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CLIENT ALERT

CMS Issues Final Rule on Medicare Advantage RADV Audits Amid Increased Program Scrutiny

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On January 30, 2023, the Centers for Medicare and Medicaid Services ("CMS") issued a highly anticipated final rule (the "Final Rule") regarding its Risk Adjustment Data Validation ("RADV") program for Medicare Advantage organizations ("MAOs").[1] The Final Rule, which will have a significant impact on MAOs as well as health systems and other providers that contract with MAOs, follows several years of debate regarding the appropriate approach to auditing and recoupment from MAOs. We anticipate that certain provisions of the Final Rule, which were strongly opposed by key stakeholders, may give rise to legal challenges. More broadly, the Final Rule arises in the context of a growing government focus on overpayments in the Medicare Advantage ("MA") program, including through increased enforcement under False Claims Act ("FCA") theories that impact both MAOs and providers.

Overview of Final Rule

CMS's monthly capitation payments to MAOs under the MA program are risk-adjusted to account for variations in health status and to address potential disincentives to treat more complex patients. CMS uses diagnosis codes reported by MAOs, which must be supported by the enrollee's medical records, to determine the risk-adjustment factor it applies to the capitation payment. Through the RADV program, CMS audits MA program payments to identify improper risk adjustments where the diagnosis codes submitted by the MAO are not supported by the enrollee's medical record.

The Final Rule makes substantial updates to the RADV audit methodology. The two most notable are new provisions for extrapolating findings and the decision not to apply a fee-for-service ("FFS") adjuster. While CMS had initially proposed to allow for extrapolation of audit findings beginning in payment year 2011, the Final Rule provides that CMS will begin extrapolating RADV audit findings beginning with payment year 2018. CMS did not endorse any particular statistical sampling methodology and instead will use methods that it determines to be "well-suited to a particular RADV audit."[2] The Final Rule provides some discretion with respect to whether and when extrapolation will be applied, but CMS states that "extrapolation is expected to be the standard practice for RADV audits beginning in [payment year] 2018."[3]

Many MAOs had argued that an FFS adjuster is necessary to ensure actuarial equivalence between payments to MA plans and payments to traditional FFS Medicare, as required by the statute. However, in the Final Rule, CMS takes

the position that the requirement for actuarial equivalence does not apply to the obligation to return improper payments for diagnosis codes that are not supported by medical records, arguing that it only applies to how CMS risk-adjusts payments to MAOs. CMS asserts that this position "is consistent with" recent case law in the D.C. Circuit.

Increased Government Focus on Medicare Advantage Overpayments

The Final Rule makes clear CMS's view that there is a high level of improper payments in the MA program, which CMS seems to posit results from the fact that there is no pre-payment review of diagnosis codes used to support risk adjustment and what CMS describes as "an incentive for MAOs to potentially over-code diagnoses to increase their payments."[4] The Regulatory Impact Analysis for the Final Rule estimates that extrapolated improper payment recoveries will equal approximately $479 million per year beginning with the 2018 payment year.[5]

Notably, the Final Rule states that "[w]hile RADV audits are intended to identify improper risk adjustment payments, they are not specifically designed to detect fraud," such as FCA violations.[6] Recent trends suggest, however, that the Department of Justice ("DOJ") is keenly aware of the potential of the FCA as a vehicle to pursue alleged fraud in the MA program. DOJ's increased focus on this space is likely spurred both by the program's increased maturity and its rapid growth in recent years—in 2022, nearly half of the eligible Medicare population was enrolled in an MA plan, and 55% of total Medicare spending was used for MA plans.[7] In comments delivered in 2020, Deputy Assistant Attorney General Michael Granston described FCA violations in the Medicare Advantage industry as an "important priority" for the DOJ.[8]

There have been several notable FCA enforcement actions involving allegedly false claims stemming from allegedly inaccurate or inflated diagnosis codes, leading to increased risk adjustment payments. For example, in July 2021, DOJ intervened in six complaints alleging that the Kaiser Permanente consortium of healthcare plans violated the FCA by submitting inaccurate diagnosis codes for its MA beneficiaries in order to increase their MA payments.[9] Importantly, DOJ's focus in this space is not limited to the MAOs that submit the diagnosis codes; it is also pursuing FCA enforcement actions against the providers who document the diagnoses in the first instance, and who typically have arrangements with MA plans to receive a portion of the plan's capitation payment from the Medicare program. For example, in August 2021, DOJ announced a settlement with Sutter Health and several affiliates for $90 million in relation to allegations of submitting inaccurate information about the health status of Medicare Advantage beneficiaries.[10] The government's theory in that case was that Sutter Health had submitted false diagnosis codes to MAOs and caused the MAO to submit false diagnosis codes to CMS.

Take-Aways

MAOs and the health systems and other providers who contract with them should carefully review the new RADV methodology and monitor its implementation. More broadly, as payors and providers continue to expand their risk-sharing arrangements and move toward value-based care, the importance of accuracy of diagnosis coding for purposes of risk adjustment will only increase, along with an inevitable increase in government scrutiny, particularly with respect to FCA exposure. Participants in the MA program may need to consult with counsel to assess their exposure to such risks.

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[1] 88 Fed. Reg., 6643 (Feb. 1, 2023) (to be codified at 42 C.F.R. Part 422).

[2] *Id*. at 6651.

[3] *Id*. at 6650.

[4] *Id*. at 6645.

[5] *Id*. at 6653.

[6] *Id*. at 6645.

[7] Meredith Freed et al., *Medicare Advantage in 2022: Enrollment Update and Key Trends*, Kaiser Family Foundation (Aug. 25, 2022), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/.

[8] U.S. Dep't of Justice, *Remarks of Deputy Assistant Attorney General Michael D. Granston at the ABA Civil False Claims Act and Qui Tam Enforcement Institute* (Dec. 2, 2020), https://www.justice.gov/opa/speech/remarks-deputy-assistant-attorney-general-michael-d-granston-aba-civil-false-claims-act.

[9] *United States ex rel. Osinek v. Permanente Med. Grp., Inc.*, 601 F. Supp. 3d 536 (N.D. Cal. 2022).

[10] U.S. Dep't of Justice, *Sutter Health and Affiliates to Pay $90 Million to Settle False Claims Act Allegations of Mischarging the Medicare Advantage Program* (Aug. 30, 2021), https://www.justice.gov/opa/pr/sutter-health-and-affiliates-pay-90-million-settle-false-claims-act-allegations-mischarging.

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