the hearing today were in line with the testimony released last night.
    - Erin Bliss from **OIG** recommended that CMS updates guidance on MAO's internal criteria that goes beyond coverage rules. The amount of denied care has reached alarming highs and without guidance from CMS they do not expect denials to cease, even when it is a standard or lifesaving treatment. OIG recommended that, with respect to chart reviews and HRAs, that CMS reassess the ability to allow unlinked chart reviews and HRAs to be the sole source of diagnosis for risk adjustment payments.
    - Leslie Gordon from **GAO** recommended that action be taken to ensure completeness of encounter data. Without accurate data, the risk adjustment payment cannot be sustained. Encounter data is also necessary to evaluate quality of care, as declining quality may be a reason for the alarming number of seniors changing plans in the final years of their lives. GAO emphasized also the timeliness of RADV audits and for CMS to complete them ASAP.
    - James Matthews from **MedPAC** recommended that the most important fix to MAOs is to address the excess payments that result from coding intensity. MedPAC that these practices contributed to excess payments. MedPAC urges that the Medicare program change its approach to calculating MA benchmarks. Currently they are calculated on FFS benchmarks which leads to more spending on MA.

- **All three testifying officials noted they do not believe that terminating Medicare Advantage plans altogether is warranted**. Ranking Member Griffiths (R-GA) posed the question to which the answer was an unequivocal No. This question followed Chair DeGette's question on if the agencies believe Congress should take additional steps for course correction of MAOs which received a unanimous yes.

- **Coding intensity accounted for $12 B in additional payments, according to MedPAC study.** Again this is not new data. Diagnosis codes collected from HRAs may not have been valid or the illness could have passed, but MAOs might still be collecting additional payments from risk adjustments here. MedPAC did not assert that these diagnoses are necessarily improper or false. However, MedPAC's Dr. Matthew stated that HRA collected data ought not to be used for risk adjustment if they are not obtaining services for them. See Washington Post article here highlighting the MA practice

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- **CMS was under scrutiny for not being proactive about the recommendations these agencies have proposed to increase transparency of MA plans**. Press articles note that Chiquita Brooks-LaSure was called to testify. OIG specifically stated that CMS needed to implement the changes to coding intensity, eliminate the use of in-home HRAs as the only verification of a diagnosis code, and the need to recover overpayments. The need for complete encounter data on behalf of CMS was also a repeated point of the representatives and agents during the hearing.

- **GAO prioritized the importance of meeting and speeding RADV timelines.** GAO urged the committee to follow up on the timeliness of RADV audits as they are taking much longer than expected. In 2016 GAO made two recommendations to CMS to speed up RADV as they were seeing year long delayed. CMS has completed some of the recommendations but the committee should place a priority to speed up RADV reforms.

- **A bipartisan Prior Auth Reform bill has not been CBO scored and is supported by BMA (Better Medicare Alliance) but individual plans may oppose.** There was a recommendation to pass *Improving Seniors Timely Access to Care Act* came up in a few of the Representatives' questions. This act would help in creating an electronic data processing system so that prior authorization, among other things, would be done efficiently and accurately. It will also require HHS to create a list of services that are routinely approved, encourage plans to use evidence-based guidelines in prior authorization process, and eliminate costs by decreasing administrative burden which stems from manual processing of data. This act received bipartisan support from representatives, as well as support from agencies.

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