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Overview and Implications of CMS's Proposed Changes to MA RADV

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Summary

If finalized as proposed, the changes to the Risk Adjustment Data Validation process could have a substantial impact on Medicare Advantage plans and enrollees.

Introduction

After delays in finalizing a rule first proposed in 2018, the Centers for Medicare & Medicaid (CMS) is expected to publish a final Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) rule by the fall of 2022.[1] Finalizing this rule as proposed would affect government spending, plan and provider participation, plan benefit design, and beneficiaries' out-of-pocket costs. As a result, stakeholders remain uncertain that the implementation of the RADV rule as proposed would result in a predictable, cohesive strategy to ensure program integrity.

Overview of MA Plan Payment and the Current MA RADV Process

MA is the privately administered coverage alternative to Medicare Fee-for-Service (FFS). Enrollment in MA is growing rapidly, and, as of 2021, nearly 50% of Medicare enrollees who are eligible (i.e., those with Medicare Part A and Part B coverage) are enrolled in an MA plan. MA plans must cover all Part A and Part B services covered by Medicare FFS. MA plan payments are based

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on county-level rates called "benchmarks," which the CMS calculates annually using estimated FFS costs for Part A and B services.

The CMS pays MA plans a capitated amount per member per month (PMPM) on a risk-adjusted basis using the CMS Hierarchical Condition Category (HCC) risk adjustment model. The capitated amount is based on the county benchmarks for each plan's service area and is determined in an audited bidding process conducted by the CMS Office of the Chief Actuary. The CMS adjusts each plan's capitated payment for the health status (i.e., risk score) of each enrolled member of the plan to determine the final payment amount.

Under the HCC model, the CMS determines risk scores based on health status and demographic characteristics. MA enrollee HCCs are assigned based on diagnosis data collected from certain healthcare providers that are then submitted by plans to the CMS for payment.[2]

The CMS annually selects a subset of plans for audit in a process called risk adjustment data validation (RADV).[3] Through these audits, the CMS seeks to ensure payment integrity by validating the accuracy of the diagnosis codes plans submit for payment. Specifically, the CMS reviews medical documentation to confirm coding accuracy and to determine whether the diagnosis data submitted by plans conforms with national standards. Diagnoses must be from a face-to-face visit with an allowed provider that is supported by a medical record.

For each health plan selected for RADV, the CMS generates a sample of enrollees (i.e., a randomly chosen subset of beneficiaries) and conducts medical record reviews to validate members' risk scores and payments to the plan for this sample. The CMS estimates payment error by taking the difference between the actual paid amount, based on plans' submitted diagnoses, and the amount that would have been paid based on RADV validated diagnoses. The CMS's methodology for selecting plans for review, the enrollee sampling criteria, and the sample size have all varied over time, but the intent of these audits is to select a sufficient sample of enrollees to generate payment error estimates with a sufficient level of precision such that plans' error rate can be calculated and payment recovery activity initiated. The process of applying the error rate of a sample of plan enrollees to the plan membership is known as extrapolation.

Summary of Key 2012 and 2018 Proposals to Modify the MA RADV Process

Over the last 10 years, policymakers proposed different approaches for when the CMS can and should recoup overpayments made to MA plans. In December 2010, the CMS proposed a 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

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adjustment." In February 2012, the CMS released a "Notice of Final Payment Error Calculation Methodology for MA RADV Contract Level Audits" (the 2012 Notice).

The methodology described in the 2012 Notice included the sampling framework, extrapolation calculation, and the application of what is known as "an FFS Adjuster" to reduce the extrapolation amount. The CMS noted that the FFS Adjuster would account "for the fact that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model (FFS claims)." In practice, the FFS Adjuster represents the level of diagnoses not supported by medical record in FFS but included in the calibration of the risk adjustment model and, by extension, plan payment. The FFS Adjuster sets a permissible level of payment error due to unsupported diagnosis codes and limits RADV audit recovery to payment errors above that level.

In November 2018, the CMS published a draft rule (4185-P) that departed, in part, from the methodology outlined in the 2012 Notice. The 2018 proposed rule included provisions regarding the applied methodology for RADV audits. To support its proposal, the CMS cited an internal study finding "that errors in the FFS claims data do not have a systematic effect on the risk scores calculated by the CMS-HCC risk adjustment model estimation and, therefore, do not have any systematic effect on the payments made to MA organizations."

Numerous stakeholders submitted comments in response to the 2018 proposed rule and, while most supported the CMS's overall goals of increasing program integrity, many cited concerns with the specifics of the CMS's approach and called for additional research into the potential impacts before the rule is finalized. These comments generally fell into the following 4 areas:

- **Elimination of the FFS Adjuster:** The CMS reversed its approach on the FFS Adjuster from the 2012 published methodology, noting it would not include a FFS Adjuster in the final methodology.[4] Stakeholders noted that this change would likely have a substantial impact on plan bidding and payment.
- **The CMS's Internal Study:** Stakeholders expressed contention with methods used in the study by the CMS to determine that no FFS Adjuster was necessary. Commenters challenged the integrity and validity of the study, as well as the applied methodology and approach. Commenters' major concerns were that the underlying CMS data were generated from a FFS study of error in procedure coding and medical necessity that did not use RADV methodology, the CMS's statistical results were based on underestimates of HCC error rates, and the CMS applied a post-hoc adjustment that removed observed differences supporting the need for a FFS Adjuster.
- **Retroactive Changes to Regulations:** The CMS proposed making changes to regulations retroactively that would allow it to use its new methodology, without a FFS Adjuster, to recover payments from audits conducted for 2011–2013. The CMS also asserted its authority to use its discretion to identify different sampling methods and auditing techniques for 2014 and subsequent

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RADV audits.[5] Stakeholders believe that the CMS's actions are not in compliance with statute or regulation, citing the statutory requirement for the CMS to announce changes to payment methodology in advance of the payment year.

- **Lack of a Legal Rationale for Using Sampling and Extrapolation:** The CMS asserted its authority to use any statistically sound methodology to conduct audits and to extrapolate results. More specifically, it noted that extrapolation can be applied "based on longstanding case law and best practices from [the Department of Health and Human Services] and other federal agencies." However, stakeholders posited that the CMS did not specify which statutory provision it relied on to extrapolate results.

In light of these above issues, legal action from stakeholders is likely to occur following publication of a final rule should it align to the tenets of the proposed rule.

Potential Impact of the Rule if Finalized as Proposed

Finalizing the rule as proposed has the potential to create disruption for plans and providers, which may, in turn, affect premiums and benefits for beneficiaries. First, to the extent that plans may have anticipated costs associated with the 2011–2013 audits, they may have expected use of a FFS Adjuster. Without the application of a FFS Adjuster, recoveries could be quite different than plans anticipated. Second, plans may have apprehensions about future participation in the MA program if the CMS is allowed to make retroactive changes to rules. Additionally, plans may not be prepared to manage the operational burdens associated with retroactive application, since plans could not have been aware of those changes as the rule had not yet been in effect. Finally, the burden on providers could also increase if health plans increase oversight to enforce a zero-error tolerance for errors in diagnostic coding in medical records and claims, while there are not similar expectations on the Medicare FFS side.

Due to these challenges, MA plans may either project decreased revenue or increase their bids (adding a "risk premium"). These potential changes in plan bidding behavior could reduce funding available to lower enrollee out-of-pocket costs or premiums or to provide supplemental benefits (e.g., dental, transportation), or it could increase government costs. As a result, if the rule is finalized as proposed, some beneficiaries could face higher costs, fewer MA plan choices, or reduced supplemental benefits under the MA program.

Further, the downstream the impact of the plan response to the RADV rule, if finalized as proposed, could be substantial for the government. The government's costs could rise if plans exit the market or reduce their areas of service or increase their bids to account for the increased risk of variable payment recoupment.

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Conclusion

As per the statute, the CMS must release the final RADV rule by November 2022 or seek an extension. While the CMS and the industry agree on the need for a program to ensure payment integrity, the policy issues are complex, and implementation of proposed changes would likely present numerous challenges. The finalized rule will offer insight into how the CMS will address the concerns that stakeholders have raised with applying FFS audit methodologies to the MA program.

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Notes

1. 4185-P was released as a proposed rule in November 2018. Since its release, there have been 2 extensions and the release of provisional data from HHS.
2. The word "providers" in this case refers to hospitals, physicians, and outpatient facilities.
3. In accordance with § 422.2, 422.310(e), the Secretary has the authority to conduct annual audits to ensure risk-adjusted payment integrity and accuracy.
4. The CMS did not save its original FFS adjuster study cited in the proposed RADV rule 4185-P and was unable to reproduce it.
5. 42 USC, §§ 1871(e)(1)(A)(i) and (ii), authorizes retroactive application of rules where "(i) such retroactive application is necessary to comply with statutory requirements; or (ii) failure to apply the change would be contrary to the public interest."

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