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Session 2 – Trends in Medicare Advantage and Managed Medicaid Reimbursement

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Agenda

- What to expect from payors post-COVID
- MA coverage of ESRD
- Progressing value-based care models
- 60-day Overpayment Rule

Transitioning Post-COVID

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Transitioning Post-COVID

Operational Impacts:

- Surge in utilization, especially preventive care that was delayed
  - Well-visits/annual wellness exams
  - Elective surgeries
- Telehealth and impact on in-person visits
  - Telehealth visits leading to increased in-person visits, requiring office space
- Nursing and personnel shortage
  - Travel nurses
  - Increased staffing costs
- Impact of inflation on all costs
- Anticipation of next variant/surge

Transitioning Post-COVID cont'd

CMS waivers and flexibilities expiring

- Sequestration to begin again
  - 1% effective 4/1/22 – 6/30/2022
  - 2% effective 7/1/22 forward
- Out of network services to MA Members
  - Coverage/beneficiary cost-differential

Some continued under Physician Fee Schedule

- Certain telehealth services extended to 12/31/23 to evaluate permanent addition to Medicare telehealth services list
- Coding/payment for longer virtual check-in service made permanent

Coverage of at-home COVID tests (8 per month)

Increased supplemental benefits offered by MA Plans

Audits on use of CARES Act funds

Transitioning Post-COVID cont'd

Medicaid Enrollment and Eligibility Activities

- Maintenance of Eligibility provisions require states to keep beneficiaries enrolled until end of the month the COVID-19 public health emergency ends
- Anticipate backlog of eligibility renewals and redeterminations coupled with processing new applications
  - CMS projects 6 months to clear backlog
- States to adopt methodology to prioritize pending eligibility/enrollment actions; focus on individuals "most likely" to no longer be eligible
- Expect changes in coverage for many Medicaid patients to commercial/exchange and even uninsured

MA Coverage of ESRD

MA Coverage of ESRD - Statistics

January 1, 2021 – Individuals with ESRD eligible to enroll in standard MAO

- 21st Century Cures Act
- Previously only eligible for C-SNPs

500,000+ Medicare beneficiaries have ESRD

- As of 2021, 130,000 are in MA
- CMS expects additional 83,000 with ESRD will enroll in MA by 2026

ESRD population less than 1% of Medicare population but accounts for over 7% of Medicare spending

- Upward pressure on MA premiums

MAO-Side Considerations

MLR focus on acute dialysis patients

- Average MA plan has 112% MLR for ESRD patients
- Decreasing inpatient LOS and moving patient to in-home dialysis
- Heavy care-coordination / wellness efforts

30-month coordination of benefits period still in effect

- Group health plan remains primary

Reduced network adequacy standards

- Across the board, but also specific to dialysis facilities
- More patients might show up in hospital
- Potential discharge planning difficulties

Payor Contracting

Value-based contracts need to be reassessed.

- Dialysis is a significant new expense

If not value-based, consider reimbursement for dialysis.

- Paid on catch-all rate or a negotiated rate already in the contract?
- Is the negotiated rate still reasonable given new MA volume for dialysis

Do reimbursement rates justify change in operations (e.g. shift towards home dialysis)?

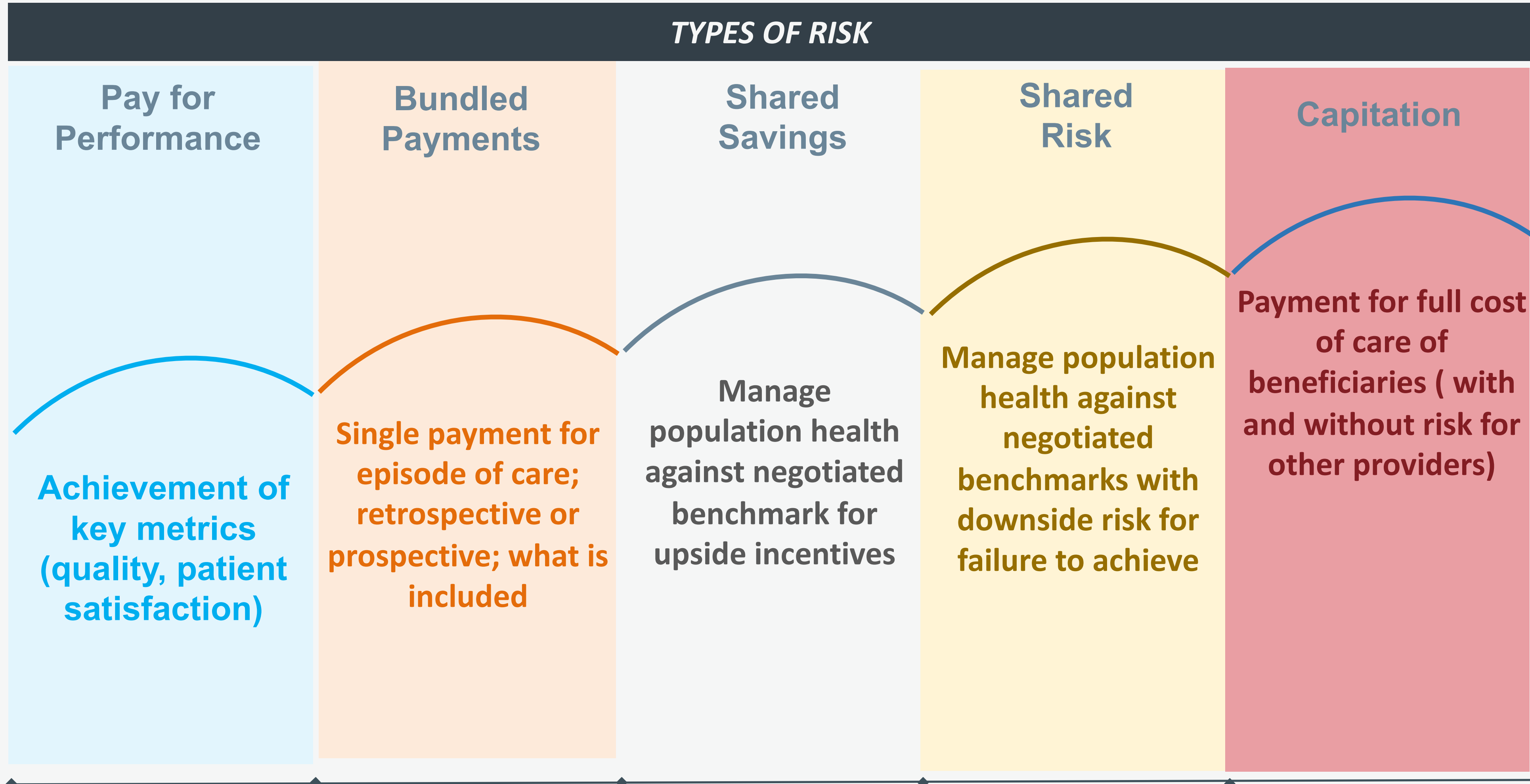
Value Based Care Models

Value Based Care (VBC)

Expect continued trend incorporating VBC models into Medicare Advantage and Medicaid Managed Care arrangements

- Payers have been aggressive in pushing providers into VBC models
- Includes a push to adopt downside risk-based programs

Common VBC Approaches



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VBC Investment Trends

- Major insurers and private equity expand investments to increase VBC arrangements into provider agreements
- US Medical Management (November 2021)
  - Focus on providing coordinated care in the home setting
  - Centene sold majority stake to Rubicon Founders, Valtruis, Oak HC/FT and HLM Venture Partners to partner in converting business to VBC and expanding "into all of Centene and Wellcare"
  - Highlights purchase of assets and moving them into organizations that take full risk
- Technology investments in tools to manage patient populations will increase

Medicaid Managed Care and VBC

- Federal limitations on approvable technology have restricted state government use of VBC models effectively, but MCO's have invested
- As Medicaid Managed Care increases so do opportunities to align:
  - Primary Care Focus
    - Behavioral Health Integration
    - Access to Care/PCP's
    - Filling Gaps in Care
  - Social Determinants of Health integration
    - "In-lieu-of services" and Value-added services
    - Serve to address the conditions in which people are born, grow, live, work and age
    - Examples:
      - Food bank working with state Medicaid program to make it reimbursable
      - Housing supports to homeless/at-risk patient populations to reduce health costs

Core VBC Issues to Navigate

- Bi-directional data sharing and reporting with payer
- Privacy/confidentiality laws and use of data
- Alignment in goals and objectives with payer
- Antitrust
- Insurance licensing
- Patient engagement and care coordination roles
- Selection of cost and quality metrics
- Selection of payment model
- Level of risk to accept

60-Day Overpayment Rule

False Claims Act - Overview

- The False Claims Act ("FCA"), 31 U.S.C. § 3729, has consistently been a tool the Government uses to combat fraud and abuse
- Prohibits any individual or business from submitting, or causing someone to submit, to the government a false or fraudulent claim for payment
  - Anyone who receives Government funds is subject to FCA
  - Defense contractors/subcontractors, financial institutions, hospitals, individuals
  - Health care industry and health care providers are among the most affected
- *Qui Tam* provision permits private citizens ("Relators") to sue on behalf of the federal government and to share in the recovery
  - Cause of action for retaliation
  - Attorney's fees for relator counsel

False Claims Act - Penalties

- FCA carries potentially enormous damages and penalties
  - Damages are always subject to a multiplier (statute allows for up to three times damages)
  - Each false claim is subject to additional penalty
    - Penalties now: $11,803 to $23,607 per claim
- Other collateral consequences may include suspension or exclusion from federal programs

Reverse False Claims

- "knowingly makes, uses or causes to be made or used, a false record or statement *material to* an obligation to pay or transmit money or property to the Government, *or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.*" - 31 U.S.C. § 3729 (a)(1)(G)
- "[G]overnment money or property that is knowingly retained by a person even though they have no right to it."
  - Senate Rept. No. 111-10 (March 23, 2009).

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60-Day Overpayment Rule

- Affordable Care Act: If any person who receives an overpayment from the Medicare or Medicaid programs — and does not report and return an overpayment within *60 days after identification* — will be subject to potential False Claims Act liability. 42 U.S.C. § 1320a-7k(d)
- CMS Rulemaking
  - Part A/B
  - Medicare Advantage – Does not impose a direct obligation on downstream managed care providers to comply with the 60-day rule
  - Managed Medicaid – MCOs must have “a mechanism” for network providers to report/return overpayments to the MCO. 42 C.F.R. § 438.608(d)(2).

DOJ Enforcement Trends

- DOJ commitment to fraud enforcement in Medicare Advantage
  - multiple public statements
  - continued increased enrollment in MA
- Until recently, DOJ enforcement only against MA providers who submitted incorrect or unsupported data that impacted risk score and risk adjustment payment.
  - This trend continues. Downstream providers who are capitated or who submit HCC-RAF/diagnosis data on behalf of MAOs are at risk
  - *United States ex rel. Osinek v. Kaiser Permanente*
  - *United States ex rel. Ormsby v. Sutter Health et al.*

DOJ Enforcement Trends

- New Legal Theory:
  - FCA liability for poor patient outcomes: *United States ex rel. D'Cunha v. Luketich*
    - DOJ alleged unnecessary delays in surgery by UPMC caused complications, lengthened surgical time, lengthened hospital stays
    - resulted in additional diagnosis codes.
- Best Practices:
  - Negotiate payor contract terms
  - Document diligently. Medical records should support claims and diagnosis codes
  - Regular internal audits for MA

Thank You

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