

# Pre-Submission Risk Adjustment Audits: Preventing Medicare Advantage Plans from Draining Medicare Funds Dry

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*ABSTRACT: The Centers for Medicare and Medicaid Services (“CMS”) pays private organizations on a capitated payment rate to provide medical services to Medicare beneficiaries in the Medicare Advantage Program. To decrease the risk of the capitated payment model, CMS uses risk adjustment to increase payment for beneficiaries with a higher risk score. The risk adjustment data submission process is at great risk for mistake given the complex nature of risk adjustment and fraud because Medicare Advantage plans stand to increase profit margins with higher risk adjustment data scores. CMS has overpaid Medicare Advantage plans by millions of dollars in the risk adjustment process. The current CMS process to validate and recover overpaid funds is not sufficient given the volume of payment errors and the inefficient system. CMS should require Medicare Advantage plans to comprehensively audit diagnosis data before being submitted for risk adjustment to reduce the number of payment errors that lead to overpayment. CMS should also improve the data validation procedures to make recovery a more efficient process.*

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## I. INTRODUCTION

In the current political climate, conversations about the government’s role in subsidizing for its citizen’s services are common. Often, the conversations focus on the greatest cost offender. In 2015, national health expenditures accounted for nearly 17.8% of the U.S. Gross Domestic Product (“GDP”).<sup>1</sup> Historically, private payers represented the majority of the payment source for national health expenditures, but this trend has been slowly shifting.<sup>2</sup> The federal government currently accounts for 28.7% of national healthcare expenditures.<sup>3</sup> It is anticipated by the Centers for Medicare & Medicaid Services (“CMS”) that the federal government’s share of healthcare spending will only continue to rise given the aging population that will be eligible for Medicare, the expansion of subsidies programs under the Affordable Care Act (“ACA”), and the cost of the possible replacement of the ACA entirely.<sup>4</sup>

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1. *National Health Expenditure Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> (last updated June 14, 2017, 3:11 PM) (explaining the expenditure amount reached three trillion, which is about \$9,990 per person).

2. See EARL DIRK HOFFMAN, JR. ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., BRIEF SUMMARIES OF MEDICARE & MEDICAID: TITLE XVIII AND TITLE XIX OF THE SOCIAL SECURITY ACT 3 (2007), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2007.pdf> (describing that there has been a shift from a majority of private funding toward public funding due to cost sharing methods and out of pocket costs).

3. See *National Health Expenditure Fact Sheet*, *supra* note 1 (noting that private households also have a majority share of 27.7%, while private businesses and state and local government have a minority share at 19.9% and 17.1% respectively).

4. HOFFMAN ET AL., *supra* note 2, at 4–5; see Exec. Order No. 13,765, 82 Fed. Reg. 8351 (Jan. 20, 2017) (indicating that the Trump Administration intended to repeal the ACA, but the plan to take its place had yet to be decided on). In an attempt to replace the ACA, the House passed the American Health Care Act. Mara Lee, *Fate of Obamacare Now is in the Senate*, MOD. HEALTHCARE (May 4, 2017), <http://www.modernhealthcare.com/article/20170504/NEWS/170509944>. However, the replacement of the ACA remains in limbo as the vote for the Senate replacement proposal, a Better Care Reconciliation Act, was delayed and the measure to partially repeal the ACA, the Healthcare Freedom Act, was rejected. See Juliet Eilperin et al., *Senate Rejects*

Federal healthcare programs—such as Medicare and Medicaid—have somewhat quietly become one of the greatest drains on federal funds, despite questions from politicians and taxpayers alike about how much money is being spent by the government. The Congressional Budget Office projects that federal healthcare program spending will increase from just over six percent to ten percent of the GDP in the next 30 years.<sup>5</sup> Of the over \$3 trillion that the federal government spent on healthcare costs in 2015, Medicare costs were approximately \$646.2 billion, which is 20% of all healthcare costs.<sup>6</sup> Federal spending on Medicare accounted for 15% of the federal budget in 2016.<sup>7</sup>

One of the largest growing components of Medicare is the Medicare Advantage program.<sup>8</sup> Medicare Advantage, or Part C of Medicare, is an alternative choice for beneficiaries who are eligible for traditional Medicare but prefer the costs and benefits that Medicare Advantage offers compared to

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*Measure to Partly Repeal Affordable Care Act, Dealing GOP Leaders a Major Setback*, WASH. POST (July 28, 2017), [https://www.washingtonpost.com/powerpost/senate-gop-leaders-work-to-round-up-votes-for-modest-health-care-overhaul/2017/07/27/ac08fc40-72b7-11e7-8839-ec48ec4cae25\\_story.html](https://www.washingtonpost.com/powerpost/senate-gop-leaders-work-to-round-up-votes-for-modest-health-care-overhaul/2017/07/27/ac08fc40-72b7-11e7-8839-ec48ec4cae25_story.html); Danielle Kurtzleben, *Senate Health Care Bill Revisions Released in Attempt to Appease GOP Critics*, NPR (July 13, 2017, 12:13 PM), <http://www.npr.org/2017/07/13/537040114/senate-gop-releases-revised-affordable-care-act-repeal-and-replace-plan>. It was estimated that from 2016 to 2025, repealing the ACA in full would raise the cost of Medicare by \$802 billion, \$350 billion of which would be related to repealing provisions related to Medicare Advantage. CONG. BUDGET OFFICE, CONG. OF THE U.S., BUDGETARY AND ECONOMIC EFFECTS OF REPEALING THE AFFORDABLE CARE ACT 10 (2015), [https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-Effects\\_of\\_ACA\\_Repeal.pdf](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-Effects_of_ACA_Repeal.pdf); JULIETTE CUBANSKI ET AL., THE HENRY J. KAISER FAMILY FOUND., WHAT ARE THE IMPLICATIONS OF REPEALING THE AFFORDABLE CARE ACT FOR MEDICARE SPENDING AND BENEFICIARIES? 2 (2016), <http://files.kff.org/attachment/Issue-Brief-What-Are-the-Implications-of-Repealing-the-Affordable-Care-Act-for-Medicare-Spending-and-Beneficiaries>.

5. Jonathan Nicholson, *Aging Population Only Second-Biggest Reason Health Care Spending to Grow: CBO Director*, BLOOMBERG BNA (Nov. 4, 2016), <http://www.bna.com/aging-population-secondbiggest-b57982082317>.

6. *National Health Expenditure Fact Sheet*, *supra* note 1.

7. JULIETTE CUBANSKI & TRICIA NEUMAN, THE HENRY J. KAISER FAMILY FOUND., THE FACTS ON MEDICARE SPENDING AND FINANCING 1 (2017), <http://files.kff.org/attachment/Issue-Brief-The-Facts-on-Medicare-Spending-and-Financing> (discussing that of the \$3.9 trillion that was spent in the federal budget, Medicare spending accounted for \$588 billion).

8. Scott Gottlieb, *The Politics of Why Medicare Advantage Is Capturing Seniors*, FORBES: PHARMA & HEALTHCARE (Jan. 23, 2015, 8:56 AM), <http://www.forbes.com/sites/scottgottlieb/2015/01/23/who-benefits-as-medicare-burns>. While it is anticipated that there may be upcoming changes to traditional Medicare and the ACA, the popularity of Medicare Advantage and the support for private insurers managing senior benefits may lead to additional growth of the Medicare Advantage program under the Trump administration. Bruce Japsen, *Aetna Won't Need Humana If Paul Ryan Privatizes Medicare*, FORBES: PHARMA & HEALTHCARE (Jan. 24, 2017, 8:07 AM), <http://www.forbes.com/sites/brucejapsen/2017/01/24/aetna-wont-need-humana-if-paul-ryan-privatizes-medicare>; Susan Morse, *Insurers Await Trump Admin's Medicare Advantage Payment Rates*, HEALTHCARE FIN. (Jan. 27, 2017), <http://www.healthcarefinancenews.com/news/insurers-await-trump-admins-medicare-advantage-payment-rates>.

traditional Part A and B Medicare.<sup>9</sup> Unlike traditional Medicare that utilizes a fee-for-service model of reimbursement, Medicare Advantage reimburses based on a set monthly amount of reimbursement per patient, or what is called a capitated amount.<sup>10</sup>

Given the risk that the capitated amount represents to insurers as they are paid a set amount no matter what the amount paid out for an enrollee's services are in a given month, CMS implemented a process called risk adjustment that allows the capitated amount to be adjusted to reflect the health risk of the beneficiaries insured by the Medicare Advantage plan.<sup>11</sup> As part of the risk adjustment process, CMS audits the health diagnosis data submitted by Medicare Advantage plans during Risk Adjustment Data Validation ("RADV") to ensure that the adjustment to the capitated amount is reflective of the patient care being provided to the insured party and that Medicare Advantage plans are following regulations.<sup>12</sup> It has been consistently found in RADV that the risk adjustment process results in substantial overpayments to the insurance companies managing the Medicare Advantage plans and that risk adjustment continues to result in significant loss of government funds.<sup>13</sup>

This Note argues that CMS should change the risk adjustment data process to prevent the volume of initial overcharges paid to Medicare Advantage plans and to improve recovery. Part II initially discusses the background on the history of Medicare and then discusses the introduction of the Medicare Advantage program. Part II then examines the Medicare Advantage process of capitated payments and how risk adjustment is used to alter these capitated amounts. Part II finally considers the evaluation process for risk adjustment data during RADV and the role of the False Claims Act in recovering overpayments. Part III examines the shortcomings of the current risk adjustment data submission and the RADV process that has led to mass overcharges. Part IV argues that CMS should require Medicare Advantage plans to complete comprehensive audit diagnosis data prior to submission to minimize errors of initial overpayment and improve the RADV process to maximize the amount that can be recovered if overpayments to Medicare Advantage plans do occur.

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9. HOFFMAN ET AL., *supra* note 2, at 8.

10. *Id.* at 8, 13.

11. 42 U.S.C. § 1395w-23(a)(1)(C)(i) (2012); 42 C.F.R. § 422.308(c)(1) (2016); CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE MANAGED CARE MANUAL: CHAPTER 7 – RISK ADJUSTMENT § 20 (2014), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86co7.pdf> [hereinafter CMS, RISK ADJUSTMENT].

12. CMS, RISK ADJUSTMENT, *supra* note 11, §§ 20, 40.

13. See *infra* Part III.C.

## II. MEDICARE ADVANTAGE AND SYSTEMS OF PAYMENT

The complexity of the Medicare Advantage payment system is a reflection of the complex nature of the Medicare program as a whole. To better understand how this payment system came about, this Part first details the history of traditional fee-for-service Medicare. This Part then discusses the creation of the Medicare Advantage program and how it differs from the traditional Medicare. Next, this Part examines the payment methodology for Medicare Advantage plans through monthly capitated payments and the use of risk adjustment to adjust the monthly payment. This Part also considers the risk adjustment data validation process and what measures CMS uses to ensure data integrity. Finally, this Part discusses the use and inadequacy of the False Claims Act to prosecute fraud to hold Medicare Advantage plans accountable for the certification of correct data that is made upon submission to CMS.

### A. TRADITIONAL MEDICARE

In 1965, in order to ensure the equitable distribution of health insurance and meet the needs of the aging and disabled, Congress created Medicare under Title XVIII of the Social Security Act.<sup>14</sup> The following year, 19.1 million people were enrolled in Medicare.<sup>15</sup> Over 50 years later, in 2016, it was estimated that nearly 57.1 million people benefited from the program.<sup>16</sup> In its current form, Medicare is a fee-for-service program comprised of four parts, Parts A–D, that serve those over the age of 65, most individuals who are permanently disabled, and persons with end-stage renal disease, in different capacities.<sup>17</sup>

Part A, hospital and inpatient services coverage, is generally available—free of premiums—to those who are eligible for social security, survivors benefits, or railroad retirement.<sup>18</sup> Part B is a supplement that covers physician services and outpatient services and supplies, and it is available to Part A eligible enrollees for a monthly premium.<sup>19</sup> Traditional Medicare coverage is

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14. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286; *see* HOFFMAN ET AL., *supra* note 2, at 2 (explaining that the demand on public assistance created by indigent medical care needs led the government to participate directly in payments to medical providers for the first time).

15. U.S. DEP'T OF HEALTH & HUMAN SERVS., 2015 CMS STATISTICS 1 (2015), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2015CMSStatistics.pdf>.

16. U.S. DEP'T OF HEALTH & HUMAN SERVS., 2016 CMS STATISTICS 2 (2016), [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2016\\_CMS\\_Stats.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2016_CMS_Stats.pdf).

17. *See* HOFFMAN ET AL., *supra* note 2, at 5.

18. *Id.* at 5, 6–7 (stating that hospital and inpatient services include: inpatient hospital stay, skilled nursing facility coverage, home health agency services, and hospice care).

19. *Id.* at 5.

generally seen as those enrollees who are covered by Part A and Part B.<sup>20</sup> Part C of Medicare, called the Medicare Advantage Program, allows beneficiaries to choose health insurance plans that are managed by private organizations.<sup>21</sup> Established in 2006, Medicare Part D is an assistance program to help with prescription medication.<sup>22</sup>

The Medicare program is financed through two trusts, the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund.<sup>23</sup> The Hospital Insurance trust provides coverage for those receiving services under Part A, while the Supplementary Medical Insurance trust covers Parts B and D.<sup>24</sup> Because Part C provides Part A, Part B, and often Part D services, it draws from both Hospital Insurance and Supplementary Medical Insurance accounts for payment coverage.<sup>25</sup> Three main sources of funds finance the Hospital Insurance and Supplementary Medical Insurance trusts.<sup>26</sup> The Hospital Insurance trust receives a majority of its funding through a payroll tax that taxes employers and employees at 2.9% of their earnings.<sup>27</sup> The majority of the Supplementary Medical Insurance trust is financed through general revenues from the Department of Treasury, with additional revenue from beneficiary premiums and other sources.<sup>28</sup>

Several governmental departments manage Medicare programs and coordinate financing. The Medicare Board of Trustees manages the Medicare Hospital Insurance and Supplementary Medical Insurance trusts.<sup>29</sup> The Department of Treasury provides the collection means for the revenue that the Board of Trustees directs to the trusts.<sup>30</sup> The Department of Health and Human Services (“HHS”) holds the ultimate responsibility for the implementation and management of the Medicare Program.<sup>31</sup> As an office of

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20. *See id.* at 7 (noting that those entitled and covered under Part A almost always choose to enroll in Part B to fully round out their coverage under Medicare).

21. *Id.* at 8.

22. *Id.* at 5 (discussing that “Part D provides subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of premium, for all beneficiaries”).

23. THE BD. OF TRS. OF THE FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, THE 2016 ANNUAL REPORT 1 (2016), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf>.

24. *Id.*

25. *See id.*

26. CUBANSKI & NEUMAN, *supra* note 7, at 5.

27. *See id.* (stating that payroll taxes account for 88% of the revenue for the Hospital Insurance trust).

28. *See id.* (discussing that general revenues account for over 75% of revenues for SMI trust accounts for Part B and Part D).

29. THE BD. OF TRS. OF THE FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, *supra* note 23, at 1 (explaining that the management model of the Medicare trusts was established by the Social Security Act).

30. *See id.*

31. HOFFMAN ET AL., *supra* note 2, at 15.

HHS, CMS is entrusted with the proper implementation and use of the Medicare Advantage program.<sup>32</sup>

### B. MEDICARE ADVANTAGE

There have been options for Medicare beneficiaries to receive benefits through private organizations since the 1970s.<sup>33</sup> Congress originally established Medicare Advantage in its current form as the Medicare+Choice program in 1997,<sup>34</sup> before it was renamed the Medicare Advantage program in 2003.<sup>35</sup> Medicare Advantage differs from the traditional Medicare Part A and Part B because beneficiaries have more choices to find a medical plan that best fits their medical needs between coordinated care or private fee-for-service plans.<sup>36</sup> Compared to the single choice of Part A, there were over 3,500 plans for Medicare beneficiaries to choose from in the Medicare Advantage program in 2015.<sup>37</sup> Medicare Advantage is often a financially appealing option, especially for those with lower incomes.<sup>38</sup> The Medicare Advantage option is attractive given the subsidies available to help cover Medicare Advantage through cost sharing that are not available to cover supplemental coverage that many traditional Medicare beneficiaries purchase to fill in the gaps.<sup>39</sup>

32. *See id.* (explaining that other than the Social Security Administration determining initial eligibility of Medicare beneficiaries, CMS manages the majority of the Medicare program).

33. THE HENRY J. KAISER FAMILY FOUND., *MEDICARE ADVANTAGE 1* (2016), <http://files.kff.org/attachment/Fact-Sheet-Medicare-Advantage> (discussing that historically the main alternative to traditional Medicare was plans from health maintenance organizations).

34. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275-327 (codified as amended at 42 U.S.C. §§ 1395w-21 to -28 (2012)).

35. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176 (codified as amended at 42 U.S.C. § 1395w-21 (2012)).

36. *See* HOFFMAN ET AL., *supra* note 2, at 8 (explaining that coordinated care comprises “health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law,” while the other plan option available, private fee-for-service plans, “allow[s] beneficiaries to select certain private providers”). While not as commonly used as the coordinated care plan and private fee-for-service plans, Medicare Advantage also provides for a combination Medicare Advantage medical savings account. *See* 42 C.F.R. § 422.4(a)(2) (2016) (outlining the medical savings account Medicare Advantage plan).

37. MEDPAC, *THE MEDICARE ADVANTAGE PROGRAM: STATUS REPORT 327, 331* (2016), <http://www.medpac.gov/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report.pdf> (explaining that while Medicare Advantage plans offer more opportunity for cost sharing and efficiency, “traditional [fee-for-service] Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers”).

38. Gottlieb, *supra* note 8.

39. *See id.* (explaining that the subsidies available to those with low incomes often cover most if not all of the additional cost of Medicare Advantage); *see also* ROBERT A. BOOK & JAMES C. CAPRETTA, *REDUCTIONS IN MEDICARE ADVANTAGE PAYMENTS: THE IMPACT ON SENIORS BY REGION 11* (2010), [http://thf\\_media.s3.amazonaws.com/2010/pdf/bg2464.pdf](http://thf_media.s3.amazonaws.com/2010/pdf/bg2464.pdf) (“Compared to the average beneficiary, those with incomes . . . between \$10,800 and \$21,600 are 19 percent more

Medicare Advantage enrollment is generally available to Medicare beneficiaries who are enrolled in or are eligible to be enrolled in Part A and Part B.<sup>40</sup> A Medicare Advantage eligible individual can choose to elect a Medicare Advantage plan at three different times: (1) during their initial qualifying Medicare enrollment period; (2) during the annual open enrollment period; or (3) through a special election process.<sup>41</sup> Medicare Advantage enrollment continues to grow as a popular alternative to traditional Medicare.<sup>42</sup> In 2017, approximately 19 million beneficiaries enrolled in Medicare Advantage.<sup>43</sup> Over the last few years Medicare Advantage has been averaging a million or more new members each year.<sup>44</sup> Advantage spending accounts for more than one fourth of all Medicare spending.<sup>45</sup> Medicare Advantage members only make up 31% of all Medicare members, despite accounting for more than a quarter of Medicare spending.<sup>46</sup>

Private organizations that wish to participate in Medicare Advantage must meet certain criteria to participate. Medicare Advantage plans must at least provide the coverage benefits that are provided to Part A and Part B beneficiaries.<sup>47</sup> The Medicare Advantage plan “must also offer an option that includes the Part D drug benefit.”<sup>48</sup> In addition to the basic coverage that plans are required to have, Medicare Advantage plans can offer other benefits “and are required to do so (or return excess payments) if plan costs are lower

likely to select [Medicare Advantage], and those with incomes between \$21,600 and \$32,400 are 10 percent more likely to enroll in [Medicare Advantage].”).

40. 42 C.F.R. § 422.50.

41. 42 C.F.R. § 422.60–62; *Medicare Open Enrollment*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Outreach-and-Education/Reach-Out/Find-tools-to-help-you-help-others/Medicare-Open-Enrollment.html> (last updated Sept. 15, 2016, 12:05 PM) (indicating that the open enrollment period is from October 15 to December 7).

42. Gottlieb, *supra* note 8 (explaining that Medicare Advantage popularity continues to grow due to plans that “offer a more comprehensive set of benefits than traditional Medicare, often plugging gaps in coverage or helping to offset out of pocket costs. Seniors also prefer a network that plans offer, and their ease of use”).

43. GRETCHEN JACOBSON ET AL., THE HENRY J. KAISER FAMILY FOUND., MEDICARE ADVANTAGE 2017 SPOTLIGHT: ENROLLMENT MARKET UPDATE 1 (2017), <http://files.kff.org/attachment/Issue-Brief-Medicare-Advantage-2017-Spotlight-Enrollment-Market-Update>; *see also* U.S. DEP’T OF HEALTH & HUMAN SERVS., FISCAL YEAR 2017 BUDGET IN BRIEF 66 (2016), [www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf](http://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf) (discussing that HHS budgeted for 19.5 million enrollees with an anticipated cost of \$204.7 billion).

44. Gottlieb, *supra* note 8 (stating that Medicare Advantage members increased by 1.1 million in 2013, 1.3 million in 2014, and was anticipated to grow by 1.5 to 2 million members in 2015).

45. CUBANSKI & NEUMAN, *supra* note 7, at 2.

46. THE HENRY J. KAISER FAMILY FOUND., *supra* note 33, at 1.

47. 42 C.F.R. § 422.101(a) (2011). *But see* HOFFMAN ET AL., *supra* note 2, at 8 (noting that Medicare Advantage plans do not have to provide the hospice benefit that is provided to Part A and Part B members).

48. MEDPAC, MEDICARE ADVANTAGE PROGRAM PAYMENT SYSTEM 1 (2015), <http://www.medpac.gov/docs/default-source/payment-basics/medicare-advantage-program-payment-system-15.pdf>.

than the Medicare payments received by the plan.”<sup>49</sup> Separate from the coverage, another condition of participation is that every Medicare Advantage contract is required to maintain a compliance program to ensure that CMS guidelines are followed and to implement certain minimum procedures internally to prevent fraud and waste.<sup>50</sup>

### C. CAPITATED PAYMENT AND RISK ADJUSTMENT

CMS manages Medicare Advantage plans’ contracts for reimbursement as CMS is the buyer of the service from the private insurer, rather than the Medicare eligible beneficiary.<sup>51</sup> CMS manages roughly 570 contracts with Medicare Advantage plans.<sup>52</sup> In 2015, CMS reimbursed approximately \$170 billion to Medicare Advantage plans.<sup>53</sup> Medicare Advantage plans are generally paid on a monthly capitated basis.<sup>54</sup> The use of the capitated rate model began in 1997 with the hope of attracting more organizations to rural areas and expanding the Medicare Advantage program.<sup>55</sup>

Regardless of what medical services are used in that month, the Medicare Advantage plan is paid the same monthly capitated amount.<sup>56</sup> Monthly capitated rate amounts are initially set through a bidding process that is done by both local and regional Medicare Advantage plans.<sup>57</sup> This bid represents “the plan’s estimated cost of providing Medicare-covered services” to a local or regional service area.<sup>58</sup> Once bids are finalized, the Secretary of HHS

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49. HOFFMAN ET AL., *supra* note 2, at 8.

50. 42 C.F.R. § 422.503(b)(4)(i)–(vi) (2016) (describing the minimum requirements for a compliance program including the policies and report structure it must contain).

51. See MEDPAC, *supra* note 48, at 1 (explaining that CMS purchases coverage from Medicare Advantage plans for the capitated amount).

52. See JAMES COSGROVE, U.S. GOV’T ACCOUNTABILITY OFFICE, MEDICARE ADVANTAGE: FUNDAMENTAL IMPROVEMENTS NEEDED IN CMS’S EFFORT TO RECOVER SUBSTANTIAL AMOUNTS OF IMPROPER PAYMENTS 1 (2016), <https://www.gao.gov/assets/680/676441.pdf> (indicating that in 2014, nearly 30% of Medicare beneficiaries were covered by some type of Medicare Advantage plan).

53. See MEDPAC, *supra* note 37, at 331 (stating that the reimbursed services included Part A and Part B coverage).

54. 42 U.S.C. § 1395w-23(a)(1) (2012).

55. See THE HENRY J. KAISER FAMILY FOUND., *supra* note 33, at 2–3 (discussing that the use of benchmarks to increase Medicare Advantage plan payment was originally only utilized in rural areas but was changed to be used in all states starting in 2003).

56. HOFFMAN ET AL., *supra* note 2, at 13.

57. See THE HENRY J. KAISER FAMILY FOUND., *supra* note 33, at 3 (explaining that a competitive bidding process was established in 2006); HOFFMAN ET AL., *supra* note 2, at 8 (“Beginning in 2006, a new regional Medicare Advantage plan program was established that allow[ed] regional coordinated care plans to participate in the Medicare Advantage program.”); MEDPAC, *supra* note 48, at 1 (discussing that local Medicare Advantage plans service one or more counties in a state whereas regional plans are made up of one or more states).

58. PAULETTE C. MORGAN, CONG. RESEARCH SERV., MEDICARE ADVANTAGE (MA) – PROPOSED BENCHMARK UPDATE AND OTHER ADJUSTMENTS FOR CY2016: IN BRIEF 2 (2015), <https://fas.org/sgp/crs/misc/R43921.pdf>.

compares the bid to a benchmark—the maximum rate the government is willing to pay based on the fee-for-services available in that regional area—and establishes the final monthly capitated amount.<sup>59</sup>

Based on the plan offered by the Medicare Advantage program, the benchmark of the monthly capitated amount determines how much an enrollee will pay.<sup>60</sup> Generally, beneficiaries must pay their premiums to maintain continued Medicare Advantage coverage of their Part B services.<sup>61</sup> If the Medicare Advantage plan bid is over the benchmark, the beneficiary pays the difference between the benchmark and the bid.<sup>62</sup> If a Medicare Advantage bid is under the benchmark for the offered services, there is no additional cost to the beneficiary.<sup>63</sup>

While the capitated amount represents the average health care cost an average beneficiary will need, health-related risk is not evenly distributed among beneficiaries.<sup>64</sup> Those who pay the top 20% of individual health care costs account for 80% of the total cost spent on beneficiaries.<sup>65</sup> To offset this risk in the capitated payment, CMS has a process called “risk adjustment.”<sup>66</sup> The monthly capitated amount can be adjusted by CMS for beneficiaries with more health needs through risk adjustment to provide more equitable payment to the Medicare Advantage plan.<sup>67</sup> Risk adjustment is done on a prospective basis prior to a service year based on prior risk adjustment data submitted.<sup>68</sup>

59. *Id.* at 1.

60. MEDPAC, *supra* note 37, at 332.

61. ROBERT FABRIKANT ET AL., HEALTH CARE FRAUD: ENFORCEMENT AND COMPLIANCE § 1.02 (2017).

62. MEDPAC, *supra* note 37, at 332.

63. *Id.* (A Medicare Advantage plan is paid the amount it bids plus a percentage of the difference as a rebate. The rebate must be used by the Medicare Advantage company to either provide additional services or reduce premiums.)

64. Mark A. Hall, *Risk Adjustment Under the Affordable Care Act: Issues and Options*, 20 KAN. J.L. & PUB. POL'Y 222, 223 (2011) (explaining that risk adjustment is necessary given the uneven distribution of health risk to a small number of beneficiaries).

65. Mark A. Hall, *The Factual Bases for Constitutional Challenges to the Constitutionality of Federal Health Insurance Reform*, 38 N. KY. L. REV. 457, 460 (2011) (discussing the unequal distribution of health care cost among beneficiaries as “the top 1% (those who cost more than \$43,000 each) accounted for almost one-fourth of total spending, the top 5% of people (who cost more than \$14,000 each) accounted for half of all spending, and the top 20% of people (who cost more than about \$4,000 each) accounted for 80% of spending”).

66. 42 U.S.C. § 1395w-23(a)(1)(C) (2012); 42 C.F.R. § 422.308(c) (2016).

67. 42 U.S.C. § 1395w-23(a)(1)(C)(ii); CMS, RISK ADJUSTMENT, *supra* note 11, § 20 (“Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries. By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs.”).

68. 42 U.S.C. § 1395w-23(a)(1)(C)(ii); *see* 42 C.F.R. § 422.310(g) (explaining that CMS calculates “[r]isk adjustment factors for each payment year . . . based on risk adjustment data

To determine the risk adjustment value, Medicare Advantage plans submit data regarding medical diagnoses and services to CMS.<sup>69</sup> This data set submitted to CMS is data that the Medicare Advantage plan has gathered from medical providers when a provider submits diagnosis codes for reimbursement of services or supplies.<sup>70</sup> The data tendered by the medical provider must be supported by the medical record of the beneficiary.<sup>71</sup> A Medicare Advantage plan has up to a year after the medical service was provided to submit this risk adjustment data to CMS.<sup>72</sup> CMS then uses “such risk factors as age, disability status, gender, [and] institutional status” from the data submitted by Medicare Advantage plans to calculate risk adjustment values for the individual beneficiary.<sup>73</sup>

The use of a diagnosis-based risk adjustment method was designed with the intent to reduce abuses of health plans that avoided taking on beneficiaries with higher risk.<sup>74</sup> While the diagnosis-based risk model used in risk adjustment has reduced this type of practice, its design creates an incentive for insurers to make their profit in the increased risk adjustment scores.<sup>75</sup> As a result of the risk adjustment, a Medicare Advantage plan that takes on beneficiaries with higher medical needs gets paid more by CMS. Risk adjustments scores for Medicare Advantage plans have been increasing at a rate faster than fee-for-service Medicare.<sup>76</sup> Recognizing the profit potential in these risk adjustment scores and the possibility of fraud, CMS has made some alterations to the risk adjustment risk score payments.<sup>77</sup> For instance, CMS

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submitted for items and services furnished during the 12-month period before the payment year that is specified by CMS”).

69. 42 C.F.R. § 422.310(b); see Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 74 Fed. Reg. 54,634, 54,673 (Oct. 22, 2009) (“In general, the current risk adjustment methodology relies on enrollee diagnoses . . . to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee.”).

70. Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 74 Fed. Reg. at 54,674.

71. See *id.* (indicating that a medical record must be supported by diagnoses that are verifiable to be considered appropriate for use in calculating risk adjustment).

72. 42 C.F.R. § 422.310(g) (stating that the deadline for the twelve-month period before “may include a 6-month data lag” time but that is subject to CMS).

73. 42 U.S.C. § 1395w-23(a)(1)(C)(i); see CMS, RISK ADJUSTMENT, *supra* note 11, § 50 (explaining that CMS uses a model called Hierarchical Condition Categories to categorize beneficiary medical information into disease groups to calculate severity and cost).

74. Richard Kronick & W. Pete Welch, *Measuring Coding Intensity in the Medicare Advantage Program*, 4 MEDICARE & MEDICAID RES. REV. E1, E2 (2014), [https://www.cms.gov/mmrr/Downloads/MMRR2014\\_004\\_02\\_a06.pdf](https://www.cms.gov/mmrr/Downloads/MMRR2014_004_02_a06.pdf).

75. *Id.*

76. *Id.* at E13.

77. *Id.* at E16.

lowered payments by deflating the risk adjustment rate by 3.41% in 2010 and 4.91% in 2014.<sup>78</sup>

The insurance market related to Medicare Advantage programs is competitive given the profits available from the capitation rates.<sup>79</sup> To prevent providers from denying coverage to many potential beneficiaries with poor health, the ACA currently prohibits private insurers from discriminating against beneficiaries with high risk indicators.<sup>80</sup> Because the Medicare Advantage plans bear more risk with these high-risk beneficiaries, risk adjustment remains an important means to protect the private insurers through extra reimbursement.

Due to the profits available through the capitated rates and the burden of high-risk beneficiaries, there is great potential for fraud in the submission of diagnoses for beneficiary risk adjustment.<sup>81</sup> This Note will next consider two measures that CMS utilizes to protect against Medicare Advantage billing fraud and recover overpaid funds: (1) risk adjustment data validation; and (2) the False Claims Act.

#### D. RISK ADJUSTMENT DATA VALIDATION

As manager of the Medicare Advantage program, CMS has a duty to “identify, report, and reduce erroneous payments in the government’s programs and activities.”<sup>82</sup> To ensure that risk adjustment values are being appropriately calculated, CMS validates the risk adjustment data that is submitted by Medicare Advantage plans in a process called risk adjustment

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78. *Id.* (indicating that CMS currently plans to lower risk adjustment payments by “at least 5.91% in 2018”).

79. Hall, *supra* note 64, at 223 (discussing the competition of insurance markets to take on beneficiaries with greater risk adjustment rates for increased value potential while balancing the risk of loss with a less healthy beneficiary).

80. *Id.* At this time it is unclear whether the private insurers that buy into Medicare Advantage plans will be allowed to discriminate against Medicare enrollees with high risk indicators if the ACA is repealed and replaced with a substitute plan. Exec. Order No. 13,765, 82 Fed. Reg. 8351, 8351 (Jan. 20, 2017); Bruce Japsen, *As GOP Backs off ACA Repeal, Obama’s Medicare Reforms Remain*, FORBES (Jan. 29, 2017, 9:00 AM), <http://www.forbes.com/sites/brucejapsen/2017/01/29/as-gop-backs-off-full-aca-repeal-obamas-medicare-reforms-stand> (“So far, detailed Republican proposals to replace the [ACA] don’t touch Medicare reforms made by President Obama’s signature legislative achievement, which has slowed federal health spending and enhanced benefits for seniors.”).

81. FABRIKANT ET AL., *supra* note 61, § 1.02.

82. *Payment Validation for Part C and D Programs*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/medicare/medicare-advantage/plan-payment/paymentvalidation.html> (last modified Feb. 29, 2016, 9:59 AM) (citing Improper Payments Information Act of 2002, Pub. L. No. 107-300, 116 Stat. 2350, amended by Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, 124 Stat. 119).

data validation (“RADV”).<sup>83</sup> First utilized by CMS in 2007,<sup>84</sup> the main goals of RADV include: identifying discrepancies, measuring for accuracy and discrepancy impact, and improving data quality.<sup>85</sup> To meet this goal, the Secretary of HHS is authorized to complete annual RADV audits.<sup>86</sup> RADV is CMS’s primary tool utilized to recover overpayments made to Medicare Advantage plans.<sup>87</sup>

CMS has the discretion to choose which Medicare Advantage plans participate in RADV.<sup>88</sup> CMS chooses which Medicare Advantage plans participate based on a coding intensity method, a method “the agency defines for each contract as the average change in the risk score component specifically associated with the reported diagnoses for the beneficiaries covered by the contract.”<sup>89</sup> An individual Medicare Advantage plan may have more than one contract selected for RADV.<sup>90</sup> CMS typically chooses around five percent, or 30 total of the Medicare Advantage plan contracts to audit in order to keep the cost to the agency manageable.<sup>91</sup> The benefit of the coding intensity method is that it identifies higher risk adjustment scores, which may be at risk for improper payments.<sup>92</sup>

Risk adjustment requires that the medical diagnosis data that is submitted be verifiable by medical record.<sup>93</sup> Once chosen by CMS to participate in RADV, Medicare Advantage plans must submit, within a given timeframe, a

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83. 42 C.F.R. § 422.310(e) (2016).

84. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., MEDICARE ADVANTAGE RISK ADJUSTMENT DATA VALIDATION AUDITS FACT SHEET 1 (2015), [https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/MA\\_RADV\\_Audit\\_Fact\\_Sheet.pdf](https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/MA_RADV_Audit_Fact_Sheet.pdf) [hereinafter CMS RADV AUDITS].

85. CTRS. FOR MEDICARE & MEDICAID SERVS., 2008 RISK ADJUSTMENT DATA TECHNICAL ASSISTANCE FOR MEDICARE ADVANTAGE ORGANIZATIONS: RESOURCE GUIDE 15 (2008), [https://www.cssoperations.com/internet/Cssc.nsf/files/2008-resource-guide\\_060109.pdf/\\$File/2008-resource-guide\\_060109.pdf](https://www.cssoperations.com/internet/Cssc.nsf/files/2008-resource-guide_060109.pdf/$File/2008-resource-guide_060109.pdf) [hereinafter CMS RISK ADJUSTMENT RESOURCE GUIDE].

86. 42 C.F.R. § 422.311(a).

87. CMS RADV AUDITS, *supra* note 84, at 1 (explaining that RADV is the “primary corrective action” available to CMS to recover Part C funds).

88. *See* CMS RISK ADJUSTMENT RESOURCE GUIDE, *supra* note 85, at 15 (explaining that when selecting RADV participants, “some organizations are randomly selected while others are targeted” by CMS).

89. COSGROVE, *supra* note 52, at 7.

90. *See id.* at 7–9 (indicating that coding intensity may result in multiple contracts for the same Medicare Advantage plan being chosen for RADV).

91. *Id.* at 7. *But see* Fred Schulte, *Some Medicare Advantage Plans Overcharged the Government by Billions of Dollars and Got Away with It*, CTR. FOR PUB. INTEGRITY (Dec. 18, 2015, 9:57 AM), <https://www.publicintegrity.org/2015/12/18/19065/some-medicare-advantage-plans-overcharged-government-billions-dollars-and-got-away> (discussing that CMS chose to do 30 audits when an undated CMS record indicated that upward of 80 audits would have been fiscally manageable).

92. COSGROVE, *supra* note 52, at 14 (stating that there is somewhat of a correlation between coding intensity and errors in diagnosis data).

93. 42 C.F.R. § 422.310(b) (2016).

sample of the identified contract that includes beneficiary medical records for CMS to evaluate.<sup>94</sup> CMS chooses “up to 201 beneficiaries” at random along the spectrum of risk that a beneficiary’s medical needs might pose.<sup>95</sup> To validate the diagnosis data and ensure that it is properly supported by medical record, CMS requests medical records from the Medicare Advantage plan.<sup>96</sup> For each category of diagnosis being audited, the Medicare Advantage plan can “submit up to five medical records.”<sup>97</sup>

CMS audits the medical records for payment errors in calculating the risk adjustment score and discrepancies in what was claimed to be supported in the medical record.<sup>98</sup> Since 2011, CMS has utilized extrapolation to determine contract-level payment error.<sup>99</sup> Payment error is calculated by taking individual beneficiary payment errors and multiplying that by the sample weight of the risk category of the beneficiary.<sup>100</sup> CMS then adds the weighted payment errors of the risk categories together to get the extrapolated payment error for the entirety of a Medicare Advantage plan contract.<sup>101</sup> Before finalizing the error payment amount, CMS adjusts for a confidence interval and for the same error that would likely occur in traditional Medicare fee-for-service risk adjustment.<sup>102</sup> Due to the extrapolation method used, the repayment amount can be in excess of what was originally overpaid, acting as a penalty amount in repayment.<sup>103</sup>

CMS then reports its RADV audit findings to the Medicare Advantage plan.<sup>104</sup> The RADV audit report includes: the adjustment amount, whether

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94. *Id.* § 422.310(e).

95. COSGROVE, *supra* note 52, at 8 (explaining that beneficiaries for review are divided equally into three levels of risk groups of low, medium, and high before being randomly selected).

96. 42 C.F.R. § 422.310(e); *see* COSGROVE, *supra* note 52, at 8 (discussing that CMS requests medical record data for all the diagnoses of the beneficiaries selected).

97. COSGROVE, *supra* note 52, at 8.

98. *Id.*

99. CTRS. FOR MEDICARE & MEDICAID SERVS., NOTICE OF FINAL PAYMENT ERROR CALCULATION METHODOLOGY FOR PART C MEDICARE ADVANTAGE RISK ADJUSTMENT DATA VALIDATION CONTRACT-LEVEL AUDITS 3–4 (2012), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf> [hereinafter CMS PAYMENT ERROR].

100. *Id.*; *see* COSGROVE, *supra* note 52, at 9 n.22 (“Sampling weights are constructed so each sample of eligible enrollees represents the group from which they were drawn.”).

101. CMS PAYMENT ERROR, *supra* note 99, at 3–4.

102. *Id.*; *see* COSGROVE, *supra* note 52, at 9 n.23 (discussing that CMS accounts for the difference between Medicare Advantage and fee-for-service Medicare given that RADV requires diagnosis data that is supportable by verifiable medical records whereas traditional Medicare risk adjustment does not).

103. Fred Schulte, *CMS Never Recouped Millions in Medicare Advantage Overpayments*, MEDCITY NEWS (Jan. 9, 2017, 5:45 AM), <http://medcitynews.com/2017/01/cms-medicare-advantage-overpayments>.

104. *See* CMS RISK ADJUSTMENT RESOURCE GUIDE, *supra* note 85, at 32.

the audit found discrepancies, and whether the audit found payment error.<sup>105</sup> If CMS identifies overpayment during the RADV process, CMS notifies the Medicare Advantage plan of a timeline for repayment to the federal government.<sup>106</sup> A Medicare Advantage plan has the options of either pursuing a RADV appeal or complying with the repayment deadline designated by CMS.<sup>107</sup>

Historically, CMS manages the RADV process.<sup>108</sup> In 2003, CMS was directed by Congress to test the use of recovery audit contractors (“RACs”) to review fee-for-service Medicare services.<sup>109</sup> Subsequently, Congress decided to permanently integrate RACs into CMS’s recovery process for Medicare funds.<sup>110</sup> Congress expanded the use of RACs to Medicare Advantage in 2010 to assist in the recovery of funds and to ensure the validity of Medicare Advantage anti-fraud programs.<sup>111</sup> For their services, RACs are paid by CMS based on how much is recovered during auditing.<sup>112</sup>

As part of the submission of risk adjustment data, Medicare Advantage plans must certify the medical record data that is submitted to CMS.<sup>113</sup> An officer or designated authority<sup>114</sup> within the Medicare Advantage plan has to certify that “based on best knowledge, information, and belief,” the data being

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105. 42 C.F.R. § 422.311(b) (2016).

106. Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 29,844, 29,922 (May 23, 2014) (to be codified at 42 C.F.R. pts. 417, 422, 423, 424).

107. 42 C.F.R. § 422.2(3) (2016) (defining the process of a RADV appeal as “an administrative process that enables [Medicare Advantage] organizations that have undergone RADV audit to appeal the Secretary’s medical record review determinations and the Secretary’s calculation of [a Medicare Advantage] organization’s RADV payment error”).

108. See CMS RADV AUDITS, *supra* note 84, at 1 (indicating that CMS has been conducting RADV audits).

109. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 306(a), 117 Stat. 2066, 2256 (stating that RACs should be used in the process of “identifying underpayments and overpayments and recouping overpayments under the [M]edicare program”).

110. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922, 2948-49 (codified as amended at 42 U.S.C. § 1395ddd(h) (2012)).

111. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6411(b), 124 Stat. 119, 775 (codified as amended at 42 U.S.C. § 1395ddd(h) (2012)).

112. See Bob Herman, *CMS To Launch RACs for Medicare Advantage*, MOD. HEALTHCARE (Dec. 28, 2015), <http://www.modernhealthcare.com/article/20151228/NEWS/151229937> (explaining that RACs get paid based on how much is recovered during auditing, which on average is anywhere from 9% to 12.5% of the total overcharges recovered and that due to this contingency fee, there have been some complaints by medical providers that RACs abuse their auditing to recover more than is necessary in order to increase their own pay out).

113. 42 C.F.R. § 422.504(l) (2016).

114. *Id.* (stating that the certifying individual from the Medicare Advantage plan must be “its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer”).

submitted to CMS for RADV “is accurate, complete, and truthful.”<sup>115</sup> By certifying the data, Medicare Advantage plans also acknowledge that the data will be used by CMS to ascertain overpayment.<sup>116</sup>

#### E. FALSE CLAIMS ACT

Originally passed by Congress in 1863, the False Claims Act (“FCA”) was signed into law by President Lincoln to combat improper claims made by government contractors during the Civil War.<sup>117</sup> The goal of the FCA is to provide the federal government with a civil cause of action to recover funds that are improperly awarded through false claims.<sup>118</sup> Congress amended the FCA in 1986 “to make clear that the FCA applied to claims against the Medicare . . . program[.]”<sup>119</sup> One of the changes made was to allow the government to seek treble damages—not only the mandatory penalty but also three times the damages sustained for each claim that is found to be improperly submitted.<sup>120</sup>

The 1986 Amendment also provides that private parties—rather than solely the federal government—can bring an FCA civil action against a government contractor.<sup>121</sup> A person who files a private party FCA suit, or a *qui tam* action, is called a relator, though they are often referred to as whistle blowers.<sup>122</sup> When a relator files a *qui tam* action on behalf of the government, it remains under seal for 60 days to allow the government to investigate the claim.<sup>123</sup> Following its investigation, the government may choose to proceed with the action, which means that it intervenes and takes the action against the contractor from the relator.<sup>124</sup> If the government declines to intervene in the action, the relator must choose whether to proceed with the action alone.<sup>125</sup> This change also provided an increased monetary reward for the *qui*

115. 42 C.F.R. § 422.504(d)(1).

116. *Id.*

117. Richard Doan, *The False Claims Act and the Eroding Scientist in Healthcare Fraud Litigation*, 20 ANNALS HEALTH L. 49, 64 (2011).

118. Press Release, Dep’t of Justice, Office of Pub. Affairs, Justice Department Celebrates 25th Anniversary of False Claims Act Amendments of 1986 (Jan. 31, 2012), <https://www.justice.gov/opa/pr/justice-department-celebrates-25th-anniversary-false-claims-act-amendments-1986>.

119. Eleanor D. Kinney, *The Affordable Care Act and the Medicare Program: The Engines of True Health Reform*, 13 YALE J. HEALTH POL’Y, L. & ETHICS 253, 273 (2013).

120. 31 U.S.C. § 3729(a)(1) (2012) (stating that the current penalty per false claim is subject to adjustment by “the Federal Civil Penalties Inflation Adjustment Act of 1990”); 28 C.F.R. § 85.3(a)(9) (2016) (stating that the current penalty is \$5,500 to \$11,000).

121. DEP’T OF JUSTICE, THE FALSE CLAIMS ACT: A PRIMER (2011), [https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS\\_FCA\\_Primer.pdf](https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf).

122. *Id.*; FABRIKANT ET AL., *supra* note 61, § 4.01A.

123. 31 U.S.C. § 3730(b)(1)–(2), (c)(1)–(2).

124. *Id.* § 3730(b)(1).

125. *Id.* § 3730(b)(4)(B).

*tam* provision, thus encouraging relators to come forward with allegations of fraud.<sup>126</sup>

Since the 1986 Amendment to the FCA, the use of the FCA has increased because both the federal government and private parties are actively using it to recover funds from health care providers.<sup>127</sup> The majority of FCA civil actions are filed under the *qui tam* provision.<sup>128</sup> Some private insurers and health care providers complain that the incentive under the *qui tam* provision merely provides an outlet for disgruntled or greedy insiders to get money from the Medicare Advantage organization.<sup>129</sup> The Department of Justice (“DOJ”), however, sees the incentive as a reward or compensation for those who expose themselves to significant risk to provide such information.<sup>130</sup> The DOJ considers the FCA a powerful deterrent to those potentially committing fraud and does not seek to discourage *qui tam* provisions.<sup>131</sup> Since 2009, the DOJ estimates that the FCA has been used to recover almost \$16.5 billion from fraudulent health care claims.<sup>132</sup>

Certifying data submissions to CMS for risk adjustment opens the door for the use of the FCA. Civil liability can be established under the FCA when a Medicare Advantage plan knowingly submits false data to the federal government to receive benefit.<sup>133</sup> Such action could be using false data to secure payments or creating and using false data to support a false claim.<sup>134</sup> Civil liability can also be incurred when a Medicare Advantage plan uses false data to avoid returning money to the federal government that has been received.<sup>135</sup>

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126. False Claims Amendments Act of 1986, Pub. L. No. 99-562, § 3730, 100 Stat. 3153, 3156–57; see Kinney, *supra* note 119, at 273 (discussing how the 1986 amendments allowed for action against fraud “by facilitating the ability of private parties, who [were] often internal whistle blowers that witnessed the fraud and abuse, to bring suit as ‘relators’ on the government’s behalf under the FCA”).

127. See FABRIKANT ET AL., *supra* note 61, § 4.01(1) (discussing how, due to an amendment in 1943 that limited the *qui tam* provision, the FCA lacked strength to be an effective tool until the 1986 amendment).

128. Press Release, Office of Pub. Affairs, Dep’t of Justice, Justice Department Recovers Over \$3.5 Billion from False Claims Act Cases in Fiscal Year 2015 (Dec. 3, 2015), <https://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015>.

129. See Susan Morse, *Whistleblower Targets Medicare Advantage Organizations for Overbilling*, HEALTHCARE FIN. (Aug. 12, 2015), <http://www.healthcarefinancenews.com/news/whistleblower-targets-medicare-advantage-organizations-overbilling> (indicating that whistleblowers bring *qui tam* suits against healthcare providers because of the potential financial gain).

130. Office of Pub. Affairs, *supra* note 128.

131. See *id.* (explaining that the FCA in prevention of loss is as valuable as the recovery of funds).

132. *Id.* (commenting that this amount is “more than half the health care fraud dollars recovered since the 1986 amendments to the [FCA]”).

133. 31 U.S.C. § 3729(a)(1)(A), (B), (G) (2012).

134. *Id.* § 3729(a)(1)(A), (B).

135. *Id.* § 3729(a)(1)(G); see FABRIKANT ET AL., *supra* note 61, § 4.01 (explaining that the reversal of positions between the person falsifying and the federal government “is known as the

A Medicare Advantage plan need not have actual knowledge of the false data or false claim to be held liable.<sup>136</sup> Historically before the 1986 amendment, many courts interpreted knowledge as an intent to defraud because the FCA did not specifically define what it meant to have knowledge.<sup>137</sup> Given that an intent to defraud sets a high burden of proof, Congress detailed the definition of knowledge in the 1986 Amendment to make the element easier to prove.<sup>138</sup> Now, an entity is deemed to have knowledge when it has actual knowledge, deliberately acts to be ignorant, or “acts in reckless disregard of the truth or falsity of the information.”<sup>139</sup> To find deliberate ignorance, a relator or the DOJ must prove that the medical providers believed that their action was unlawful and that they purposefully chose not to investigate.<sup>140</sup> Reckless disregard requires showing more than gross negligence<sup>141</sup>—“a conscious indifference to a high risk that harm would result from an act or omission.”<sup>142</sup>

### III. THE BURDEN OF RISK ADJUSTMENT

CMS has created a reimbursement system that allows Medicare Advantage plans to benefit, both purposefully and unintentionally, at the high cost to the federal government. Despite the risk in insuring medically complex beneficiaries, the reimbursement potential for a risk adjustment beneficiary allows Medicare Advantage plans to maintain their profit margins.<sup>143</sup> With the opportunity for great profit, Medicare Advantage plans are potentially motivated to maximize the risk adjustment data score by manipulating the rules and process.<sup>144</sup> This Part first examines the risk

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‘reverse false claims’ provision, referring to the fact that it prohibits avoiding an obligation to return money already obtained, rather than affirmatively requesting payment”).

136. 42 C.F.R. § 422.504(l) (2016); see *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1174 (9th Cir. 2016) (stating that the knowingly standard “CMS made clear . . . as the one establishing liability under the False Claims Act . . . that it encompasses not only actual knowledge of falsity but also reckless disregard and deliberate ignorance”).

137. See *FABRIKANT ET AL.*, *supra* note 61, § 4.01(3)(a).

138. *Id.* (indicating that Congress’s intent, in addition to making knowledge easier to prove, was to also clearly define the mens rea requirement).

139. 31 U.S.C. § 3729(b)(1)(A)(i)–(iii).

140. *United States v. Erickson*, 75 F.3d 470, 481 (9th Cir. 1996) (finding that a jury instruction for deliberate ignorance was appropriate when a provider had reason to believe that billing practices were illegal and chose to purposefully not review them).

141. See *United States v. Krizek*, 111 F.3d 934, 941–42 (D.C. Cir. 1997) (explaining that the record supported a finding of reckless disregard because the medical provider had failed to review claims submitted on his behalf and there was no evidentiary basis for most of the claims).

142. Doan, *supra* note 117, at 67 (citing *Helms v. Universal Atlas Cement Co.*, 202 F.2d 421, 423 (5th Cir. 1953)).

143. *Id.* at 56–57.

144. See *id.* at 57 (explaining that the CMS reimbursement process encourages improper claims as the complexity of the reimbursement and risk adjustment process allows providers,

adjustment data process and how it is prone to both mistake and fraud. It then looks at the mass overcharges that CMS has paid out because of the faulty risk adjustment process.

A. *RISK ADJUSTMENT DATA SUBMISSION PROCESS*

The current method for submitting risk adjustment data is a process that allows ample opportunity for mistake in the submission for reimbursement.<sup>145</sup> Calculating risk adjustment data scores requires Medicare Advantage plans to submit accurate diagnosis codes of the individual beneficiary.<sup>146</sup> In order to guarantee the greatest amount of risk adjustment reimbursement, vast amounts of diagnosis codes are submitted by Medicare Advantage plans to CMS.<sup>147</sup> Submitting diagnosis codes can be a complex process given that: (1) a medical diagnosis of the beneficiary must be first made by a medical provider; (2) the diagnosis is then matched to a valid and identifiable diagnosis code; and (3) the diagnosis code must then be properly submitted by the medical provider to the Medicare Advantage plan for submission per guidelines to CMS.<sup>148</sup> Despite the fact that CMS requires diagnosis codes that are verifiable by medical record,<sup>149</sup> there is a large amount of submitted risk adjustment data that is unsupported by medical records.<sup>150</sup>

The number of actors involved in submitting risk adjustment data also contributes to the frequent miscalculation of risk adjustment scores. Medicare Advantage plans can directly accept diagnosis data from the medical provider, and for a given beneficiary there can be any number of medical providers submitting medical records.<sup>151</sup> Medicare Advantage plans are also allowed to have third-party subcontractors that manage their claim submission.<sup>152</sup>

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including care level providers and managed care organizations, to claim ignorance if caught trying to commit fraud).

145. FABRIKANT ET AL., *supra* note 61, § 1.03; see Doan, *supra* note 117, at 57 (commenting that the complex nature of CMS reimbursement procedures as well as state and federal statutes leads to mistake and opportunity for fraud).

146. 42 C.F.R. § 422.310(b) (2016).

147. Doan, *supra* note 117, at 57.

148. *Id.*; see CMS, RISK ADJUSTMENT, *supra* note 11, § 120.2.4 (discussing that diagnosis codes are published for fiscal years and must be an approved diagnosis code to be valid).

149. 42 C.F.R. § 422.310(e).

150. Fred Schulte, *Medicare Advantage Audits Reveal Pervasive Overcharges*, CTR. FOR PUB. INTEGRITY (Aug. 29, 2016, 5:01 AM), <https://www.publicintegrity.org/2016/08/29/20148/medicare-advantage-audits-reveal-pervasive-overcharges> (“Auditors on average could confirm just 60 percent of more than 20,000 medical conditions plans were paid to treat. The confirmation rates were much lower for some conditions, such as diabetes with serious complications, depression and some forms of cancer.”).

151. See CMS, RISK ADJUSTMENT, *supra* note 11, § 120.1.1 (explaining that approved sources of medical diagnosis data from Medicare Advantage plans includes inpatient and outpatient facilities and physicians); Doan, *supra* note 117, at 57.

152. 42 C.F.R. § 422.504(i).

However, Medicare Advantage plans are ultimately responsible for the risk adjustment data submissions of third-party subcontractors.<sup>153</sup>

Despite the indication that there is great potential for error and fraud in risk adjustment data collection, Medicare Advantage plans are not required to audit the diagnosis codes submitted to CMS for errors prior to submission.<sup>154</sup> Diagnosis code inflation, or upcoding, is one method that Medicare Advantage plans and medical providers can use to increase reimbursement rates.<sup>155</sup> An unpublished study from CMS noted as early as 2009 “that risk scores for Medicare Advantage enrollees grew twice as fast between 2004 and 2008 as they would have had the same person remained in standard Medicare.”<sup>156</sup> An example from the unpublished study of the rapid growth in risk scores explained that diabetes rates unlikely doubled for Medicare Advantage beneficiaries as compared to those in traditional Medicare and that discrepancy in the rates was likely attributable to inflation of documentation to boost the diagnosis codes.<sup>157</sup>

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153. *Id.* § 422.504(1); see CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE MANAGED CARE MANUAL, MEDICARE ADVANTAGE APPLICATION PROCEDURES AND CONTRACT REQUIREMENTS § 110.1 (2007), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c11.pdf>.

154. See CTRS. FOR MEDICARE & MEDICAID SERVS., 2008 RISK ADJUSTMENT DATA TECHNICAL ASSISTANCE FOR MEDICARE ADVANTAGE ORGANIZATIONS PARTICIPANT GUIDE § 7.7 (2008) (explaining that CMS does not require Medicare Advantage plan audits but encourages plans that do internal reviews to consider diagnosis accuracy from providers, a team to validate the process, and training tools approved by CMS).

155. Leemore Dafny & David Dranove, *Regulatory Exploitation and Management Changes: Upcoding in the Hospital Industry*, 52 J.L. & Econ. 223, 224 (2009) (describing upcoding as “an opportunity to increase operating margins by several percentage points simply by reclassifying patients to more lucrative diagnostic codes”); see Austin Frakt, *Missing from Medicare Advantage: True Competition*, N.Y. TIMES: THE UPSHOT (May 2, 2016), <https://www.nytimes.com/2016/05/03/upshot/missing-from-medicare-advantage-true-competition.html> (explaining that lack of competition allows Medicare Advantage plans to use upcoding as a means to gain higher reimbursement rates); see also Kronick & Welch, *supra* note 74, at E15–16 (discussing that based on analysis the rate of cost growth from Medicare Advantage plans was mostly due to inflated coding intensity, not standard growth factors or patient characteristics). See generally Michael Geruso & Timothy Layton, *Upcoding: Evidence from Medicare on Squishy Risk Adjustment* (Nat’l Bureau of Econ. Research, Working Paper No. 21,222, 2015), <http://www.nber.org/papers/w21222.pdf> (discussing evidence that implies upcoding in Medicare Advantage risk adjustment through analysis of Medicare statistics, coding practices, and patient health factors).

156. Fred Schulte, *Feds Were Advised of Medicare Advantage Overcharges Years Ago*, CTR. FOR PUB. INTEGRITY (Mar. 13, 2015, 5:00 AM), <https://www.publicintegrity.org/2015/03/13/16882/feds-were-advised-medicare-advantage-overcharges-years-ago> (The CMS unpublished study was found in documents released under a Freedom of Information Act request to the Center for Public Integrity. CMS indicated the study was unpublishable due to length and an inability to revise for publication.).

157. *Id.*

Since 2010, there have been more than a half-dozen *qui tam* actions filed under the FCA that allege abuse in Medicare Advantage plan billing.<sup>158</sup> In *United States v. United Healthcare Insurance*, a relator alleged that the Medicare Advantage plan designed a template to collect data for CMS that ignored errors and over reports of diagnosis codes by medical providers, and it did so knowing that their contract was over the error rate allowed by RADV guidelines, in order to maximize their profits with a higher risk adjustment rate.<sup>159</sup> The reoccurring allegation in these *qui tam* actions is that Medicare Advantage plans or their subcontractors are using coding schemes to get higher risk adjustment rates to maximize profit margins.<sup>160</sup>

In 2014, CMS considered a proposed rule change to RADV to help prevent overpayments.<sup>161</sup> The proposal required Medicare Advantage plans to complete a comprehensive review of risk adjustment data.<sup>162</sup> The purpose of such review would be to not only catch errors causing negative payment adjustments, but also to prevent Medicare Advantage plans from doing unilateral reviews for their own benefit (e.g., to only catch errors that would result in positive payment adjustments).<sup>163</sup> CMS ultimately decided against finalizing the rule proposal because Medicare Advantage plans certify the risk adjustment data that is submitted to CMS, and CMS felt this was a sufficient incentive to submit truthful data.<sup>164</sup>

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158. Fred Schulte, *More Whistleblowers Allege Health Plan Overcharges*, CTR. FOR PUB. INTEGRITY (Apr. 23, 2015, 11:35 AM), <https://www.publicintegrity.org/2015/04/23/17212/more-whistleblowers-allege-health-plan-overcharges>.

159. *United States v. United Healthcare Ins.*, 848 F.3d 1161, 1166 (9th Cir. 2016).

160. See *United States ex rel. Ramsey-Ledesma v. Censeo Health, L.L.C.*, No. 3:14-CV-00118-M, 2016 WL 5661644, at \*2–3 (N.D. Tex. Sept. 30, 2016) (claiming that a third-party subcontractor had inflated the risk adjustment scores through certain coding processes, causing the Medicare Advantage plan to have falsely submitted data under the certification standard); *Bonewitz v. NewQuest, LLC*, No. 3:14-CV-00096, 2015 WL 1825375, at \*1 (M.D. Tenn. Apr. 22, 2015) (alleging a Medicare Advantage plan was giving poor performance reviews to an employee who identified errors leading to the inflation of risk adjustment data).

161. Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, *supra* note 106, at 29,925.

162. See *id.*; 42 C.F.R. § 422.310(e) (2016).

163. Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, *supra* note 106, at 29,925 (“[M]edical record reviews conducted by [a Medicare Advantage] organization could not be designed *only* to identify diagnoses that would trigger additional payments by CMS to the [Medicare Advantage] organization; medical record review methodologies would have to be designed to identify errors in diagnoses submitted to CMS as risk adjustment data, regardless of whether the data errors would result in positive or negative payment adjustments.”).

164. *Id.* at 29,926 (explaining that even without finalizing the rule, Medicare Advantage plans are still under contract to submit data under certification that can be verified by medical record to CMS).

*B. THE STRUGGLES ASSOCIATED WITH RADV*

The potential problems of risk adjustment data submission are compounded by CMS's retroactive approach to verifying the accuracy of the risk adjustment data in the RADV process.<sup>165</sup> Risk adjustment rate setting is a prospective process that is done based on the risk adjustment data submitted from the year before.<sup>166</sup> CMS does not immediately validate this risk adjustment data that is used to set the prospective rate.<sup>167</sup> CMS continues to use risk adjustment data that has not been validated for subsequent rate setting, despite knowing the potential for abuse and that the risk adjustment data used will likely not be audited for several years.<sup>168</sup> CMS has consistently been about four years behind on RADV audits despite its goal to review risk adjustment data annually.<sup>169</sup>

The Congressional Accountability Office has questioned the strength of the RADV process due to how CMS selects which Medicare Advantage plan contracts it will audit that year.<sup>170</sup> An audit conducted by CMS in 2011 showed that despite CMS's designated procedure to focus on contracts with high rates of coding intensity, that is contracts with high rates of increased beneficiary risk scores, the contracts actually selected by CMS for RADV were below the range of what CMS defines as a high coding intensity contract.<sup>171</sup> Two additional factors raise the bulk of concern about the efficacy of the RADV process proceeding forward. First, CMS does not consider the results from previous audits when selecting the current Medicare Advantage contracts to audit, which means that a Medicare Advantage contract that previously had high levels of unsupported risk adjustment data may not be audited in that year's RADV.<sup>172</sup> Second, CMS fails to account not only for Medicare

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165. See CMS RADV AUDITS, *supra* note 84, at 1.

166. 42 C.F.R. § 422.311(g).

167. See *id.* § 422.311(g)(2); Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 74 Fed. Reg. 54,634, 54,674 (Oct. 22, 2009).

168. See Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, *supra* note 167, at 54,674 (indicating that CMS originally used RADV audits for individual audits of beneficiaries a year or two after the fact and for educational purposes until 2004 when Medicare Advantage began the process to address contract-level auditing).

169. COSGROVE, *supra* note 52, at 17–21 (explaining that CMS both lacks a timetable to manage to keep the agency on track for yearly RADV audits and the process used in RADV audits contributes heavily to the delay).

170. *Id.* at 14–17.

171. *Id.* at 14–15.

172. *Id.* at 16 (“While CMS selected 6 contracts for 2011 that also underwent 2007 contract-level RADV audits, only 1 of these contracts was among the 10 with the highest rates of unsupported diagnoses in 2007.”); see Schulte, *supra* note 150 (discussing that there was little follow up of Medicare Advantage plans in audits, “no matter the size of the overpayment”).

Advantage contracts that were consolidated or expanded but also for the number of enrollees in a contract.<sup>173</sup>

Once a Medicare Advantage plan is notified by CMS of RADV audit results, the plan has a choice to immediately pay back the overage or proceed with an appeal within 60 days.<sup>174</sup> Once CMS approves the type of appeal requested by the Medicare Advantage plan, an official reviews the medical record or payment error calculation.<sup>175</sup> If the Medicare Advantage plan still disagrees with CMS's determination, they can appeal within 60 days for a hearing before a CMS hearing official.<sup>176</sup> If a Medicare Advantage plan disagrees with the CMS hearing official, the final means of appeal is within 60 days to a CMS Administrator, who has the ultimate say regarding the appeal.<sup>177</sup> Due to the delay in RADV audit results, the amount of steps to the RADV appeals process, and the deadlines involved, it often takes years for a single RADV audit dispute to make it through the RADV appeal process.<sup>178</sup>

### C. THE UNINTENDED COST OF RISK ADJUSTMENT

There is indication of pervasive overcharges by CMS due to mistake and the abuse of the risk adjustment data process. While the median capitated amount for a Medicare Advantage beneficiary was \$750 per month in 2014, there were 14 Medicare Advantage contracts that received at least \$1,000 per

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173. COSGROVE, *supra* note 52, at 16–17 (indicating that RADV process is hindered by CMS not considering contract histories given how often Medicare Advantage plans change but remain in the service area providing the same type of contract).

174. 42 C.F.R. § 422.311(c)(1) (2016) (“[Medicare Advantage] organizations that do not agree with their RADV audit results may appeal.”); COSGROVE, *supra* note 52, at 21–23. Medicare Advantage plans “have 60 days from [the] date of issuance of the RADV audit report to file a written request with CMS for RADV appeal.” 42 C.F.R. § 422.311(c)(5)(ii). This provision, implemented by the Affordable Care Act in 2014, has recently come under attack by Medicare Advantage plans since the provision provides CMS a means to sue the Medicare Advantage plans under the FCA for negligence if overpayments are not repaid in the timeframe, which does not align with the standard of recklessness that usually applies with FCA claims. *UnitedHealthcare Ins. Co. v. Price*, No. 16-cv-00157 (RMC), 2017 WL 1207424, at \*8 (D.D.C. Mar. 31, 2017) (finding that Medicare Advantage plans have standing to sue CMS regarding this overpayment rule to ensure that additional obligations are not being imposed upon Medicare Advantage plans); Erica Teichert, *UnitedHealthcare Can Sue over Medicare Advantage Overpayment Rule*, MOD. HEALTHCARE (Apr. 3, 2017), <http://www.modernhealthcare.com/article/20170403/NEWS/170339971>.

175. 42 C.F.R. § 422.311(c)(6)(iii).

176. *Id.* § 422.311(c)(6)(iv)(C), (c)(7)(iii), (c)(7)(viii), (c)(7)(x) (“The hearing officer decides whether to uphold or overturn the reconsideration official’s decision” and the decision made by the hearing officer is final, subject to a CMS Administrator.).

177. *Id.* § 422.311(c)(8) (indicating that a CMS has a 15-day window to acknowledge the decision for a CMS Administrator review, and once the review has been heard a CMS Administrator has up to 60 days to issue their decision).

178. COSGROVE, *supra* note 52, at 21–22 (noting that due to the delay in starting the 2007 RADV audit, RADV appeals for that contract year were still ongoing in 2016).

month for every beneficiary.<sup>179</sup> With an average benchmark of \$10,000 for each Medicare Advantage plan beneficiary, the Medicare Advantage plan costs the government nearly \$120 more per beneficiary, or about \$2 billion in total for all beneficiaries, than the traditional fee-for-service Medicare even with CMS rate deflation.<sup>180</sup> CMS estimates that it overpaid Medicare Advantage plans by \$14.1 billion due to risk adjustment data in 2013.<sup>181</sup> This year, the Congressional Accountability Office reported that it estimates the 2016 improper payment rate to Medicare Advantage plans was ten percent, resulting in more than \$16 billion in overpayments by CMS.<sup>182</sup> In its inaugural year, CMS reported that it recovered approximately \$13.7 million in overpayments in an audit of 37 Medicare Advantage plans.<sup>183</sup> Of the 37 Medicare Advantage plans audited, only two were not overpaid.<sup>184</sup> Of the majority that were overpaid, Medicare Advantage plans averaged being overpaid by several hundred thousand dollars.<sup>185</sup>

When CMS does identify overcharges through RADV, there is a significant cost to recovering the overcharges, mostly due to the RADV appeals process.<sup>186</sup> Once overcharges are identified, it is not necessarily as simple as CMS requesting the overpaid money from a Medicare Advantage plan.<sup>187</sup> RADV appeals process takes significant time and money for CMS to adjudicate.<sup>188</sup>

Medicare Advantage plans have pushed back on the RADV process since 2011, when CMS adopted the plan to extrapolate payment error to evaluate

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179. Herman, *supra* note 112 (discussing that profit available from risk adjustment beneficiaries had led to increased concern and whistleblower suits regarding artificial inflation of medical diagnosis submitted for risk adjustment scoring but that there has been no official report by the government confirming fraud).

180. Geruso & Layton, *supra* note 155, at 31–32 (noting that without the deflation method reducing the risk adjustment rate by 4.91%, the additional cost per beneficiary would be \$640, or about \$10.5 billion total for the over 16 million beneficiaries).

181. COSGROVE, *supra* note 52, at 1.

182. Fred Schulte, *Fraud and Billing Mistakes Cost Medicare—and Taxpayers—Tens of Billions Last Year*, CTR. FOR PUB. INTEGRITY (July 19, 2017, 5:06 PM), <https://www.publicintegrity.org/2017/07/19/21011/fraud-and-billing-mistakes-cost-medicare-and-taxpayers-tens-billions-last-year> (discussing the testimony of James Cosgrove, of the Government Accountability Office, to the House Ways and Means Committee).

183. CMS RADV AUDITS, *supra* note 84, at 1 (explaining that RADV recovery amount is subject to a dispute and appeals process for Medicare Advantage plans that could alter how much CMS ultimately recovers).

184. *Id.* at 2.

185. *Id.*

186. See Schulte, *supra* note 91.

187. See 42 C.F.R. § 422.311(c) (2016); Schulte, *supra* note 91 (explaining that while it would seem like CMS could simply demand that Medicare Advantage plans return the overpaid money, such demands would likely cause some organizations to withdraw from providing Medicare Advantage plans).

188. See COSGROVE, *supra* note 52, at 3, 17–21.

contracts for overages.<sup>189</sup> The use of extrapolation to calculate payment error could find overages to Medicare Advantage plans upwards of “tens of millions of dollars a year.”<sup>190</sup> Medicare Advantage plans are prepared to battle in the appeals process to protect as much of their profit margin as possible.<sup>191</sup> Appeals related to RADV in 2007 are still ongoing because of the untimely appeals process.<sup>192</sup> Due to the amount of appeals and the protracted appeal process, by the end of 2015, CMS had recovered only \$14 million of the \$500 to \$800 million it was expecting.<sup>193</sup>

While the FCA has greatly assisted in the recovery of overpaid funds, the cost of associated litigation and damages awarded ultimately reduces how much CMS can recover.<sup>194</sup> Litigation to pursue FCA actions and recover overpayments represents an additional cost to the government.<sup>195</sup> The Health Care Fraud and Abuse Control Program, run jointly by HHS and the DOJ, estimates that for every \$6.10 in overcharges recovered from healthcare fraud, one dollar is spent on litigation-related costs.<sup>196</sup> In 2015, the “DOJ opened 808 new civil health care fraud investigations and had 1,048 civil health care fraud matters pending at the end of the fiscal year.”<sup>197</sup> The HHS Office of Inspector General had 667 civil actions that included cases related to false claims and unjust enrichment.<sup>198</sup>

Most of the government’s litigation efforts are spent in litigation on *qui tam* suits. When the government joins a *qui tam* suit, there is no guarantee of recovery, especially if the relator is unable to meet the burden of proof required by the FCA.<sup>199</sup> In a successful *qui tam* suit with the government, a relator can collect between 15–25% of what is recovered in overpayments.<sup>200</sup> Without government intervention, a successful suit can bring a relator 25–30% of the recovered overpayments.<sup>201</sup> In 2015, \$597 million of the \$2.8 billion

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189. Schulte, *supra* note 91.

190. *Id.*

191. *Id.*

192. COSGROVE, *supra* note 52, at 17 (discussing that, for example, a 2007 RADV audit case where the Medicare Plan was notified in late 2008 that it would be audited, yet CMS did not complete the audit until early 2013, which is why the appeals process is still ongoing).

193. Schulte, *supra* note 91.

194. Schulte, *supra* note 158.

195. Doan, *supra* note 117, at 58.

196. DEP’T OF HEALTH & HUMAN SERVS. & DEP’T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM ANNUAL REPORT FOR FISCAL YEAR 2015, at 8 (2016), <https://oig.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf>.

197. *Id.* at 1.

198. *Id.*

199. *See id.* at 59 (discussing that while the government does not always choose to intervene in *qui tam* suits, there is a higher success rate when the government joins, given the number of resources available to the government as compared to a private individual).

200. 31 U.S.C. § 3730(d)(1) (2012).

201. *Id.* § 3730(d)(2).

recovered healthcare overpayments were paid out to relators who had brought suit under the *qui tam* provision.<sup>202</sup> From 2009–2015, it is estimated that of the total \$19.4 billion recovered in healthcare overpayments from *qui tam* suits, relators have been awarded around \$3 billion for their involvement in the claims.<sup>203</sup>

Because there is so much money being overcharged or lost, CMS is considering expanding the use of RACs in the RADV process.<sup>204</sup> The Patient Protection and Affordable Healthcare Act directed CMS to expand use of RACs to the Medicare Advantage program by 2010.<sup>205</sup> CMS sought comment on RAC implementation in 2010 and subsequently requested proposals in 2014 to implement a program that would assist CMS in narrowly tailored audits.<sup>206</sup> Upon not receiving any proposals, CMS decided in late 2015 to alter its plan and seek guidance from RACs and other industry leaders on how to expand RAC audits to broader audits including RADV.

Lacking both a timeline and a process for implementing RADV audits, CMS is unlikely to use RACs to assist in the recovery of overpayments for some time.<sup>207</sup> In addition to lacking a timetable for RAC implementation, CMS must consider the costs of RACs. RACs are paid on a contingency plan for the amount that they recover, which can range anywhere from 9 to 12.5% of overpayments recovered.<sup>208</sup> Given the large number of overpayments made to Medicare Advantage plans that are currently outstanding, the recovery amount percentage paid to RACs would be significant. Until actual use of RACs, it is unclear if the amount recovered in overpayments would be large enough to offset the high cost of the RAC payment plan.

#### IV. RISK ADJUSTMENT AUDITS AND RADV PROCESS IMPROVEMENTS

The current risk adjustment data process allows a significant number of overpayments to be made to Medicare Advantage, whether due to mistake or fraud. Even though CMS audits only a small fraction of Medicare Advantage contracts, CMS's current RADV process is simply overwhelmed by the auditing process. The cost and delay of RADV suggests that CMS's approach to its risk adjustment process needs reform.

This Part examines changes that CMS should make to the risk adjustment data and RADV process to reduce risk adjustment score errors and improve

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202. Press Release, Office of Pub. Affairs, *supra* note 128.

203. *Id.*

204. COSGROVE, *supra* note 52, at 24.

205. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6411(b), 124 Stat. 119, 775 (codified as amended at 42 U.S.C. § 1395ddd(h) (2012)).

206. COSGROVE, *supra* note 52, at 23–24 (indicating that CMS was seeking proposals to use RACs to audit “Medicare secondary payer, end-stage renal disease, and hospice” services).

207. *Id.* at 24–25.

208. Herman, *supra* note 112.

the RADV process. Subpart A suggests that CMS should require Medicare Advantage plans to complete comprehensive audits of the risk adjustment data prior to submitting to CMS. Subpart B assesses two adjustments, targeted audits on high risk accounts and more timely guidelines, that could be made to the RADV process to improve the recovery of CMS overpayments.

#### A. MEDICARE ADVANTAGE PLAN INTERNAL AUDITS

With the high frequency of risk adjustment data error, it would be beneficial to minimize the problem upfront. One way to reduce such error would be to change CMS rules explicitly to require Medicare Advantage plans to comprehensively audit the diagnosis data submitted to CMS for error. CMS has previously considered such a rule but chose not to finalize it.<sup>209</sup> Ongoing *qui tam* litigation, however, has led to some confusion about whether CMS and the DOJ are holding Medicare Advantage plans to this proposed rule.<sup>210</sup> CMS chose not to finalize the proposed rule because CMS believed that requiring Medicare Advantage plans to certify data submitted, plus the risk of FCA liability regarding improper certification, created adequate pre-submission safeguards to ensure that Medicare Advantage plans submitted accurate data.<sup>211</sup> Also, CMS received push back from Medicare Advantage plans because of the scope of work and cost that pre-submission audits would place on the Medicare Advantage plan.<sup>212</sup> To bolster its safeguard of the certification, CMS requires Medicare Advantage plans to have compliance integrity programs to reduce fraud and waste.<sup>213</sup>

The measures that CMS relies on to require Medicare Advantage plans to submit accurate diagnosis data is not sufficient. Using certification as the standard for data submission, rather than an explicit expectation for pre-

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209. Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 29,844, 29,925–26 (May 23, 2014) (to be codified at 42 C.F.R. pts. 417, 422, 423, 424).

210. *UnitedHealthcare Ins. Co. v. Price*, No. 16-cv-00157, 2017 WL 1207424, at \*2 (D.D.C. Mar. 31, 2017); United States' Complaint-in-Partial-Intervention and Demand for Jury Trial at 2–7, *United States ex rel. Poehling v. UnitedHealth Grp., Inc.*, No. 2:16-cv-08697 (C.D. Cal. May 16, 2017). See Mara Lee, *DOJ's Medicare Advantage Lawsuits, Investigations Likely to Change Insurance Culture*, MOD. HEALTHCARE (May 19, 2017), <http://www.modernhealthcare.com/article/20170519/NEWS/170519815> (discussing that “an associated whistle-blower case against UnitedHealth has set the precedent that if a plan does a retrospective chart review ‘they have an obligation to look both ways’”); Mary Williams Walsh, *UnitedHealth Overbilled Medicare by Billions*, U.S. SAYS IN SUIT, N.Y. TIMES: DEALBOOK (May 19, 2017), <https://www.nytimes.com/2017/05/19/business/dealbook/unitedhealth-sued-medicare-overbilling.html> (indicating that parties disagree over whether CMS has put in place regulations that require Medicare Advantage plans to “look both ways”).

211. Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. at 29,925–26.

212. *Id.*

213. 42 C.F.R. § 422.503(b)(4)(vi) (2016).

submission review, has left the door open for potential mistake given the complex risk adjustment process and abuse by Medicare Advantage plans looking to increase their profits. Recent *qui tam* actions allege that Medicare Advantage plans are using their compliance integrity programs for one-sided retrospective reviews that catch only diagnosis errors that reduce risk adjustment scores, increasing the payments to Medicare Advantage plans rather than reducing overpayments.<sup>214</sup> If such allegations are true, Medicare Advantage plans are knowingly certifying data under certification to CMS that is false.<sup>215</sup>

CMS should require Medicare Advantage plans to conduct comprehensive audits. CMS could thus prevent unilateral reviews and further reduce the amount of mistake and fraudulent diagnosis data Medicare Advantage plans submit. If the plan submits more accurate diagnosis data to CMS, then the number of payment errors that would need to be pursued in RADV and recovery efforts would decline. Reduction of payment errors would also mean a reduction of money spent litigating and appealing FCA actions. Pre-submission audits also cement the plan's knowledge of the data it is submitting to CMS. If overpayment is found as a result of audited risk submission data, a Medicare Advantage plan would be less able to claim mistake rather than fraud during appeal. In addition, given the pre-submission audit result, a Medicare Advantage plan would meet the knowledge standard for an FCA claim.<sup>216</sup>

While the implication of fraud, increased liability of knowledge, and increased efficiency of RADV would likely prevent Medicare Advantage companies from trying to inflate their risk adjustment rates, there is some risk that pre-submission audits could exacerbate the problem. The cost of pre-submission audits may incentivize Medicare Advantage plans to further inflate data to maintain their profit margins from risk adjustment. In looking at CMS's current safeguard of self-governed certification of data, the certification seems to hold little weight against a Medicare Advantage plan unless it is being used as the basis for an FCA claim. A pre-submission audit of risk adjustment data could prove just as toothless as the certification standard if CMS treats the process lightly.

There are a few options for CMS to increase adherence of pre-submission audits by Medicare Advantage plans. Instead of solely relying on Medicare Advantage plans' self-governance, CMS could require, with submission of the risk adjustment data, documentation that demonstrates either the audit of the

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214. *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1170 (9th Cir. 2016); *United States ex rel. Ramsey-Ledesma v. Censeo Health, L.L.C.*, No. 3:14-cv-00118-M, 2016 WL 5661644, at \*3 (N.D. Tex. Sept. 30, 2016).

215. *United Healthcare*, 848 F.3d at 1175.

216. See 31 U.S.C. § 3729(b)(1)(A)(i)-(iii) (2012) (explaining the standard to be deemed "knowing" for the purposes of an FCA claim).

submitted data or contract-level audit information. The inclusion of audit data could ensure that the pre-submission audits are occurring and that they are not unilateral. CMS could also consider the use of fines or contract penalties for Medicare Advantage plans that do not fully and faithfully execute these compressive pre-submission audits. As an alternative to a penalty to incentivize a Medicare Advantage's plan pre-submission audits, CMS could instead assist Medicare Advantage plans in audits, through supplemental rates or flat payments, to prevent significant burdens to the Medicare Advantage plan.

#### B. IMPROVING THE RADV PROCESS

While pre-submission audits of risk adjustment data would reduce the amount of overpayments, RADV would still be needed to catch overpayment errors related to mistakes missed in audits and fraud by the Medicare Advantage plan. The RADV process is currently an inefficient process that is years behind in auditing and recovering overpayments;<sup>217</sup> however, there are several steps that CMS could take to improve the RADV process. The Government Accountability Office recommended to Congress that the following would most benefit the RADV process: (1) change the RADV audit selection process; and (2) improve the timing of the RADV and the appeals process.<sup>218</sup>

To have efficient RADV, CMS needs to change how it selects contracts for audit. CMS should refocus its contract audit selection to focus on Medicare Advantage contracts that are a greater risk for improper payments on larger risk adjustment scores.<sup>219</sup> To ensure that contracts with the greatest risk are chosen, CMS first needs to fix how it calculates the coding intensity of individual contracts.<sup>220</sup> Contracts with high coding intensity should reflect those contracts with greater changes in a beneficiary risk adjustment.<sup>221</sup> Once coding intensity is improved, CMS could select contracts with the higher risk adjustment rates. To ensure the best sample for RADV, CMS could also choose (1) those contracts that have historically had payment errors due to unsupported diagnosis data; or (2) a new contract for a Medicare Advantage plan that covers the service area of a now defunct contract that historically had unsupported diagnosis data.<sup>222</sup>

CMS also needs to improve the timing for RADV and the appeals process.<sup>223</sup> Currently, CMS has appeals that are still ongoing from the 2007

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217. See *supra* Part III.B.

218. COSGROVE, *supra* note 52, at 26–27.

219. *Id.* at 26.

220. *Id.*

221. See *id.* at 10–11, 14–15.

222. *Id.*

223. *Id.* at 27.

RADV audit.<sup>224</sup> The longer these are ongoing, the more CMS has to pay and the less likely it becomes that it will recover the maximum amount of overpaid funds.<sup>225</sup> CMS could improve the timeliness of RADV by improving notification of audit speed to Medicare Advantage plans, reducing the time allowed for medical record review during RADV, and improving reconsideration decisions to be more timely.<sup>226</sup>

## V. CONCLUSION

The current process that CMS uses to collect and evaluate risk adjustment data for reimbursement to Medicare Advantage plans is simply not sufficient given the amount of money the federal government loses in overpayments. CMS's risk adjustment process creates ample opportunities for mistake or purposeful fraud in the submission of diagnosis data that is used in the calculation of risk adjustment data scores. The RADV process that CMS uses to verify the risk adjustment data scores is not only untimely but ineffective given the often minimal amount of the overall overpayment that the auditing process recovers. When the RADV process fails, or there is indication that the Medicare Advantage plan has achieved this overpayment through fraudulent means, the government spends additional money to recover the overpayments through FCA actions.

Instead of focusing all of its attention on recovering overpayments retroactively through the RADV process and litigation, CMS should implement a rule requiring Medicare Advantage plans to audit its data more thoroughly prior to being submitted for risk adjustment. By requiring compressive audits of Medicare Advantage diagnosis data prior to submission, CMS would reduce the amount of errors being submitted for risk adjustment. Pre-submission audits would also ensure that these Medicare Advantage plans have a thorough understanding of the data they submit, so they could be held fully accountable to the certification of data standard. Improvements to the current RADV process would better catch what payment errors remain, whether from mistake or fraud. With the addition of comprehensive Medicare Advantage plan audits and improvements to the RADV process, CMS would prevent gross overpayments and be able to recover what overpayments are made in a much timelier and more efficient manner.

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224. *Id.* at 17.

225. *See supra* Part III.B.

226. COSGROVE, *supra* note 52, at 27.