Medicare Advantage insurers will score $2 billion gift thanks to limited audits

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By Bob Herman[2] [3] *and* Tara Bannow[4] [5] Feb. 1, 2023

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Medicare officials made a clear statement four years ago[7] about how best to audit the country's Medicare Advantage insurers: Failing to take back all overpayments "would be contrary to the public interest."

But based on a final regulation[8] published Monday, Medicare is going against that public interest by giving a free pass to Medicare Advantage

plans for any erroneous codes they submitted between 2011 and 2017. The amount of taxpayer money that insurers will get to keep because of that decision: $2 billion.

“They gave the insurance companies a break,” said Melissa James, a senior health care consultant at Wolters Kluwer. James used to work at UnitedHealth Group and Aetna, where she internally audited the Medicare Advantage plans’ risk adjustment, chart review, and compliance. “There’s a bunch of money that is being left on the table by [the Centers for Medicare and Medicaid Services] by only doing the extrapolation from 2018 and beyond,” she said.

The final rule covered “risk adjustment data validation” audits, which scrutinize whether Medicare Advantage insurers are inappropriately coding how sick their members are. In 2018, when the federal government first proposed its revised rule[9], Medicare auditors intended to take a sample of patients, compare what insurers coded with what existed in the patients’ medical records, and then extrapolate those results to a company’s entire Medicare Advantage contract. The insurers would have to return any overpayments back to the government.

But the rule this week would grant immunity to all Medicare Advantage plans between 2011 and 2017. In essence, during that time period, the insurers would only have to refund money based on coding errors found in the audit’s sample, and would not have those errors applied to their entire membership. Extrapolation of Medicare Advantage audits from 2011 to 2017 would have yielded $2 billion for taxpayers, a Medicare spokesperson confirmed. The audits for 2011, 2012, and 2013 alone — which Kaiser Health News sued to obtain, and then published the results[10] — represent $683.2 million of those overpayments.

The $2 billion in foregone recoveries compares to just $41 million Medicare now expects to collect in "non-extrapolated" overpayments for those seven years. And considering it costs $51 million for Medicare to run these audits every year, the entire oversight program will be running at a huge loss for that seven-year stretch — all on the public's dime.

Medicare officials said in the regulation that they believe extrapolating all audited plans dating back to 2011 "would be a supportable decision and consistent with our mandate to protect taxpayer dollars," but that in the interest of maintaining the "long-term success" of RADV audits, they also considered "the projected level of effort and likelihood of collecting improper payments along with other practical realities."

"This policy debate started a long time ago," Dara Corrigan, director of Medicare's Center for Program Integrity, told reporters on Monday. She said not extrapolating results from before 2018 would help finally get the auditing program off the ground and "struck the right balance."

Legal experts also believe the government was trying to protect itself from insurance industry lawsuits. Not enforcing extrapolation on any audits before 2018, when the revised proposed rule first came out, may be beneficial for the feds in court.

"I think they set the benchmark in 2018 as, 'Everybody should have really known how to do this correctly by that point, so we're going to have a much higher bar of scrutiny,'" said Stephen Bittinger, a partner at the law firm K&L Gates who has experience with Medicare audits.

Health insurers decried the entire rule, although there appeared to be some support for Medicare's decision not to extrapolate overpayment amounts in older auditing years.

“The rules for the program should be established for the time when plans bid. 2018 was a change in policy that the plans couldn’t have anticipated when they bid,” said Kris Haltmeyer, vice president of policy analysis at the Blue Cross Blue Shield Association, which represents Blues insurers and has lobbied heavily against these audits. When asked if his group would sue over the rule, Haltmeyer said it was “too early” to comment.

America’s Health Insurance Plans, the most prominent health insurer lobbying group, was less diplomatic, calling the final rule “unlawful and fatally flawed.”

Medicare likely recognized insurers would take them to court no matter what the final rule said, so the agency could have been more bold in trying to recoup what it already found had been inappropriately paid, said David Lipschutz, an attorney and associate director of the Center for Medicare Advocacy, a nonprofit advocacy group.

“The insurance industry wants to say, ‘Water under the bridge.’ But that’s a lot of water under the bridge to let go,” Lipschultz said.

It’s not just lawsuits that will hold up the auditing program. Legal experts said insurers will make heavy use of the administrative appeals process when faced with unfavorable findings. Bittinger said providers have aggressively appealed their own Medicare audits, and the same will likely be the case for Medicare Advantage.

“They’re going to audit and produce extrapolated overpayment findings that will undoubtedly get trapped in the appeal process,” Bittinger said. “I think there’s going to be an enormous backlog.”

Medicare doesn't expect to recoup any money until 2025 — giving insurers two years to gum up or dilute the program even more. Their likely tactics include appeals, challenges to the agency's audit and extrapolation methodology, and legal challenges.

Although RADV audits are an important tool to enforce accountability within Medicare Advantage, their scope is still relatively limited, and they do not come close to recouping the full amount of overpayments that plans receive every year.

Just in 2022, the government estimates it overpaid Medicare Advantage plans by $11.4 billion[13]. Since 2018, overpayments to insurers have exceeded $25 billion. The Medicare Payment Advisory Commission estimates coding overpayments are even higher — roughly $17 billion in 2021 alone. The RADV audit program, meanwhile, expects to claw back $4.7 billion in the next 10 years.

Even heading into 2023, a year in which the government is expected to pay Medicare Advantage plans more than $473 billion[14], coding errors are still outpacing any type of potential oversight.

"We know there are still accuracy issues going on," James of Wolters Kluwer said. A lot of it comes back to basic coding errors for common diagnoses like stroke, heart attack, and cancer. "If a doctor documents a history of cancer, but the coder ends up coding as an active cancer, then that's where those types of issues happen," James said.

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