Transcript

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[00:00:00] Jeffrey De Los Reyes: I think this will be a significant change that we've been waiting for because, over the next three years, I do believe that there's going to be an acceleration of both OIG and RADV audits. I think on the OIG side, we've seen a proliferation of OIG findings that have slowly been published by the Office of Inspector General. On the CMS side with the RADV, I do expect that there is going to be an acceleration of the RADV years for which DMS is auditing.

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[00:00:35] Christina Steiner: Welcome to an A&M Healthcare Industry Group podcast. This podcast will feature an update on some of the recent regulations impacting payers. I'm Christina Steiner, a senior director in Alvarez & Marsal's Healthcare Industry Group. I'm joined today by my colleague, Jeff Delos Reyes, a managing director at A&M, and Brian Stimpson, a partner at McDermott Will & Emery.

Brian is the former acting General Counsel and Principal Deputy General Counsel for the US Department of Health and Human Services in Washington, D.C. He represents health clients in litigation, arbitration, and government investigations, and advises clients on how to navigate disputes with overlapping legal, regulatory, public policy, and business considerations.

Jeff has more than 15 years of industry and consulting experience. He advised clients who participate in federal and state-sponsored programs such as Medicare, Medicaid, and the ACA. His main areas of concentration include all aspects of revenue management, including financial projections and accruals, data submissions and reconciliation, performance improvement, and compliance.

We are excited to have you join and get your insights on these important regulations affecting the payer landscape. Jeff, earlier this year, CMS finalized multiple rules that drastically impact Medicare Advantage Organizations, also known as MAOs. Amidst many of the changes are significant ramifications to procedures for Risk Adjustment Data Validation, RADV audits. What actions should plans start to consider in preparation of these RADV changes?

[00:02:17] Jeffrey: Hey, Christina. Thanks for having me here on the podcast. Before I go into the significance of these changes that CMS recently published, I do want to point out to the audience that while we're talking about RADVs, I do want to point out that there's a separate set of audits that is being coordinated by a separate body of the government, which is the Office of Inspector General.

While CMS put forth a final notice on the RADV, I also just want to make sure that we cover in, as part of this topic, the Office of Inspector General, OIG audit. At a high level, CMS's oversight and monitoring of the Medicare Advantage program is completed through what they call Risk Adjustment Data Validation audits. These audits are targeting specific dates of service years while the Office of Inspector General and Department of Justice audits are those audits that are coordinated through another body of the federal government.

This isn't regulated or required by CMS. This is audits targeting plans under the guise of the False Claims Act. The intents of the audits are the same. The intents of the audits are to uncover where they're improper payments that were paid to plans for inappropriate diagnoses that were submitted by health plans. I think this will be a significant change that we've been waiting for because, over the next few years, I do believe that there's going to be an acceleration of both OIG and RADV audits. I think on the OIG side, we've seen a proliferation of OIG findings that have slowly been published by the Office of Inspector General.

On the CMS side with the RADV, I do expect that there is going to be an acceleration of the RADV years for which CMS is auditing, but I want to make sure that our audience understands right now if you're looking through mitigation for these audits, they can really start with the 2018 dates of service audits because the 2018 date of service years is the first year for which CMS will actually extrapolate the errors from the audits, which means that instead of just having a plan being liable for the errors for only the sample of members selected for the RADV, in the extrapolation, CMS has stated that they're going to take the errors and then extrapolate it either to the full plan or to just the members in that specific H contract.

As far as risk mitigation, plans should definitely at least start with 2018 dates of service, pull some records for which they feel have a high risk of failing an audit, and then doing their own deletes so that CMS doesn't have those records to pull for an actual RADV audit, which will significantly decrease their error rates if they are selected. Prospectively, in addition to looking at 2018 dates of services for potential high-risk diagnoses, plans should also start to look at their risk adjustment operations and identify whether or not they have the operational components in place to mitigate any diagnoses that might be getting through to CMS for which there is not sufficient documentation.

What we're telling plans right now is CMS certainly is going to accelerate the RADVs starting this year. They should certainly start to look at past RADVs to see what their error rates have been. They should definitely start to at least look at their own 2018 dates of service whether or not they get selected or not. This will identify rolling barriers in the program. Prospectively, plans should definitely look to identify if there are any high-risk diagnoses for which they're submitting that don't have the appropriate documentation.

[00:06:32] Christina: Thanks, Jeff. That's really helpful advice. In March, CMS also released the 2024 Medicare Advantage Capitation Rate and Part C and D payment policies. In that announcement, there were provisions that affect the current or then current risk adjustment model. Can you explain the changes?

[00:06:51] Jeffrey: I'll explain it at a high level. CMS is effectively going to put into place a new risk adjustment model, which essentially for plans essentially means that they're going to shift from a model known as the V24 model, which is what's currently to what's called the V28. The V28 model contained some new HCCs that weren't in the old model, and they're also going to suppress some HCCs as well as suppress some actual diagnosis codes and introduce some new diagnosis codes.

It is going to be a shift in models. It was all originated. The genesis of all this was that CMS every few years has to recalibrate their HCC models to make sure that it's in line with the most current fee-for-service claims. Overall, plans will have a variable impact to their risk scores. Some plans might see a depression in risk scores. Some plans might actually see better performance in risk scores.

This is all going to be plan-specific. In some of the studies that I've seen and some of the work that we've done here at A&M, we feel that certainly, there are going to be some populations that are going to be impacted more than others. We think that duals will probably have a higher impact with a new model than non-duals. We also feel that because of the introduction of some HCCs and the new model and the removal of some HCCs in the new model, that plans are going to have to focus more on what we term in the industry as prospective programs, meaning less reliance on pulling charts to capture additional HCCs.

In addition, I think one thing's important to realize is that this new model will not be implemented all at once. It's actually going to be blended in and phased in over the next few years. For the 2024 payment year, which is 2023 dates of service, it's going to be a blend of the V24 model at 70% and the V28 at 30%. Then over time, they're going to fully phase in the V28 model.

[00:09:09] Christina: Jeff, that was all really interesting. With these changes in mind, is there anything that risk-bearing providers that enter into value-based contracts with Medicare Advantage payers need to be aware of?

[00:09:22] Jeffrey: Absolutely, Christina. Great question. It becomes more popular for providers to take risks on Medicare Advantage members. I do think they're going to also have to start to look at their own internal operations for how they validate and submit ICD-10 HCCs to their health plan partners to CMS in that type of partnership model. Recently, there was an Office of Inspector General that was recently published where they audited an actual physician practice and found a physician practice liable for improper payments that they received as part of their risk adjustment practices.

While the health plan ultimately holds the contract with the CMS for that Medicare Advantage contract, I do think plans that start to take risks should also start to consider the liabilities that they might be faced with going forward, especially if CMS performs a RADV audit on a particular claim that was submitted by that provider. Certainly, if there's money flowing from the health plan to the provider for any of these HCC risk adjustment changes, I do think plans will have to start to consider their own liability going forward, especially if they take full or partial risk.

[00:10:49] Christina: Great. Thanks, Jeff. Shifting gears a little, it's obvious through all of the conversations with Jeff that CMS has been really busy. They've also issued the 2023 Medicare Advantage and Part D final rule in April. Brian, can you please provide a high-level overview of some of the changes implemented by this rule?

[00:11:08] Brian Stimpson: At a high level, the changes impact prior authorizations, star ratings, health equity, and behavioral health. On prior authorizations, there's a streamlining of the requirements, including adding continuity-of-care requirements and reducing disruptions for beneficiaries. More specifically, approval of a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary to avoid disruptions in care, in accordance with the coverage criteria and the patient's medical history and the treating provider's recommendation.

Coordinated care plan prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria or to ensure that an item or service is medically necessary. Then coordinated care plans have to provide a minimum 90-day transition period for when an enrollee currently undergoing treatment switches to a new plan during which time the plan may not require prior authorization for the active course of treatment.

On star ratings, there are enhancements to further drive quality improvement for beneficiaries. There's a finalized health equity index reward, beginning with the 2027 star ratings to encourage plans to improve care for enrollees with certain social risk factors. The weight of patient experience and complaints and access measures have been reduced. There is an additional rule for the removal of star rating measures and a removal of the 60% rule that's part of the adjustment for extreme and uncontrollable circumstances, also called the disaster adjustment.

I mentioned health equity a moment ago. In addition to the index, CMS has clarified the broad application of its policy to require MA organizations to ensure that services are provided in a culturally competent manner. It's codified best practices by requiring organizations to include providers' cultural and linguistic capabilities in their directories. It's finalized policies that require MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy.

Then MAOs now have to incorporate one or more activities into their overall quality improvement program that reduce disparities in health and healthcare among their enrollees. On behavioral health, the network adequacy requirements have been enhanced. There's additional clinical psychologists and licensed clinical social workers and specialty types that will now be evaluated as part of network adequacy reviews.

There are amendments to general access to services standards that include behavioral health. There are clarifications that some behavioral health services may qualify as emergency services and are not subject to prior authorization and then there's an extension of current requirements for MA organizations to establish programs to coordinate covered services with community and social services for purposes of behavioral health services programs.

There were other changes implemented in the final rule, and those generally echo the shift in healthcare towards more patient-centered care. We won't go into all of those right now. The rule is quite lengthy and robust. Those are the big ones that I've covered.

[00:15:04] Christina: Great. Thanks for that overview, Brian. Turning our attention to changes related to the recently removed public health emergency, particularly everything we're hearing related to the effect on Medicaid redeterminations, can you explain a little bit to us about what that is and the impact it's having?

[00:15:26] Brian: Sure. At the beginning of the pandemic, Congress passed a law called the Families First Coronavirus Response Act, and it included a provision that Medicaid programs keep people continuously enrolled until the end of the COVID-19 public health emergency in exchange for enhanced federal funding. What you saw was people maintaining Medicaid coverage throughout the PHE, whereas they would not have, under ordinary circumstances.

Many would've transitioned to the exchanges or would've moved on and off the Medicaid roles. What that resulted in was a swelling of Medicaid enrollment during the pandemic well above historical norms. Enrollment grew by 23 million lives, and Congress passed legislation this most recent December, effective in March of this year, to end that continuous enrollment provision.

States have, within the last few months, begun the Medicaid redetermination process. They've got about 14 months to complete redeterminations, and that's expected to reduce the level of Medicaid enrollment with a lot of those former Medicaid members moving to the

exchanges. It's a change that will unfold most likely over the next 9 to 12 months with states probably leaving a few months of cushion to work out the bugs and get the transition across the line.

[00:17:12] Jeffrey: Brian, it's Jeff. I do want to point out to you that it's interesting and thanks for that information on the lifting of the PHE for continuous Medicaid. I do want to point out, also, that this would impact the Medicare Advantage plans, especially those plans that have a higher proportion of their population that are duals that have both Medicaid and the Medicare coverage.

Losing that Medicaid entitlement would impact their risk scores because of the fact they will no longer have that dual demographic on the Medicaid flag. Also for those MAOs that have robust SNPs or Special Needs Plans that are targeted at these dual populations, losing a Medicaid portion of their benefits in a lot of plans would actually be a cause for a disenrollment from the plan because they don't have that dual status.

[00:18:12] Christina: Thanks, Jeff and Brian. That's really helpful and useful information. Brian, piggybacking off of that thought, are there any federal policies aimed at enabling the movement of enrollees from Medicaid over to the exchanges?

[00:18:26] Brian: Yes. There are a few, and they're both legal and sub-regulatory. The Inflation Reduction Act extended premium tax credits and expanded eligibility for the exchanges through 2025. Then CMS has issued guidance on how states and managed care organizations should work together to reach out to eligible members in danger of losing coverage. CMS has encouraged MCOs to help individuals enroll in the exchanges.

Then finally, there's a Medicaid unwinding special enrollment period, and that allows individuals who roll off of Medicaid to enroll in exchange coverage from April of 2023 through July of 2024. There are several policies, both at the statutory and sub-regulatory level, that are intended to facilitate this migration from Medicaid to the exchanges.

[00:19:34] Christina: Got it. Thank you. Well, I think with all of that in mind, it definitely seems like there's a lot of regulatory changes and impacts that have been seen in the first half of this year. I think time will tell if the remainder of the year continues on like this. I would think that it's probably a fair statement that the government will be issuing some additional rules and regulations that are impacting payers before the end of this calendar year and definitely, throughout the rest of this administration.

Thanks very much to our presenters, Jeff De Los Reyes and Brian Stimson. We really appreciate your time. For any further information on the material on this podcast, you can visit our website at www.alvarezandmarsal.com. Thank you.

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[00:20:33] [END OF AUDIO]

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