CMS Issues Final Rule to Protect Medicare, Strengthen Medicare Advantage, and Hold Insurers Accountable

Risk Adjustment Data Validation (RADV) final rule strengthens Medicare Advantage and restores payment oversight program

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS) finalized the policies for the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) program, which is CMS's primary audit and oversight tool of MA program payments. Under this program, CMS identifies improper risk adjustment payments made to Medicare Advantage Organizations (MAOs) in instances where medical diagnoses submitted for payment were not supported in the beneficiary's medical record. The commonsense policies finalized in the RADV final rule (CMS-4185-F) will help CMS ensure that people with Medicare are able to access the benefits and services they need, including in Medicare Advantage, while responsibly protecting the fiscal sustainability of Medicare and aligning CMS's oversight of the Traditional Medicare and MA programs.

As required by law, CMS' payments to MAOs are adjusted based on the health status of enrollees, as determined through medical diagnoses reported by MAOs. Studies and audits done separately by CMS and the HHS Office of Inspector General (OIG) have shown that Medicare Advantage enrollees' medical records do not always support the diagnoses reported by MAOs, which leads to billions of dollars in overpayments to plans and increased costs to the Medicare program as well as taxpayers. Despite this, no risk adjustment overpayments have been collected from MAOs since Payment Year (PY) 2007.

"Protecting Medicare is one of my highest responsibilities as Secretary, and this commonsense rule is a critical accountability measure that strengthens the Medicare Advantage program. CMS has a responsibility to recover overpayments across all of its programs, and improper payments made to Medicare Advantage plans are no exception," said HHS Secretary Xavier Becerra. "For years, federal watchdogs and outside experts have identified the Medicare Advantage program as one of the top management and performance challenges facing HHS, and today we are taking long overdue steps to conduct audits and recoup funds. These steps will make Medicare and the Medicare Advantage program stronger."

"CMS is committed to protecting people with Medicare and being a responsible steward of taxpayer dollars," said CMS Administrator Chiquita Brooks-LaSure. "By establishing our approach to RADV audits through this regulation, we are protecting access to Medicare both now and for future generations. We have considered significant stakeholder feedback and developed a balanced approach to ensure appropriate oversight of the Medicare Advantage program that aligns with our oversight of Traditional Medicare."

The RADV final rule reflects CMS's consideration of extensive public comments and robust stakeholder engagement after the release of the 2018 Notice of Proposed Rulemaking. The finalized policies will also allow CMS to continue to focus its audits on those MAOs identified as being at the highest risk for improper payments.

The RADV final rule can be accessed at the Federal Register at https://www.federalregister.gov/public-inspection/current.

RADV Final Rule (CMS-4185-F2) Fact Sheet

In a final rule, the Centers for Medicare & Medicaid Services (CMS) finalized technical details regarding the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) program that CMS uses to recover improper risk adjustment payments made to Medicare Advantage (MA) plans. The RADV final rule will help CMS to protect the MA program (also known as "Medicare Part C") by addressing instances where Medicare paid Medicare Advantage Organizations (MAOs) more than they otherwise should have received because the medical diagnoses submitted for risk adjustment payment were not supported in the beneficiary's medical record. Specifically, this final rule codifies in regulation that, as part of the RADV audit methodology, CMS will extrapolate RADV audit findings beginning with payment year (PY) 2018.

MA Payment and the Role of RADV Audits

CMS contracts with private companies, called Medicare Advantage Organizations (MAOs), to offer various health plan options for Medicare beneficiaries. These MAOs provide all Medicare Part A and Part B benefits (also known as "Traditional Medicare" or "Medicare Fee-For-Service" (FFS)), and most offer additional benefits, such as Medicare drug coverage, beyond those covered under the Medicare FFS program. Nearly 30 million individuals receive their Medicare benefits through MA. CMS has a statutory obligation and fiduciary duty to ensure payments in the Medicare program are accurate, including conducting oversight of payments made to MAOs. This approach is well-established among other CMS programs and ensures consistency in CMS' oversight of the Medicare FFS and MA programs.

Section 1853(a)(1)(C) of the Social Security Act (the Act) requires CMS to risk-adjust payments made to MAOs. CMS pays each MAO a monthly amount for each beneficiary enrolled in an MA plan, which is adjusted to account for differences in health status amongst enrolled beneficiaries. This adjustment is referred to as "risk adjustment." Risk-adjusted payments are based on medical diagnoses submitted by the MAOs that, by long-standing regulations, must be supported in the Medicare enrollees' medical records to ensure accurate payment. Risk adjustment strengthens the MA program by ensuring that accurate payments are made to MAOs based on the health status and demographic characteristics of their enrolled beneficiaries, and that MAOs are paid appropriately for their plan enrollees (that is, less for healthier enrollees who are expected to incur lower health care costs, and more for less healthy enrollees who are expected to incur higher health care costs).

Making accurate payments to MAOs is part of CMS' responsibility to ensure accurate payments across the Medicare program and ensures continued access to benefits and services for people with Medicare while safeguarding federal taxpayer dollars. Studies and audits done separately by CMS and the HHS Office of Inspector General (OIG) have shown that medical records do not always support the diagnoses reported by MAOs, which leads to billions of dollars in overpayments and increased costs to the Medicare program. RADV audits are the main corrective action for those improper payments. Through RADV audits, a sample of beneficiary medical records are provided by MAOs, and CMS reviews those records to verify that diagnoses reported

for risk adjusted payments are accurate and supported in the medical record. Risk adjustment discrepancies can be aggregated to determine an overall level of payment error, which can then be extrapolated. The HHS-OIG also undertakes audits of MAOs, similar to RADV audits, as part of its oversight functions. CMS can collect the improper payments identified during those HHS-OIG audits, including the extrapolated amounts calculated by the HHS-OIG.

Final Rule Policies

Extrapolation

Rather than applying extrapolation beginning for payment year (PY) 2011 audits as we proposed, we are finalizing a policy not to extrapolate RADV audit findings for PYs 2011-2017 and beginning extrapolation with the PY 2018 RADV audit. As a result, CMS will only collect the non-extrapolated overpayments identified in the CMS RADV audits and OIG audits between PY 2011 and PY 2017. CMS is not adopting any specific sampling or extrapolation audit methodology but will rely on any statistically-valid method for sampling and extrapolation that is determined to be well-suited to a particular audit. However, any extrapolation methodology adopted by CMS for RADV audits will be focused on MAO contracts that, through statistical modeling and/or data analytics, are identified as being at the highest risk for improper payments. While not required, CMS will continue to disclose our extrapolation methodology to MAOs, providing MAOs with the information sufficient to understand the means by which CMS extrapolated the RADV payment error.

Extrapolation has historically been a normal part of auditing practice at CMS, including in FFS Medicare, and CMS interprets our existing authority as authorizing the use of sampling and extrapolation in RADV audits. It is also expected that the use of extrapolation will incentivize MAOs to take meaningful steps to reduce improper risk adjusted payments in the future.

FFS Adjuster

The rule also finalizes a policy, as proposed, that CMS will not apply an adjustment factor (known as an FFS Adjuster) in RADV audits. As described in the final rule, and consistent with a recent D.C. Circuit Court decision in *UnitedHealthcare Insurance Co. v. Becerra*, 16 F.4th 867 (D.C. Cir. August 13, 2021, reissued November 1, 2021), *cert*. *denied*, 142 S. Ct. 2851 (U.S. June 21, 2022) (No. 21-1140), the requirement for actuarial equivalence in MA payments applies to how CMS risk adjusts the payments it makes to MAOs and not to the obligation to return overpayments for unsupported diagnosis codes, including overpayments identified during a RADV audit. In addition, we do not believe that it is reasonable to read the Act as requiring a reduction in payments to MAOs by a statutorily set minimum adjustment in the coding pattern adjustment, while at the same time prohibiting CMS from paying at those reduced rates by mandating a FFS Adjuster for RADV audits.