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The RADV final rule overview and considerations for healthcare providers who participate in Medicare Advantage plans

by Christine Worthen and Lily Shannon

Medicare Advantage (MA) plans provide Medicare Parts A and B benefits to over 30 million beneficiaries.[1] The number continues to increase as MA plans gain popularity through the inclusion of such features as additional benefits (e.g., dental, vision, fitness, assistance with utility bills, healthy food), and low/no premium offerings. MA encourages providers to identify and treat illness in early stages to enable early intervention, coordinate care for those seeing multiple providers, and provide care management and disease management programs. (For the purposes of this article, "providers" includes all members of the patient care team, such as physicians, advanced practice clinicians, and nurse care managers.)

These approaches often include care teams focused on beneficiaries with multiple chronic conditions, such as nurse care managers who support beneficiaries and help with appointment scheduling and ensuring patients keep their scheduled appointments, as well as medication management, nutrition/fitness resources, and in-home evaluation/care. To ensure effective identification and treatment of beneficiaries with chronic illness, MA payments must accurately reflect the health status of MA beneficiaries.

Payments

The Centers for Medicare & Medicaid Services (CMS) makes capitation payments to MA organizations (MAOs) with whom it contracts, who then enter into participation agreements with providers to deliver services to beneficiaries. CMS sets the payment rate based on local area benchmarks representing the maximum amount CMS will pay health plans for benefits for beneficiaries in that locale.[2] The benchmarks for each area are based on a statutory formula using average traditional Medicare spending per beneficiary. The CMS annual Advance Notice and Rate Announcement are used to update the factors that impact the yearly benchmark. These factors include the growth rate in the traditional Fee-For-Service Medicare, the MA growth rate, and changes to the Star Ratings system. Overall, payment to health plans varies by geography, with higher payments made in rural areas and lower payments in urban areas.

Health plan payment is also modified by the risk scores of enrollees and quality performance payments. The capitation payments that MAOs receive from CMS are intended to reflect the health status and demographic characteristics of the members participating in MA plans. Health conditions and diseases are assigned diagnosis codes. CMS groups individual diagnosis codes into broader diagnosis groups, which are then filtered into hierarchical condition categories (HCCs). HCCs help predict care costs and are considered as part of the

adjustment process for payments. The adjustment is known as "risk adjustment." Risk-adjusted payments are based on medical diagnoses submitted by MAOs that need to be supported in patients' medical records to ensure payment accuracy. Diagnoses from certain sources are not included in HCC calculations, such as from skilled nursing facilities, home health providers, as well as other factors that impact a patient's health and well-being (e.g., health-related social needs). The home provides a lot of insight into the challenges patients may face; it is why many MA plans deploy nurses to go into patients' homes to do an assessment and then provide summaries and flag potential issues for the primary care provider to follow up on at the next visit. As social determinants and coding for the same continue to evolve, patient pictures become much more accurate as a complete, whole-person process. Z codes can identify additional needs that should be considered in care planning for both high-risk and rising-risk patients.[3] MAOs are increasingly focused on diagnosis coding to ensure the payments they receive are adequate to treat the beneficiaries who choose their MA plans. Many providers have seen an uptick in requests for chart reviews to identify coding gaps, as well as more targeted efforts by MA plans to encourage providers to focus on coding efforts—with many offering to deploy on-site staff and resources to educate providers and their care teams.

Risk Adjustment Data Validation (RADV) audits and final rule

Medicare risk adjustment is prospective, meaning diagnoses from the previous year and demographic information are used to predict future costs and adjust payment. CMS is responsible for ensuring the payments are accurate and conducting audits to verify their accuracy. MAOs have come under increased scrutiny over the last few years for the payments they received, where diagnosis codes were not supported by patients' medical records. This has resulted in media coverage, lawsuits, a controversial proposed rule, and a scaled back—but still impactful—final rule that addresses how CMS conducts RADV audits of MA plans.

CMS issued its long-awaited RADV final rule in January.[4] The final rule codifies in regulation that, as part of the RADV audit methodology, CMS will extrapolate RADV audit findings beginning with payment year 2018. Section 1853(a)(1)(C) of the Social Security Act sets forth the requirement that CMS risk-adjust payments be made to MAOs. Payments are less for MAOs with healthier enrollees as they should have lower healthcare costs and more for MAOs with less healthy and more chronic conditions, who are expected to incur higher healthcare costs. The RADV final rule addresses instances where MAOs received more than they otherwise should have received because the medical diagnoses submitted for risk adjustment payment were not supported in the enrollee's medical record. The final rule authorizes CMS to extrapolate RADV audit findings beginning with payment year 2018 to determine those instances. The RADV final rule also confirms that CMS will not apply a fee-for-service adjuster in the audits to account for any effect of erroneous diagnosis codes in Medicare Parts A and B data that are used to calibrate the MA risk adjustment model. The fee-for-service adjuster was previously utilized to calculate a permissible level of payment error and limit RADV audit recovery to payment errors above that level. Although the final rule and the Advance Notice directly apply to the entities that sponsor MA plans, providers participating in MA plan networks must understand how the final rule and the Advance Notice could impact their network participation agreements.

CMS also recently published the MA final rate announcement, which sets forth rates and payment policies for the 2024 MA program.[5] CMS indicated it expects an average change in revenue of 3.32% (compared with 1.03% in the Advance Notice) and opted to phase in the finalized risk adjustment program over three years. The updated risk adjustment model uses ICD–10 codes and includes clinically based adjustments to support the inclusion of conditions that are stable predictors of costs to discourage discretionary coding. It removed 2,000 codes from its HCC model, including major depressive disorder, diabetes with chronic conditions, vascular disease, rheumatoid arthritis, and inflammatory connective tissue disease. CMS also asked for feedback on potential measure updates, new measure ideas, and adding measures to align with other CMS programs. This could pave the way for

what CMS referred to as a "Universal Foundation" of quality measures, which would be a core set of measures aligned across programs.

The recent CMS activity is a good reminder to providers to pay careful attention to the terms of their payer contracts and their strategies for negotiation. This will help ensure financial stability for providers as healthcare delivery continues to transform, and traditional reimbursement models continue to evolve. CMS has not backed down from its commitment to value-based care and ensuring providers are in value-based reimbursement models. The RADV final rule is an important part of that commitment to ensure that MA plans receive accurate payment. Providers need to be aware of how their coding and care efforts contribute to the process and impact reimbursement.

Conclusion

For providers participating in MA plan networks, the final rule may filter down to them in several ways. Below are takeaways to keep in mind.

Takeaways

- Medicare Advantage organizations (MAOs) downstream most regulatory requirements to their network providers, including requirements related to Risk Adjustment Data Validation (RADV) audits. Providers should understand their contractual obligations under their provider agreements and the impact that RADV audit adjustments may have on their payments. These contractual obligations could be a source of disputes in the coming years.
- In a value-based payment system, the coding extracted from documentation determines whether a physician is properly compensated for managing patients with chronic diseases. The more accurate the risk scores, the more accurate the benchmark for expenses, and the more accurate the physician's reimbursement. MAOs penalized by the Centers for Medicare & Medicaid Services for inaccurate coding and incurring negative payment adjustments will likely seek repayment from their contracted providers.
- The proposed "Universal Foundation" could help solve a lot of the frustration with value-based models in general, lessening the burden of having dozens of quality measures across payers and instead focusing on a core set of measures. Many providers do this anyway and base compensation and bonuses on performance under a subset of standard measurements.
- Patient engagement is an essential component in this era of patients as consumers. Heightened attention to coding should sharpen providers' focus on annual checks to identify patients with unreported chronic conditions and ensure follow-up on these patients to better manage and recapture their chronic conditions. Further, many plans offer a variety of supplemental benefits such as access to healthy food and utility assistance, gaps which we now understand can greatly impact a patient's overall health.
- Social determinants of health are critical to understanding a patient's needs and potential impediments to compliance with treatment plans. Taking time to document these risks and utilizing Z codes can help to better shape care plans and serve as additional items of discussion for the importance of fair payment to providers who need to take the time to discuss these essential issues with patients and document accordingly.

1 Centers for Medicare & Medicaid Services, "Medicare Advantage/Part D Contract and Enrollment Data," last modified March 20, 2023, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-

and-Reports/MCRAdvPartDEnrolData.
2 Better Medicare Alliance, "Fact Sheet: Medicare Advantage Rate Setting Process," January 2021, https://bettermedicarealliance.org/wp-content/uploads/2021/02/Medicare-Advantage-Rate-Setting-Process-copy.pdf.
3 Jessica L. Maksut et al., "Utilization of Z codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries 2019," Office of Minority Health Data Highlight No. 24, Centers for Medicare & Medicaid Services, 2021, https://www.cms.gov/files/document/z-codes-data-highlight.pdf.
4 Centers for Medicare & Medicaid Services, "Medicare Advantage Risk Adjustment Data Validation Final Rule (DMS–4185–F2) Fact Sheet," news release, January 30, 2023, https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-risk-adjustment-data-validation-final-rule-cms-4185-f2-fact-sheet.
5 Centers for Medicare & Medicaid Services, "Fact Sheet: 2024 Medicare Advantage and Part D Rate Announcement," news release, March 31, 2023, https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2024-medicare-advantage-and-part-d-rate-announcement.