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MEDICARE ADVANTAGE

Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments

GAO Highlights

Highlights of GAO-16-76, a report to the Chairman, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

In 2014, Medicare paid about $160 billion to MA organizations to provide health care services for approximately 16 million beneficiaries. CMS, which administers Medicare, estimates that about 9.5 percent of its payments to MA organizations were improper, according to the most recent data—primarily stemming from unsupported diagnoses submitted by MA organizations. CMS currently uses RADV audits to recover improper payments in the MA program.

GAO was asked to review the extent to which CMS is addressing improper payments in the MA program. This report examines the extent to which (1) CMS's contract selection methodology for RADV audits facilitates the recovery of improper payments, (2) CMS has completed RADV audits and appeals in a timely manner, and (3) CMS has made progress toward incorporating RACs into the MA program to identify and assist with improper payment recovery. In addition to reviewing research literature and agency documents, GAO analyzed data from ongoing RADV audits of 2007 and 2011 payments—CMS's two initial contract-level RADV audits. GAO also interviewed CMS officials.

What GAO Recommends

GAO is making five recommendations to CMS to improve its processes for selecting contracts to include in the RADV audits, enhance the timeliness of the audits, and incorporate RACs into the RADV audits. HHS concurred with the recommendations.

View GAO-16-76. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Medicare Advantage (MA) organizations contract with the Centers for Medicare & Medicaid Services (CMS) to offer beneficiaries a private plan alternative to the original program and are paid a predetermined monthly amount by Medicare for each enrolled beneficiary. These payments are risk adjusted to reflect each enrolled beneficiary's health status and projected spending for Medicare-covered services. CMS conducts risk adjustment data validation (RADV) audits of MA contracts which facilitate the recovery of improper payments from MA organizations that submitted beneficiary diagnoses for payment adjustment purposes that were unsupported by medical records. With a separate national audit, CMS estimated that it improperly paid $14.1 billion in 2013 to MA organizations, primarily because of these unsupported diagnoses.

GAO found that CMS's methodology does not result in the selection of contracts for audit that have the greatest potential for recovery of improper payments. First, CMS's estimate of improper payment risk for each contract, which is based on the diagnoses reported for the beneficiaries in that contract, is not strongly correlated with unsupported diagnoses. Second, CMS does not use other available information to select the contracts at the highest risk of improper payments. As a result, 4 of the 30 contracts CMS selected for its RADV audit of 2011 payments were among the 10 percent of contracts estimated by CMS to be at the highest risk for improper payments. These limitations are impediments to CMS's goal of recovering improper payments and do not align with federal internal control standards, which require that agencies use quality information to achieve their program goals.

CMS's goal of eventually conducting annual RADV audits is in jeopardy because its two RADV audits to date have experienced substantial delays in identifying and recovering improper payments. RADV audits of 2007 and 2011 payments have taken multiple years and are still ongoing for several reasons. First, CMS's RADV audits rely on a system for transferring medical records from MA organizations that has often been inoperable. Second, CMS audit procedures have lacked specified time requirements for completing medical record reviews and for other steps in the RADV audit process. In addition, CMS has not established timeframes for appeal decisions at the first-level of the MA appeal process, as it has done in other contexts.

CMS has not expanded the recovery audit program to MA by the end of 2010, as it was required to do by the Patient Protection and Affordable Care Act. RACs have been used in other Medicare programs to recover improper payments for a contingency fee. In December 2015, CMS issued a request for information seeking industry comment on how an MA RAC could be incorporated into the RADV audit framework. CMS noted in its request that incorporating a RAC into the RADV framework would increase the number of MA contracts audited each year. CMS currently includes 30 MA contracts in each RADV audit, about 5 percent of all MA contracts. Despite the importance of increasing the number of contracts audited, CMS does not have specific plans or a timetable for incorporating RACs into the RADV audit framework, contrary to established project management principles, which stress the importance of developing an overall plan to meet strategic goals.