KEY TAKEAWAYS

Medicare Advantage plans are committed to meeting high standards of accountability in compliance with Medicare Advantage program requirements, including those designed to ensure payment accuracy.

CMS’ proposed changes to the RADV audit process are inadvisable in their current form and could disrupt care for enrollees.

Medicare Advantage has a better track record compared to traditional fee-for-service Medicare with fewer payment errors.
Background

Payments to Medicare Advantage plans are adjusted based on health risk of enrollees. The goal of risk adjustment is to ensure beneficiaries, including those with chronic conditions, are enrolled in plans that are appropriately reimbursed to meet their individual health needs. Diagnosis codes submitted by Medicare Advantage plans for their enrollees’ medical conditions are used by the Centers for Medicare & Medicaid Services (CMS) to determine enrollee risk scores. The Agency performs risk adjustment data validation (RADV) audits to confirm these diagnoses are supported in beneficiary medical records and meet other CMS requirements.

Recent reports from the Government Accountability Office (GAO) and Department of Health and Human Services Office of the Inspector General (OIG) raise concerns that CMS is not performing RADV audits quickly enough and urge the Agency to implement a proposal reflected in a CMS Request for Information that would incorporate Medicare Recovery Audit Contractors (RACs) into the RADV process and significantly expand the scope and scale of RADV audits. AHIP’s member organizations are dedicated to meeting high standards of accountability in compliance with Medicare Advantage program requirements, including those designed to ensure payment accuracy. However, incorporating RACs in the RADV audit process and expanding the scope of the audits:

a. is premature given the RADV process is not yet stable and reliable, and
b. could disrupt the care being provided by plans that are working hard to meet the needs of their enrollees.

Key Issues

*Medicare Advantage has a better payment track record than Medicare fee-for-service*

The Department of Health and Human Services (HHS) has consistently demonstrated Medicare fee-for-service has more payment errors than Medicare Advantage. For example, a government analysis found the net improper payment rate in the Medicare fee-for-service program is 11.4 percent, much higher than the 4.3 percent rate in Medicare Advantage in 2014.

*“Unconfirmed” diagnoses do not necessarily mean beneficiaries do not have the conditions reported by the plans*

Government rules do not consider diagnoses from certain data sources, such as prescription

HHS Finds Greater Proportion of Improper Payments in Medicare Fee-for-Service than Medicare Advantage

<table>
<thead>
<tr>
<th></th>
<th>Fee-for-Service</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.40%</td>
<td>4.30%</td>
<td></td>
</tr>
</tbody>
</table>
drug data or claims data from a previous year, which provide additional support indicating beneficiaries have the conditions reported by their Medicare Advantage plan.

Studies have shown that Medicare Advantage plans more effectively identify beneficiary conditions than Medicare fee-for-service providers, allowing plans to design person-centered treatment regimens that are improving health outcomes. Before considering an expansion of the RADV process, CMS should change its methodology to allow plans to submit more alternative sources of data justifying submitted diagnoses to ensure the integrity of the audit process.

The RADV methodology has yet to be finalized and remains under development

CMS currently conducts RADV audits on 30 contracts per payment year. Under the audit methodology, the payment error calculated for 201 sampled beneficiaries is extrapolated to the entire contract population. The Agency is still in the process of conducting the initial rounds of audits—for contract years 2011 and 2012—to which it will apply the current methodology, and has not yet released its methodology for calculating the “Fee-for-Service Adjuster” necessary to account for improper payments in the Medicare fee-for-service program under the current payment system. Expanding RADV audits without first ensuring the audit process is reliable could jeopardize the viability of the Medicare Advantage program, disrupt care for beneficiaries and limit the ability of CMS and plans to incorporate valuable lessons learned from the audit results.

Expanding audit process will increase burden on providers

Expanding the number of RADV audits through the use of RACs will likely increase the burden on physicians and other health care providers to find, review, and submit medical record documentation substantiating patient diagnoses upwards of six years prior. In many instances, network providers contract with numerous plans, meaning additional audits on these practices would be multiplied. This increased administrative burden detracts much needed provider resources from care delivery, which could harm beneficiaries.

RAC performance is raising concerns in the Medicare Fee-for-Service program

There are serious questions and concerns regarding contingency fees and the incentives for RACs to find errors, the administrative burdens associated with the program (including significant numbers of appeals), and the level of knowledge and experience RACs have. While CMS indicated in its Request for Information and draft Statement of Work that it would include certain procedures relating to RACs in the RADV audit process to provide some protections against incentives that contingency fees could create (e.g., use of the Secondary Review Contractor), we continue to have serious concerns that these internal procedures will not completely eliminate this problem. In addition, before using RACs in Medicare Advantage RADV audits, we believe it is important that the Agency assess whether processes implemented in the Medicare fee-for-service program are effective in addressing other RAC performance issues.
Conclusion

Medicare Advantage plans are committed to meeting high standards of accountability to ensure payment accuracy. However, CMS should not expand the scope of RADV audits until the issues described above are addressed and the audit process is reliable.

Related Topic

New Report: Proposed Cuts to Medicare Advantage Put Seniors’ Coverage at Risk