BluePeak Advisors is a division of Gallagher Benefit Services, Inc.

Final Rule: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021

February 7, 2023

On February 1, 2023, the Centers for Medicare & Medicaid Services (CMS) published this Final Rule (CMS 2023-01942) in the Federal Register. This final rule announces certain policies to improve program integrity and payment accuracy in the Medicare Advantage (MA) program. The purpose of this final rule is to outline the CMS audit methodology and related policies for the MA Risk Adjustment Data Validation (RADV) program. Specifically, this final rule codifies in regulation that, as part of the RADV audit methodology, CMS will extrapolate RADV audit findings beginning with payment year (PY) 2018 and will not extrapolate RADV audit findings for PYs 2011 through 2017. CMS is also finalizing a policy whereby CMS will not apply an adjustment factor (known as a Fee-For-Service (FFS) Adjuster) in RADV audits. CMS is also codifying in regulation the requirement that MA organizations (MAOs) remit improper payments identified during RADV audits in a manner specified by CMS.

The final rule is effective on April 3, 2023.

An index to the proposed rule, along with a highlight of its most significant provisions, is set forth below.

1. Executive Summary (pgs. 1 - 2 of the PDF)

a. Extrapolation and Sampling
(pgs. 1- 2 of the PDF)

i. Finalizes that CMS will begin extrapolation with the PY 2018 RADV, however CMS will collect non-extrapolated overpayments identified in the CMS RADV audits and Department of Health and Human Services Office of Inspector General (HHS-OIG) audits between PY 2011 and PY 2017 and will begin collection of extrapolated overpayment findings for any CMS and OIG audits conducted in PY 2018 and any subsequent payment year.

A. CMS is not adopting any specific sampling or extrapolated audit methodology but will rely on any statistically valid method for sampling and extrapolation that is determined to be well-suited to a particular audit.

B. CMS will not apply a Fee-For-Service (FFS) Adjuster in RADV audits as they have determined that an FFS Adjuster is not appropriate.

b. Remittance of Improper Payments
(pgs. 1- 2 of the PDF)

i. CMS is codifying into regulation that Medicare Advantage Organizations (MAOs) remit improper payments identified during RADV audits in a manner specified by CMS.

ii. After the effective date CMS will begin issuing the enrollee-level audit findings from the CMS RADV audits that have been completed, as well as recovering the enrollee-level improper payments identified in HHS-OIG audits.

2. Background and Provisions of Final Rule (pgs. 2 – 19 of the PDF)

a. Extrapolation and Sampling
(pgs. 3 - 13 of the PDF)

i. CMS will employ statistical methods to determine statistically valid sample sizes, accurately identify payment errors, and extrapolate to the universe of enrollees from which sample is selected.

ii. CMS may use its discretion to not utilize extrapolation in a particular instance, but this will be rare.

iii. Statistically valid audit methodologies may include applying one or more RADV audit methodology for a given RADV audit.

A. CMS emphasizes that they are not adopting the contract-level sampling and extrapolation technique from the 2012 methodology, or a specific extrapolated audit methodology based on sub cohorts of enrollees.

B. CMS will rely on any statistically valid method for sampling and extrapolation that it deems as appropriate and well-suited to a particular audit.

iv. Extrapolation will begin in PY 2018 RADV audits.

v. Payment recovery for PY 2011 through 2017 RADV audits limited to enrollee-level adjustments for those enrollees sampled in payment validation audits.

b. Purpose of RADV Audits
(pgs. 3- 19 of the PDF)

i. Purpose of the RADV audits is to validate that diagnoses submitted by MAOs for risk-adjusted payments are supported by medical record documentation. See 42 CRF 422.310(e).

ii. RADV audits are CMS's main corrective action for overpayments made to MAOs when there is a lack of documentation in the medical records to support risk adjustment.

c. Selection of MAOs
(pgs. 3, 10 of the PDF)

i. MAOs will be selected for RADV audits using a risk-based approach that focuses on Hierarchical Condition Categories (HCCs) that are more likely to be in error based on prior RADV audits.

ii. CMS does not currently subject PACE organizations to RADV audits and CMS' selection methodology for each year will describe any adjustments for PACE or other low enrollment contracts.

d. RADV Audit Appeals
(pgs. 2-13 of the PDF)

i. There will be no change to the appeal process. MAOs will continue to use the RADV appeals process currently set forth in § 422.311.

e. Regulation Revisions
(pgs. 13 of the PDF)

i. Revising § 422.300 to include "collection of improper payments."
ii. Amending § 422.310(e) to announce that extrapolation may be applied in RADV audits for PY 2018 forward and by adding a requirement for MAOs to remit improper payments based on RADV audits in accordance with a manner specified by CMS.
iii. Amending § 422.311 by clarifying that recovery of improper payments from MAOs will be conducted according to the Secretary's payment error extrapolation and recovery methodologies and that CMS may apply extrapolation to RADV audits for PY 2018 and subsequent payment years.

f. FFS Adjuster
(pgs. 13- 18 of the PDF)

i. FFS Adjuster will not be applied to RADV audits because the "actuarial equivalence" and "same methodology" provisions do not apply to the obligation of an MAO to report and return improper payments for diagnoses lacking medical record support, including those improper payments identified during a RADV audit.

3. Collection of Information Requirements (pg. 18 of the PDF)

a. Collection of Information
(pgs. 18 of the PDF)

i. There are no new or revised collection of information requirements or related burden.

4. Regulatory Impact Analysis (RIA) (pgs. 18 - 23 of the PDF)

a. Audit Expected Impact
(pgs. 18 -23 of the PDF)

i. CMS estimates a positive return on investment with extrapolation applied to audit findings beginning with the 2018 payment year audits in the expected level of recovery in calendar year 2025 (the year in which they project to initiate improper payment recoveries for PY 2018 audits).
ii. Extrapolating audit findings does not increase the cost burden on the plan. The cost to the plan of complying with a RADV audit is neither the subject of nor affected by this provision.
iii. The intent of this rule is to protect taxpayer dollars and ensure oversight of the MA program, in part by reducing the Part C improper payment rate.