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Overpayment Ruling Has Broad Implications Beyond MA Plans

A federal judge's recent ruling in a UnitedHealth Group lawsuit, which challenged a CMS 2014 final rule requiring the reporting and returning of Medicare Advantage overpayments, reads as a major victory for MA insurers. But it also raises questions as to what constitutes false claims when it comes to not reporting overpayments and how overpayments should be identified, and leaves the door open for CMS to revisit the issue after taking those questions into consideration, according to industry experts.

CMS in the 2014 rule clarified the statutory definition of an overpayment and codified provisions of the Affordable Care Act that required MA organizations to return identified overpayments within 60 days. Under the so-called 2014 Overpayment Rule, any diagnostic code that is inadequately documented in a patient's medical chart results in an overpayment, which is "identified" whenever an MAO determines or "should have determined through the exercise of reasonable diligence" that it received a payment to which it was not entitled. Furthermore, CMS defined reasonable diligence as requiring "at a minimum...proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments."

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MA Stakeholders Question Viability of Proposed MAQI Demo

With the July release of two proposed rules containing changes to the third year of the Quality Payment Program established by the Medicare Access and CHIP Reauthorization Act of 2015, CMS proposed to advance a five-year demonstration that will waive clinician requirements for the Merit-Based Incentive Payment System (MIPS) track of the QPP if they accept a certain amount of risk in contracts with Medicare Advantage plans while continuing to serve fee-for-service (FFS) patients.

But that proposal left out an important incentive — a 5% bonus that is afforded to qualifying participants in the Advanced Alternative Payment Model (Advanced APM) track — which industry observers are now saying is needed to achieve sufficient participation in the demo.

The purpose of the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demo is to "test whether exempting, through the use of waiver authority, clinicians who participate to a sufficient degree" in certain payment arrangements with MA organizations from the MIPS reporting requirements and its resulting payment adjustment will "increase or maintain participation in payment arrangements with MAOs similar to Advanced APMs and change the manner in which clinicians deliver care," CMS explained in a recent Paperwork Reduction Act (PRA) information collection request (83 Fed Reg. 20372, Sept. 19, 2018).

APM — which starting in 2019 includes non-Medicare payment arrangements (e.g., commercial, MA, Medicaid) that meet criteria that are similar to Advanced APMs under Medicare — because two-sided risk deals with self-funded employers aren't as prevalent, he adds.

Speaking at CMS's Fall Conference and Webcast, held Sept. 6 in Baltimore, CMS official Jason Petroski explained, "CMS thinks this is something worthwhile to test because MAOs may have or are considering payment arrangements that already resemble Advanced APMs. However, without this demonstration physicians may still be subject to MIPS, even if they participate extensively in Advanced APM-like arrangements in MA."

CMS Is Asking MAOs to Assist Clinicians

Petroski, who is director of the Division of Delivery System Demonstrations and Seamless Care Models Group within the CMS Innovation Center, added that CMS is advising MAOs to let their clinicians know about the MAQI opportunity and assist them in providing the qualifying participant and threshold information. "Anything you can do to help with the individual clinicians in submitting this information to see if they achieve the waivers would be helpful," he told attendees. "And lastly, if the intent of this project is to encourage innovation and to encourage Advanced APM-like arrangements in MA, we'd ask you to consider innovative changes and/or new arrangements with clinicians if you haven't done so already."

But UnitedHealth Group in formal comments submitted on Sept. 4 expressed concern over the burdensome paperwork involved in applying for the demo. While UnitedHealth

agreed that the MAQI demo will be a "useful way" to determine if Advanced APM-like arrangements in MA can be effective in changing the way clinicians deliver care, it suggested there are ways CMS can look at reducing administrative burden for interested clinicians. For example, the insurer observed that the forms CMS has proposed using for clinicians to identify their qualifying payment arrangements and threshold data are too detailed and seek information that may not be readily available to the clinician through the normal course of business.

UnitedHealth Sees Forms as Burdensome

UnitedHealth also noted that while it is "certainly willing" to assist clinicians in filling out the forms, it suggested that "an extensive reliance on multiple payers to complete the forms adds another layer of complexity that clinicians must contend with. We do not believe this is what CMS intended and does not align with CMS's initiative to promote patients over paperwork." As a result, the company urged CMS to simplify the forms, especially given the tight timeframes for determination while CMS awaits approval of the waiver in the QPP Year 3 final rule. "UHG is concerned that CMS is rushing the implementation to be effective for the 2018 performance period prior to gathering, considering and incorporating comments and feedback from stakeholders."

Moreover, UnitedHealth urged CMS to consider ways to "incentivize providers in order to promote the continued move to value-based contracting." Although it did not take issue with the lack of a 5% bonus available to eligible MAQI participants, it pointed out that the MAQI demo will effectively exclude more clinicians from MIPS, which would result in "further

collapsing clinicians' Composite Performance Score (CPS) and decreasing payments to those remaining eligible clinicians participating in MIPS." In other words, the "pool" from which either negative or positive payment adjustments in MIPS would become smaller, explained UnitedHealth.

View comments on the MAQI demo at <https://www.regulations.gov/docket?D=CMS-2018-0088> and more information about the demo at <https://innovation.cms.gov/initiatives/maqi>.

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Medi-Cal Health Homes Aim to Enhance Care Coordination

Medi-Cal managed care plans are in the early stages of standing up California's new Health Homes Program (HHP), which aims to deliver comprehensive care management for qualifying Medicaid enrollees with chronic conditions. Starting in San Francisco County, the HHP will target the highest risk 3% to 5% of Medi-Cal beneficiaries and coordinate a range of physical health, behavioral health, substance use disorder, long-term services and other supports through a network of community-based care management entities (CB-CMEs) that is established by managed care plans.

Under Section 2703 of the Affordable Care Act, states have the option to submit a State Plan Amendment to create health homes. States receive enhanced federal funding during the first two years of implementation to support the rollout of the benefit; that funding does not apply to the underlying Medicaid services also provided to individuals in a health home. As of April 2018, 22 states and the District of Columbia have a total of 34 ap-

proved Medicaid health home models, according to CMS.

All Medi-Cal plans are required to participate in the HHP in counties where it is being offered, must build an HHP network in which a member can choose the CB-CME that they want for their care coordination, and will reimburse the CB-CMEs for the provision of HHP services. Plans will also be responsible for monitoring the provision of services, which include the development of a Health Action Plan for each member, according to the HHP Program Guide posted by the Dept. of Health Care Services (DHCS).

Through this enhanced care coordination and the partnership between the plan and CB-CME, the state hopes to reduce avoidable health care costs, including hospital admissions/readmissions, emergency department visits and nursing facility stays. Models may vary by geographic region, DHCS noted, so while models in urban areas might embed care coordinators on-site in community provider offices, acting as CB-CMEs, models in more rural areas served by low-volume providers might feature care management being handled by another community-based entity or staff members within the plan's existing care management department,

which will act as the CB-CME, or some hybrid of the two.

San Francisco Health Plan (SFHP), one of the two plans in San Francisco County that kicked off the initiative on July 1, tells AIS Health that the HHP builds on its own community-based care management program that uses community clinics and federally qualified health centers (FQHCs) but will enhance the community-based role that those and other organizations were already playing to provide additional outreach efforts in the community. "The goal is really to meet the folks that are identified for the program where they're at, identify their priorities and help them utilize health care and community-based resources in the best way to achieve optimal health," says Fiona Donald, M.D., the health plan's medical director.

Primary Care Is Basis of SFHP Network

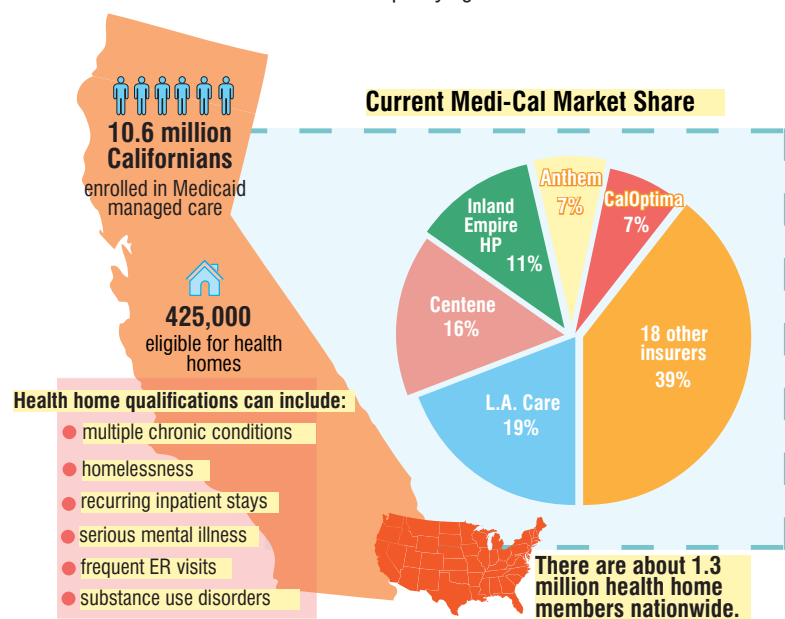
"We had somewhat of a head start because of our programs...but we also have the advantage of being a small county geographically, so it's easier for us to meet members in the community and the home than a rural health plan," adds James Glauber, M.D., chief medical officer for SFHP.

The plan first contracted with CB-CMEs that were already conducting the types of care coordination activities needed to target its highest-risk, sickest members, had the staffing in place to help with outreach and enrollment and were ready to commit to being a CB-CME starting in July. "Right now, our goal is to really have our CB-CMEs be those places where our members seek care, so we started with our primary care medical homes," explains Donald. "And some of our clients seek services primarily at behavioral health clinics and these entities are well set up to provide the coordination of physical,

California's Health Homes Program, With Current Medicaid Market Share

by Carina Belles

California's Medicaid program is the latest to launch health homes, which closely coordinate health services for members with chronic conditions. In California, state officials estimate about 3% to 5% of the Medi-Cal population is eligible for health home enrollment. Anthem Blue Cross, one of the state's largest Medi-Cal plans (see chart below), launched its first health home in July, in San Francisco County. By July 2019, all Medi-Cal insurers in 29 target counties will need to offer health homes to qualifying members.



SOURCE: MMM, AIS's Medicare and Medicaid Market Data; California Department of Health Care Services

behavioral and substance use services and connect people to community-based resources,” says Donald.

“There’s also the ability and the hope that over time additional community partners will be able to make that commitment and invest in the resources so that they too can serve as care management entities for their patients,” adds Glauber.

Outreach Is Exceeding Expectations

The plan estimates that “several thousand” individuals out of the 130,000 it currently serves will qualify for the HHP, depending on the presence of medical, psychiatric or substance use conditions and level of utilization. SFHP is still in the outreach phase but has already exceeded its goals by engaging 30% of the individuals it has targeted in the two months since implementation.

Both Anthem Blue Cross and SFHP launched their HHPs on July 1; the program will next launch in Riverside and San Bernardino counties starting on Jan. 1, 2019, then expand to the 26 other targeted counties starting on July 1, 2019. L.A. Care Health Plan, which serves 2 million Los Angeles County residents and estimates it will provide HHP services to 10,000 of those members even though as many as 100,000 may qualify, is in the early stages of considering how it will structure the benefit and its CB-CME to adequately serve that population.

John Baackes, CEO of L.A. Care, says he has “no concern whatsoever” about identifying the right people, inviting them to participate and getting them to use the resources that the HHP provides and “prove that this actually provides a benefit.” But meeting the CB-CME contracting requirement and making sure that they have qualifying entities with the capacity to take

care of eligible participants is the “No. 1 challenge,” he tells AIS Health.

Giving high-risk members a care manager to help them navigate the complex health care system and “deliver the trifecta of providing the right care in the right place at the right time” is something that L.A. Care and many other plans have already been doing for their needier members, but the HHP provides them additional dollars to do so for a targeted population and in a more formalized way, explains Baackes. L.A. Care has its own complex care management department that currently serves about 1,500 members; the HHP will enable it to expand those services to many more members.

L.A. Care Will Build on Internal Skills

That department currently employs nurse care managers and community health workers to help people who fall into the complex care category. “Contracting outside is going to be a problem because you’ve got more hands in the till and more handoffs when what we need is fewer handoffs and more integration and consolidation,” Baackes contends. So as L.A. Care gets ready to roll out the program and establish its CME contracts, it will be looking to build the internal capability to meet the program’s requirements as much as possible.

“The way I see this working is our care management team would probably have two aspects to it: (1) the nurse care manager who we really want to work with the primary care physician who has the power to order services, write scripts, etc., and (2) and the community health workers, who will identify the social determinants that are acting as barriers to care, such as food insecurity or homelessness, and then link people to other services that

would help them address those social determinants,” says Baackes.

“Helping people manage that stuff, getting them the proper nutrition, signing them up for food stamps — that’s what a good care management program does, and we’ve been doing it,” he adds. “This is just putting more of a spotlight on it and giving us additional resources to do that and to do that for more people.”

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Judge Vacates 2014 Rule

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UnitedHealth Group, the largest sponsor of MA products in the U.S., its UnitedHealthcare subsidiaries and other MA insurers in January 2016 filed a complaint against the federal government. It alleged that CMS in finalizing its 2014 Overpayment Rule, among other things, violated the statutory mandate of “actuarial equivalence” by asking sponsors to return overpayments based on audited records while the methods used to determine MA payment rates are based on unaudited records of fee-for-service (FFS) Medicare transactions.

UnitedHealthcare pointed out that CMS in 2012 adopted a “FFS adjuster” to account for the different data sources in its Risk Adjustment Data Validation (RADV) audits but omitted any such adjuster from the 2014 rule regarding overpayments.

In her Sept. 7 opinion on *UnitedHealthcare Insurance Co. et al. v. Azar* (16-157), U.S. District Court Judge Rosemary Collyer wrote that the 2014 Overpayment Rule “fails to recognize a crucial data mismatch” and “establishes a system where ‘actuarial equivalence’