



## Testimony

Before the Subcommittee on Oversight  
and Investigations, Committee on  
Energy and Commerce, House of  
Representatives

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# MEDICARE ADVANTAGE

## Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight

Statement of Leslie V. Gordon  
Acting Director, Health Care

# GAO Highlights

Highlights of [GAO-22-106026](#), a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

## Why GAO Did This Study

The Medicare program, which includes MA, is on GAO's High Risk List, because of its size, complexity, and susceptibility to mismanagement and improper payments. Under MA, CMS pays MA organizations a fixed monthly amount per Medicare beneficiary to provide health care coverage no matter how many services are provided or how much those services cost. These organizations can retain savings if their costs to provide services are lower than their payments, but can incur losses if their costs exceed payments. In 2021, Medicare paid MA organizations about \$350 billion to provide health care benefits to about 27 million beneficiaries.

This testimony is based on GAO's prior work and focuses on, among other things, key findings and the status of CMS's efforts to implement GAO recommendations related to (1) monitoring disenrollments from MAOs by Medicare beneficiaries in the last year of life, and (2) validating encounter data used to risk adjust MA organization payments. This testimony draws from GAO reports on Medicare Advantage issued from 2014 through 2021 ([GAO-21-482](#), [GAO-16-76](#), [GAO-15-710](#), and [GAO-14-571](#)). GAO also reviewed documents from CMS regarding steps taken to address GAO's recommendations.

View [GAO-22-106026](#). For more information, contact Leslie V. Gordon at (202) 512-7114 or [GordonLV@gao.gov](mailto:GordonLV@gao.gov)

June 28, 2022

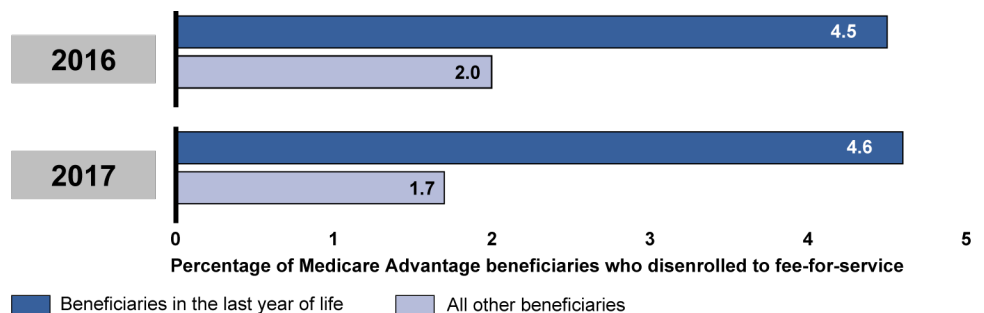
## MEDICARE ADVANTAGE

### Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight

## What GAO Found

Under Medicare Advantage (MA), the Centers for Medicare & Medicaid Services (CMS) contracts with private MA organizations to provide health care coverage to Medicare beneficiaries. CMS pays MA organizations a fixed amount per beneficiary, which gives them an incentive to provide cost-effective and efficient care. CMS oversight of these organizations is designed to ensure that they do not respond to this incentive by inappropriately restricting beneficiaries' access to care. MA beneficiaries in the last year of life are generally in poorer health and often require high-cost care. High rates of disenrollment from MA to join traditional Medicare fee-for-service may indicate issues with the quality of care, such as potential limitations accessing specialized care under some MA organizations' provider networks. In 2021, GAO reported that MA beneficiaries in the last year of life disenrolled to join traditional Medicare at more than twice the rate of all other MA beneficiaries in both 2016 and 2017—the most current years of data at the time of GAO's analysis. GAO recommended—and CMS implemented—reviews of MA disenrollments by beneficiaries in the last year of life. In 2022, CMS analyzed disenrollments by MA beneficiaries for 2019 through 2021 and similarly found higher disenrollment rates by MA beneficiaries in the last year of life under certain MA organization contracts. Such findings underscore the value of continued monitoring. GAO also estimated that these disenrollments increased Medicare program costs by nearly half of a billion dollars each year in 2016 and 2017, as beneficiaries moved from MA's fixed payment arrangement to traditional Medicare, where Medicare payments are generally based on the costs of services provided.

**Medicare Advantage Beneficiary Disenrollments to Join Medicare Fee-for-Service, 2016-2017**



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | [GAO-22-106026](#)

The data submitted by MA organizations on the services MA beneficiaries receive—known as encounter data—contain information on beneficiaries' clinical diagnoses. CMS uses the diagnoses to adjust payments to MA organizations by increasing or decreasing payments to reflect beneficiaries' projected health care costs. In 2014, GAO recommended that CMS validate MA encounter data for completeness and accuracy. However, as of June 2022, CMS had completed some, but not all, of the necessary steps. For example, CMS has not reviewed beneficiaries' medical records to verify the accuracy of the diagnosis information CMS uses in its risk adjustments. By using encounter data that have not been fully validated for completeness and accuracy, the soundness of adjustments to MA organization payments remains unsubstantiated.

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Chair DeGette, Ranking Member Griffith, and Members of the Subcommittee:

I am pleased to be here today to discuss oversight of the Medicare Advantage (MA) program, a private plan alternative to traditional Medicare. The Centers for Medicare & Medicaid Services (CMS) contracts with private MA organizations (MAO) that provide health care coverage to Medicare beneficiaries. In traditional Medicare fee-for-service, Medicare pays claims for health care services directly to health care providers. In contrast, under MA, CMS pays MAOs a fixed monthly payment per beneficiary to provide health coverage, no matter how many services are provided or how much those services cost. MAOs can retain savings if their costs to provide services are lower than their payments, but can incur losses if their costs exceed payments. This payment structure gives MAOs a financial incentive to provide efficient and cost-effective care. CMS oversight of MAOs is designed in part to ensure that, in their pursuit of cost-effective care, MAOs do not inappropriately restrict beneficiaries' access to care. In 2021, Medicare paid MAOs approximately \$350 billion to provide health care coverage to about 27 million beneficiaries—nearly half of all eligible Medicare beneficiaries.

As a part of setting payment rates for MAOs, CMS uses information on beneficiaries' clinical diagnoses to adjust payments to MAOs to reflect beneficiaries' higher or lower projected health care costs. Risk adjustment of payments to MAOs helps ensure that they have the same incentives to enroll and provide care for beneficiaries regardless of health status, including beneficiaries in poorer health that may require more care, or more expensive care.

In addition, CMS oversight of MA is important to help ensure the quality of care to MA beneficiaries and the integrity of payments to MAOs. For example, CMS monitors beneficiary disenrollments from MAOs, as high levels of disenrollment may indicate potential issues with the quality of care provided. CMS also reviews encounter data submitted by MAOs on the services provided to beneficiaries—similar to provider claims data in traditional Medicare—which include beneficiary diagnoses used for risk adjusting payments to MAOs. The integrity of risk adjusted payments hinges on whether the diagnoses in the encounter data are accurate and

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complete.<sup>1</sup> To identify and recover improper payments to MAOs, CMS conducts audits of the beneficiary diagnoses that have been used to risk adjust payments. CMS estimated that in fiscal year 2021 improper payments accounted for about 10 percent of total payments to MAOs and totaled about \$23 billion.<sup>2</sup>

Due to our concerns about the program's susceptibility to mismanagement and improper payments as well as its size and complexity, we have designated Medicare, including Medicare Advantage, as a high-risk program.<sup>3</sup> We—along with the Department of Health and Human Services Office of Inspector General and others—have identified significant concerns with CMS's oversight of the MA program.<sup>4</sup> As a part of our work, we have made a number of recommendations to prompt CMS action to improve MA monitoring and oversight, including recommendations related to beneficiary disenrollment, the validity of MA encounter data, and audits to identify and recover improper payments to MAOs.<sup>5</sup>

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<sup>1</sup>To risk adjust payments to MAOs in calendar year 2015 through 2021, CMS used data on beneficiary diagnoses from a combination of two sources—encounter data and the Risk Adjustment Processing System—and CMS's audits of diagnoses have focused on the latter of these two sources. To risk adjustment payments to MAOs beginning in calendar year 2022, CMS relied entirely on encounter data for beneficiary diagnoses.

<sup>2</sup>An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements.

<sup>3</sup>See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, [GAO-21-119SP](#) (Washington, D.C.: Mar. 2, 2021).

<sup>4</sup>For example, a recent audit by the Department of Health and Human Services Office of Inspector General identified at least \$3.7 million in net overpayments in 2015 and 2016 resulting from diagnosis codes used to adjust payments to an MAO that were not supported by beneficiary medical records. See Department of Health and Human Services Office of Inspector General, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Tufts Health Plan (Contract H2256) Submitted to CMS, A-01-19-00500* (Washington, D.C.: February 2022).

<sup>5</sup>See GAO, *Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending*, [GAO-21-482](#) (Washington, D.C.: June 28, 2021); *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use*, [GAO-14-571](#) (Washington, D.C.: July 31, 2014); and *Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*, [GAO-16-76](#) (Washington, D.C.: Apr. 8, 2016).

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My testimony summarizes key findings from our prior work and the status of CMS's efforts to implement our recommendations to:

- 1) monitor disenrollments from MAOs by beneficiaries in the last year of life;
- 2) validate MA encounter data; and
- 3) strengthen audits used to identify and recover improper payments to MAOs.

My remarks are based on our body of work examining MA oversight—specifically reports issued and recommendations made from 2014 through 2021—and steps CMS has taken as of June 2022 to address these recommendations.<sup>6</sup> Those reports provide further details on our scope and methodology. (See the end of this statement for a list of related GAO reports.) We also reviewed documents from CMS regarding steps taken to address our recommendations. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

MAOs must provide coverage for all Medicare services with a few exceptions, including hospice services, which are covered under traditional Medicare for all beneficiaries.<sup>7</sup> MAOs may offer more generous benefits, such as less cost sharing—including \$0 premium plans—and additional covered services, such as vision or dental care. In addition, competition for beneficiaries provides MAOs with incentives to reduce expenses and control premium costs. MAOs may also limit beneficiaries' access to care to a network of physicians, hospitals, and other providers that contract with an MAO. Certain industry stakeholders have said that

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<sup>6</sup>See [GAO-21-482](#), [GAO-16-76](#), [GAO-14-571](#); and GAO, *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy*, [GAO-15-710](#) (Washington, D.C.: Aug. 31, 2015).

<sup>7</sup>MA beneficiaries who elect hospice can remain enrolled in their MA plan, though care related to their terminal illness and related conditions is generally provided under traditional Medicare. Medicare payments to MA plans are accordingly reduced to reflect the plans' limited financial responsibility for hospice care. CMS currently has a demonstration underway in which certain MA plans are covering hospice services as an MA benefit.

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MAOs may shape their networks to include high-quality, low-cost care providers, and that narrower networks may allow MAOs to better oversee provider performance.

CMS has certain protections in place, and engages in monitoring and oversight activities to help ensure that MAOs adequately meet the care needs of beneficiaries and to identify and recover improper payments.<sup>8</sup> For example, CMS monitors a number of measures of the quality of care provided to beneficiaries in MAOs, including a measure for beneficiary disenrollment. CMS also reviews MAOs' provider networks to help ensure that they are sufficient to provide adequate access to all Medicare-covered services for all beneficiaries.<sup>9</sup> In addition, CMS conducts audits—called risk adjustment data validation (RADV) audits—to identify and recover improper payments made to MAOs. These audits identify improper payments by determining whether the beneficiary diagnoses submitted by MAOs for use in risk adjustment are supported by beneficiaries' medical records.

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## CMS Has Begun Monitoring MA Disenrollments in the Last Year of Life, as GAO Recommended

Beneficiaries in the last year of life are generally in poorer health and often require high-cost and specialized care, and disparities in disenrollment may indicate potential issues with having their care needs met by their MAOs. In 2021, we reported that MA beneficiaries in the last year of life disenrolled to join traditional Medicare at more than twice the rate of all other MA beneficiaries in both 2016 and 2017—the most current years of data at the time of our analysis. (See fig. 1.) Based on these findings, we recommended that CMS specifically analyze disenrollments by beneficiaries in the last year of life.<sup>10</sup> CMS has since implemented our recommendation. In May 2022, CMS officials provided us with analyses that CMS has conducted thus far, which found that disenrollment from 2019 through 2021 among beneficiaries in their last year of life were elevated in certain MA contracts. CMS's findings underscore the value of continued monitoring and, according to CMS officials, the agency plans to conduct these analyses annually.

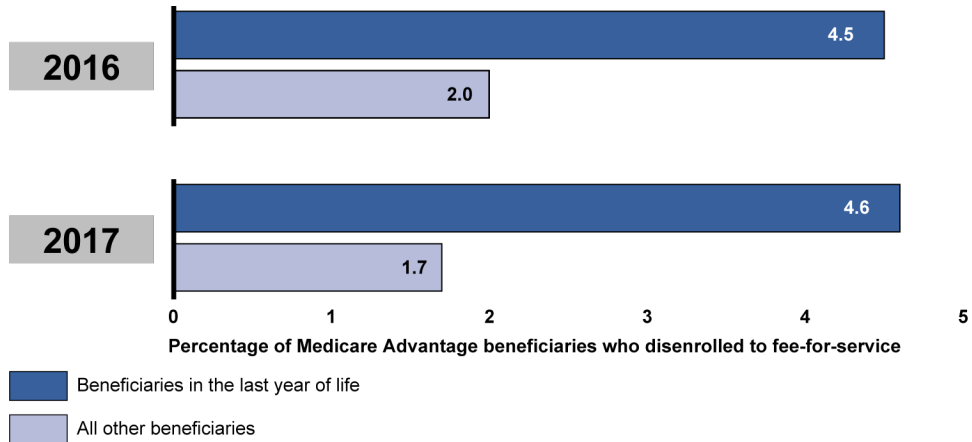
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<sup>8</sup>For example, MAOs are prohibited from limiting beneficiary coverage based on health status. 42 U.S.C. § 1395w-22(b)(1).

<sup>9</sup>Part C-Medicare Advantage Application, §§ 2.8; 3.11.A.; see also 42 C.F.R. § 422.112(a)(1)(i) (2021). 42 C.F.R. § 422.100(f) (2021). If a given physician or hospital is not in the MA plan's network, beneficiaries' out-of-pocket costs to use that physician or hospital may be considerably higher than the costs associated with the plan's network.

<sup>10</sup>See [GAO-21-482](#).

**Figure 1: Medicare Advantage Disenrollments to Join Traditional Medicare Fee-for-Service by Beneficiaries in the Last Year of Life Compared to All Other Beneficiaries, 2016-2017**



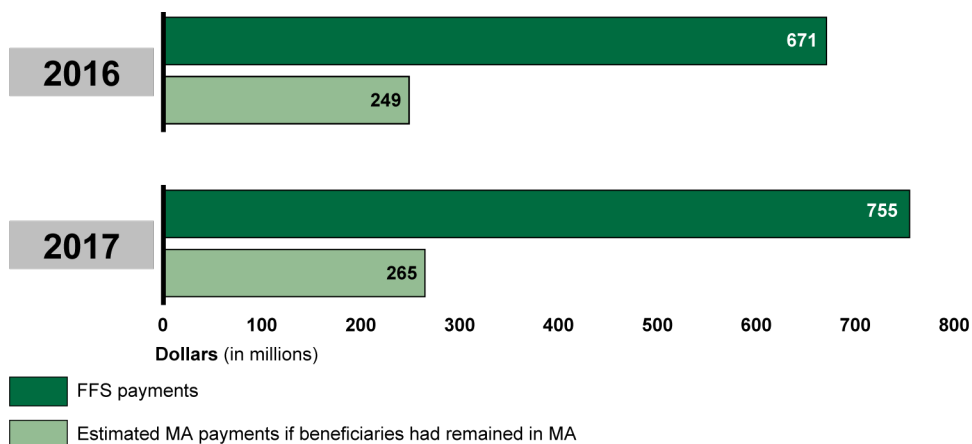
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-106026

In addition, we found that some of the highest increases in the rates of disenrollment from MA to traditional Medicare in the last year of life were among dual eligible beneficiaries. These beneficiaries are eligible for both Medicare and Medicaid, and are generally in poorer health than non-dual beneficiaries. In particular, dual eligible beneficiaries in the last year of life disenrolled to join traditional Medicare at nearly three times the rate of all other dual eligible beneficiaries, while non-dual beneficiaries in the last year of life disenrolled to join traditional Medicare at about twice the rate of all other non-dual beneficiaries. Further, we found that the rates of disenrollment to join traditional Medicare increased more in the last year of life in certain MAOs than in others. For example, we reported that in 2017, the MAO with the highest increase in disenrollment rates to join traditional Medicare saw beneficiaries in the last year of life disenroll at nearly 10 times the rate of all other beneficiaries.

As part of our analysis for our 2021 report, we also estimated that the beneficiaries in the last year of life who disenrolled from MA to join traditional Medicare in 2016 and 2017 increased Medicare program costs by nearly half of a billion dollars in each year. When MA beneficiaries with high-cost care needs disenroll to join traditional Medicare, Medicare program costs can increase, because these beneficiaries are leaving MA's fixed payment arrangements to join traditional Medicare, under which payments for services are generally based on the amount and cost of services provided. We found that traditional Medicare payments for

beneficiaries in the last year of life who disenrolled to traditional Medicare in 2016 were \$671 million—\$422 million higher than their estimated MA payments of \$249 million had they remained in MA. In 2017, traditional Medicare payments for these beneficiaries were \$755 million—\$490 million higher than their estimated payments of \$265 million.<sup>11</sup> (See fig. 2.)

**Figure 2: Estimated Medicare Advantage (MA) Payments for Beneficiaries in the Last Year of Life Who Disenrolled to Fee-for-Service (FFS) Compared to Actual FFS Payments, 2016-2017**



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-106026

Note: MA payments are fixed, risk adjusted monthly payments to MA plans, while FFS payments to providers are based on the amount and cost of services provided. We used MA benchmark and Medicare beneficiary risk score data to estimate MA payments for disenrolled beneficiaries from the month of their disenrollment through the month of their death, and compared our estimated MA payments against beneficiaries' actual post-disenrollment FFS payments. The data include payments for the following year for some beneficiaries who disenrolled mid-year.

Several stakeholders we interviewed for the 2021 report—including health care researchers, provider associations, and beneficiary advocacy organizations—cited a number of factors that could make beneficiaries in the last year of life more likely than other beneficiaries to disenroll to join traditional Medicare. In particular, stakeholders noted that certain MAOs'

<sup>11</sup>We estimated the costs of disenrollment by estimating payments for disenrolled beneficiaries had they remained in MA, and compared those estimates against those beneficiaries' actual FFS costs. To estimate payments for disenrolled beneficiaries had they remained in MA, we used MA benchmark and Medicare beneficiary risk score data to estimate payments from the month of their disenrollment through the month of their death. Our analysis includes payments for the following year for some beneficiaries who disenrolled mid-year.



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provider networks may provide limited access to specialized care. In 2015, we reported that CMS's oversight did not ensure that MAO networks were adequate to meet the care needs of MA enrollees.<sup>12</sup> For example, we found that CMS did not adequately verify the accuracy of provider network information submitted by MAOs, and accordingly could not verify whether MAO networks were in compliance with the agency's provider network criteria. We also found that the agency's network criteria did not account for aspects of provider availability, such as whether a provider is accepting new patients. We made two recommendations to address each of these issues: CMS should take steps to verify the accuracy of provider network information submitted by MAOs, and change its criteria for MAO provider networks to account for provider availability. CMS agreed with these two recommendations; as of March 2022, the recommendations had not yet been fully implemented.

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## CMS Has Not Fully Validated Encounter Data Needed to Accurately Adjust Payments to MAOs, As GAO Recommended













The encounter data submitted by MAOs on the services provided to MA beneficiaries contain beneficiaries' clinical diagnoses used by CMS to adjust payments to MAOs. These adjustments increase or decrease payments to reflect beneficiaries' projected health care costs. In 2014, we recommended that CMS complete all the steps necessary to validate encounter data for completeness and accuracy—including performing statistical analyses, reviewing medical records, and providing MAOs with summary reports on CMS's findings—before using the data to risk adjust payments.<sup>13</sup> CMS agreed with our recommendation and recognized the importance of ensuring that the data collected are accurate and complete—representing a correct record of all encounters that occurred—to help ensure the accuracy of beneficiary diagnoses for risk-adjusting payments to MAOs, among other things. However, as of June 2022, CMS had not yet implemented all of the steps necessary to validate encounter data for completeness and accuracy. (See fig. 3.)




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<sup>12</sup>See [GAO-15-710](#).

<sup>13</sup>See [GAO-14-571](#).

**Figure 3: Status of the Centers for Medicare & Medicaid Services' Actions to Validate Medicare Advantage (MA) Encounter Data, as of June 2022**

| Activity  | July 2014   | June 2022   |
|---|---|---|
| Establish benchmarks for collecting and submitting MA encounter data                    |  |  |
| Review MA organizations' capability to collect and submit encounter data                |  |  |
| Perform automated checks on submitted data for completeness and accuracy                |  |  |
| Conduct statistical analyses for completeness and accuracy                              |  |  |
| Review medical records to verify encounter data   |  |  |
| Provide summary reports to MA organizations on encounter data completeness and accuracy |  |  |

 Addressed  
 Partially addressed  
 Not addressed

Source: GAO. | GAO-22-106026

Note: Status for July 2014 based on GAO-14-571.

As figure 3 shows, as of June 2022, CMS has not completed four of the six actions necessary to validate encounter data for completeness and accuracy:

- Establish benchmarks for completeness and accuracy.** Objective benchmarks for each data field are necessary for determining whether the encounter data MAOs report to CMS are complete and accurate. As of June 2022, CMS had established a limited number of benchmarks related to the total number of encounter data records submitted.<sup>14</sup> However, CMS has yet to establish benchmarks for each encounter data field.
- Conduct statistical analyses for completeness and accuracy.** Analyses such as these are necessary for CMS to detect potentially inaccurate or unreliable data. As of June 2022, CMS had taken steps to assess the accuracy and completeness of encounter data. However, because CMS has not established benchmarks for the completeness and accuracy of each data field, these analyses are

<sup>14</sup>For example, CMS considers an MAO to have an “extremely low” total number of encounter data records if the number of records per enrollee is below a minimum threshold.

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insufficient to detect whether a given data field contains inaccurate or unreliable data.

- **Review medical records to verify encounter data.** Medical record reviews are necessary to help ensure the accuracy of encounter data. Without these reviews, CMS cannot determine whether the diagnoses CMS uses to risk adjust payments are supported by beneficiary medical records. As of June 2022, CMS had not implemented these reviews.
- **Provide summary reports to MAOs on encounter data completeness and accuracy.** This step would provide recommendations to MAOs for how to improve the completeness and accuracy of their encounter data submissions. CMS has provided summary reports to MAOs, including quarterly report cards containing basic information, such as the number of encounter records submitted overall and by type of service. However, because CMS has not yet conducted statistical analyses and reviewed medical records as described above, it cannot report information from these activities to each MAO.

CMS officials stated in March 2022 that the agency would continue to expand upon its processes for assessing encounter data as MAOs continue to submit these data. However, CMS did not indicate when the agency plans to complete all steps necessary to fully validate the data for completeness and accuracy. Because CMS adjusts payments based on diagnoses in encounter data that have not been fully validated for completeness and accuracy, the soundness of the adjustments made to billions of dollars in payments to MAOs remains unsubstantiated.

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## CMS Has Not Implemented GAO Recommendations to Improve Timeliness of MA Audits and Appeals to Recover Improper Payments

In 2016, we reported on several factors that hampered CMS's risk adjustment data validation (RADV) audit program and the recovery of improper payments in MA. We made two recommendations related to improving the timeliness of RADV audits and appeals process, and a recommendation to improve CMS's methodology for selecting MAO contracts for RADV audits. CMS has not yet fully implemented the two recommendations to improve the timeliness of RADV audits and appeals, but has implemented the recommendation to improve the agency's selection methodology.

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**Timeliness of RADV audits.** In 2016, we found that RADV MA contract-level audits were subject to substantial delays.<sup>15</sup> Specifically, we found that the RADV program was not conducting annual contract-level audits of MA payments, and had not completed audits of payments made in 2007 and 2011. Although CMS’s goal is to annually conduct contract-level audits to recover improper payments, we found that CMS lacked a timetable that would allow the agency to complete such audits on an annual basis. According to CMS’s own estimates at the time of our report, conducting annual MA contract-level audits would potentially allow the agency to recover hundreds of millions of dollars more in improper MA payments each year.

We recommended that CMS take several actions to improve the timeliness of RADV audit processes. CMS agreed with our recommendation, and CMS officials have reported that as of June 2022 the agency has completed some, but not all of these actions. For example, according to CMS officials, the agency has improved audit timeliness by reducing the time gap between notifying MAOs of contract audit selection and notifying them about the beneficiaries and diagnoses that would be audited. We reported in 2016 that this time gap was 3 months; in March 2022, CMS officials stated that they had reduced the gap to 7 weeks. In addition, CMS officials stated that they had improved audit timeliness by conducting audits for two payment years simultaneously, and by automating certain aspects of the medical record review process.

Although CMS has taken some steps to improve audit timeliness, contract-level audits continue to be delayed significantly. For example, as of June 2022, CMS has not yet issued final contract-level audit findings for payments made in 2011 through 2014.<sup>16</sup> In contrast, CMS uses a specific timetable that allows the agency to complete national-level RADV audits on an annual basis to calculate estimated improper payments for MA. Until CMS improves the timeliness of its contract-level RADV audits, the agency may miss out on recovering hundreds of millions of dollars in improper payments annually.

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<sup>15</sup>See [GAO-16-76](#). CMS conducts two types of RADV audits: national RADV activities to annually estimate the MA improper payment rate, and contract-level RADV audits focused on identifying and recovering improper payments at the contract level. Our findings and recommendations from this report generally concern RADV contract-level audits.

<sup>16</sup>CMS stated in June 2022 that the agency plans to issue these findings after publishing the final rule on RADV audits, which the agency expects to issue in November 2022.

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**Timeliness of RADV appeals.** MAOs are able to appeal RADV improper payment determinations, and we reported in 2016 that the appeals process for contract-level RADV audits had been ongoing for years. We found that such delays hindered CMS's ability to recoup identified improper payments. We recommended that CMS improve the timeliness of the RADV appeals process by, for example, requiring that decisions on MAO appeals of RADV findings be rendered within a specified number of days. CMS agreed with our recommendation. In March 2022, CMS officials stated that they are considering issuing a final rule specifying timelines for MAO appeal decisions, but as of June 2022 the agency did not provide an estimate for when any such final rule would be issued.

**Selection of MAOs for RADV audits.** CMS has implemented our 2016 recommendation to improve its methodology for selecting a sample of MA contracts for RADV audits. In our 2016 report, we found that, due to shortcomings of CMS's methodology, the agency did not select MA contracts for audit that have the greatest potential for payment recovery. We recommended that CMS modify its selection of MA contracts to focus on contracts most likely to have high rates of improper payments. In May 2021, CMS implemented our recommendation by revising the agency's contract selection methodology to better target RADV audits on MA contracts that are more likely to have high rates of improper payments. Under CMS's revised approach the agency incorporates results from prior contract-level RADV audits to inform contract selection. Moving forward, the revised methodology should allow CMS to more effectively target and recover improper payments.

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Chair DeGette, Ranking Member Griffith, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

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## GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Leslie V. Gordon at (202) 512-7114 or [GordonLV@gao.gov](mailto:GordonLV@gao.gov). Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement.

Other individuals who made key contributions to this testimony include William Black (Assistant Director), Michael Erhardt (Analyst-in-Charge), Manuel Buentello, Sonia Chakrabarty, Amy Leone, Drew Long, Brandon Nakawaki, Vikki Porter, and Lillian Riehl Schultze. Other staff who made key contributions to the reports cited in the testimony are identified in the source products.

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# Related GAO Reports

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- *Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending.* [GAO-21-482](#). Washington, D.C.: June 28, 2021.
- *Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight.* [GAO-17-393](#). Washington, D.C.: April 28, 2017.
- *Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments.* [GAO-17-223](#). Washington, D.C.: January 17, 2017.
- *Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments.* [GAO-16-76](#). Washington, D.C.: April 8, 2016.
- *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy.* [GAO-15-710](#). Washington, D.C.: August 31, 2015.
- *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use.* [GAO-14-571](#). Washington, D.C.: July 31, 2014.

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