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MEDICARE ADVANTAGE

Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-13-206, a report to congressional requesters

Why GAO Did This Study

CMS pays plans in MA—the private plan alternative to FFS—a predetermined amount per beneficiary adjusted for health status. To make this adjustment, CMS calculates a risk score, a relative measure of expected health care for each beneficiary. Risk scores should be the same among all beneficiaries with the same health conditions and demographic characteristics. Differences in diagnostic coding between MA plans and Medicare FFS led to inappropriately high MA risk scores and payments to MA plans, and CMS adjusted for coding differences in 2010. In January 2012, GAO reported that CMS's adjustments to risk scores did not sufficiently correct for coding differences, resulting in excess payments to MA plans. Since completing the analysis for the January 2012 report, risk score data for two additional years have become available. GAO (1) determined the extent to which differences, if any, in diagnostic coding between MA plans and Medicare FFS affected MA risk scores and payments to MA plans in 2010, 2011, and 2012; and (2) identified what changes, if any, CMS made to its risk score adjustment methodology for 2013 and intends to make for future years. To do this, GAO compared risk score growth for MA beneficiaries with an estimate of what risk score growth would have been for those beneficiaries if they were in Medicare FFS for 2010 and projected the growth to 2011 and 2012, and determined if there were changes to CMS's methodology by reviewing agency documentation and interviewing agency officials.

View GAO-13-206. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

GAO found that the cumulative impact of coding differences on risk scores increased from 2010 through 2012 and was greater than the Centers for Medicare & Medicaid Services' (CMS) risk score adjustment of 3.4 percent for each of the 3 years. In updating the analysis from its January 2012 report, GAO estimated that cumulative Medicare Advantage (MA) risk scores in 2010 were 4.2 percent higher than they likely would have been if the same beneficiaries had been enrolled continuously in Medicare fee-for-service (FFS). For 2011, GAO estimated that differences in diagnostic coding resulted in risk scores that were 4.6 to 5.3 percent higher than they likely would have been if the same beneficiaries had been continuously enrolled in FFS. This upward trend continued for 2012, with estimated risk scores 4.9 to 6.4 percent higher.

CMS's adjustment to risk scores for 2010 through 2012 to account for diagnostic coding differences was too low, resulting in estimated excess payments to MA plans of at least $3.2 billion. CMS's annual 3.4 percent reduction in risk scores is equivalent to $2.8 billion in 2010, $3.0 billion in 2011 and $3.2 billion in 2012. According to GAO's estimates, the amount of the excess payments to MA plans after accounting for CMS's adjustments was $0.6 billion in 2010, between $1.1 billion and $1.6 billion in 2011, and between $1.5 billion and $2.9 billion in 2012. Cumulatively across the 3 years, this equals excess payments of between $3.2 billion and $5.1 billion.

For 2013, CMS continues to use the risk score adjustment of 3.4 percent it used in 2010, 2011, and 2012. To conduct its data-based analysis, CMS officials reported that they used the same methodology used in 2010, but they incorporated more recent data. CMS officials told us that, in addition to the results of the data analysis, they incorporated additional factors such as recent payment changes made to the MA program under the Patient Protection and Affordable Care Act and the maintenance of benefits for seniors. The Social Security Act does not prescribe CMS's methodology for adjusting for differences in diagnostic coding. However, the express purpose of the requirements to conduct and incorporate into the risk scores a data-based analysis of coding differences is to ensure payment accuracy. The act does not provide for factors other than the results of the analysis to be incorporated into the adjustment, suggesting that accuracy would be ensured solely through the incorporation of analytical results. CMS officials stated that they believed there was policy discretion with respect to the most appropriate adjustment factor but did not identify the specific source of their authority to consider factors other than the required data analysis when determining the adjustment amount. While CMS did not change its risk score adjustment methodology for 2013, agency officials said they may revisit their methodology for future years.

GAO's findings underscore the importance for CMS to implement the recommendation from GAO's January 2012 report that the agency improve the accuracy of its MA risk score adjustments by taking steps such as using the most current data available and incorporating adjustments for additional beneficiary characteristics.

CMS reviewed a draft of this report and stated that it had no comments.