Updates
February 13, 2023
New CMS Rule Requires Extrapolation of Medicare Advantage RADV Audit Findings

The Centers for Medicare and Medicaid Services (CMS) published its final rule regarding the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) program in early February 2023.[1] Among other matters, the final rule codifies contract-level extrapolation of RADV audit findings beginning with payment year 2018. CMS expects to recover nearly $5 billion in risk adjustment overpayments from MA organizations (MAOs) because of the new rule.

RADV Background

Under federal law, CMS is required to risk adjust payments made to MAOs on behalf of enrollees whose health status carries predictably higher healthcare costs.[2] Studies and audits conducted by CMS and the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services, along with federal False Claims Act litigation and increasing enrollment in and costs associated with MA, have placed crosshairs on perceived inadequacies in medical record support for diagnoses that prompt risk adjustments for chronic conditions. The government estimates that, in 2021 alone, over $15 billion in overpayments was made to MAOs for risk adjustments that lacked sufficient or compliant supporting documentation.[3] RADV audits have been CMS's main tool for identifying such overpayments. Historically, findings from such audits resulted in recoupment for only the sampled enrollee-level claims and were not extrapolated to the universe of similarly situated adjustments in the same MAO contract. But that hasn't stopped CMS from proposing contract-level extrapolation for over a decade.

New RADV Policy

Under the new RADV regulations, which become effective on April 3, 2023, CMS will begin extrapolating RADV audit findings on a contract-level basis beginning with payment year 2018. (CMS originally proposed implementing the extrapolation starting with payment year 2011 but dropped that proposal in the final rule.) By using extrapolation and assuming the average level of audit findings per contract holds constant ($9.5 million in overpayment per audited contract), CMS estimates that it will recover, over the next nine years, more than $4.7 billion in alleged overpayments made to MAO plans.[4] But despite adopting a new extrapolation policy, CMS has not committed to using an identified RADV audit methodology. Instead, CMS plans to use one or more "statistically valid methodologies" that CMS determines are "well-suited to a particular audit."[5] MAOs may continue to contest adverse audit determinations through CMS's administrative dispute and appeals process, but according to the final rule, they cannot appeal the statistically valid methodology CMS chooses to apply to their respective RADV audits.[6]

The final rule does, however, make at least one thing clear about CMS's methodology going forward—and it's not good news for MAOs. Despite previously informing MAOs that it would apply a fee-for-service (FFS) adjuster before finalizing audit recoveries, CMS now says its RADV methodology will not include application of the adjuster. MAOs had encouraged CMS to adopt an FFS adjuster to account for differences in coding between managed care and FFS environments, and application of an FFS adjuster may have resulted in documentation requirements that were more consistent with comparable requirements for FFS providers—and lower alleged overpayments.[7] Following the U.S. Court of Appeals for the District of Columbia Circuit holding in the *UnitedHealthcare case*, which challenged, among other matters, the lack of an FFS adjuster in MA audit findings, CMS takes the position that the actuarial equivalence provisions in the federal statute authorizing risk

adjustment does not apply to MAO obligations to return overpayments.[8]

The final rule also highlights that CMS has outstanding RADV audit findings for payment years 2011-2015 that it plans to issue after the rule's effective date. Those RADV audit findings will seek to recover only sampled, or enrollee-level, overpayments.[9]

Compliance Considerations

CMS foreshadows that it will focus its future RADV audits on contracts with the highest risk for alleged overpayments, including those with the highest coding intensity scores or high rates of unsupported diagnosis codes in prior RADV audits.[10] Contracts with high enrollments will also receive heightened scrutiny.[11]

MAOs are still required to establish compliance programs and processes to ensure they submit to CMS accurate diagnosis coding supported by enrollees' medical records and accurate diagnosis data and to return ostensible overpayments that they discover or are brought to their attention.[12]

This final rule signals that CMS is placing greater emphasis on its interpretation of risk adjustment documentation requirements. Given the potentially massive scale of extrapolated audit findings, MAOs are well-advised to redouble their efforts to ensure the rigor of their risk-adjustment documentation screening mechanisms and obtain experienced statistical experts, coding experts, and legal counsel to thoroughly address any adverse audit findings.

Takeaways

- At long last, CMS has codified regulatory changes to its RADV audit program of risk adjustments submitted by MAOs. Most significantly, CMS will begin applying contract-level extrapolation to its RADV audit findings beginning with audits of calendar year 2018, which will significantly increase MAO exposure based upon alleged overpayment findings.
- Documentation standards for risk-adjusted diagnosis codes remain unchanged—CMS rejected MAO requests to include a fee-for-service adjuster that would have required parity in documentation standards between MA and fee-for-service programs.
- The changes should spur MAOs to redouble efforts to ensure the accuracy of diagnostic coding for risk adjustment purposes. MAOs should be prepared to engage coding, statistical, and legal experts to address adverse results.

Endnotes

[1] Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 88 Fed. Reg. 6643 (Feb. 1, 2023) (to be codified at 48 C.F.R. pts. 442).

[2] 42 U.S.C. § 1395w–23(a)(1)(C).

[3] 88 Fed. Reg. 6643, 6645.

[4] *Id.* at 6663.

[5] *Id.* at 6651.

[6] *Id.* at 6654.

[7] *See id.* at 6657.

[8] *Id.* at 6643, 6644, 6656–57, 6660.

[9] *Id.* at 6655.

[10] *Id.* at 6653–52, 6658.

[11] *See id*.

[12] *Id.* at 6652; *see also* 31 U.S.C. § 3729(a)(1)(G).

Authors

Explore more in

Business Litigation Healthcare

Related insights

Update

USPTO’s Significant Restructuring of Trademark Fees Takes Effect January 18, 2025

Update

Trump’s FDA and USDA: Five Key Issues To Watch in 2025