Healthcare Regulatory Roundup #112

CMS Enforcement to Provider Risk:
The Downstream Impact of RADV Audits

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Introductions



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Learning Objectives

1. **Medicare Advantage (MA) Flow of Funds**
   Understand how Medicare Advantage (MA) payments flow from CMS to MA plans to network providers, and where risk is introduced
2. **Risk Adjustment Fundamentals and Oversight**
   Review the fundamentals of MA risk adjustment and Risk Adjustment Data Validation (RADV) audits
3. **Role of Providers**
   Identify the role of providers in compliance, clinical documentation, and operational support
4. **Provider Strategies**
   Evaluate how providers can assess, mitigate, and respond to risk through contractual obligations, internal risk assessment, auditing and monitoring, and payer alignment

1. MA Flow of Funds

Medicare Advantage (MA) Definition

- Insurance plans offered by private insurance companies to Medicare beneficiaries
- Provides the same benefits as the original Medicare plan (Medicare Parts A and B), but plan may offer additional benefits, such as vision, hearing, dental, and/or health and wellness programs, and/or include varying restrictions
- Beneficiaries elect to join a MA plan or stay with traditional Medicare
- Medicare services are covered through the plan and are not reimbursed under Parts A or B
  - Managed care with a health plan network
  - May offer prescription drug coverage (Part D)

What are the differences in Traditional Medicare vs. MA?

- **Funding**
  - **Traditional (CMS risk):** Medicare Trust Fund and beneficiaries pay premiums, deductibles, and co-pays
  - **MA Plan (risk):** CMS pays MA Plan a capitated amount (adjusted for risk adjustments); beneficiaries only pay copays or co-insurance if chosen plan requires them.
    - MA Plan receives additional sums directly based on risk adjustment scores.

- **Provider Payments**
  - **Traditional:** Providers are paid by CMS based on procedures performed.
  - **MA:** Providers are paid by the MA plan:
    - Based on procedures performed, ***or***
    - Based on a risk adjusted capitated model

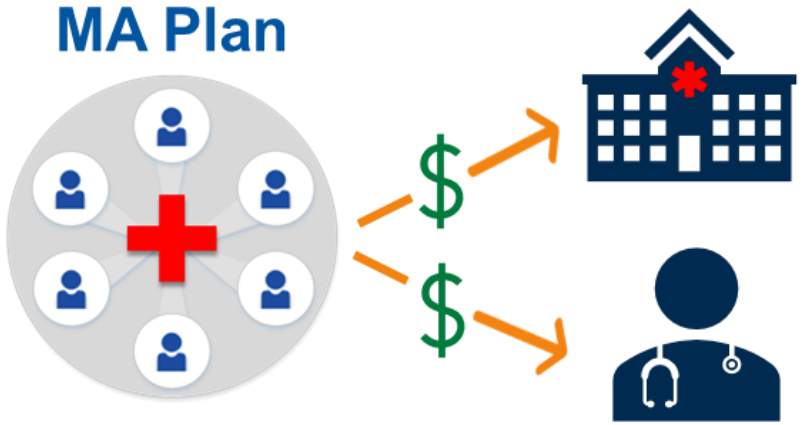
Payment to MA Plans

- **CMS Payments**
  - Submit an annual bid to CMS
  - Receive a fixed (or capitated) monthly payment from CMS per enrollee (beneficiary)
  - Monthly payments are based upon the following factors:
    - Geographic benchmarks as determined during the annual bid process
    - MA plan's Star rating
    - Enrollee's **Risk Adjustment Factor** (RAF) scores

- **Enrollee Payments**
  - Fixed monthly premium payments based on benefit plan selected

Payment to Providers

- **How do MA Plans pay for medical services on behalf of their enrollees?**
  - MA Plan directly contracts with Providers in their network to provide covered services for their enrollees.
  - MA Plans can pay for such services under various methods:
    - FFS
    - Capitation
    - Other payments (quality, shared savings)



Risk Adjustment vs. FFS

- **Risk Adjustment**
  - CMS assigns plan payments for patients based on risk (not as reimbursement of services provided).
  - Higher specificity of diagnosis code(s) better defines financial risk.
  - CMS will only pay for health conditions currently being managed.

- **FFS**
  - Physicians paid on FFS; bill services based on CPT/HCPCS procedure codes.
  - Diagnosis codes used minimally for payment policies, only to support the medical necessity of procedures.

MA Plan's Risk Adjustment Programs

- **MA plans typically administer two risk adjustment programs to identify supported HCCs:**

Prospective Risk Adjustment Program

- The purpose is predominately for case management of high-risk members who have co-morbid conditions and/or may be suspect to incur a major clinical event.
- MA Plan may send their own clinical staff or third-party to conduct a health risk assessment in the enrollee's home
    - Designed to capture missed diagnoses and chronic illnesses

Retrospective Risk Adjustment Program

- The purpose is to validate suspected diagnoses for members in the current year based on complex algorithms driven from past and current claims

Traditional Medicare and MA Plans: Compliance Differences

- **How do the reimbursement differences between Traditional Medicare and MA affect the analysis of compliance?**
  - ***Example***: Who is responsible for the false claim?
    - Plan differences:
      1. **Traditional:** Claim is submitted by the provider to CMS (e.g., direct false claim)
      2. **MA:** Claim is submitted by the provider to the MA Plan (e.g., possible false claim to federal contractor)
  - **Compliance Risk:**
    - The looming split in the Circuits concerning the causation standard for AKS/FCA cases (3rd vs. 6th and 8th; and USDC split in D. Mass. that is being heard in the 1st Cir.)

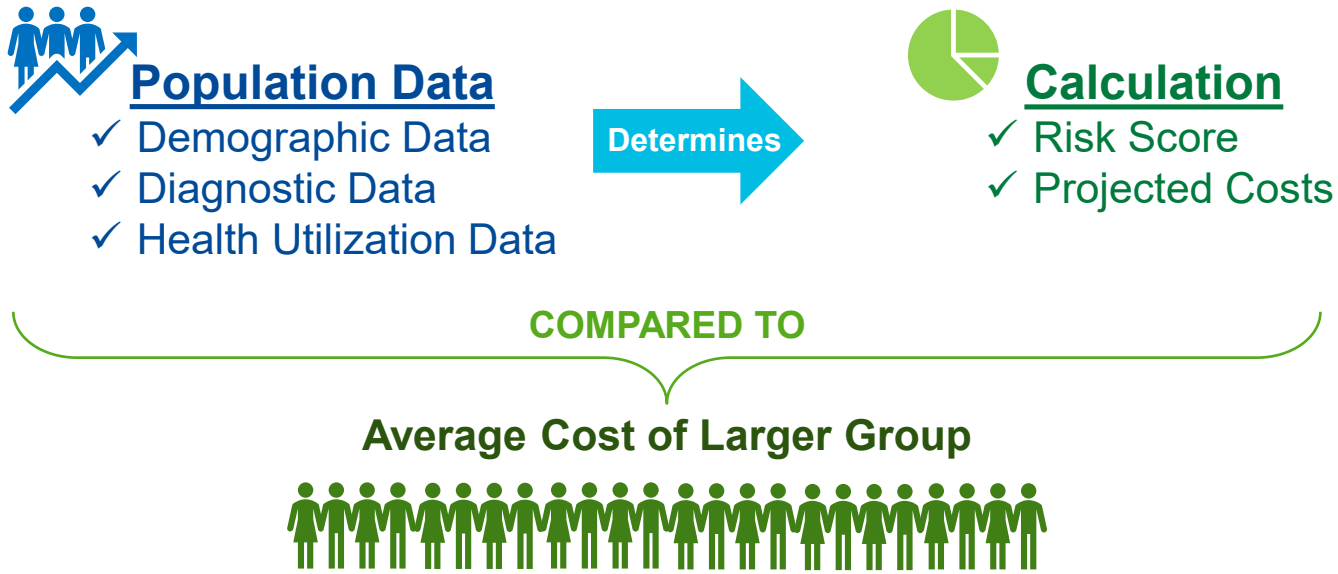
Traditional Medicare and MA Plans: Compliance Differences

- **Reimbursement differences** (*continued*)
  - **Compliance Risk:**
    - Diagnosis codes drive reimbursement
      - Providers submit diagnoses to the MA plan:
        - Providers do not submit records to validate the diagnoses.
        - This results in prospective and retrospective reviews by MA plans of data and records to ensure accuracy.
          - Health Risk Assessments
          - Substantial Govt interest/litigation involving retrospective chart reviews

2. Risk Adjustment Fundamentals and Oversight

Risk Adjustment Methodology

- Risk adjustment is an **actuarial tool**
  - Measures morbidity and/or health service utilization to assess the relative risk of a population
- **Risk factors = health status or health spending**
  - Age, gender, diagnostic information, and healthcare utilization



MA Principal Components

Base Rate

- Before the start of each year, each MA organization submits bids to CMS that reflect the MA organization's estimate of the monthly revenue required to cover an enrollee with an average risk profile.
- CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that an MA organization is paid for each of its enrollees.

Risk Score

- A risk score is a relative measure that reflects the additional or reduced costs that each enrollee is expected to incur compared with the costs incurred by enrollees on average.
- CMS calculates risk scores based on an enrollee's health status and demographic characteristics (such as the enrollee's age and gender).
- This process results in an individualized risk score for each enrollee, which CMS calculates annually.

RADV Audit Schedule

- The following table includes the month in which the Centers for Medicare & Medicaid Services (CMS) intends to initiate RADV audits by MA payment year.
- Note that these dates are subject to change. CMS will update this schedule as needed.

Date of Service (DOS) Year	Payment Year (PY)	Planned Audit Start
2019	2020	March 2026
2020	2021	May 2026
2023	2024	August 2026
2022	2023	November 2026
2021	2022	January 2027
2024	2025	April 2027
2025	2026	2026 MA payments are based on 2025 diagnoses
2026	2027	2027 MA payments are based on 2026 diagnoses

RADV Audits: 2025

- Verify diagnoses used to calculate MA risk scores are documented in enrollee medical records
  - If diagnoses not validated, plan may be required to repay CMS
- **CMS announcement May 21, 2025:**
  - Backlog from 2018 thru 2024 to be completed by early 2026
    - Enhanced technology: use of advanced systems to efficiently review medical records and flag unsupported diagnoses
    - Workforce expansion: Increase medical coders from 40 to ~2,000 by September 2025
    - Increased audit volume: Increase audits from ~60 MA plans a year to all eligible MA plans each year; increase from auditing 35 records per health plan per year to between 35 and 200 records per health plan per year
- **September 25, 2025:**
  - Court vacated parts of RADV final rule following litigation by Humana in federal court (2023); decision appealed by CMS November 1

RADV Audits: 2026

- CMS issued a memo January 27, 2026, indicating CMS plans to move forward with RADV audits and use of AI to streamline coding reviews
  - Notice included a 5-month record submission window
  - Extended the hardship exception request window for PY 2019 audits
  - Clarified that smaller contracts unlikely to be subject to 200 enrollee sample
  - All medical record coding decisions that could result in overpayment determinations to be made by “human certified medical coders”
- Potential for provider clawbacks: check contracts’ indemnification provision

3. Role of Providers

Provider's Role

- Documentation should demonstrate complete and concise picture of the patient's condition.
- Diagnosis assignment must reflect the highest level of specificity supported by provider documentation in the medical record.
- Excellent documentation is reflective of the "thought process" of provider when treating patients.



Administrative Guidelines

- ☐ **Face-to-face visit**
- ☐ **Appropriate provider type**
  - ✓ MD
  - ✓ DO
  - ✓ PA
  - ✓ NP
  - ✓ DPM
  - ✓ DC
  - ✓ OD
  - ✓ CNS
  - ✓ Nurse-midwives
  - ✓ Independently practicing PT's
- ☐ **Appropriate location**
  - ✓ Inpatient hospital stays longer than 24 hrs
  - ✓ Outpatient hospital services
  - ✓ Provider practice
- ☐ **Inappropriate location**
  - ✓ Clinical lab
  - ✓ Diagnostic radiology
  - ✓ SNF
  - ✓ Hospice
  - ✓ Ambulance
  - ✓ Free-standing dialysis centers
  - ✓ Free-standing ambulatory service centers
  - ✓ DME/Prosthetics/Orthotics
- ☐ **Appropriate signature, including credentials and date**
- ☐ **Condition impacts medical decision making**
- ☐ **Evidence of monitoring, evaluation or treatment**

HRA Documentation and Coding Guidance

- **Health Risk Assessment**
  - Conditions can only be coded/reported if there is documentation that the condition has affected the patient's treatment and management on that particular encounter.
  - Chronic conditions affect the management of the patient, even when the patient is presenting with a straightforward illness that would appear unrelated to the chronic condition.
  - Document all conditions that co-exist at the time of the visit and how they impact current care and treatment (medical decision making)
    - Document all cause and effect relationships
    - Link conditions to medications in the treatment/plan
    - Each note for each date of service stands alone

Affordable Care Act Section 4103(b)[1] states that an HRA is to be completed before, or as part of, an annual wellness visit with a health professional who may be a physician, medical practitioner, medical professional (e.g., health educator, registered dietician, nutrition professional) or a team of medical professionals. The law specifies that the HRA:

1) must identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of an individual (Element 1)
2) may be furnished through an interactive telephonic or web-based program (Element 2)
3) may be offered during the encounter with a health care professional or through community-based prevention programs (Element 3)
4) may be provided through any other means appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of beneficiaries (Element 4)

Source: CDC Interim Guidance for Health Risk Assessments and their Modes of Provision for Medicare Beneficiaries https://www.cms.gov/files/document/healthriskassessmentscdcfinalpdf

ICD-10 Documentation and Coding Guidance

- Accurate diagnosis code reporting that is supported by clinical documentation ultimately supports the accuracy of a patient's RAF score.
  - **Do <u>not</u> report:**
    - Problem list diagnoses that have been resolved
    - Conditions that were previously treated and no longer exist
    - Diagnoses that have resolved or are no longer treated
- "History of" conditions are informational unless the provider documents how the patient's care was impacted by that history.
  - Only document diagnoses as "history of" or "PMH" when they no longer exist or are not a current condition.

ICD-10 Coding Impact to RAF Score



- Completeness and specificity of diagnosis coding are important in supporting risk score calculations because accurate diagnosis code reporting and supporting clinical documentation increases the accuracy of a patient's RAF score.
- More categories of diagnoses reported over a year creates a higher risk score.
- Only one diagnosis per category is used in the risk score calculation, the highest risk.
  - ***Example:*** If both angina and AMI are reported in one year, only the AMI is scored as it is at a higher level of specificity within the heart category.

Differences Between V24 and V28 HCCs

Model Components	2020 Model V24	2024 Model V28	Removed	Added
ICD-10-CM Code Set	ICD-9-CM	ICD-10-CM	Acute kidney failure	Anorexia nervosa, bulimia nervosa
FFS Data Years	2014-2015	2018 – 2019	Angina pectoris	Severe, persistent asthma
ICD-10-CM Total	73,926	73,926	Atherosclerosis of the extremities (PVD)	Malignant pleural effusion
ICD-10-CM HCC	9,797	7,770	Protein calorie malnutrition	Alcoholic hepatitis with and without ascites
HCC Categories	86	115	Amputation of toe	Toxic liver disease with hepatitis
ICD-10-CM Deletions		2,236		Primary sclerosing cholangitis
ICD-10-CM Additions		209		Other cholangitis
				Obstruction of the bile duct
				Malignant ascites

HCC Documentation Requirements

- Patient name and date of service must appear on all pages of the record.
- Encounter must be based on a face-to-face visit.
- Condition(s) must be documented in the medical record and be clear, concise, consistent, complete and legible.
- Acceptable provider's signature, credentials and date of authentication must be appended.

Helpful Acronym and Examples – MEAT

- **M** – Monitor (e.g., Order labs or diagnostic test/radiology)
- **E** – Evaluate (e.g., Review labs or radiology results and physical exam)
- **A** – Assess/Address (e.g., Condition described as stable or improving)
- **T** – Treatment (e.g., Referral to a specialist, ordering or refilling medications, surgery)

- These can be found in any section of the patient record – Provider's active voice.
- Ensure there is at least one element of the above acronym documented for each coded condition.

The Intersection with E/M Guidelines

- **Problem Addressed Definition (AMA/CPT E/M Guidelines)**
  - *"A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/ surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service."*

Most Impacted Diagnosis Codes

- OIG selects certain groups of HCC diagnosis codes it considers as **high-risk** for Medicare Advantage risk adjustment audit, examples include:

High-Risk Category	Typical Issue
Acute Stroke	No hospital/imaging support
Acute MI	AMI sequelae; hx of
Embolism	Rule out diagnosis; hx of
Lung Cancer	No evidence of active treatment
Breast Cancer	History coded as active
Colon Cancer	Surveillance ≠ active cancer
Prostate Cancer	Elevated PSA ≠ malignancy
Mis-Keyed Dx	Clinically implausible

Source: https://oig.hhs.gov/reports/all/?issue-date=custom&from_date-=01%2F01%2F2026&to_date-=12%2F31%2F2026#results

Common Risk Adjustment Coding and Documentation Errors

History of

Condition no longer present, or patient no longer has the condition

- **Examples:**
  1. Coding a past condition as active
  2. Coding history of when the condition is still active

Billed vs. Documented

Discrepancy of diagnosis between what is billed and what is documented in the EMR

- **Examples:**
  1. **CKD unspecified N18.9 – does not risk adjust**
  2. **CKD stage 4 N18.4 – does risk adjust**

Common Risk Adjustment Coding and Documentation Errors (cont.)

- Providers report only the first-listed or principal diagnosis and not all diagnoses that require care and treatment.
  - Best practices, include documenting:
    1. **Main reason for visit**
    2. **Co-existing acute conditions**
    3. **Chronic conditions (e.g., Atrial Fibrillation, CHF, COPD, CKD, RA, DM)**
    4. **Care provided**
    5. **Conclusion and diagnoses**

4. Provider Strategies

Recent Changes to the MA Program

- MA plans must cover the services CMS covers at a minimum
- Coverage policies must be published and otherwise follow CMS published coverage guidelines
- CMS standardized the RADV audit appeals process; medical review process will complete adjudication prior to payment error appeal process can start
- Revision of V24 to V28, but the toolkit logic still applies

Sources:

1. https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program
2. https://www.federalregister.gov/documents/2023/11/15/2023-24118/medicare-program-contract-year-2025-policy-and-technical-changes-to-the-medicare-advantage-program

Office of Audit Services (OAS)

H2320	Priority Health	Medical records did **not support 252 of 300 sampled enrollee-years**,	**$828,010** in net overpayments.	OIG extrapolated **at least $4.4 million in net overpayments** for payment years 2018–2019.	Refund **$4.4 million** to the Federal Government
H5932	Gateway Health Plan, Inc.	**232 of 286 sampled enrollee-years** lacked supporting documentation	**$830,334** in net overpayments.	OIG estimated **at least $4.3 million** in overpayments for 2018–2019.	Refund **$4.3 million** in estimated overpayments
H0104	Blue Cross and Blue Shield of Alabama	**247 of 271 sampled enrollee-years** were unsupported,	**$769,195** in overpayments	OIG extrapolated **at least $7 million** in overpayments for 2018–2019.	Refund **$7 million** to the Federal Government
H1951	Humana Health Benefit of Louisiana	**218 of 240 sampled enrollee-years** were unsupported,	**$553,049** in overpayments.	OIG estimated **$10.5 million** in overpayments for 2017–2018, but limited recovery to **$5.5 million** due to regulatory restrictions. [oig.hhs.gov], [ebs.publicnow.com]	Refund **$5.5 million** in estimated overpayments

Source: https://oig.hhs.gov/reports-and-publications/oas/cms.asp

MA Industry Segment-Specific Compliance Program Guidance as a Downstream Compliance Partner

- **Ensure diagnosis coding accuracy**
  - Report only diagnoses that are clinically supported and fully documented; avoid unsupported HCCs and vendor-driven coding inflation
- **Protect documentation and data integrity**
  - Maintain complete, auditable medical records supporting medical necessity, chronic conditions, and services billed
- **Actively oversee delegated vendors**
  - Monitor coding, risk adjustment, analytics, and in-home assessment vendors; prohibit inappropriate coding practices
- **Align utilization decisions with Medicare rules**
  - Follow Medicare coverage standards (NCDs/LCDs); avoid incentives or processes tied to inappropriate denials or care delays
- **Maintain a functional compliance program**
  - Implement MA-relevant policies, training, auditing, issue reporting, and corrective actions—even if not payer-mandated
- **Anticipate increased MA plan oversight**
  - Be prepared for audits, data validation, and enhanced compliance requirements driven by MA plan obligations

Risk >> Compliance Considerations

RISK	Compliance Exposure
Provider coding variability drives MA reporting	Data integrity risk in CMS submissions
Unsupported diagnoses submitted	Potential overpayments and recoupment exposure
Education can create “specificity creep”	Upcoding/steering allegations if specificity is not warranted
No routine audits to validate coding	Undetected errors persist → corrective action/repayment risk
Retrospective audits create selection bias	One-sided findings increase scrutiny of audit rigor and intent
Member switching reduces incentive to identify HCCs	Artificial RAF suppression for disenrolling members → reporting accuracy concerns
Analytics flag outliers, but not root cause	Documentation review required to substantiate aberrant behavior

Our Next Healthcare Regulatory Roundup Webinar

Wednesday, May 6; 11 am – 12 pm ET

Spring into 2027: CMS Proposed Rules and Payment Policy Updates for Providers

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