Health Insurance Trifecta: MA, Medicaid, Dual Policy In Hopper

RADV Unlikely '22, Medicaid MOE Lame-Duck & Duals Policy 2023+

MEDICARE ADVANTAGE

- **We do not believe that Medicare Advantage (MA) risk adjustment data validation (RADV) rules will be released before year-end despite conspiracy theories pointing to Congressional savings.** We believe that one of the reasons that the most recent CMS delay took place was that new RADV rules released in the fall of 2022 would impact bids for 2024. Releasing the rules in 1Q23 amount to bid strategies that plans can put into place for 2025, and are therefore less problematic near-term.

- **RADV final rules are currently scheduled to be issued in Jan or Feb 2023.** Last October, HHS announced (here) a new Nov 1, 2022 deadline for final rules and a subsequent delay to Feb 1, 2023. "The proposed rule discussed the Secretary's authority to: (1) extrapolate in the recovery of RADV overpayments, starting with the 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.

- **What's the conspiracy theory?** Some opine that the sooner RADV rules are released, the sooner Congress can incorporate that new savings in the baseline, so that lawmakers may use the funds for something else. We are not convinced this is in the cards.

- **Two (other) MA rules are scheduled for release in December.** These literally could be any day now.

    - **ePA (Prior Authorization) proposed rule completed OMB review.** See here. The interoperability rule/ePA proposed rule is expected to speed up the PA process and reduce provider administrative burden. We are not expecting to materially limit MA plans using prior auth (unlike the bill, see below), so it shouldn't move the baseline. We look to the CMS impact analysis, as it will be telling.
    - **MA & Part D rule is under review at OMB.** See here. We could see Fall 2022 Medicare Advantage (MA) Technical Rules hit on MA plans & marketing practices harder. Recall that as of Oct 1, 2022 agent & brokers are *required* to record calls with Medicare beneficiaries, as well as provide certain disclosures (i.e., they do not represent the full MA plan option universe). Each fall CMS releases technical rules that act as a "clean up" collection of policies for MA plans and general rules of the road e.g., network adequacy, provider directory rules. Given the scrutiny over aggressive and predatory practices, we could see CMS enact tougher marketing guidelines possibly borrowing from the Senate report we summarized on 11/3. *See background issue, and Oct 1 MA broker & agent new call recording & other requirements.*

- **As a reminder, Medicare Advantage prior authorization bill passed the House this fall but costs $16 B and is unlikely to pass anytime soon (unless the core is reduced).** "Improving Seniors' Timely Access to Care Act of 2021," here introduced by Rep. DelBene (D-WA) aims to lessen burden for providers. The bill aids hospitals, physicians & others, while burdening payers (MA Plans). H.R. 3173 has a whopping 322 House cosponsors. It (1) establishes an electronic prior

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authorization program that can provide "real time decisions" (definition to be updated by HHS every 2 years) (2) report to HHS on use of PA and approval/denial rates and a list of services subject to PA, (3) meet PA technical, quality and timeliness standards set by CMS, (4) share policies with providers and suppliers, and (5) tell beneficiaries criteria used to make determinations.

- **LONGER-TERM:** The agency wants to engage more with plans and improve the MA program given how large the program now is with 50% of Medicare folks enrolled in a MA plan. We expect CMS comments and/or new policies floated in the Fall technical rule due in December (see above). Medicare Advantage RFI (Request for Information) was released this summer, with 4,000 industry comments received, in the effort to enact more thoughtful policy in 2023+.

MEDICAID

- **Medicaid directors ask Congress for certainty on PHE requirements.** Medicaid directors want CMS to be prohibited from changing Medicaid eligibility rules during the redetermination period. Extending the FMAP and phasing it out over a 12-month period would help stabilize the Medicaid provider workforce.

- **Provisions help Medicaid MCOs and could conceivably pass at year-end.**
  - When Medicaid coverage redeterminations will begin, with at least 120 days advance notice
  - Existing federal guidance on the redetermination period will not change.
  - Available financial resources during the redetermination period, by specifically maintaining the current 6.2%-point FMAP through the 1Q of redeterminations and phasing the enhancement down over 12 months after the quarter.
  - Underlying Medicaid eligibility rules won't change during the redetermination period.

- **Pregnant women & Infants: current law allows limited continuous coverage requirements and options.** Pregnant individuals in Medicaid must be covered through their pregnancies and 60 days postpartum. Their infants must be covered continuously for up to one year. States also have the option of continuously covering children for up to a year through an SPA, by which states must seek section 1115 demonstration authority from the federal government.

- **About 2/3 (34) states offer children 12 months of continuous coverage under Medicaid and/or CHIP.** See states that have this option through an SPA, even if families experience a change in income during the year, here. States include Alabama, Alaska, Arkansas, California, Colorado, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Washington, West Virginia, Wyoming.

- **Policies would be paid for.** The PHE ending sooner than July 2023 -- currently due to end April 15, 2023 -- results in government savings, due to CBO projections and baseline assumptions. In May of 2022, CBO projected the PHE ends in July 2023 here. CBO estimates emergency allotments end in August 2023. This means that the PHE ending "early" actually saves the government dollars.

DUAL ELIGIBLES

- **As Congress seeks to improve coverage for dual eligibles, Senator Cassidy (R-LA) seeks information on existing data and ways to improve beneficiary care for policy 2023+.** A NAMD

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recent letter highlights that Medicare and Medicaid spending on dual enrollees rose to a total of $440 B in 2019, with $164 B of spending being Medicaid. The fragmented and disjointed care contributes to (over) spending. Two examples of overspend (1) Medicaid may not be notified of a dual-eligible patient being hospitalized until they need long-term care or other Medicaid-covered services. (2) Medicaid MCOs are not financially incentivized to prevent patients' hospitalization since Medicare would be footing the bill for the inpatient stay. The letter has a set of questions on dual eligible care posed to patients, providers, payers, and other stakeholders.

- **Redeterminations will make the dual situation worse**. Dual enrollees have been hit hard by COVID-19, with rates of illness and hospitalization more than twice as high as those on just Medicare, see CMS analysis here. Duals are more likely than others to lose Medicaid coverage due to eligibility churn, and periods of disruption of coverage can be disastrous for enrollees needing critical health services and long-term services and supports (LTSS). This short-term lack of care can create pain points for states down the line, as individuals would return with more expensive high-intensity care needs.

- **More churn among duals**. Under the ACA, states are obligated to conduct ex parte renewals, wherein all available data sources, state wage databases, for example, are checked before the enrollee is requested to submit documentation. However, in many states, ex parte renewal rates are generally low, and tend to be even lower for dual populations. Only 11 states report completing more than 50% of renewals as ex parte, 22 states report less than 50% being ex parte, and 11 states say that less than 25% use the ex parte renewal processes. See more details from KFF here. This contributes to additional churn among dual enrollees.

- **CMS financial alignment model for duals to end in 2025.** The Medicare-Medicaid Financial Alignment Initiative (FAI) started as early as July 2013, and enrolled 424,000+ dual eligibles into capitated managed care models. Through this approach, a single plan was responsible for providing all Medicare and Medicaid benefits, through state and federal funding. In May 2022, CMS released an approach to convert Medicare-Medicaid Plans (MMPs) into integrated Medicare Advantage dual eligible special needs plans (D-SNPs) by December 31, 2025 or ending their operation by December 31, 2023 in its CY 2023 Medicare Advantage and Part D Final Rule. See rule here.

- **There are currently 40+ combinations of Medicaid and Medicare coverage, but only three are considered "integrated" that rely on the managed care framework.** These programs cannot benefit patients that live in FFS states. The managed care integration frameworks follow.

    - **Medicare Medicaid Plan (MMP).** MMP is a demonstration (ends in 2025) that includes a three-way contract between the state, CMS, and a health plan that receives capitated payment (takes on risk) for all Medicare and Medicaid services. States share in Medicare savings with CMS. There is a single set of plan communications and materials.
    - **Fully Integrated D-SNP (FIDE SNP).** This is a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) that bears financial and clinical risk through a comprehensive managed care contract for behavioral health and long-term services. The state does not directly share in Medicare savings. CMS and the states may or may not jointly administrate the program. There is a single set of plan communications and materials.
    - **Highly Integrated D-SNP (HIDE SNP).** A HIDE SNP is similar to FIDE. However, enrollees have separate Medicare and Medicaid communications and plan materials. States and CMS administer the program through separate programs. States do not share in Medicare savings.

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BACKGROUND

RADV

- **CMS announced that Part C (MA) net error rates between 2014 and 2020 were in the 1-5% range.** Part C error rates were quietly released by CMS ahead of Thanksgiving (here). Table 1 shows that $11.4 B and 7.2 B were erroneous payments to all MA plans in 2020 and 2019, respectively. The trend over time is likely troubling to CMS and lawmakers, and adds fuel to the RADV fire. We note that the figures include overpayments and underpayments to plans. Improper payment estimates are due to (1) missing or insufficient HCC documentation (2) medical record discrepancies (3) insufficient documentation to determine whether proper or improper.

- **Headline risk for MA plans in 2023 is the long-standing risk adjustment audits that the agency started over a decade ago.** HHS must release final rules by Feb 1, 2023 or request an extension, or even start over. In the Program Integrity Group at CMS, 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) 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 accordingly. We note that program integrity / anti-fraud measures are bipartisan issues.

- **Three policies 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, which does not align with MA plans' position.

    - 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 physicians. A radiology claim, for 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 used diagnosis 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.

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- **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).

MEDICARE ADVANTAGE

- **There was an 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.

- **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 MA oversight hearing were in line with the testimony released.
    - 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

- **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.

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- **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 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.

- **BACKGROUND**: 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. Rates have been exceedingly healthy over the last 5-7 years, and things may soon change.

- **OUR TAKE – FALL TECHNICAL RULE:** We could see Fall 2022 Medicare Advantage (MA) Technical Rules hit on MA plans & marketing practices harder. Recall that as of Oct 1, 2022 agent & brokers are *required* to record calls with Medicare beneficiaries, as well as provide certain disclosures (i.e., they do not represent the full MA plan option universe). Each fall CMS releases technical rules that act as a “clean up” collection of policies for MA plans and general rules of the road e.g., network adequacy, provider directory rules. Given the scrutiny over aggressive and predatory practices, we could see CMS enact tougher marketing guidelines possibly borrowing from the Senate report we summarized on 11/3.

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