Medicare Advantage Payment Validation

FACT SHEET January 2021

BETTER MEDICARE ALLIANCE

Key Facts

- Medicare Advantage plans are paid a capitated amount based on average cost of Fee-For-Service. It is then risk adjusted for each enrollee.
- Law requires CMS to conduct Risk Adjustment Audits (RADV) to verify data accuracy.
- Overpayments identified in RADV must be returned to the government. If fraud occurs, penalties and fines are applied.

Policy Recommendation

Risk Adjustment Data Validation (RADV) audits are part of the process used by CMS to ensure payment accuracy in Medicare Advantage. CMS should work with Medicare Advantage plans, providers, and other stakeholders to improve the transparency, efficacy, and accuracy of RADV without excessive burden on providers.

CMS verifies the accuracy of Medicare Advantage payments by conducting Risk Adjustment Data Validation (RADV) audits.

Medicare Advantage Payments

The Centers for Medicare & Medicaid Services (CMS) pays Medicare Advantage plans a monthly, per-person, fixed rate, also known as a capitated payment, to deliver care to Medicare beneficiaries. This capitated payment is based on county level average Fee-For-Service (FFS) Medicare cost and is then risk adjusted for each individual to account for differences in health, demographics, and other risk factors. Risk scores are subsequently reduced by the "coding intensity adjustment" applied annually, across-the-board to reduce the risk scores to account for the difference in coding patterns between FFS Medicare and Medicare Advantage.

Law Requires CMS to Audit Payments in Medicare Advantage

Law requires government agencies to identify, report, and reduce erroneous payments in all government programs and activities. In Medicare Advantage, this includes regular validation of payments based on risk scores.

Risk Adjustment Data Validation (RADV) Verifies Data Accuracy

- CMS conducts Medicare Advantage RADV activities to ensure the accuracy and integrity of risk adjustment data and risk adjusted payments.
- RADV is the process of verifying that diagnosis codes and other data submitted for payment by a Medicare Advantage plan are supported by medical record documentation.
- Medicare Advantage plans and providers develop, refine, and use sophisticated data systems and processes, as well as skilled personnel, to provide accurate data and to comply with CMS rules.

RADV is a Rigorous Process

- As with other government programs, audits are conducted to catch fraud and abuse and ensure such erroneous payments are returned to the government.
- For each RADV audit cycle, CMS selects a subset of plans to review and then samples enrollee records and extrapolates findings to all payments.
- During the RADV process, Medicare Advantage plans are required to provide CMS access to facilities and records used in the determination of amounts payable under Medicare Advantage.
- Any overpayments found through RADV (e.g. from miscoding diagnoses) must be returned by Medicare Advantage plans to the government. If fraud is found, additional fines and penalties may be applied.