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CMS Goes After Medicare Advantage Overpayments

August 28, 2019

The Centers for Medicare & Medicaid Services (CMS) knows that a significant amount of money is being overpaid to insurance companies in the Medicare Advantage program, but they have yet to recover these overpayments. That's about to change. CMS says it will increase the audits being performed on Medicare Advantage risk-adjusted code submissions and apply extrapolation to the samples when calculating overpayments.

Standard Audits Prove Much, Accomplish Little

Insurance companies could go years without being chosen for review; and when chosen to be audited, they most often only paid back a few hundred thousand dollars, based on any improper payments found in the audit sample. Medicare Advantage audits have recouped a total of about $14 million, which is reportedly less than what it has cost CMS to conduct the audits.

CMS is trying again to recoup overpayments from Medicare Advantage insurers through RADV audits. They have a goal to get back about $1 billion in Medicare Advantage overpayments by 2020. This represents just a tenth of what CMS estimates the plans have overcharged the government in a given year. CMS estimates that plans have been overcharging the government $10 billion per year for over a decade.

CMS Finds Millions in Overpayments

The new audits include a sample of a random 200 patients, and the findings are then extrapolated to the plan's full membership. CMS has already conducted 90 of these enhanced audits for payments made in 2011, 2012, and 2013, and found overpayments amounting to $650 million as a result of the extrapolation.

The audit plan from 2011 expected CMS to finish up and assess penalties by the end of 2016. That has yet to happen while the industry continues to protest.

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Insurers Fight Back

The American Health Insurance Plans (AHIP) is asking CMS to back off the extrapolation on the 90 audits from 2011-2013, at a minimum, and apply it only to 2014 and forward. This would mean writing off more than a half a billion dollars that could be recovered by the treasury, if CMS agrees.

The insurance industry is criticizing CMS, stating that the audits are “technically unsound” and unfair. The industry has also stated that the audits could “jeopardize medical services for seniors.”

Cigna stated in their May financial filing (source): “If adopted in its current form, [the audits] could have a detrimental impact” on all Medicare Advantage plans and “affect the ability of plans to deliver high quality care.”

The insurance industry wants CMS to adjust the findings downward any extrapolated penalties to account for coding errors that exist in standard Medicare.

Most audits that CMS performs identify overpayments based on ICD-10 coding that is inconsistent with provider documentation, but the overpayments are limited to the sample of charts being audited. The errors fall on the shoulders of providers who inadequately document patients’ conditions. Some say aggressive payer audits may set the ICD-10 coding rules too liberally and encourage conditions to be coded when they are not adequately reflected in the documentation.