MEDICARE ADVANTAGE OVERSIGHT MECHANISMS 2024

There are numerous mechanisms and programs that provide oversight of the Medicare Advantage program to ensure Medicare Advantage operates in the best interest of Medicare beneficiaries and taxpayers. These programs cover many areas from careful review of plan bids and benefit packages to reporting requirements and audits that make sure plans operate in compliance and accordance with the statutes and rules of Medicare Advantage.

BID AUDITS AND REVIEW OF BENEFIT PACKAGES

Medicare Advantage plans must submit annual bids outlining their projected costs and benefits, which CMS audits to ensure compliance. The bid must be certified by an actuary to ensure it meets CMS guidelines and is based on sound actuarial principles.[1] CMS also closely monitors the design of benefit packages to ensure they provide the same benefits as Fee-For-Service (FFS) Medicare while also meeting additional coverage and cost-sharing requirements. In the Medicare Managed Care Manual, CMS states that Medicare Advantage organizations' contracts with CMS will outline the provisions related to auditing rights, which include CMS' right to inspect the services provided by Medicare Advantage plans.[2]

NETWORK ADEQUACY

Medicare Advantage plans must meet specific standards for network adequacy, ensuring that beneficiaries have timely access to enough in-network providers.[3] These standards include minimum requirements by county for the number of providers and the maximum travel times and distances to these providers. For example, the maximum distance to primary care providers is 5 miles in a large metro.[4] In a June 2020 Final Rule, CMS published plan network adequacy rules for Medicare Advantage plans to codify the existing network adequacy methodology and finalize policies that address maximum time and distance standards in rural areas, telehealth, and Certificate of Need (CON) laws.[5]

ONE-THIRD AUDITS

On a 3-year cycle, Medicare Advantage plans are subject to extensive audits for operation, compliance, and finances. Specifically, CMS is required by statute to audit at least one-third of Medicare Advantage organizations' financial records every year. Financial records include data related to utilization, costs, and bid development.[6] CMS issues an audit notice to plan sponsors outlining the specifics of the upcoming audit.[7]

PROGRAM AUDITS

The Medicare Parts C and D Oversight and Enforcement Group within CMS annually measures Medicare Advantage plans compliance with requirements associated with access to medical services, drugs, and other enrollee protections.[8]

RISK ADJUSTMENT PROGRAM

Unlike FFS Medicare where payment is based on the provision of services for specific procedures, payment in Medicare Advantage is driven by patient demographics and disease status. A series of provisions are in place to ensure accurate payment to Medicare Advantage plans:

THE CMS HIERARCHICAL CONDITION CATEGORY (HCC)

The CMS Hierarchical Condition Category (HCC) is used to adjust per member per month payments to Medicare Advantage plans.[9] The CMS-HCC model was first used for payment in 2004 and has been routinely modified to ensure payment accuracy. To date, CMS has revised the model many times to improve its accuracy, clinical relevance, and eliminate risk to payment integrity.

In 2024, CMS finalized the transition to the updated version of the model— V28.[10] This model includes an expanded number of HCCs (from 86 to 115) as well as a revised clinical categorization, based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). CMS also removed over 2,000 ICD-10 codes to ensure coding integrity and comparability with FFS Medicare. V28 is being phased in over a 3-year period and will be fully phased in in 2026.

RISK ADJUSTMENT DATA VALIDATION (RADV) PROGRAM

CMS' Risk Adjustment Data Validation (RADV) program audits risk adjustment data submitted by health plans and recoup potential overpayments. Diagnoses submitted by Medicare Advantage plans are reviewed and compared to enrollees' medical records to ensure accurate payment.[11] 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. RADV audits are performed after the final risk adjustment data submission deadline and CMS recalculates the risk factors for enrollees to determine if payment adjustments are necessary. On January 30, 2024, CMS released a final Medicare Advantage RADV rule. CMS noted that it expects to recoup approximately $4.7 billion over 10 years through RADV based on the updated policies.[12]

OFFICE OF THE INSPECTOR GENERAL (OIG) AUDITS

The Department of Health & Human Services (HHS) Office of the Inspector General (OIG) conducts separate audits of risk adjustment data submissions to provide oversight of the Medicare Advantage program.[13]

PARTS C AND D DATA COLLECTION AND VALIDATION

Medicare Advantage plans must collect and submit detailed data on Part C and Part D services, which is used for performance assessment.[14] The purpose of data collection and validation is to ensure health plan data is reliable, complete, and timely. Data collection and validation also provides assurance for CMS that the data provided by Medicare Advantage plans is credible, and CMS uses this data to report to Congress and oversight agencies, and to allow CMS to effectively monitor and compare this information over time.[15]

QUALITY IMPROVEMENT PROGRAMS

Medicare Advantage plans must have an ongoing Quality Improvement Program (QIP), as required by section 1852(e) of the Social Security Act (the Act) and 42 CFR § 422.152(a), which must include a Chronic Care Improvement Program (CCIP) for all non-special needs coordinated care plans.[16] CMS states that Medicare Advantage plans must develop improvement programs that are appropriate for the target population. CMS outlines chronic conditions to target, but plans are not restricted to the list.

QUALITY REPORTING

Medicare Advantage plans are evaluated by a comprehensive set of measures, making up the Star Rating System. Plans are given a star rating (1 to 5 stars) based on several performance metrics, including quality of care, customer service, and member satisfaction.[17] CMS uses the Star Rating program as a compliance tool; CMS can terminate plan contracts with consistently less than 3 stars.[18] In addition, CMS will issue a notice to enrollees in plans that have been identified as a consistent poor performer and encourages them to review other plans available in their area.[19] Data from two surveys are incorporated into the calculation for Star Ratings:

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEYS

These surveys collect information regarding beneficiaries' experiences with their health plans and services, including aspects such as customer services, access to care, and overall satisfaction.

HEALTH OUTCOMES SURVEYS (HOS)

HOS are conducted to measure the physical and mental health of Medicare Advantage enrollees. The results assist CMS in assessing the effectiveness of care management programs and health interventions provided by Medicare Advantage plans.

While quality reporting does exist in FFS Medicare, the specifics needed for Medicare Advantage plans differ. While plans are evaluated based on a comprehensive set of performance measures that include care management and member satisfaction, FFS Medicare focuses on individual provider and facility performance.

REQUIREMENTS FOR SPECIAL NEEDS PLANS

A Special Needs Plan (SNP) is a Medicare Advantage coordinated care plan that must be designed to provide targeted care to certain enrollees; SNPs must meet specific CMS integration requirements to coordinate care for these individuals, including those with specific chronic conditions (C-SNP), are dually eligible for Medicare and Medicaid (D-SNP), or require institutional level care (I-SNP)). Each SNP must meet a separate Model of Care (MOC) as outlined by CMS, which are audited to evaluate the implementation.[20] In the auditing process, if it appears to CMS that the MOC does not meet CMS' standards, a SNP may be requested to resubmit the MOC to ensure it meets regulatory requirements.[21]

STATE LICENSING REQUIREMENTS

When applying to contract, Medicare Advantage organizations must document that they are authorized under state law to provide healthcare services in the requested service area. Each state must also, in turn, certify that the Medicare Advantage organization is authorized to bear the risk associated with the plan.[22]

Sources

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