Medicare Advantage Risk Adjustment Data Validation Audit Methodology

Final Rule Takes Effect April 3, 2023

As Medicare Advantage has grown significantly in recent years (with enrollment exceeding 29 million enrollees in 2022—nearly half of all Medicare enrollment), program sustainability and potential improper payments to Medicare Advantage organizations (MAOs) have come under extensive review. The Centers for Medicare and Medicaid Services (CMS) estimates $15 billion in improper payments occurred in 2021—almost 7% of total payments to MAOs. The **final rule** updating Medicare Advantage Risk Adjustment Data Validation (RADV) program audit methodologies and related policies was issued on February 1, 2023. The rule is effective April 3, 2023.

In the final rule, CMS has established substantial changes to how the risk adjustment program works, including the extrapolation of audit findings to payment recovery going back to payment year (PY) 2018, instead of PY 2011 as initially proposed. The final rule excludes the fee-for-service (FFS) adjuster that many health plans had advocated for to address potentially erroneous codes in FFS diagnosis data that understate the cost of treating various conditions. While this rule may be challenged in the near term, health plans must prepare to repay potential improper payments made since 2018, support new audit requirements, and mitigate risk of near-term improper payments in current and future payment years.

Highlights of the Final RADV Audit Methodology

- **RADV audits are designed to detect improper payments** after the final risk adjustment data submission deadline for a payment year. The audits are not designed to detect fraud or identify all improper diagnosis codes submitted as part of a health plan's risk adjustment payment.
- **CMS identifies contracts that are "at-risk" and subjected to the RADV audit process** through an approach that focuses on CMS Hierarchical Condition Categories (HCCs) that are more likely to be in error as identified by prior RADV audits, Part C Improper Payment Measurements, Department of Health & Human Services Office of the Inspector General (HHS-OIG) audit findings, and other vulnerability analyses.
- **CMS may use any statistically valid method for sampling and extrapolation it determines appropriate for a particular audit.** CMS will aggregate risk adjustment discrepancies to determine an overall level of payment error for a sample of enrollees and then extrapolate an estimated total payment error rate to all enrollees within that MAO contract.
- **The final rule removes the FFS adjuster,** which was initially proposed by health plans to meet section 1853(a)(1)(C)(i) of the Social Security Act. The section requires CMS to adjust MAO payments based on demographics and health-related risk factors to meet actuarial equivalence with Medicare FFS. Health plans have argued that FFS claims are not audited and therefore errors could lead to inaccuracies in how MAOs are paid. CMS conducted a study published in 2018 that found that errors in FFS claims data did not have a systematic effect on the risk scores calculated and, by extension, the payments made to MAOs.[1] Notably, since CMS has not issued any RADV audit findings for PY 2011 or subsequent years, the FFS adjuster **has** not been applied to any RADV results.
- **CMS will collect overpayments based on extrapolation from RADV audit findings, beginning with PY 2018 and subsequent years.** For PY 2011-2017, only non-extrapolated enrollee-level overpayments from RADV and HHS-OIG audits will be collected.

What This Means for Medicare Advantage Organizations

- The potential for retrospective improper payment remittance is high and per previous CMS audits could impact up to 80% of 30 audited contracts per year, even if litigation of the rule occurs in the near term.
- Non-extrapolated recoveries are estimated to reach $41 million for PY 2011 through 2015, based on CMS estimates.
- Audit findings for PY 2018 and subsequent years will be released starting in 2025.
- Financial impacts of extrapolation from audit findings could be substantial. CMS estimates that improper payment recoveries will reach $479 million per audit year.

What Medicare Advantage Organizations Need to Do Now

- Review current risk adjustment program for compliance with the final rule, including ensuring provider contracts support compliance with medical record documentation requirements.
- Prepare for the release of enrollee-level RADV and HHS-OIG audit findings for PY 2011 through PY 2015, as indicated by CMS, and the enrollee-level recoveries based on those findings that will follow.
- Mobilize resources and processes to analyze and prepare for potential appeals of RADV and HHS-OIG audit findings as they are released.
- Assess retrospective performance and prepare for possible recoveries based on extrapolation for PY 2018 and subsequent years, using findings from internal audits, previous RADV and OIG audits, and Part C Improper Payment Measurements.
- Deploy capabilities to optimize your program integrity, including the ability to identify and prevent coding inaccuracies that could result in improper payments for PY 2023.

Are You Ready?

We can help. Contact us to learn more about how to prepare for these changes to the Medicare Advantage RADV program, ensure compliance, and mitigate risk of future improper payments.

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[1] CMS, "FFS Adjuster Technical Appendix," 2018, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/FFS-Adjuster-Technical-Appendix.pdf.