SQUIRE PATTON BOGGS

CMS Proposes Invalidating Adjuster Methodology and Recouping Past Improper Payments From Medicare Advantage Organizations

On October 26, 2018, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that will, among others initiatives, allow CMS to recover higher dollar amounts of improper payments made to Medicare Advantage Organizations.[1]

Improper payments are identified through Risk Adjustment Data Validation (RADV) audits, which are audits conducted to determine whether the risk adjusted payments submitted by Medicare Advantage Organizations are for diagnoses supported by proper documentation. If there are any improper payments based on these audits, CMS is able to recover those payments.

In 2012, CMS issued a final RADV audit methodology that calculated the payment error rate using a small sampling of data across patients covered by various Medicare Advantage plans and then extrapolated that error rate to the entire population covered by that plan to determine whether the insurer had received an aggregate overpayment. The methodology provided for a "Fee-For-Service" adjuster to offset the recovery amount, i.e., ensure traditional Medicare and Medicare Advantage plans receive actuarially equivalent payments. The adjuster methodology effectively recognized that when an audit results in a determination that payment was based on unsupported diagnosis, the repayment to CMS must be adjusted down based on an estimated traditional Medicare payment error rate. This adjuster methodology was applied to audits in 2011-2013; however, the finalization of the audits were pending CMS's determination of the application of the adjuster.

On October 26, 2018, CMS completed its analysis on the application of an adjuster in determining how to recover improper payments made to Medicare Advantage Organizations.[2] CMS ultimately concluded the adjuster is no longer warranted after finding the error rates in traditional Medicare do not have any systematic effect on the payments made to the Medicare Advantage Organizations.

With the removal of the adjuster, CMS will be able to recover larger sums of these improper payments. Critically, CMS proposes applying the changes retroactively back to 2011. CMS also notably stated that even if the study had found the error rates had a substantial effect on the payments, the agency would still reverse the 2012 policy and invalidate the adjuster.

The concern now is that because Medicare Advantage payments are based on claims in traditional Medicare (which were not audited), without the adjuster, Medicare Advantage Organizations could be held to a higher standard than traditional Medicare. This is a violation of the requirement that payments between traditional Medicare and Medicare Advantage must be actuarially equivalent. Medicare Advantage Organizations that underwent audits in 2011-2013 using the adjuster methodology may be required to repay large sums.

CMS stated the proposed rule is intended to "strengthen" the ability of CMS to recover these improper payments and, if finalized, would result in an estimated $4.5 billion in savings to the Medicare Trust Funds over a 10-year period. Feedback on the proposal will be open until December 31, 2018.[3]

For more information about this ruling, please contact one of the individuals listed in this publication.

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1 https://www.federalregister.gov/documents/2018/11/13/2018-24145/medicare-and-medicaid-programs-cy-2019-home-health-prospective-payment-system-rate-update-and-cy.

2 https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Resources.html.

3 https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking.

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