



Report to the Chairman,  
Committee on Ways and Means,  
House of Representatives

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April 2016

# 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](mailto:cosgrovej@gao.gov).

April 2016

## MEDICARE ADVANTAGE

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

## 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.

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## Abbreviations

AHA	American Hospital Association
AHIP	America's Health Insurance Plans
AMA	American Medical Association
CDAT	Central Data Abstraction Tool
CMS	Centers for Medicare & Medicaid Services
ESMD	Electronic Submission of Medical Documentation
FFS	fee-for-service
HCC	hierarchical condition category
HHS	Department of Health and Human Services
IPIA	Improper Payments Information Act of 2002
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
RAC	Recovery Audit Contractor
RADV	risk adjustment data validation

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April 8, 2016

The Honorable Kevin Brady  
Chairman  
Committee on Ways and Means  
House of Representatives

Dear Mr. Chairman,

In 2014, the federal government paid approximately \$160 billion to Medicare Advantage (MA) organizations—entities that offer a private plan alternative to the Medicare fee-for-service (FFS) program.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), administers Medicare, contracts with MA organizations, and pays them a monthly amount to provide health care benefits to beneficiaries enrolled in these plans. In 2014, CMS had 570 contracts with MA organizations that served 15.8 million beneficiaries, constituting about 30 percent of all Medicare beneficiaries.<sup>2</sup>

Improper payments to MA organizations can result from unsupported information those organizations provide to CMS for the calculation of payment amounts. The Social Security Act requires that payments to MA organizations be adjusted for variation in the cost of providing health care to beneficiaries on the basis of various risk factors, including health status.<sup>3</sup> Through the risk adjustment process, for example, CMS

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<sup>1</sup>See The Boards of Trustees, *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: July 2015).

Medicare FFS consists of Medicare Parts A and B. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance and covers hospital outpatient, physician, and other services. Medicare beneficiaries have the option of obtaining coverage for Medicare Part A and B services from private health plans that participate in the MA program—also known as Medicare Part C. MA organizations must cover all Medicare Part A and B services, except for hospice care.

<sup>2</sup>The 570 MA contracts in 2014 exclude Medicare-Medicaid 1876 Cost, 1833 Cost, Program of All-inclusive Care for the Elderly, and pilot contracts.

<sup>3</sup>42 U.S.C. § 1395w-23(a)(1)(C)(i).

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increases payments to MA organizations that enroll beneficiaries in poorer health to compensate the organizations for the expected higher spending on health care services for those beneficiaries. To risk adjust payments, CMS first calculates a risk score—a relative measure of projected Medicare spending based on diagnosis and demographic information—for every Medicare beneficiary, including those in MA plans and those in the FFS program. CMS requires MA organizations to submit diagnosis codes for each beneficiary in a contract in order to calculate risk scores.<sup>4</sup> CMS has determined that improper payments in the MA program stem from beneficiary diagnoses submitted for risk adjustment purposes by MA organizations to CMS that are not supported by medical documentation.<sup>5</sup> As the MA program continues to grow, safeguarding the program from loss is critical.

CMS conducts two types of risk adjustment data validation (RADV) audits to identify and correct MA improper payments: national RADV activities and contract-level RADV audits. Both types of audits determine whether the diagnosis codes submitted by MA organizations are supported by a beneficiary's medical record documentation. CMS conducts national RADV activities annually to estimate the national MA improper payment rate under the Improper Payments Information Act of 2002 (IPIA), as amended.<sup>6</sup> Based on the most recent national audit, which reviewed 2013 payments, CMS released an MA improper payment estimate of 9.5

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<sup>4</sup>A beneficiary's health status is incorporated into payments using CMS hierarchical condition categories (HCC), which are groups of medical diagnoses in which related groups of diagnoses are ranked on the basis of disease severity and cost.

<sup>5</sup>An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

<sup>6</sup>IPIA, as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012, requires executive branch agencies to annually identify programs and activities susceptible to significant improper payments, estimate the amount of improper payments, and report these estimates along with actions planned or taken to reduce them. Pub. L. No. 107-300, 116 Stat. 2350 (2002), as amended by Pub. L. No. 111-204, 124 Stat. 2224 (2010) and Pub. L. No. 112-248, 126 Stat. 2390 (2013) (codified at 31 U.S.C. § 3321 note).

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percent or \$14.1 billion.<sup>7</sup> CMS also estimated that 73 percent of the improper payments resulted from MA organizations submitting insufficient medical record documentation to CMS that did not support the diagnoses those organizations had previously submitted to CMS to determine risk adjustment payments. The second type of RADV audit, referred to as contract-level audits, seeks to identify and recover improper payments from MA organizations and thus to deter MA organizations from submitting inaccurate beneficiary diagnoses. In 2008, CMS began contract-level audits of 2007 payments to identify and recover payments made in error for a sample of enrollees in 32 MA contracts.<sup>8</sup> CMS stated it had recovered about \$14 million in improper payments from these RADV audits of 2007 payments and may recover additional amounts depending on the adjudication of appeals filed by MA organizations challenging some of the audit findings.<sup>9</sup> Since 2010, CMS has spent about \$117 million on both types of audits.

CMS's goal is to annually conduct contract-level audits to recover improper payments efficiently, among other things. That is, CMS plans to recoup overpayments by calculating a payment error rate for a sample of enrollees in each audited contract and then extrapolating that error rate to

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<sup>7</sup>The most recent national RADV estimate was conducted in 2015 and is based on 2013 data, as there is a 2-year lag in payment data availability. The national sample is used to estimate the overall improper payment estimate in the MA program. Previously, the estimate was based on a stratified random sample of approximately 600 beneficiaries for whom a risk adjustment payment was made. CMS also estimates a net improper payment rate that accounts for diagnoses that were omitted by MA organizations but would have been permissible for payment purposes. However, CMS does not consider these payments to be improper because the agency considers the submission of these diagnoses to be the responsibility of the MA organization. The net improper payment rate in 2013 was 4.3 percent of total payments or \$6.4 billion. See Department of Health and Human Services, *FY 2015 Agency Financial Report* (Washington, D.C.: November 2015).

<sup>8</sup>Prior to selecting contracts for the targeted audits, CMS conducted pilot audits of 2007 payments for five MA contracts. These pilot audits encompass about \$3 million of the approximate \$14 million in recovery.

<sup>9</sup>For fiscal year 2015, CMS collected approximately \$650 million in overpayments from MA organizations per the "report and repay" requirement, among other things. In the calendar year 2015 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center final rule, CMS introduced the new "report and repay" requirement, by which MA organizations must report and return any overpayments they identify to CMS. This requirement complements the contract-level RADV audits as a vehicle for CMS to collect overpayments made to MA organizations. Medicare Advantage Organizations and Part D Sponsors: CMS-Identified Overpayments Associated with Submitted Payment Data, 79 Fed. Reg. 66770-66999 (November 10, 2014).

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estimate the total amount of improper payments made under the contract.<sup>10</sup> As a first step, CMS officials stated that the agency has begun contract-level audits of 2011 payments using the same contract selection and beneficiary sampling methodology as its contract-level audits of 2007 payments.<sup>11</sup> Using this methodology, CMS selected a sample of 30 contracts to audit in November 2013. According to CMS officials, the agency will offset any overpayments by the amount of any underpayments the agency discovers, but will not reimburse payments to MA organizations if estimated underpayments exceed overpayments. MA organizations have the right to appeal audit results within 60 days of receiving them. CMS estimates that the contract-level audits of 2011 payments will recover about \$370 million (about 3 percent of 2011 MA improper payments) after extrapolation. In addition, the Patient Protection and Affordable Care Act required CMS to expand the recovery audit program into the MA program to identify and assist CMS with improper payment recovery. Recovery audit contractors (RAC) are entities that conduct postpayment reviews to identify and correct potential improper payments.

You asked us to examine the extent to which CMS is addressing improper payments in MA. In this report, we examine

- (1) the extent to which CMS's contract selection methodology for contract-level RADV audits facilitates the recovery of improper payments;
- (2) the extent to which CMS has completed contract-level RADV audits and appeals in a timely manner; and
- (3) CMS's progress toward incorporating RACs into the MA program to identify and assist with improper payment recovery.

To examine the extent to which CMS's contract selection methodology for contract-level RADV audits facilitates the recovery of improper payments, we reviewed agency documents such as HHS's Financial Report for fiscal years 2014 and 2015, which contain CMS's objectives and goals for the

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<sup>10</sup>CMS officials stated that the agency believes that these contract-level RADV audits also will deter MA organizations from submitting unsupported diagnoses, thereby reducing future improper payments.

<sup>11</sup>In fiscal year 2015, CMS selected contracts for audit to initiate contract-level RADV audits of 2012 payments. See *FY 2015 Agency Financial Report*.

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contract-level audits; analyzed contract-level RADV audit data from CMS; reviewed research documents; and interviewed CMS officials about MA contracts. We examined the extent to which CMS's contract selection methodology accounts for a contract's total improper payment recovery potential in several ways. First, we examined whether the contracts selected for the contract-level RADV audits of 2007 payments were among those likely to have had high improper payment rates by comparing CMS's estimate of risk for those contracts with the actual rates of unsupported diagnoses documented in the audit.<sup>12</sup> Second, we examined the extent to which CMS's contract selection methodology for the 2011 contract-level RADV audits successfully identified contracts with the greatest improper payment risk by comparing the agency's estimate of risk of improper payment for its selected contracts with its estimate of risk for all other MA contracts. Third, because contract-level audits of 2011 payments are ongoing, we analyzed the results of the 2007 contract-level RADV audits of payments to inform our assessment of CMS's current measurement of improper payment risk. We reviewed literature on MA contracts to determine whether CMS's estimate of improper payment risk for each contract (referred to as coding intensity) properly accounted for changes in beneficiary health status. In addition, we evaluated CMS's contract selection methodology against applicable internal control standards for federal agencies.<sup>13</sup>

To examine the extent to which CMS has completed contract-level RADV audits and appeals in a timely manner, we compared the total time required for the 2007 and 2011 contract-level RADV audits in light of CMS's goal of conducting contract-level RADV audits annually. To do so, we reviewed agency documents and contract-level RADV audit results and interviewed CMS officials. We also compared RADV time frames to those from similar audit processes in Medicare's FFS program. To determine the timeliness of one part of the audit process—CMS's time frame for the MA organizations to submit medical records—we examined the percentage of audited diagnoses that were submitted by MA organizations by CMS's deadline. We also assessed the prevalence of

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<sup>12</sup>The percentages of unsupported diagnoses after medical record review do not include potential underpayments or RADV findings overturned after appeal.

<sup>13</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1, 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

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RADV appeals for the 2007 contract-level RADV audits, the number of appeals adjudicated by CMS after MA organizations were notified of contract-level RADV audit decisions, and how long it has taken to complete the medical record dispute and appeal process. We evaluated CMS's audit activities against established project management principles.<sup>14</sup> For additional context, we interviewed officials from the American Medical Association (AMA), American Hospital Association (AHA), America's Health Insurance Plans (AHIP), and two MA organizations with contracts that underwent both 2007 and 2011 contract-level RADV audits. The views of these two MA organizations do not represent the views of all MA organizations.

To examine CMS's progress toward incorporating RACs into the MA program to identify and recover improper payments, we reviewed CMS documents, including CMS's 2014 Medicare Part C RAC Statement of Work and CMS's proposed 2015 Medicare Part C RAC Statement of Work, and interviewed CMS officials. We evaluated CMS's progress toward incorporating a RAC in the MA program against established project management principles, which call for developing an overall plan and monitoring framework to meet strategic goals.<sup>15</sup> We also interviewed officials representing three of the four RACs that conduct claims review in Medicare's FFS program to obtain their perspectives on CMS's plans for incorporating RACs into the MA program.<sup>16</sup> For additional context, we interviewed officials from the AMA, AHA, and AHIP.

We conducted this performance audit from October 2014 to April 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>14</sup>GAO, *Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, [GAO-09-3SP](#) (Washington, D.C.: March 2009). GAO developed this compilation of best practices that can be used across the federal government for developing, managing, and evaluating capital program cost estimates.

<sup>15</sup>[GAO-09-3SP](#).

<sup>16</sup>One of the four RACs that conduct postpayment claims reviews in the FFS Medicare program declined GAO's request for an interview.

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## Background

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### Contract-Level RADV Audit Process

There are four major steps in the contract-level RADV audit process as reported by CMS:

- MA contract selection. CMS selects 30 MA organization contracts for contract-level RADV audits, which agency officials stated provides a sufficient representation of contracts (about 5 percent) without imposing unreasonable costs on the agency.<sup>17</sup> An MA organization may have more than one contract selected for a contract-level RADV audit. CMS selects contracts based on diagnosis coding intensity, which the agency defines for each contract as the average change in the risk score component specifically associated with the reported diagnoses for the beneficiaries covered by the contract.<sup>18</sup> That is, increases in coding intensity measure the extent to which the estimated medical needs of the beneficiaries in a contract increase from year to year; thus, contracts whose beneficiaries appear to be getting “sicker” at a relatively rapid rate, based on the information submitted to CMS, will have relatively high coding intensity scores. Contracts with the highest increases in coding intensity are those with beneficiaries whose reported diagnoses increased in severity at the fastest rates. CMS officials stated that the agency adopted this selection methodology to (1) focus the contract-level RADV audits on MA organization contracts that might be more likely to have submitted diagnoses that are not supported by the medical records and (2) provide additional oversight of contracts with the most aggressive coding. To be eligible for a contract-level audit, MA contracts must have had at least three pair-years of data that can be used to distinguish a change in disease risk scores from one year to the next; that is, the contract must have been in place for at least 4 years of continuous payment activity plus the audit year. For each pair year, CMS’s coding intensity calculation excludes beneficiaries not enrolled in the same contract or not eligible for Medicare in consecutive years. CMS ranks contracts by coding intensity and divides them into three categories: high, medium, and low. CMS then randomly selects

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<sup>17</sup>For the 2011 contract-level RADV audits, the 30 MA organization contracts that CMS selected accounted for 11 percent of MA enrollees.

<sup>18</sup>Information on a beneficiary’s age, sex, Medicaid enrollment status, and original reason for Medicare entitlement (age, disability) also are used to calculate risk scores.

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contracts for audit: 20 from the high category, 5 from the medium category, and 5 from the low category.<sup>19</sup> According to CMS officials, this strategy ensures contracts with the highest coding intensity—considered high risk for improper payments by CMS—have a higher probability for audit while keeping all contracts at risk for review.

- MA beneficiary sampling. After CMS selects 30 MA contracts to audit, the agency selects the beneficiaries whose medical records will be the focus of review. Up to 201 beneficiaries are chosen from each contract based on the individuals' risk scores using a stratified random sample: 67 beneficiaries from each of the three risk score groups (highest one-third of risk scores, the middle one-third, and the lowest third).<sup>20</sup>
- Medical record collection and review. After selecting beneficiaries for review, CMS requests supporting medical record documentation for all diagnoses submitted to adjust risk in the payment year.<sup>21</sup> The MA organization may submit up to five medical records per audited diagnosis. CMS contractors review the submitted medical records to determine if the records support the diagnoses submitted by the MA organizations. If the initial reviewer determines that a diagnosis is not supported, a second reviewer reviews the case.
- Payment error calculation and extrapolation. When medical record review is completed, CMS extrapolates a payment error rate to the entire contract beginning with contract-level audits of 2011 payments.

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<sup>19</sup>For the 2011 contract-level RADV audits, CMS selected 6 contracts for which the HHS Office of Inspector General conducted audits of 2007 payments. The remaining 24 of the 30 contracts were randomly selected from each coding intensity group per CMS's selection methodology described above.

<sup>20</sup>CMS chooses beneficiaries to sample who meet the following criteria: (1) were enrolled in the MA contract in January of the payment year; (2) were continuously enrolled in the MA contract for all 12 months preceding the payment year; (3) did not have end-stage renal disease in or before the payment year; (4) did not receive hospice care between January of the collection year and January of the payment year, with less than 12 months of hospice during the payment year; (5) were enrolled in Medicare Part B for all 12 months during the data collection year; and (6) were diagnosed with at least one risk adjustment diagnosis submitted during the data collection year that resulted in a least one coded CMS-HCC.

<sup>21</sup>MA-submitted diagnoses must be based on clinical medical record documentation from a face-to-face encounter with a provider, coded in accordance with the ICD-9-CM Guidelines for Coding and Reporting, assigned based on dates of service within the data collection period, and submitted to the MA contracts by an acceptable provider type and data source. Beginning October 1, 2015, all Medicare claims with a date of service on or after October 1, 2015, will only be accepted if they contain a valid ICD-10 code, which is the next iteration of codes.

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Each beneficiary's payment error is multiplied by a sampling weight and the number of months the beneficiary was enrolled in the MA contract during the payment year.<sup>22</sup> After these beneficiary-level payment errors are summed, the amount CMS will seek to recover will be reduced by (1) using the lower limit of a 99 percent confidence interval based on the sample and (2) reducing the recovery amount by a FFS adjuster amount that estimates payment errors that would have likely occurred in FFS claims data.<sup>23</sup> Once the recovery amount is finalized, CMS releases contract-level RADV audit finding reports to each audited MA organization, which may dispute the results of medical record review or appeal the audit findings. Beginning with the contract-level RADV audits of 2011 payments, CMS will collect extrapolated overpayments from MA organizations once all appeals are final.

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## Recovery Audit Contractors

Recovery auditors have been used in various industries, including health care, to identify and collect overpayments. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed CMS to test the use of RACs to identify overpayments and underpayments through a postpayment review of FFS medical claims and recoup overpayments.<sup>24</sup> The Tax Relief and Health Care Act of 2006 required CMS to implement a permanent national recovery audit contractor program by January 1, 2010 and to compensate RACs using a contingency fee structure under which the RACs are paid from recovered overpayments.<sup>25</sup> The Patient

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<sup>22</sup>Sampling weights are constructed so each sample of eligible enrollees represents the group from which they were drawn. These weights are used to scale-up the sample payment error findings to the population it represents.

<sup>23</sup>The FFS adjuster accounts for the fact that contract-level RADV audits require diagnoses to be supported by medical record documentation reviews that include those coded by providers in claims, but the same standard is not used in FFS claims to develop the MA risk adjustment model. The actual amount of the adjuster will be calculated by CMS based on a RADV-like review of records submitted to support FFS claims data. CMS officials stated that the agency expects to solicit public comments from stakeholders regarding the FFS adjuster in 2016.

<sup>24</sup>Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57 (2003).

<sup>25</sup>Pub. L. No. 109-432, div B., title III, § 302, 120 Stat. 2922, 2991-92 (2006) (codified at 42 U.S.C. § 1395ddd(h)).

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Protection and Affordable Care Act expanded the recovery audit program initiated in Medicare FFS to MA plans under Part C, among other things.<sup>26</sup>

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## CMS Encounter Data

In future contract-level RADV audits, CMS also will review diagnoses submitted through MA encounter data. While CMS previously collected diagnoses from MA organizations, in 2012 the agency also began collecting encounter data from MA organizations similar to that submitted on FFS claims. CMS requires MA organizations to submit, via the Encounter Data System, encounter data weekly, biweekly, or monthly depending on their number of enrollees.<sup>27</sup> Encounter data include diagnosis and treatment information recorded by providers for all medical services and may either originate from claims that providers submit to MA organizations for payment or from MA organizations' medical record review. CMS started including the diagnosis information from MA encounter data from 2014 dates of service when calculating 2015 enrollee risk scores.

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## CMS Does Not Focus MA RADV Audits on Contracts with the Highest Potential for Improper Payments

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### CMS's Estimate of MA Improper Payment Risk Has Shortcomings

While coding intensity scores can be helpful in assessing the likelihood of improper payments for MA contracts, results from the CMS contract-level RADV audits of 2007 payments indicate that the coding intensity scores CMS calculated were not strongly correlated with the percentage of unsupported diagnoses within a contract. The fact that this correlation is not strong reduces the likelihood that contracts selected for audit would be those most likely to yield large amounts of improper payments and

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<sup>26</sup>Pub. L. No. 111-148, § 6411(b), 124 Stat. 119, 775 (2010) (codified at 42 U.S.C. § 1395ddd(h)).

<sup>27</sup>MA organizations with more than 100,000 enrollees must submit encounter data weekly, those with between 50,000 and 100,000 enrollees biweekly, and those with fewer than 50,000 enrollees monthly.

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hampers CMS's goal of using the audits to recover improper payments.<sup>28</sup> In addition, internal control standards for federal agencies state that agencies should use and communicate quality information in achieving program goals.<sup>29</sup> Figure 1 shows, for example, that CMS reported that the percentage of unsupported diagnoses (36.0 percent) among the high coding intensity contracts it audited was nearly identical to the percentage of unsupported diagnoses (35.7 percent) among the medium coding intensity contracts audited. In addition, 7 contracts in the high coding intensity group had unsupported diagnosis rates below 30 percent, including the contract with the highest coding intensity score.<sup>30</sup>

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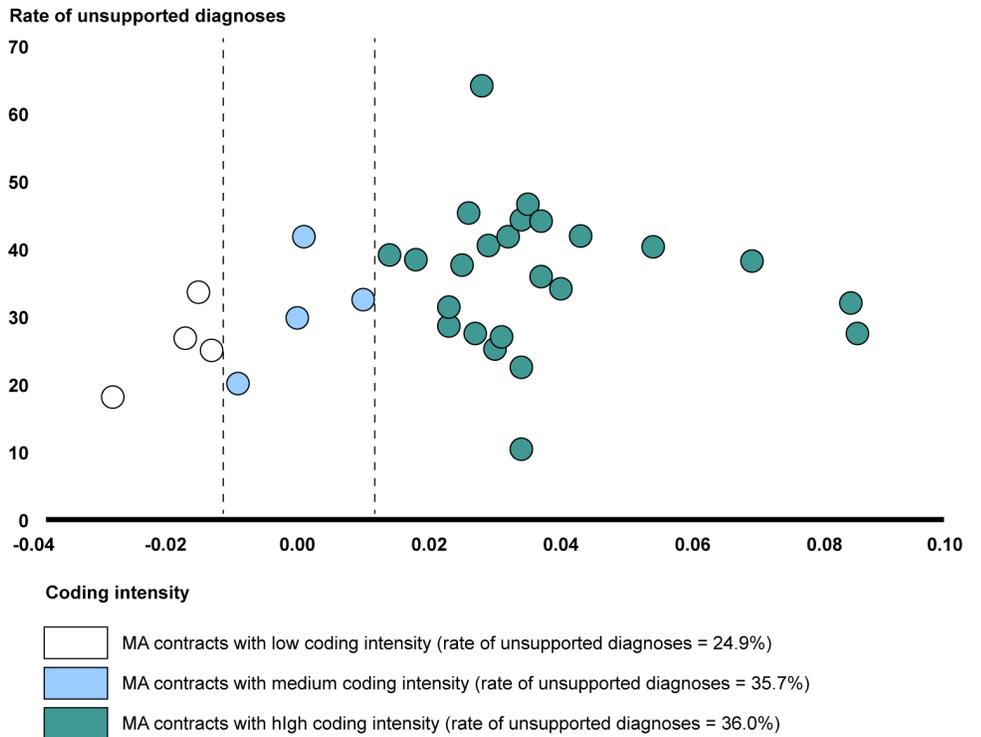
<sup>28</sup>The coefficient of correlation between coding intensity and rate of unsupported diagnoses was slightly less than 0.3 for these 32 contracts, indicating a relatively low positive correlation given that CMS uses coding intensity as the basis for risk of MA improper payments. The coefficient of correlation between CMS's coding intensity and the unsupported diagnosis rate was less than 0.3 when using either the Pearson or Spearman method. The coefficient of correlation was lower when the five 2007 pilot contract-level audits were included in our calculation. The rate of unsupported diagnoses was highly correlated (Pearson 0.9 coefficient of correlation) with improper payment recovery. The coefficient of correlation between coding intensity and improper payment recovery was about 0.3 and was not statistically significant. The coefficient of correlation between coding intensity and payment recovery was lower when the five 2007 pilot contract-level audits were included in our calculation. Improper payment recovery may increase when beneficiaries with high average risk scores are enrolled in an MA contract.

<sup>29</sup>[GAO/AIMD-00-21.3.1](#).

<sup>30</sup>Twelve of the 32 contracts that were selected for contract-level audits of 2007 payments had rates of unsupported diagnoses at or below 30 percent, 10 of the 32 had rates between 30 and 40 percent, and 10 of the 32 contracts had rates at or above 40 percent.

Ten of the 32 contracts that were selected for contract-level audits of 2007 payments had recoveries above \$400,000, 12 of the 32 had recoveries between \$200,000 and \$400,000, and 10 of the 32 had recoveries below \$200,000 (including two contracts with recoveries of \$0). The average contract payment recovery was \$323,545, and the median was \$325,413. Seven contracts in the high coding intensity group had recoveries below \$200,000.

**Figure 1: Percentage of Unsupported Diagnoses within Medicare Advantage (MA) Contracts by the Centers for Medicare & Medicaid Services (CMS) Coding Intensity, 2007 Risk Adjustment Data Validation (RADV) Audits**



Source: GAO analysis of CMS data. | GAO-16-76

Notes: Unsupported diagnoses represent CMS hierarchical condition categories that were not validated by medical records during contract-level RADV audits. CMS defines coding intensity as the average change in the disease component of the contract's risk scores for all available years.

Several shortcomings in CMS's methods for calculating coding intensity could have weakened the correlation between the degree of coding intensity and the percentage of improper payments. These shortcomings and their potential effects are as follows.

**Comparability of Risk Scores across Years**

CMS's coding intensity calculation may be based on noncomparable coding intensity scores across contracts because (1) the years of data used for each contract may not be the same and (2) coding intensity scores are not standardized to control for year-to-year differences. First, although CMS officials stated that the agency requires at least three pair-years of data for each contract, the agency includes data from all available years for each contract, which may vary between contracts. Because the growth in risk scores was lower in the MA program in earlier

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Targeting Diagnoses Most Likely Related to Coding Intensity

years among beneficiaries that continuously enrolled in the program, CMS's inconsistent standard of years measured for each contract would tend to calculate higher coding intensity scores for contracts that entered the MA market during periods of higher risk score growth.<sup>31</sup> Among beneficiaries who enrolled in MA in consecutive years, the growth in average risk scores was 0.106 from 2004 through 2006, 0.119 from 2006 through 2010, and 0.132 from 2010 through 2013.<sup>32</sup> Second, CMS officials stated that the agency does not standardize its coding intensity data relative to a measure of central tendency. Because CMS's coding intensity calculation does not account for the expected increase in risk scores during each period of growth, changes in risk scores may be more volatile from year to year than they would likely be if standardized or indexed to a measure of central tendency.

CMS's coding intensity calculation does not distinguish between the diagnoses that were likely coded by providers and the diagnoses that were likely revised by MA organizations. MA organizations may receive diagnoses from providers that are related to services rendered to MA beneficiaries. Because these diagnoses are submitted by providers, the medical records they create may be more likely to support these diagnoses compared with diagnoses that are subsequently coded by the MA organization through medical record chart reviews. For future years, CMS has an available method to distinguish between diagnoses likely submitted by providers to MA organizations and diagnoses that were likely later added by MA organizations. CMS's Encounter Data System provides a way for MA organizations to designate supplemental diagnoses that the organization added or revised after conducting medical record review.<sup>33</sup> CMS has not outlined plans for incorporating encounter data into its contract selection methodology, even though the encounter data could help target the submitted diagnoses that may be most likely related to improper payments in the future.

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<sup>31</sup>CMS first incorporated diagnoses for risk adjustment payment in 2000, and the phase-in of these diagnoses was complete in 2007.

<sup>32</sup>Richard Kronick and W. Pete Welch, "Measuring Coding Intensity in the Medicare Advantage Program," *Medicare and Medicaid Research Review*, 4, no. 2 (Baltimore, Md.: 2014).

<sup>33</sup>CMS allows MA organizations to submit all encounter data up to 25 months after the original date of service.

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## Contract Consolidation

CMS follows contracts that are renewed or consolidated under a different existing contract within the same MA organization; however, the agency's coding intensity calculation does not include the prior risk scores of the prior contract in the MA organization's renewed contract. This may result in overestimated improper payment risk if MA organizations move beneficiaries with higher risk scores—such as those with special needs—into one consolidated contract.<sup>34</sup>

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## CMS Does Not Always Select Contracts Based on Evidence of the Potential for Improper Payments

CMS's contract selection methodology did not (1) always target contracts with the highest coding intensity scores, (2) use results from prior contract-level RADV audits, (3) account for contract consolidation, and (4) account for contracts with high enrollment. These shortcomings are impediments to CMS's goal of recovering improper payments and are counter to federal internal control standards, which require that agencies use quality information to achieve their program goals.<sup>35</sup>

## Contracts with Highest Coding Intensity

For the 2011 contract-level RADV audits, CMS used a contract selection methodology that did not focus on contracts with the highest coding intensity scores. While we found that coding intensity scores are not strongly correlated with diagnostic discrepancies, they are somewhat correlated. CMS failed to fully consider that correlation for the 2011 contract-level RADV audit. For that audit, CMS officials stated that 20 of the 30 contracts were chosen because they were among the top third of all contracts in coding intensity, but we found that many of the 20 contracts were not at the highest risk for improper payments according to

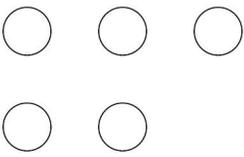
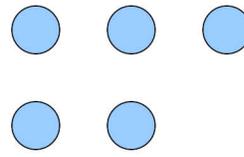
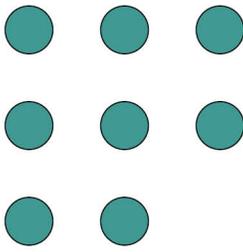
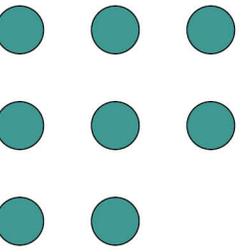
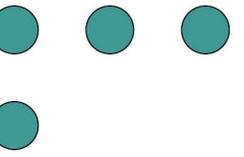
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<sup>34</sup>To help beneficiaries select an MA plan, CMS rates MA organization contracts on a 5-star scale, with 5 stars indicating the highest quality. An MA organization contract's overall star rating indicates its performance relative to that of all other plans on about 50 measures of clinical quality, patient experience, and contractor performance. CMS permits MA organizations to move enrollees from a contract with a low star rating to a contract with a higher star rating, and the Medicare Payment Advisory Commission has reported that contracts with low quality ratings tend to disproportionately serve beneficiaries with special needs—including those under the age of 65 who are disabled. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy: Online Appendixes, Chapter 14* (Washington, D.C.: March 2013), 6. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2015), 337.

<sup>35</sup>[GAO/AIMD-00-21.3.1](#).

CMS's estimate of coding intensity.<sup>36</sup> Only 4 of the 20 contracts ranked among the highest 10 percent in coding intensity, while 8 of the 20 contracts ranked below the 75th percentile in the coding intensity distribution (see fig. 2). In addition, CMS chose 5 of the 30 contracts because they were among the bottom third of all contracts in coding intensity, even though CMS's contract-level RADV audits of 2007 payments found that all contracts in the lowest third of the agency's coding intensity calculation had a below-average percentage of unsupported diagnoses. CMS officials stated that the RADV contract selection methodology includes these contracts to show that all contracts are at risk of being audited. However, officials also stated that MA organizations are not informed of their contracts' coding intensity relative to all other MA contracts; thus, MA organizations cannot be certain their contracts will not be audited even if CMS announced it will no longer audit low coding intensity contracts.

**Figure 2: Distribution of Medicare Advantage (MA) Contracts Selected for 2011 Risk Adjustment Data Validation (RADV) Audits, by Coding Intensity Group and Percentile**

Low coding intensity	Medium coding intensity	High coding intensity		
33rd percentile and below	33rd to 66th percentile	66th to 75th percentile	75th to 90th percentile	90th percentile and above
				
<b>[5]</b>	<b>[5]</b>	<b>[8]</b>	<b>[8]</b>	<b>[4]</b>

Source: GAO analysis of CMS data. | GAO-16-76

<sup>36</sup>CMS's reported range of coding intensity for the high-risk group of contracts was far greater than the range of the low- and medium-risk groups, resulting in a large discrepancy of coding intensity within the high-risk group. The range in coding intensity for the low-risk group was -.39 to -.04; for the medium-risk group, .04 to .07; and for the high-risk group, .07 to .91.

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Note: A total of 30 MA contracts were selected for the 2011 contract-level RADV audits. Each MA contract was assigned to only one category of coding intensity, and percentiles were calculated based on all MA contracts eligible for the 2011 contract-level RADV audits (contracts with at least three pair-years of data). CMS defines coding intensity as the average change in the disease component of the contract's risk scores for all available years.

## Results from Prior Audits

According to agency officials, CMS's 2011 contract-level RADV contract selection methodology also did not consider results from the agency's prior RADV audits, potentially overlooking information indicating contracts with known improper payment risk. Thus, contracts with the highest rates of unsupported diagnoses in the 2007 contract-level RADV audits were not among those selected for 2011 contract-level RADV audits. While CMS selected 6 contracts for 2011 that also underwent 2007 contract-level RADV audits, only 1 of these contracts was among the 10 with the highest rates of unsupported diagnoses in 2007.<sup>37</sup> For the 2011 contract-level RADV audits, CMS officials stated that the agency selected 6 MA contracts because the HHS Office of Inspector General had conducted audits of 2007 payments on those contracts, but CMS did not know the rates of unsupported diagnoses for those contracts and did not determine which of them were at high risk of improper payments.<sup>38</sup>

## Contract Consolidation

By not considering results from prior contract-level RADV audits, CMS's contract selection methodology also did not account for contract consolidation. An MA organization may have more than one contract in a service area; further, it may no longer have a contract that underwent a prior RADV audit but continue to operate another contract within the same service area. For example, the contract with the highest rate of unsupported diagnoses in the 2007 contract-level RADV audit is no longer in place, but the MA organization continues to operate a different contract that includes the service area from its prior contract.<sup>39</sup> Thus,

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<sup>37</sup>CMS did not examine the relative changes in coding intensity for contracts that underwent 2007 contract-level RADV audits, and agency officials stated that they were unaware whether rates of unsupported diagnoses dropped for those contracts or for other contracts under the same MA organization.

<sup>38</sup>CMS officials stated that they chose these six contracts because the agency wanted to see what the improper payment rate would be using CMS's contract-level RADV audit methodology, which differed substantially from the audit methodology used by the HHS Office of Inspector General.

<sup>39</sup>The contract with the high rate of unsupported diagnoses decreased its enrollment in 2010 and was no longer in place after that year. However, total enrollment under the MA organization's two contracts was nearly unchanged, and the contract that was not audited included the same service area.

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without considering all of an MA organization's contracts in that service area, CMS cannot audit the beneficiaries affiliated with the highest percentage of unsupported diagnoses in 2007.

#### Contracts with High Enrollment

Although the potential dollar amount of improper payments to MA organizations with high rates of unsupported diagnoses is likely greater when contract enrollment is large, CMS officials stated that the 2011 contract-level RADV contract selection methodology did not account for contracts with high enrollment. In 2011, the median enrollment among MA contracts was about 5,000, while enrollment at the 90th percentile was nearly 45,000. Some MA contracts with large enrollment had high rates of unsupported diagnoses under prior contract-level RADV audits. For example, 5 of the 10 MA contracts with the highest rates of unsupported diagnoses for the 2007 contract-level RADV audits had 2011 enrollment above the 90th percentile.

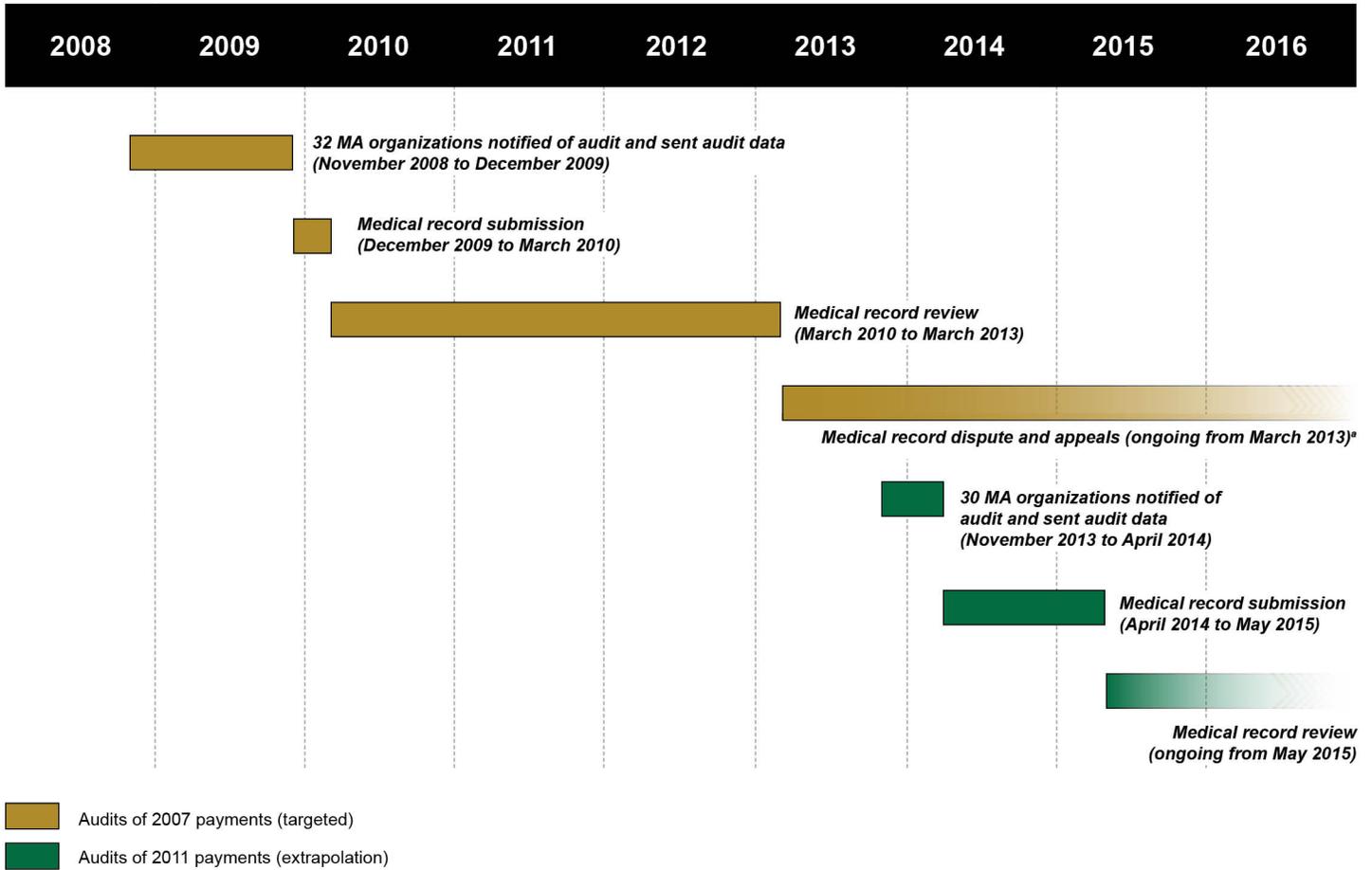
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### CMS's RADV Process Has Experienced Substantial Delays in Completing Contract-Level RADV Audits and Appeals

#### Prior Contract-Level RADV Audits Have Been Ongoing for Years, and CMS Lacks a Timetable to Annually Conduct and Complete Audits

CMS officials reported that current contract-level RADV audits have been ongoing for several years, including the appeals associated with the 2007 contract-level RADV audits. (See fig. 3.) For audits of 2007 payments, CMS notified MA organizations in November 2008 that their contracts would be audited but did not complete medical record review until approximately 4-1/2 years later in March 2013. Similarly, 2011 contract-level RADV audits had not been completed as of August 2015. CMS notified MA organizations of contract audit selection in November 2013 but did not begin medical record review for these contracts until May 2015. CMS officials said the agency will start collecting payments from the 2011 contract-level RADV audits in fiscal year 2016. As the agency is in the medical record review phase, appeals have not yet started. This slow progress in completing audits is contrary to CMS's goal to conduct contract-level RADV audits on an annual basis and slows its recovery of improper payments.

**Figure 3: Timeline of Contract-Level Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Audits and Related Appeals**



Source: GAO analysis of statements from CMS officials. | GAO-16-76

\*CMS began reviewing appeals in May 2013. Because MA organizations had 30 days to appeal CMS's contract-level RADV audit findings in 2013, there may be a 30-day gap between the end of medical record review and the start of appeals.

In addition, CMS lacks a timetable that would help the agency to complete these contract-level audits on an annual cycle. In contrast, the national RADV audit that calculates the national improper payment estimate uses a timetable, but this is not applied to the contract-level

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audits.<sup>40</sup> The national RADV audits that CMS annually conducts to estimate the national MA improper payment rate under IPIA provide the agency with a possible timetable for completing annual contract-level RADV audits.<sup>41</sup> CMS has not followed established project management principles in this regard, which call for developing an overall plan to meet strategic goals and to complete projects in a timely manner.<sup>42</sup>

In addition to the lack of a timetable, other factors have lengthened the time frame of the contract-level audit process. First, CMS's sequential notification to MA organizations—first identifying which contracts had been selected for audit and then later identifying which beneficiaries under these contracts would be audited—hinders the agency's goal of conducting annual contract-level audits because it creates a time gap.<sup>43</sup> For example, for the 2011 contract-level audits, CMS officials stated that the agency notified MA organizations about the beneficiaries whose diagnoses would be audited 3 months after notifying these same MA organizations about which contracts had been selected for audit. Both the selection of contracts and beneficiaries currently require risk score and beneficiary enrollment data.

Second, ongoing performance issues with the web-based system CMS uses to receive medical records submitted by MA organizations for contract-level RADV audits caused CMS to substantially lengthen the time frame for MA organizations to submit these medical records for the 2011 contract-level RADV audits. According to CMS officials, for the 2007 contract-level RADV audits, MA organizations submitted medical records for 98 percent of all audited diagnoses within a 16-week time frame. However, system performance issues with the Central Data Abstraction Tool (CDAT)—CMS's web-based system for transferring and receiving

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<sup>40</sup>For the national improper payment estimate of 2008 MA payments, CMS conducted RADV audits from December 2009 through July 2010. This involved notifying MA organizations of contracts selected for audit, completing medical record submission, and completing medical record review.

<sup>41</sup>AHIP officials stated that MA organizations' most frequent concerns about the RADV process are CMS's lack of an annual timetable for audits and the misalignment with the annual RADV audits the agency uses to estimate the national MA improper payment rate.

<sup>42</sup>[GAO-09-3SP](#).

<sup>43</sup>According to CMS officials, once MA organization contracts are notified of selection for RADV audit, the agency prevents the MA organization from submitting any additional payment data that could affect CMS's selection of beneficiaries for audit.

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contract-level RADV audit data—led CMS to more than triple the medical record submission time frame for the 2011 contract-level RADV audits to over 1 year.<sup>44</sup> Officials from AHIP and the two MA organizations we interviewed indicated that CDAT often proved inoperable, with significant delays and errors in uploading files. CMS officials stated that the agency suspended the use of CDAT for 8 months and implemented steps to monitor and test CDAT's performance. CMS officials stated that they have implemented steps to continue monitoring and testing CDAT's performance. However, officials from MA organizations stated that CDAT continued to experience significant delays in uploading files after CMS reopened CDAT for use. Officials of one MA organization suspected that the system may have been overwhelmed because CMS increased the number of medical records allowed per audited diagnosis from one to five between the 2007 and 2011 contract-level audits. For future medical record submissions, CMS officials subsequently told us that they plan to use a 20-week submission period and did not indicate to us any plans for an additional medical record submission method if CDAT's problems persisted.

CMS's Medicare FFS program has increasingly used the Electronic Submission of Medical Documentation System (ESMD) to transfer medical records reliably from providers to Medicare contractors since 2011. Both ESMD and CDAT allow for the electronic submission of medical records by securely uploading and submitting medical record documentation in a portable document format file.<sup>45</sup> CMS officials stated that the agency did not use ESMD to transfer medical records primarily because it could not also be used for medical record review like CDAT. However, medical records could be reviewed without being transferred through CDAT. The transfer of medical records has been the main source of delay in completing CMS's contract-level audits of 2011 payments, and CMS has not assessed the feasibility of updating ESMD for transferring medical records in contract-level RADV audits. While ESMD was not

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<sup>44</sup>MA organization officials stated that they had experienced problems with CDAT for 2007 contract-level RADV audits, but these problems were substantially worse for 2011 contract-level RADV audits. MA organization officials also stated that the problems with CDAT forced them to divert more staff resources to medical record submission.

<sup>45</sup>CMS authorizes Health Information Handlers—organizations that handle health information on behalf of a provider—to assist providers with submitting medical records through ESMD. In contrast, CMS only provides training directly to MA organizations for submitting medical records for contract-level RADV audits through CDAT.

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available when CMS began its 2007 contract-level RADV audits, the system has demonstrated a greater capacity for transferring medical records than CDAT. In fiscal year 2014, providers used ESMD to transfer nearly 500,000 medical records—far beyond the capacity necessary for contract-level RADV audits.<sup>46</sup> In interviews, officials of two FFS RACs stated that ESMD was very reliable and did not have technical issues that affected audits.

In addition, CMS has not applied time limits to contract-level RADV reviewers for completing medical record reviews. These reviews took 3 years for the 2007 contract-level RADV audits. In contrast, CMS generally requires its Medicare Administrative Contractors (MAC)—a type of FFS contractor—to make postpayment audit determinations within 60 days of receiving medical record documentation.<sup>47</sup> Because CMS has not required that contract-level RADV auditors complete medical record reviews within a specific time period, the agency is hindering its ability to reach its goal of conducting annual contract-level RADV audits.<sup>48</sup>

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### Disputes and Appeals of Contract-Level RADV Audits Have Been Ongoing for Years, and CMS Has Not Incorporated Measures to Expedite the Process

Disputes and appeals stemming from the 2007 contract-level RADV audit findings have been ongoing for years and the lack of time frames at the first level of the appeal process hinders CMS from achieving its goal of using contract-level audits to recoup improper payments. Nearly all MA organizations whose contracts were included in the 2007 contract-level RADV audit cycle disputed at least one diagnosis finding following medical record review, and five MA organizations disputed all the findings of unsupported diagnoses. CMS officials stated that MA organizations in total disputed 624 (4.3 percent) of the 14,388 audited diagnoses, and that

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<sup>46</sup>During the first 13 weeks of fiscal year 2014, providers transferred 173,234 medical records through ESMD. This volume of medical records would exceed the number of medical records necessary for contract-level RADV audits if each audited beneficiary had 5 audited diagnoses and MA organizations submitted the maximum five medical records per diagnosis. For the 2007 contract-level RADV audits, the average beneficiary had 2.4 audited diagnoses.

<sup>47</sup>MACs are a type of contractor used by CMS to process and pay claims in the FFS Medicare program. MACs also conduct postpayment claims reviews on a small percentage of paid claims to determine if the payments were proper based on underlying documentation in an effort to prevent future FFS Medicare payment errors.

<sup>48</sup>For 2011 contract-level RADV audits, the medical record review process began in May 2015, and CMS expects to complete medical record review and send RADV results to MA organizations in 2016.

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the determinations on these disputes, which were submitted starting March 2013 through May 2013, were not complete until July 2014.

If an MA organization disagrees with the medical record dispute determination, the MA organization may appeal to a hearing officer. This appeal level is called review by a CMS hearing officer. Because the medical record dispute process for the 2007 contract-level RADV audit cycle took nearly 1-1/2 years to complete, CMS officials stated that the agency did not receive all 2007 second-level appeal requests for hearing officer review until August 2014. CMS officials stated that the hearing officer adjudicated or received a withdrawal request from the MA organization for 377 of the 624 appeals (60 percent) from August 2014 through September 2015.<sup>49</sup>

Appeals for the 2011 contract-level RADV audit cycle have yet to begin, as CMS officials stated that the agency is currently in the process of reviewing medical records submitted by MA organizations for the 2011 contract-level RADV audits. CMS officials stated that the medical record dispute process for the 2011 contract-level RADV audit cycle will differ from the process used during the 2007 cycle in certain respects. In particular, for the 2011 RADV audit cycle, the medical record dispute process will be incorporated into the appeal process instead of being part of the audit process, as it was during the 2007 cycle. The new first-level appeal process, in which an MA organization can submit a written request for an independent reevaluation of the RADV audit decision, will be called the reconsideration stage. This change will allow MA organizations to request reconsideration of medical record review determinations simultaneously with the appeal of payment error calculations, rather than sequentially, as was the case during the 2007 contract-level RADV audit cycle.

While such a change may be helpful, the new process does not establish time limits for when reconsideration decisions must be issued. In contrast, CMS generally imposes a 60-day time limit on MA organization decisions

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<sup>49</sup>Due to the complexity of the contract-level RADV audit process, the agency stated that appeal decisions will be made on a case-by-case basis. CMS officials estimated that some cases could be settled in as little as 2 weeks, with more complex cases taking as long as 18 to 24 months.

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regarding beneficiary payment first-level appeals in MA.<sup>50</sup> CMS measures the timeliness of decisions regarding MA beneficiary first-level appeals to assist the agency in assigning quality performance ratings and bonus payments to MA organizations.<sup>51</sup> Similarly in Medicare FFS, officials generally must issue decisions within 60 days of receiving first-level appeal requests.<sup>52</sup> CMS officials stated that due to the agency's limited experience with the contract-level RADV audit process, time limits were not imposed at the reconsideration appeal level and that this issue may be revisited once CMS completes a full contract-level RADV audit cycle. The lack of explicit time frames for appeal decisions at the reconsideration level hinders CMS's collection of improper payments as the agency cannot recover extrapolated overpayments until the MA organization exhausts all levels of appeal and is inconsistent with established project management principles.<sup>53</sup>

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## CMS Has Made Little Progress toward Incorporating a Recovery Audit Contractor in MA

CMS has not expanded the RAC program to MA, as it was required to do by the end of 2010 by the Patient Protection and Affordable Care Act. CMS issued a request for industry comment regarding implementation of the MA RAC on December 27, 2010, seeking stakeholder input regarding potential ways improper payments could be identified in MA using RACs. CMS reported that it had received all stakeholder comments from this request by late February 2011. CMS issued a request for proposals for the MA RAC in July 2014. As defined by the Statement of Work in that request, the MA RAC would audit improper payments in the audit areas of

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<sup>50</sup>Beneficiary payment appeals are handled under an appeal process specifically for MA organizations. The first level of review is reconsideration by the health plan offered by an MA organization. If the health plan offered by an MA organization issues a decision against the beneficiary at the first level of appeal, the beneficiary's appeal is automatically sent to the next level of review, reconsideration by an independent review entity.

<sup>51</sup>Beginning in 2015, MA organizations must earn an overall rating of 4 or more stars to be eligible for quality bonus payments.

<sup>52</sup>We are currently examining recent trends in Medicare FFS appeals and any efforts by HHS to monitor and improve the appeal process and plan to issue a report in spring 2016.

<sup>53</sup>[GAO-09-3SP](#).

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Medicare secondary payer, end-stage renal disease, and hospice.<sup>54</sup> In October 2014, CMS officials told us that the agency did not receive any proposals to conduct the work in those three audit areas and that CMS's goal was to reissue the MA RAC solicitation in 2015.

In November 2015, CMS officials told us that the agency is no longer considering Medicare secondary payer, end-stage renal disease, and hospice services as audit areas for the MA RAC. Instead, the officials told us that CMS was exploring whether and how an MA RAC could assist CMS with contract-level RADV audits. In December 2015, CMS issued a request for information seeking industry comment regarding how an MA RAC could be incorporated into CMS's existing contract-level RADV audit framework.<sup>55</sup> In the request document, CMS stated that it is seeking an MA RAC to help the agency expand the number of MA contracts subject to audit each year. In the request, CMS stated that its ultimate goal is to have all MA contracts subject to either a contract-level RADV audit or what it termed a condition-specific RADV audit for each payment year.<sup>56</sup> Officials we interviewed from three of the current Medicare FFS RACs all acknowledged that their organizations had the capacity and willingness to conduct contract-level RADV audits.

Despite its recent request for information, CMS does not have specific plans or a timetable for including RACs in the contract-level RADV audit process. Established project management principles call for developing

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<sup>54</sup>Based on our own analysis, we believe that targeting RAC audit work to Medicare secondary payer, end-stage renal disease, and hospice would have minimal impact on MA improper payments and that these are areas that could be addressed through administrative processes CMS already has in place. For example, CMS already has a contractor in place to ensure that Medicare is not incorrectly billed as a primary payer. CMS's proposal would have applied to relatively few MA enrollees with end-stage renal disease, and MA organizations do not control when CMS reduces payments to them for a beneficiary who seeks hospice services since the election forms are submitted by the hospice provider.

<sup>55</sup>Centers for Medicare & Medicaid Services, Medicare Advantage Part C Recovery Auditor Request for Information, December 22, 2015, RFI-CMS-2016-RADV-RAC, accessed January 4, 2016, [https://www.fbo.gov/index?s=opportunity&mode=form&id=83f1ec085c52a81a6a6ce7cba3fbbc5d&tab=core&\\_cview=0](https://www.fbo.gov/index?s=opportunity&mode=form&id=83f1ec085c52a81a6a6ce7cba3fbbc5d&tab=core&_cview=0).

<sup>56</sup>CMS described condition-specific RADV audits as audits that would be focused on specific diagnoses that had been determined to have a high probability of being erroneous. CMS envisions that these audits would be conducted for MA contracts that were not subject to contract-level RADV audits for a particular payment year.

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an overall plan and monitoring framework to meet strategic goals.<sup>57</sup> A plan and timetable would help guide CMS's efforts in incorporating a RAC in MA and help hold the agency accountable for implementing this requirement from the Patient Protection and Affordable Care Act. Once the requirement is implemented, CMS could leverage the MA RAC in order to increase the number of MA organization contracts audited. CMS's recovery of improper payments has been restricted because it has not established an MA RAC. For example, CMS currently plans to include 30 MA contracts in contract-level RADV audits for each payment year, about 5 percent of all contracts.

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## Conclusions

Limitations in CMS's processes for selecting contracts for audit, in the timeliness of CMS's audit and appeal processes, and in the agency's plans for using MA RACs to assist in identifying improper payments hinder the accomplishment of its contract-level RADV audit goals: to conduct annual contract-level audits and recover improper payments. These limitations are also inconsistent with federal internal control standards and established project management principles. Our analyses of these processes and plans suggest that CMS will likely recover a small portion of the billions of dollars in MA improper payments that occur every year. Shortcomings in CMS's MA contract selection methodology may result in audits that are not focused on the contracts most likely to be disproportionately responsible for improper payments. Furthermore, CMS's RADV time frames are so long that they may hamper the agency's efforts to conduct audits annually, collect extrapolated payments efficiently, and use audit results to inform future RADV contract selection. By CMS's own estimates, conducting annual contract-level audits would potentially allow CMS to recover hundreds of millions of dollars more in improper payments each year. Agency officials have expressed concerns about the intensive agency resources required to conduct contract-level RADV audits. To address the resource requirements of conducting contract-level audits, CMS intends to leverage the MA RACs for this purpose; however, the agency has not outlined how it plans to incorporate RACs into the contract-level RADV audits and is in the early stages of soliciting industry comment regarding how to do so.

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<sup>57</sup> [GAO-09-3SP](#).

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## Recommendations for Executive Action

As CMS continues to implement and refine the contract-level RADV audit process, we recommend that the Administrator of CMS take actions in the following five key areas to improve the efficiency and effectiveness of reducing and recovering improper payments.

First, to improve the accuracy of CMS's calculation of coding intensity, the Administrator should modify that calculation by taking actions such as the following:

- including only the three most recent pair-years of risk score data for all contracts;
- standardizing the changes in disease risk scores to account for the expected increase in risk scores for all MA contracts;
- developing a method of accounting for diagnostic errors not coded by providers, such as requiring that diagnoses added by MA organizations be flagged as supplemental diagnoses in the agency's Encounter Data System to separately calculate coding intensity scores related only to diagnoses that were added through MA organizations' supplemental record review (that is, were not coded by providers); and
- including MA beneficiaries enrolled in contracts that were renewed from a different contract under the same MA organization during the pair-year period.

Second, the Administrator should modify CMS's selection of contracts for contract-level RADV audits to focus on those contracts most likely to have high rates of improper payments by taking actions such as the following:

- selecting more contracts with the highest coding intensity scores;
- excluding contracts with low coding intensity scores;
- selecting contracts with high rates of unsupported diagnoses in prior contract-level RADV audits;
- if a contract with a high rate of unsupported diagnoses is no longer in operation, selecting a contract under the same MA organization that includes the service area of the prior contract; and
- selecting some contracts with high enrollment that also have either high rates of unsupported diagnoses in prior contract-level RADV audits or high coding intensity scores.

Third, the Administrator should enhance the timeliness of CMS's contract-level RADV process by taking actions such as the following:

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- closely aligning the time frames in CMS's contract-level RADV audits with those of the national RADV audits the agency uses to estimate the MA improper payment rate;
  - reducing the time between notifying MA organizations of contract audit selection and notifying them about the beneficiaries and diagnoses that will be audited;
  - improving the reliability and performance of the agency's process for transferring medical records from MA organizations, including assessing the feasibility of updating ESMD for use in transferring medical records in contract-level RADV audits; and
  - requiring that CMS contract-level RADV auditors complete their medical record reviews within a specific number of days comparable to other medical record review time frames in the Medicare program.

Fourth, the Administrator should improve the timeliness of CMS's contract-level RADV appeal process by requiring that reconsideration decisions be rendered within a specified number of days comparable to other medical record review and first-level appeal time frames in the Medicare program.

Fifth, the Administrator should ensure that CMS develops specific plans and a timetable for incorporating a RAC in the MA program as mandated by the Patient Protection and Affordable Care Act.

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## Agency Comments

We provided a draft of this report to HHS for comment. HHS provided written comments, which are printed in appendix I. HHS concurred with our recommendations. In its comment letter, HHS also reaffirmed its commitment to identifying and correcting improper payments in the MA program. HHS also provided technical comments, which we incorporated as appropriate. Based on HHS's technical comments, we revised our suggested actions for how HHS could meet GAO's first recommendation.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees and the Secretary of Health and Human Services. In addition, this report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on

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the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

Sincerely yours,

A handwritten signature in black ink, appearing to read "James Cosgrove". The signature is stylized with large, sweeping loops and a cursive style.

James Cosgrove  
Director, Health Care

# Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

MAR 1 5 2016

James Cosgrove  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *'Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments'* (GAO-16-76).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADVANTAGE: FUNDAMENTAL IMPROVEMENTS NEEDED IN CMS'S EFFORT TO RECOVER SUBSTANTIAL AMOUNTS OF IMPROPER PAYMENTS (GAO-16-76)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is strongly committed to program integrity in the Medicare Advantage (MA) program and takes seriously our responsibility to protect taxpayer dollars by identifying and correcting improper payments.

CMS is required to risk adjust payments to Medicare Advantage Organizations (MAOs). In general, the current risk adjustment methodology relies on enrollee diagnoses to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee. Diagnosis codes submitted by MA organizations are used to determine beneficiary risk scores, which in turn determine the risk-adjusted payment.

Risk adjustment data validation (RADV) audits of MAOs are designed to ensure the accuracy and integrity of risk adjustment data and Medicare Part C program risk adjusted payments in order to protect the Medicare Trust Funds. RADV audits verify whether the diagnosis codes submitted for payment by MAOs are supported by medical record documentation. These audits recover overpayments identified by RADV; encourage accurate coding; increase the incentive for MAOs to submit valid and accurate diagnosis codes; and encourage MAOs to self-identify, report, and return overpayments they have received.

HHS began conducting RADV audits in 2010 and has initiated audits in which the results will be extrapolated for payment years 2011 and 2012. MAOs are currently submitting medical records for the RADV audits of payment year 2012. In addition, HHS will continue to conduct RADV audits for subsequent payment years and increase the number and type of audits under a Part C Recovery Audit (RA) program.

The implementation of RADV audits has had a significant sentinel effect on plan sponsors' identification and return of overpayments. During fiscal year 2015, MAOs reported and returned approximately \$650 million in overpayments. Overall, this process has resulted in \$1.7 billion in self-identified overpayment returns.

In December 2015, HHS issued a Request for Information (RFI) to solicit feedback on a proposal to contract with one or more RAs to identify and correct improper payments in Medicare Part C to significantly expand the RADV audit initiative. Under the proposal, HHS would contract with a Part C RA to conduct audits of particular high-error diagnoses or conditions reported by MAOs that are not subject to a RADV audit for a given payment year. HHS's goal is to have all MA contracts subject to either a Comprehensive or Condition-Specific RADV audit for each payment year. The comment period for this RFI has closed, and HHS is currently reviewing comments.

**GAO Recommendation**

The Administrator should improve the accuracy of CMS's calculation of coding intensity.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADVANTAGE: FUNDAMENTAL IMPROVEMENTS NEEDED IN CMS'S EFFORT TO RECOVER SUBSTANTIAL AMOUNTS OF IMPROPER PAYMENTS (GAO-16-76)**

**HHS Response**

HHS concurs with GAO's recommendation. HHS will examine GAO's suggestions for improving the calculation of coding intensity. HHS will determine if these or other steps would improve the accuracy of the calculation.

**GAO Recommendation**

The Administrator should modify CMS's selection of contracts for contract-level RADV audits to focus on those contracts most likely to have high rates of improper payments.

**HHS Response**

HHS concurs with GAO's recommendation. The selection methodology was initially adopted to provide additional oversight of contracts with the most aggressive coding. Within the context of the expanded RADV program described in the Part C RA RFI, HHS's ultimate goal is to have all MA contracts subject to either a Comprehensive or Condition-Specific RADV audit for each payment year, which would provide oversight for all contracts including those with the highest rates of improper payments.

**GAO Recommendation**

The Administrator should enhance the timeliness of CMS's contract-level RADV process.

**HHS Response**

HHS concurs with GAO's recommendation. HHS has worked to establish processes in the initial stages of the RADV program and will leverage the current policies and procedures to enhance the timeliness of our audits going forward. RADV audits for payments years 2011 and 2012 have been initiated, and HHS will continue to conduct additional audits such that the most recently available data are used to conduct RADV audits annually. HHS's goal is to have all MA contracts subject to either a Comprehensive or Condition-Specific RADV audit for each payment year.

**GAO Recommendation**

The Administrator should improve the timeliness of CMS's contract-level RADV appeals process by requiring that reconsideration decisions be rendered within a specified number of days comparable to other medical record review and first-level appeal time frames in the Medicare program.

**HHS Response**

HHS concurs with GAO's recommendation. HHS will develop a timetable for resolving reconsideration appeals.

**GAO Recommendation**

The Administrator should ensure that CMS develops specific plans and a timetable for incorporating a Recovery Audit Contractor in the MA program as mandated by the Patient Protection and Affordable Care Act.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADVANTAGE: FUNDAMENTAL IMPROVEMENTS NEEDED IN CMS'S EFFORT TO RECOVER SUBSTANTIAL AMOUNTS OF IMPROPER PAYMENTS (GAO-16-76)**

**HHS Response**

HHS concurs with GAO's recommendation. The comment period for the Part C RA RFI has closed. HHS is currently reviewing comments to determine how the Part C RA should be implemented. This includes developing a timetable for incorporating an RA in the MA program.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

James Cosgrove, (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov).

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## Staff Acknowledgments

In addition to the contact named above, individuals making key contributions to this report include Martin T. Gahart, Assistant Director; Luis Serna III; and Marisa Beatley. Elizabeth T. Morrison and Jennifer Whitworth also provided valuable assistance.

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