27th Annual Revenue Cycle and Finance Conference
Building Beyond: Leading the Future of Revenue & Finance

CODE RED: ALIGNING RISK ADJUSTMENT WITH CMS'S NEW AUDIT MANDATE

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Jason Jobes, MSPA, is the senior vice president (SVP) of Norwood solutions and oversees all solution partnerships and delivery for Norwood's healthcare partners. These partnerships focus on bringing health to hospitals' bottom lines, improving performance across the revenue cycle and value-based care terrains.

During his career, Jobes has delivered over $500 million in return on investment for partners. Jobes holds a bachelor's degree in economics from The University of Hawaii at Hilo and obtained his master's degree in predictive analytics from Northwestern University in Evanston, Illinois.

He is passionate about making healthcare better and more affordable, particularly for those who may not be able to pay for or access it.

Learning Outcomes

- At the completion of our time together you should be able to:
  - Explain the evolving risk adjustment landscape and the rise of Medicare Advantage
  - Understand the various audits and the importance of documentation accuracy
  - Apply best practice techniques to help your organization know and understand potential risks associated with risk adjustment

My Goal For You Today:

My goal is that you walk away from our session with 3 learnings. They can be new ways to look at things, new ideas, or new best practices to implement at your organization.

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THE VALUE BASED CARE LANDSCAPE

A Broad Overview of Reimbursement

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Fee for Service

Fee for service contracts compensate healthcare organizations for each service rendered and there are generally no quality, cost, or outcome expectations. What this means is that organizations increase revenue by increasing the volume of care provided. There is little incentive to control healthcare utilization.

Value Based Care Contracts

Value based care contracts come in multiple forms but at their core they seek to share cost savings, incentivize high quality outcomes, and drive lower healthcare utilization. Providers are paid a certain amount for each patient encounter but can earn additional revenue through metrics defined in the contract. The goal is to create incentives across the healthcare continuum for high-quality, low-cost care.

Introducing the Concept of Medical Loss Ratios (MLR)

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Health plans must annually calculate their medical loss ratio. This ratio reflects the percent of all premiums that are paid for claims. The lower the ratio, the more controlled costs are relative to the premium collected. This can be an indicator of overall performance but is by no means an absolute metric.

MLR Calculation

$$\text{MLR Ratio} = \frac{\text{Medical Claims Expense}}{\text{Total Premiums Received}}$$

Profit Calculation

$$\text{Profit} = \text{Premiums} - \text{Expenses}$$

To improve medical loss ratios, an organization must do at least one of the following two items:

1. **Decrease Medical Claims** : To do this, organizations must either decrease the volume of services being provided or decrease the cost per patient encounter.
2. **Increase Total Premiums**: To do this, organizations must capture all appropriate conditions. The capture of these conditions will impact risk scores and therefore increase risk adjusted premiums.

So, What Drives Total Premiums Received?

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In its simplest form, annual premiums received are calculated monthly and then aggregated across the 12-month period. The calculation uses the number of member months, the per member per month (PMPM) payment, and the risk adjustment factor (RAF) score. It is important to note that this is calculated at the patient level and added up but for illustrative purposes this is done in aggregate for the entire year below.

Eligible Population Member Months ✖ Per Member Per Month Payment ✖ Total RAF Score for all Patients = Total Premiums

	Member Months	PMPM	RAF Score	Premiums
Baseline	125,000	$800.00	1.00	$100,000,000
Scenario #2	125,000	$800.00	1.10	$110,000,000
Difference	0	0	0.10	$10,000,000

Breaking down how risk scores are calculated

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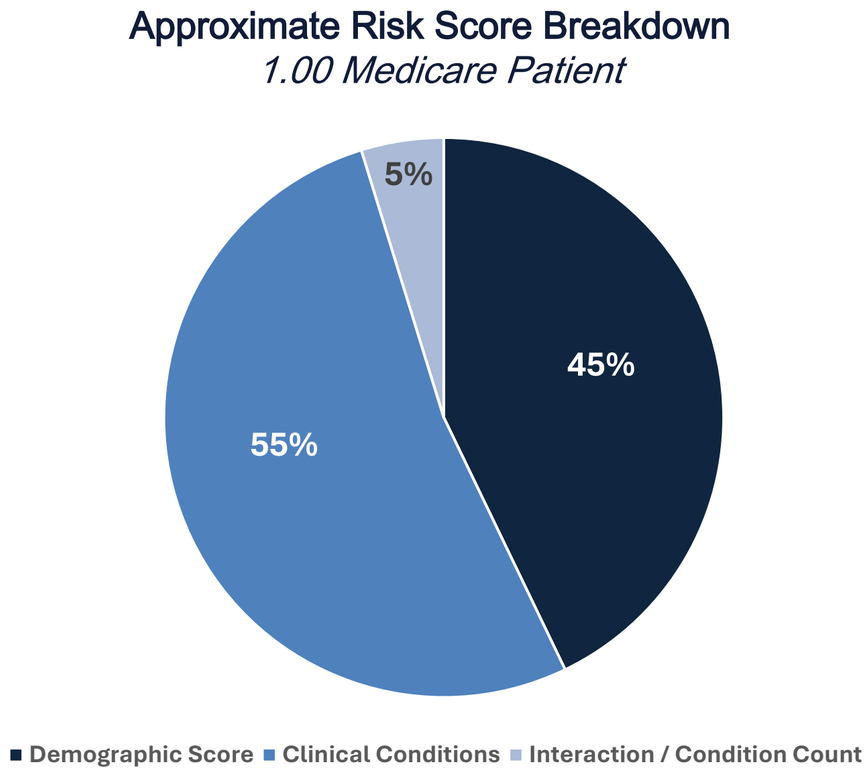
The CMS-HCC model is calibrated so that the average Medicare patient has a 1.00 risk score. The risk score has multiple components to it including the patient's demographics, the clinical conditions captured for the patient, and additional complexity drives such as the interaction factor and the count of HCCs.



Score Component	Comments on Component
Demographic RAF	A patient's age and sex is used to generate a score for their demographics. If no conditions are captured the entire year, this will represent the patient's entire RAF score.
Clinical RAF	This is driven by the HCCs captured for the patient. Many organizations focus on the chronic conditions, those that are long-term and often not subject to resolution. These conditions often are the subject of recapture and outpatient CDI programs. Approximately 80% of clinical RAF is associated with chronic conditions.
Interaction Factor	The simultaneous presence of some conditions adds extra complexity to patient care and the expected resource consumption. When the conditions appear, an interaction bonus is calculated and increased the patient's score.
Condition Count	Patients with 5 or more conditions will receive an additional increase in RAF given the expected increase in resource consumption for these more highly complex patients.

A Patient Example of How Condition Capture Matters

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A patient schedules an office visit for a prescription refill. Her care has been inconsistent as it is November, and this is the patient's first trip to her provider all year. Below are conditions that are noted on the problem list.

Condition	HCC Category (v28)	HCC Weight (v28)[1]	Estimated Care Funding[2]
E11620- Type 2 diabetes mellitus with diabetic dermatitis	37- Diabetes with Chronic Complications	0.166	$1,594
J449- Chronic obstructive pulmonary disease, unspecified	111- COPD, Interstitial Lung Disorders, and Other Chronic Lung Disorders	0.319	$3,062
I270- Primary pulmonary hypertension	226- Heart Failure, Except End-Stage and Acute	0.360	$3,456
N1831- Chronic kidney disease, stage 3a	329- Chronic Kidney Disease, Moderate (Stage 3, Except 3B)	0.127	$1,219
Interaction Factors Based on Conditions Above	• Diabetes + Heart Failure • Heart Failure + Chronic Lung Disorder • Heart Failure + Kidney	• 0.112 • 0.078 • 0.176	• $1,075 • $749 • $1,690
	Total- Assuming All Conditions Captured	**1.338**	**$12,845**

Sources: 1) https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf 2) Care Funding: Assumes $9,600 per point of RAF

A Look at the Medicare Advantage Landscape

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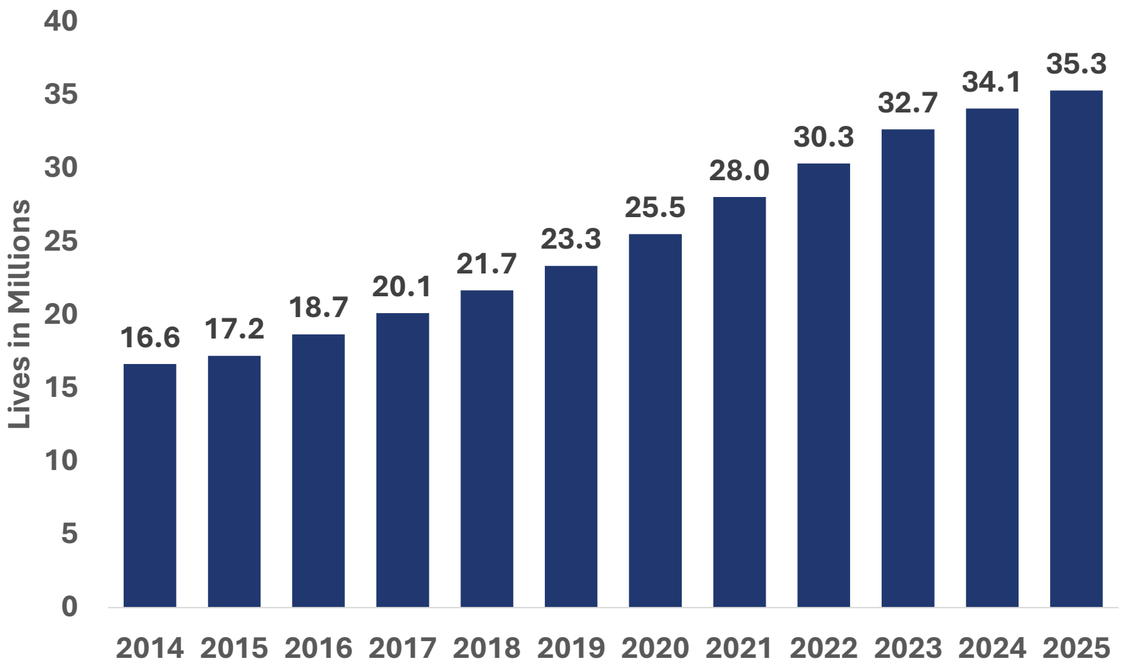
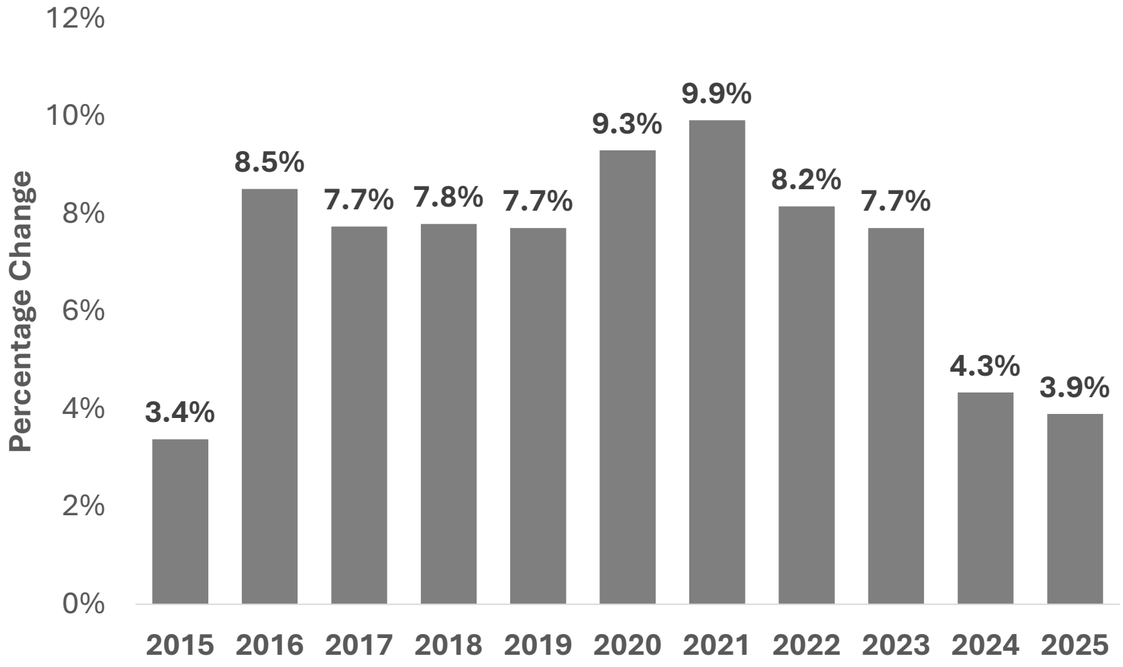
Total Medicare Advantage Lives

Annually – With 2025 Projections



Annual MA Enrollment Growth Rate

Annually – With 2025 Projections



35.2 Million

As of September 2025, there are over 35 million Medicare Advantage beneficiaries. While risk scores are normalized each year, if left unchecked a 0.01 increase in risk score would equate to over $3.5 billion in extra revenue.

Source- https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data

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BREAKING DOWN THE CMS MANDATE

Why Are MA Plans Coming Under Scrutiny?

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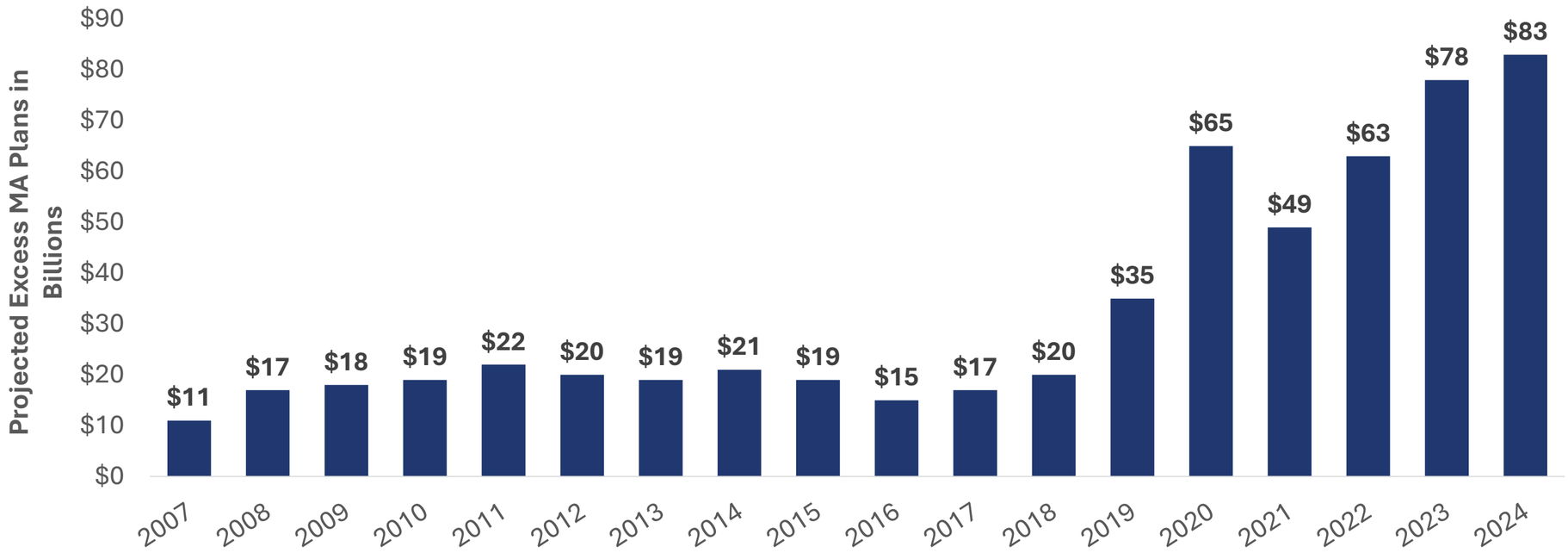
The Medicare Payment Advisory Committee (MedPAC) annually reports to congress a state of the union on Medicare payments. The 2024 report shows that there has been a significant increase in perceived overpayment to MA plans relative to spending on Medicare fee for service patients.

Perceived Excess Payments to MA Plans

Calendar Year Excess Payments in Billions



Since 2020 MedPAC estimates that costs for MA payments relative to Medicare fee for service has been $338B.

By comparison from 2007 to 2019 it was $253B.

https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-3.pdf

Additional Scrutiny Beyond MedPac

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The Office of the Inspector General (OIG) also has found that upon review of medical records there is a perception that MA plans have submitted unsubstantiated diagnoses leading to billions in excess reimbursement.

"Payments to Medicare Advantage (MA) organizations are risk-adjusted on the basis of the health status of each beneficiary. MA organizations are required to submit risk-adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts (SSA §§ 1853(a)(1)(C) and (a)(3)). In general, MA organizations receive higher payments for sicker patients. ***CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations.*** Prior OIG reviews have shown that some diagnoses are more at risk than others to be unsupported by medical record documentation. We will perform a targeted review of these diagnoses and will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS's risk score calculations and determine whether the diagnoses submitted complied with Federal requirements."[1]

$462 Billion

Total Estimated 2024 Medicare Advantage Payments[2]

$44 Billion

Estimated Overpayment to MA Plans for Unsupported Billed Conditions

1.https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000422.asp
2.https://www.cbo.gov/system/files/2024-06/51302-2024-06-medicare.pdf

The New, or Expanded, CMS Audit Mandate

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On May 21st CMS announced that it would drastically expand retrospective audits to ensure accurate risk adjustment. Effective with 2018 reviews, CMS will now evaluate risk score accuracy for all eligible MA plans.

Leveraging Technology

- "CMS will deploy advanced systems to efficiently review medical records and flag unsupported diagnoses."
- It is unclear what technology will be deployed but statistical anomalies are included in how prior contracts were selected for RADV audits

Expanding Resources

- CMS currently employs 40 total auditors
- CMS will expand from 40 to 2,000 FTEs by September 1, 2025.
- Represents a 50X increase in overall resources

Increasing Audits and Records

- Increase contracts reviewed from approximately 60 to 550
- Current RADV reviews audit 35 records per contract per year to 35-200 records reviewed
- Increasing sample size to increase the reliability of extrapolating impact to MA plans

https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits

What Are RADV Audits?

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Risk adjustment data validation (RADV) audits are intended to review and examine documentation supporting the risk eligible diagnoses submitted by Medicare Advantage plans to CMS for payment. Providers and MA plans are ultimately responsible for the accuracy of submissions and CMS reviews submitted medical records for the sample for validation.

Sample Selection
CMS selects a sample of enrollees from a specific MA contract for a given calendar year.
Often includes a national sample and/or targeted audits (e.g., of high-risk or high-outlier plans).

Medical Record Request
MA plans must obtain the necessary medical records to support the coded condition from individual providers.
Plans can submit 5X as many encounters as HCCs under review for the patient.

Record Submission / Validation
MAOs are required to submit medical records that support the diagnosis codes used in the CMS risk score calculations for the sampled beneficiaries.

Medical Record Review
Independent coders review the submitted documentation to determine whether the diagnoses are clinically supported, documented according to CMS guidelines, and coded correctly using ICD codes.

Error Rate Calculation
CMS compares the original risk-adjusted score to the validated one. An error rate is calculated, and this can be extrapolated across the entire contract population to estimate total overpayments.

Appeals and Dispute Resolution
MAOs have the right to appeal findings if they believe CMS made an error in its conclusions. This involves a structured administrative process.

https://www.cms.gov/files/document/payment-year-2018-ma-radv-audit-methods-instructions.pdf

Leveraging Technology to Maximize Impact

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In its notice on May 21st, CMS shared that it will be leveraging technology to enhance its audit reach. What specific technology will be used remains unclear; however, it stands to reason that CMS will use this to identify patients as well as possibly reviewing records.

Identifying Risk or Anomalies

- Prevalence rate variation
- Frequency and location of conditions captured
- Diagnoses anomalies compared to treatment received

Examining Records Quickly

- Chart retrieval or acquisition
- Natural language processing
- Automating second and third level reviews

https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits

The Impact of Expanded Audits and Sample Sizes

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Before the announcement, each year approximately 2,100 patients were reviewed across 60 plans to assess risk accuracy. With 550 plans and up to 200 patients per plan, this number jumps significantly to 110,000 possible patients being reviewed.

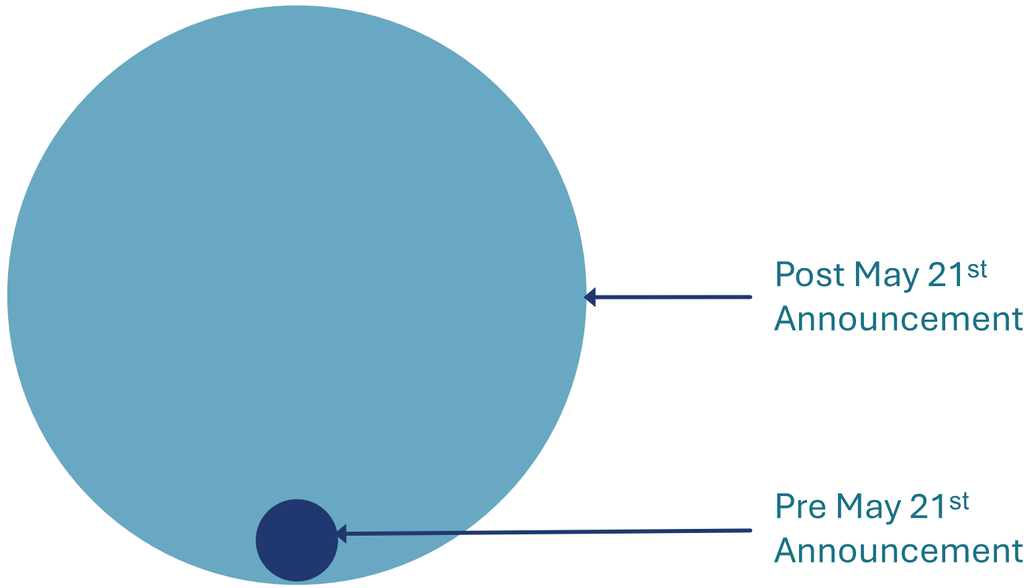
2,100 or 1 in every 16,190 MA enrollees

Estimated Pre Announcement Review Volume

110,000 or 1 in every 309 MA enrollees

Estimated Post Announcement Review Volume

Graphical Representation of Expansion



Exponential Growth in CMS Risk Adjustment Coders

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The RADV expansion transforms the risk adjustment coding industry from a RAF maximization engine to a compliance-first discipline. Coders will become even more central players in protecting revenue. This move also reinforces the need to have processes and technology to set providers up for success at every step of the documentation and coding process.

Increased Need for Coders

- CMS is adding 50X the number of coders/auditors that they have
- MA plans will likely add even more coders and auditors given the additional scrutiny
- Provider groups will also have to follow suit here as diagnosis accuracy will be a core piece of their contracts

Critical Need for Ongoing Education and Training

- Risk adjustment coding is very different from CPT coding. The continued shift from a pure volume focus with an emphasis on CPT codes to a value based emphasis with diagnoses will require subject matter expertise and training.
- Clinical validation and aligning coding with RADV audit standards, not just payer requirements will be imperative.

Identifying Risk or Anomalies

- Coders' work is now directly tied to millions of dollars in audit exposure.
- Internal and external auditors will scrutinize coding output more rigorously.
- Organizations may tighten quality control, retrain or replace underperforming coders.

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RECENT REVIEW FINDINGS

RADV Published Results Lag Tremendously

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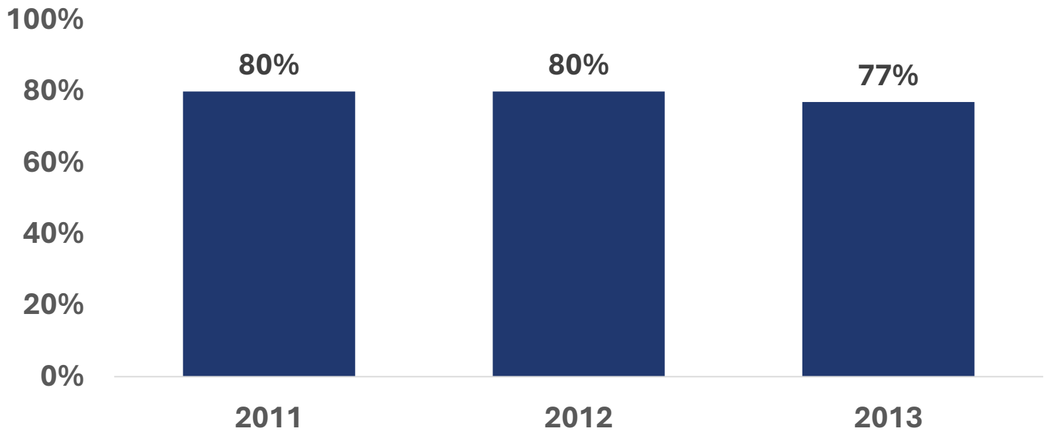
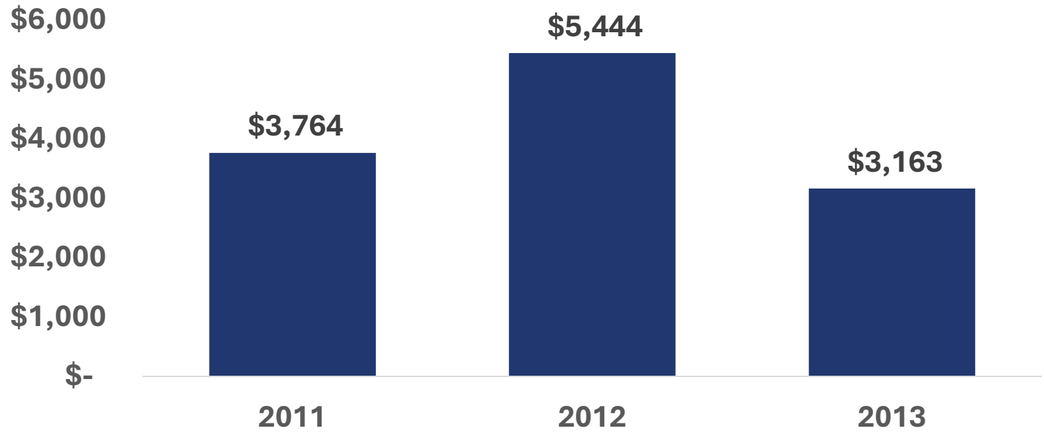
In May, CMS finally released some of the 2012 and 2013 reviews. These reviews serve limited purpose because of how dated they are. However, this shows a preliminary look at overall impact of these reviews.

Percent of Plans with a Penalty
2011-2013 RADV Audits



Average Penalty per Record Reviewed
2011-2013 RADV Audits



Across 2011-2013 the average penalty per record reviewed was $4,123. If hypothetically that penalty is reduced by 90% but extrapolated across the MA population, the potential penalties for organizations exceed $14B per year.

https://www.cms.gov/data-research/monitoring-programs/medicare-risk-adjustment-data-validation-program

Let's Review More Recent Findings - OIG Reviews

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The OIG's reports show two different types of reviews based on approach. Norwood has coined these as being random or targeted. Each serves a different purpose, selects patients differently, and has different review processes associated with them.

Random Reviews

- The OIG uses these audits to reviews to examine above average complexity patients
- Review 200 patients with at least 1 HCC, but prior reviews show they average 6+ HCCs
- Review billed codes to validate them plus they will include documented but not billed codes to give payers credit for conditions missed

Targeted Reviews

- The OIG uses these audits to pinpoint high risk diagnosis codes often inappropriately captured
- Generally review about 30 patients per condition looking for over capture
- Review between 6-10 high risk conditions per review
- Reviews do not look for documented but uncaptured conditions to give payers credit

Recent Random Reviews

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Since 2022, the OIG has finalized 7 random chart reviews on different payers. Each of these reviews focused on 200 high complexity patients to ensure their risk scores are accurate. Admittedly reviews are not done very timely and the reviews covered dates of service ranging from 2015 to 2017.

OIG Random Reviews: *Calendar Years 20222024*

Payer Reviewed	Date Published	Patients Reviewed	Conditions Reviewed	Average HCCs per Patient Reviewed
SCAN Health Plan	2/23/2022	200	1,577	7.9
Cigna HealthSpring of Florida	8/19/2022	200	1,417	7.1
Inter Valley Health Plan	9/26/2022	200	1,533	7.7
HealthNet of California	9/22/2023	200	1,325	6.6
CarePlusHealth Plans	10/26/2023	200	1,656	8.3
MMM Healthcare	8/14/2024	200	688	3.4
EmblemHealth	9/26/2024	200	1,222	6.1

Sample Random Review Findings – EmblemHealth

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EmblemHealth's review is the most recent review published by the OIG. The published document includes a deep dive into the review, findings, and Emblem's response to the OIG. Different scenarios exist in each review but the sample patients below represent consistent themes from random reviews.

Enrollee A

- Submitted HCCs: 3
- Validated HCCs: 2
- Review Findings: The submitted HCC for Polyneuropathy was not supported by documentation in the medical record
- Impact: $1,992 overpayment to plan

Enrollee B

- Submitted HCCs: 2
- Validated HCCs: 2
- Review Findings: The submitted HCC for DM with Complications was not supported; however, DM without complications was supported by the medical record
- Impact: $2,328 overpayment to plan

Enrollee D

- Submitted HCCs: 2
- Validated HCCs: 4
- Review Findings: Reviewers validated submitted HCCs and identified two additional HCCs that were not reflected in the claims submitted
- Impact: $4,438 underpayment to plan

Overall OIG Findings – EmblemHealth

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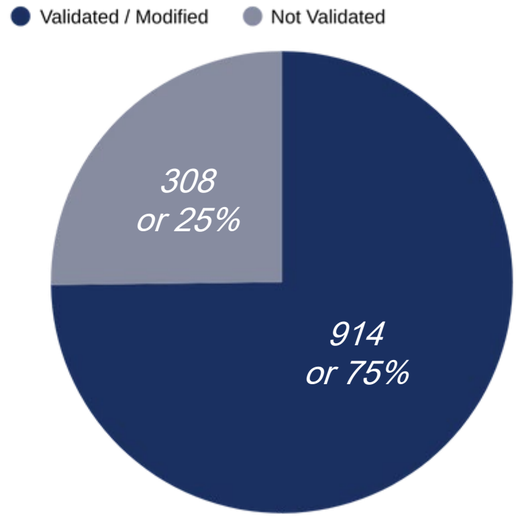
In a 43 page detailed report, the OIG shows how it came to its findings for Emblem. The report details the OIG's approach, what it found in chart reviews, the methodology used to calculate payment impact, and includes Emblem's responses to the OIG.

Breakdown of HCCs Reviewed by the OIG | *EmblemHealth Random Review Posted 2024*

1,222
Total Initially Submitted HCCs



65
OIG Identified HCCs

979
HCCs Used for Payment

$552k

The OIG's review found that 25% of submitted conditions were not supported by the medical record. However, the OIG found 65 additional conditions that Emblem hadn't submitted. The result was a decrease of 243 HCCs for payment. These HCCs generated $552k of perceived overpayment that the OIG is recommending Emblem pay back.

Accuracy Rates From Recent OIG Random Reviews

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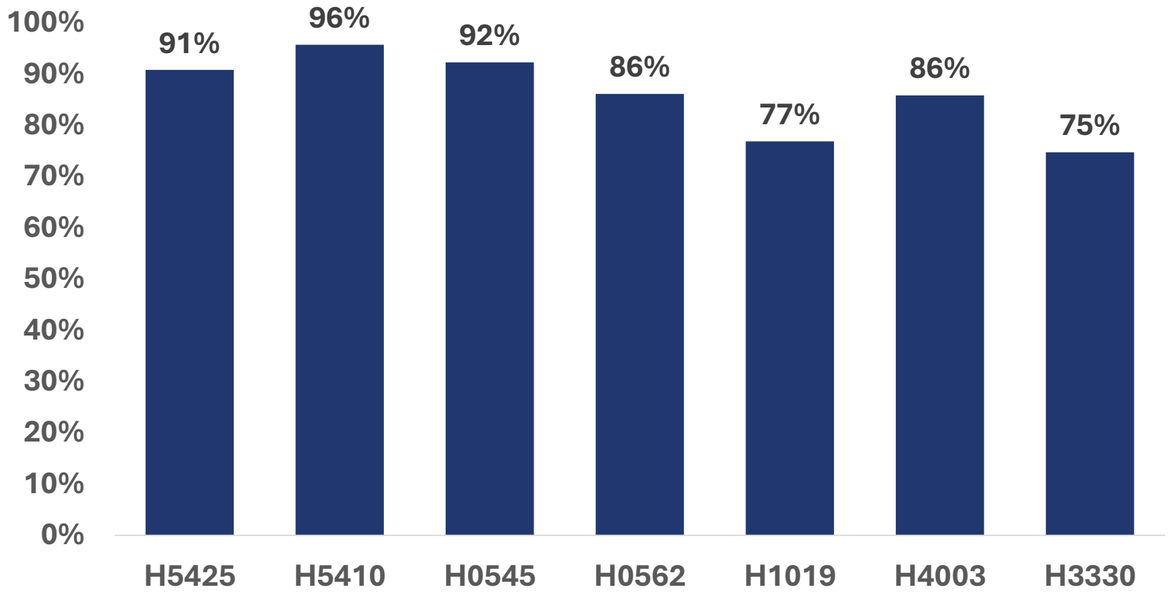
The OIG publishes details from every report including the count of HCCs reviewed, validated, changed, or added. Performance will vary by review but overall findings show low validation rates and instances of high unsubmitted HCC counts by payers.

HCC Validation Rates

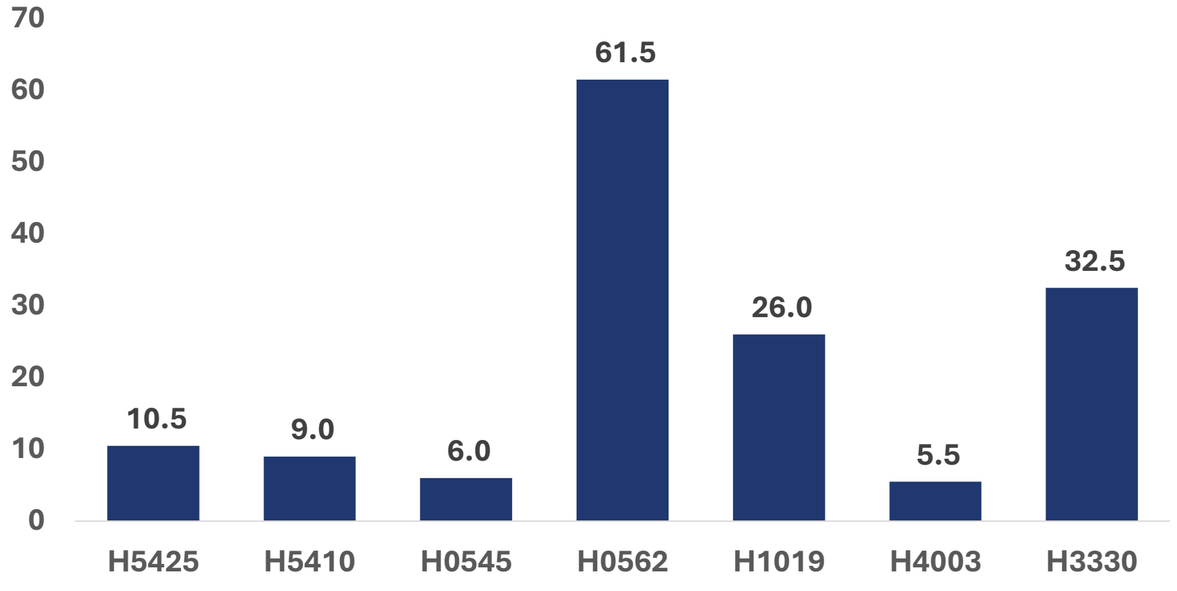
OIG Random Reviews 2022-2024



13.6%
Percent of HCCs reviewed that were not validated by the OIG

OIG Added HCCs per 100 Patients Reviewed

OIG Random Reviews 2022-2024



21.6
Number of HCCs per 100 patients reviewed that were found as documented but not submitted.

Targeted Reviews on High-Risk Diagnoses

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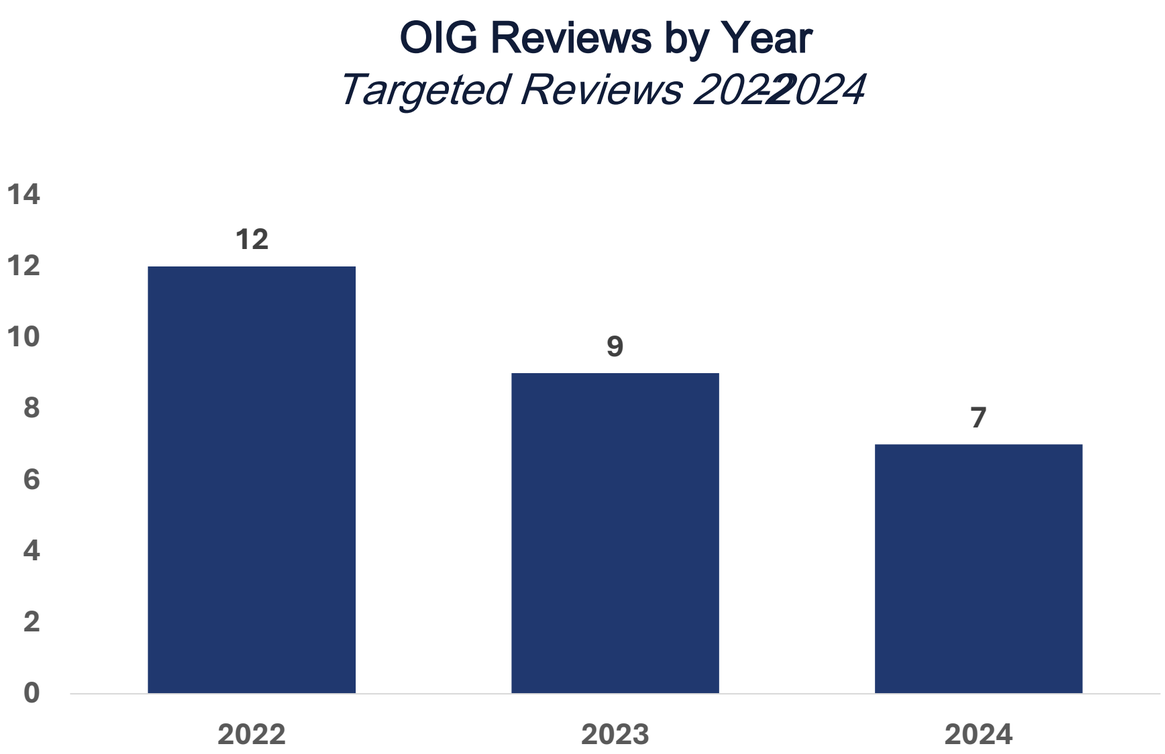
Targeted audits have zeroed in on areas with very low validation rates. The OIG reviews conditions and findings to adapt its review strategy, something organizations should also do. This helps stay current with risks and drives submission accuracy.



Condition	% of Reviews	Most Recent Year
Acute Heart Attack	100%	2024
Acute Stroke	100%	2024
Embolism	100%	2024
Major Depressive Disorder	71%	2024 (1)
Vascular Claudication	71%	2024 (1)
Breast Cancer	68%	2024
Prostate Cancer	68%	2024
Colon Cancer	68%	2024
Lung Cancer	68%	2024
Miskeyed Diagnoses	39%	2023
Acute Stroke and Heart Attack	32%	2023
Sepsis	11%	2024
Pressure Ulcer	7%	2024
Ovarian Cancer	4%	2024

The OIG's Approach to Targeted Reviews

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Per the OIG, the audit is done "using data mining techniques and considering discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups."[1]

Sample Criteria for High -Risk Diagnosis Reviews

Condition	Criteria
Stroke	An acute stroke diagnosis on only one physician claim during the service year but did not have an acute stroke diagnosis on a corresponding inpatient or outpatient hospital claim
Heart Attack	A diagnosis that mapped to the HCC for Acute Myocardial Infarction on only one physician or outpatient claim during the service year but did not have an acute myocardial infarction diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician or outpatient claim
Embolism	A diagnosis that mapped to an Embolism HCC on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf

Additional High Risk Diagnosis Code Criteria

In addition to strokes and heart attacks, every report released in 2024 highlighted cancers. New to the most recent reports are sepsis and pressure ulcers. Below you can see the criteria used for each high-risk diagnosis codes.

Additional Criteria for High -Risk Diagnosis Reviews

Condition	Criteria
Sepsis	A sepsis diagnosis on one physician or outpatient claim during the service year but did not have a sepsis diagnosis on a corresponding inpatient hospital claim.
Lung Cancer	A cancer diagnosis on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period either before or after the diagnosis.
Breast Cancer	
Colon Cancer	
Prostate Cancer	
Ovarian Cancer	
Pressure Ulcers	A stage 3 or 4 pressure ulcer diagnosis on only one claim during the service year but did not have a pressure ulcer diagnosis on another inpatient, outpatient, or physician claim for either the calendar year before or the calendar year after the service year.

1) https://oig.hhs.gov/documents/audit/10008/A-02-22-01001.pdf

Sample Targeted Review Findings- Humana

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Humana's review is the most recent targeted review published by the OIG[1]. The published document includes a deep dive into the review, findings, and Humana's response to the OIG. The examples below are fairly consistent across most targeted reviews.

Heart Attack

- Total HCCs Reviewed: 30
- Validated HCCs: 0
- Review Findings:
  - 15 patients had prior AMIs
  - 6 patients had support for other and unspecified angina
  - 5 patients records provided did not meet Medicare requirements regarding credentials

Stroke

- Total HCCs Reviewed: 30
- Validated HCCs: 0
- Review Findings:
  - 19 patients had prior strokes
  - 9 patient records did not support acute stroke criteria

Embolism

- Total HCCs Reviewed: 30
- Validated HCCs: 5
- Review Findings:
  - 13 patients had prior embolisms
  - 9 patient records did not support embolisms
  - 3 medical records provided were radiology reports signed and credentialed by radiologists

1) https://oig.hhs.gov/documents/audit/10008/A-02-22-01001.pdf

High Risk HCCs Validation Rates Reviewed by the OIG

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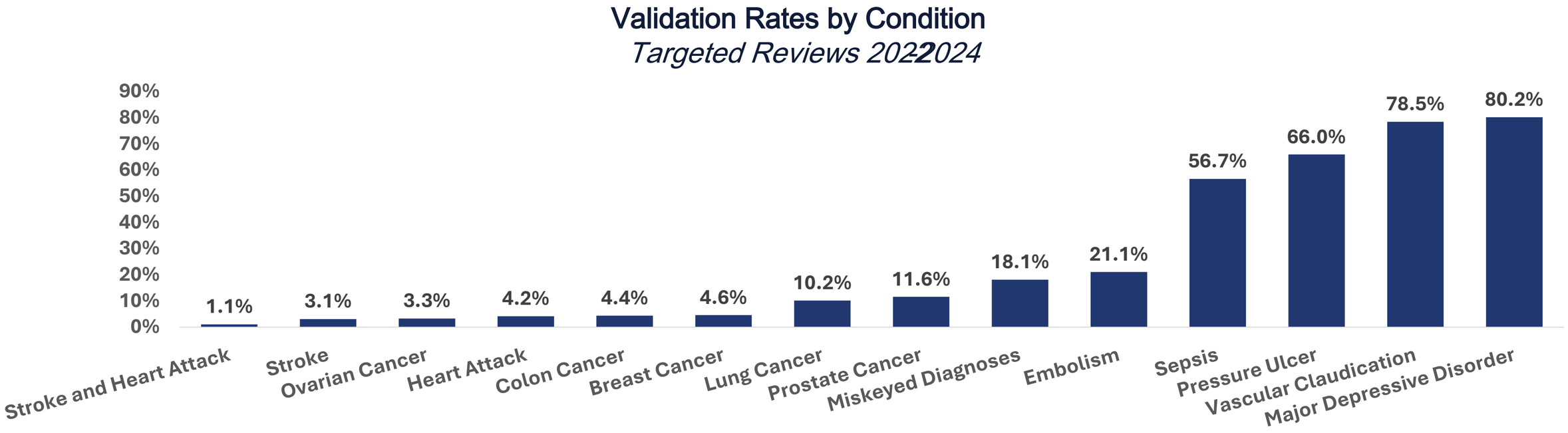
The OIG leverages data submitted by payers to look for risks of unsupported conditions. Their validation rates show how they use the data to identify a larger percentage of conditions without support.



23.9%

Percent of HCCs reviewed that were supported by the medical record

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HEALTHCARE IMPACTS AND BEST PRACTICES TO IMPLEMENT

Financial Implications From Reviews

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Each report from the OIG identifies the overpayment for the sample reviewed. Given the small sample size, impacts are small. However, with the 2023 MA final rule penalties will drastically increase.

Payment Extrapolations

The 2024 payment rule for Medicare Advantage payments created a process by which the payment impacts from the OIG and RADV can be extrapolated from the sample size to gauge overall impact. The implications of this may cause historically small impacts to skyrocket.

100%
The percent of plans with an OIG targeted review released in 2022-2024 that had a repayment

$441K
Average plan repayment after an OIG targeted audit

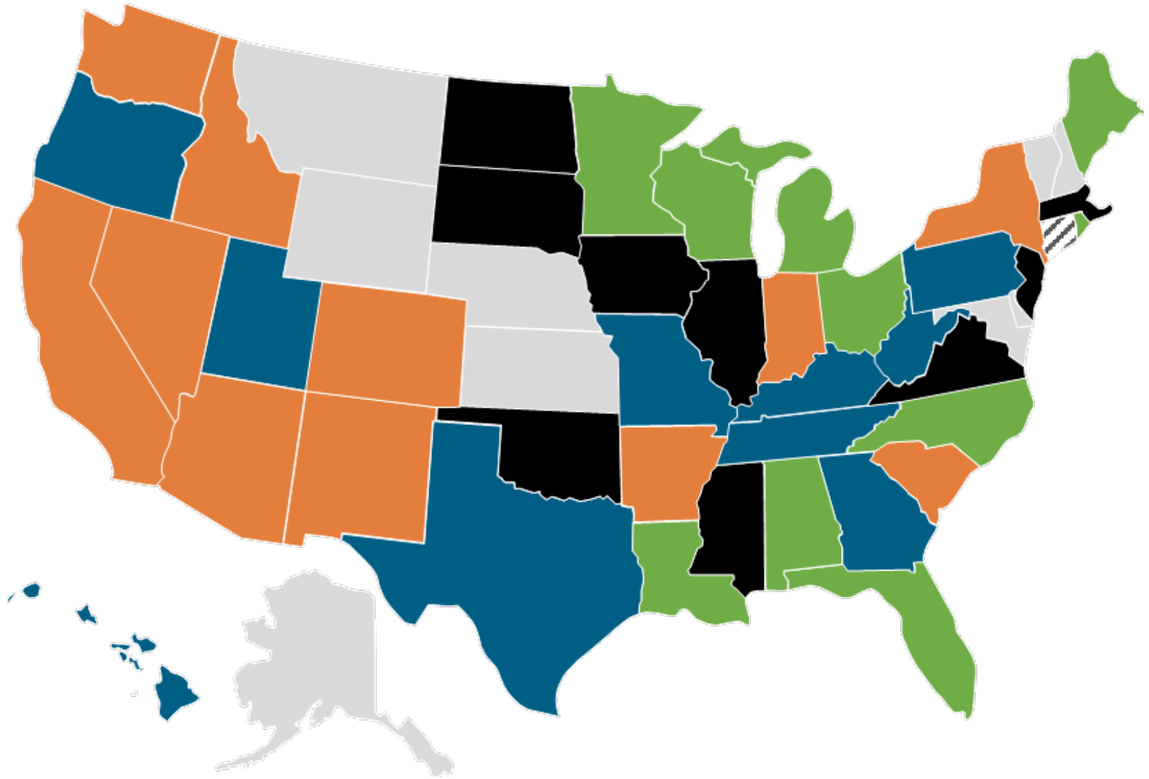
19M per Audit
The amount that would have been requested in overpayments had extrapolation been allowed

1.09%
The amount of total revenue that would have been lost had extrapolation been allowed

Geographical Exposure to MA Will Influence Impacts

One way to examine where impacts will be the largest are the states with the largest percentage of patients enrolled in MA plans. The map shows which states have the highest MA penetration rate. This naturally means that plans and providers in these states may have outsized initial impacts.

MA Penetration Rate by State
October 2025



MA Penetration Rate Map Legend

Impact Level	Map Colors	MA Penetration Rate
Highest Impact		57%-63%
Medium – High		53%-56%
Medium Impact		47%-53%
Medium – Low		36%-44%
Lowest Impact		2%-36%

https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data

Implications for Health Plans

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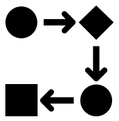
The mandate will have ripple effects across the industry. The primary focal point is on Medicare Advantage revenue. Reducing premiums by 4-8% could have a crushing blow on the underlying economics for MA plans. In addition, expenses tied to administrative burden are likely to increase as well.



Operational and Documentation Burden

- **Stricter Coding Validation**: MA plans will need to enhance documentation and coding accuracy to avoid unsupported diagnoses.
- **Audit Preparation**: More extensive audits mean more resources must be allocated to medical record retrieval, internal reviews, and external audit defense.

Expanded Financial Liability

- **Retrospective Recoveries:** CMS now intends to extrapolate audit findings beginning with the 2018 payment year, which could result in hundreds of millions in recoupments for some plans.
- **No Fee-for-Service Adjuster:** CMS decided not to apply a FFS Adjuster, which MA plans had hoped would reduce extrapolated error rates. This increases potential clawbacks.

Legal or Compliance Exposure

- **Increased Scrutiny**: Broader audits could bring more enforcement actions, whistleblower suits, or Department of Justice investigations if systemic overpayments are found.
- **Heightened Compliance Monitoring**: MA plans may need to invest more in internal compliance infrastructure to proactively identify and correct risk adjustment issues.

Shifting Market / Partnership Strategies

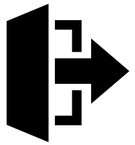
- **Network and Provider Engagement**: Plans may shift strategy to focus on provider education and improve documentation practices to ensure compliant coding.
- **Risk Score Management**: Some plans may adjust risk adjustment strategy to limit exposure in high-risk coding areas.
- **Market Selection-** Plans may accelerate leaving unprofitable markets

Implications for Providers

The RADV audit expansion forces a paradigm shift in how providers document care for MA patients—from focusing on accurate care delivery to ensuring that each diagnosis is audit-defensible. Those who don't adapt risk financial loss, increased plan oversight, and reputational risk.

Pressure to Document with Audit Grade Precision

- **Providers must treat every progress note as a potential audit artifact**. If documentation is vague or insufficient, MA plans lose payment—and may push back on providers.
- **Documentation Scrutiny-** There will now be more scrutiny from plans to ensure all diagnoses are documented clearly and compliantly, linking diagnoses to assessment, treatment, or monitoring, and avoiding ambiguous or unsupported coding



Increased Demand for the Release of Information

- **Release Requests:** Sampling is done at the plan level and plans may accelerate record requests. For smaller providers this could create significant administrative burden.
- **Payer-Provider EHR Integration:** Will this accelerate the demand for payer platforms on EHRs to increase efficiency and reduce administrative burden.

Increased Emphasis for Ambulatory CDI

- **CDI Teams:** Organizations will need to invest in:
  - CDI specialists
  - Coder-provider collaboration
  - Point-of-care documentation support
- **Technology Expansion**: Expect to see more use of AI-driven documentation prompts or EHR tools nudging providers toward audit-compliant phrasing and specificity.

Revenue and Financial Impacts

- **Shared Savings Clawbacks**: Should an organization's documentation be a driver for a MA plan payment takeback, it could create a ripple effect for shared savings payments back to plans.
- **Evolving MA Landscape**: Does this increased scrutiny lead to a change in MA-provider relations? What does this do for the shared savings model if care funding from risk capture is reduced?

Questions That CMS Must Answer

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CMS has set a bold direction with RADV reform—but the details, fairness mechanisms, and operational implications remain incomplete. Until CMS provides more clarity, MA plans, providers, and coders will be forced to operate under elevated compliance risk with limited foresight.

1	**Audit Criteria -** Will CMS revisit or update the audit criteria (e.g., MEAT, Clinical Validation)? Will CMS provide updated guidance on clinical validation standards, especially for borderline or ambiguous conditions? Coders and providers are working in a gray zone. Without consistent criteria, audit outcomes will vary—and may not hold up under legal scrutiny.
2	**Performance Transparency-** Will CMS provide aggregate industry insights or error trends ins a manner like the OIG? Transparency could raise industry standards and promote self-correction—reducing overpayments proactively.
3	**Timing and Visibility -** With CMS just releasing 2012 and 2013 results, what is a practical timeline for the expanded RADV audits? CMS released that beginning with 2018 dates of service (underway now) that all plans will have reviews. Plans need to forecast risk and build audit readiness operations. Without clarity, budgeting and resource planning become guesswork.
4	**ACOs / MSSP** Historically, these entities have come under less scrutiny than MA plans. Given there are more than 10 million Medicare beneficiaries in MSSP programs alone, will CMS expand audits to these reimbursement structures in the coming years?
5	**Appeals Process-** Given the tremendous financial risk at stake, will there be a formal appeals process for extrapolated recoveries? Without a structured appeals mechanism, MA plans are exposed to one-sided judgments with potentially massive financial consequences.

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BEST PRACTICES TO POSITIVELY POSITION YOUR ORGANIZATION

Four Best Practices to Mitigate Your Risk

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There are countless recommendations for providers and payers to enact to help minimize exposure to regulatory risk. Organizations should have a strategy to ensure HCC accuracy and regularly review it for opportunities to improve and evolve their approach.

Support Providers Through Education

Review All High-Risk Diagnoses Before Billing

Review HCCs Captured Only One Time Per Calendar Year

Perform Annual Retrospective Reviews

Best Practice #1: Support Providers Through Education

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The core of every risk adjustment program is education. Organizations should have processes in place during onboarding and throughout a provider's tenure to drive continuous education. Where possible, bringing examples of the provider's specific documentation enhances value and impact.

General Documentation Education

- Teach basic documentation principles and guidelines
- Share how to leverage technology available to providers
- Ensure clinicians understand human and technological prompts

Acute versus Historical Conditions

- Reinforce the differences of acute vs. historical diagnosis codes for:
  - Strokes
  - Heart attacks
  - Embolisms
  - Neoplasms

Leveraging Case Reviews for Education Impact

- Complete chart reviews at least annually for all clinicians
- Bring examples of good and opportunistic documentation to clinicians
- Use chart reviews to help identify/prioritize future reviews for continuous learning

Best Practice #2:
Review All High Risk Dx Before Billed

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The OIG has shared not only what conditions it reviews but how it selects them. Organizations must replicate the methodology to understand what risks are being created and how to mitigate them. It is critical to also recognize that the OIGs list is always evolving so the organization must stay up to date on reports to adapt to changing scenarios.

Determine the High -Risk Diagnoses for Review

- Leverage the OIG toolkit to determine high risk diagnosis codes
- Examine other areas where prevalence rates are higher than state/national norms
- Use prior chart reviews to assess organizational risk areas

Implement Coding Edits to Ensure Claims are Held

- Collaborate with professional coding to determine workflows needed to pend claims until a review is completed
- Stop all claims for target diagnoses as long as a condition hasn't been billed with supporting documentation previously in the year

Modify the Claim and/or Seek Clarification

- Query clinicians as appropriate to seek clarity for conditions in question
- Remove unsupported codes from the claim prior to claims submission
- Explore NLP as needed to achieve greater scale in reviews

Best Practice #3: Review HCCs Billed Only Once in a Year

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To be eligible for risk adjustment inclusion, a diagnosis mapping to a HCC must only be submitted one time per year. While satisfactory for risk adjustment, capturing a condition once in a year means that a regulatory body must only refute one date of service to deem a condition ineligible for risk purposes.

Run a Report of Conditions Captured Only Once in a Calendar Year

- Run an internal report of all submitted codes for eligible CPT codes
- Evaluate which conditions were captured only once
- Alternatively, ask payers for reports for attributed patients for conditions captured only once

Prioritize Conditions for Review and Assess Documentation Sufficiency

- Top priority- any OIG high risk conditions
- Second priority- any net new conditions not previously captured
- Third priority- conditions historically acute in nature only captured in the medical office setting

Submit List of Unsupported Codes from Encounters to Payer

- If reviewing only internally captured codes, collaborate with payer to see if the condition was captured by other providers
- Submit a supplemental file to your payer to remove the condition from risk inclusion
- NOTE- you can also submit codes for conditions documented but not billed

Best Practice #4: Perform Annual Retrospective Reviews

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Organizations often complete retrospective reviews to examine for opportunities to submit additional risk eligible codes. While an absolute best practice, only looking to add codes isn't appropriate. Organizations should evaluate when conditions lack sufficient documentation and remove them when necessary.

Confirm Eligible Patient Populations

- Collaborate with payer partners to determine in-scope patient populations
- Determine which patients had visits during the calendar year
- If concurrent coding is not done for every account, determine a retrospective review strategy that is complimentary to the resources available

Ensure Coding and Documentation Alignment

- Assess if conditions were coded but not documented. If so, evaluate removing them from risk eligibility.
  - Note- it is imperative to collaborate with payers to ensure episodic removals don't jeopardize risk score accuracy
- Review for the opportunity to add conditions if warranted

Submit Supplemental Files as Appropriate

- Work with payers to determine the file structure needed to submit supplemental claims
  - Note- this is only applicable with MA payers and for ACA lives. Traditional Medicare beneficiaries would require a re-bill of the encounter
- Submit code additions or removals prior to the designated sweep period

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WRAPPING UP

Recapping Today's Presentation

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Thank you for attending today's presentation.

CMS Mandate to Expand Reviews

- CMS will expand RADV audits significantly by now reviewing all plans
- CMS will hire nearly 2,000 new FTEs to bolster the review program
- CMS will leverage technology but it isn't clear yet how

Recent Results Show Direction

- Prior RADV and OIG reviews show that nearly all published audits have found deficiencies
- Organizations should examine OIG target areas as well as random reviews to glean insights on approaches
- Evaluate risks by also leveraging prevalence rates

Assess + Implement Best Practices

- Organizations should immediately assess their current performance.
- Organizations should look at best practices before visits, at the point of care, post visits but pre-bill, and retrospectively to mitigate risk
- Organizations should have a dual focus on maximizing appropriate revenue while protecting revenue from takebacks

Some Handy Resources

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Resource Type	Description	Link
RADV Homepage	The CMS website holding all of the RADV methodology, results, and Q&A	https://www.cms.gov/data-research/monitoring-programs/medicare-risk-adjustment-data-validation-program
OIG Toolkit	A toolkit published by the OIG to help payers and providers to replicate the OIG methodology to help identify and mitigate risks	https://oig.hhs.gov/reports/all/2023/toolkit-to-help-decrease-improper-payments-in-medicare-advantage-through-the-identification-of-high-risk-diagnosis-codes/
OIG Reports	List of all OIG Medicare Advantage reports for both random and targeted reviews	https://oig.hhs.gov/reports/all/
HCC Mapping	List of all ICD-10 codes and the models that they map to for risk adjustment purposes	https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment
Eligible CPT Codes for Risk Adjustment	For risk adjustment inclusion, ICD-10 codes must be submitted by eligible providers and in conjunction with a valid CPT code for submission	https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/risk-adjustors-items/cpt-hcpcs
Prevalence Rates	The file can be used to calculate what percentage of Medicare patients have conditions that map to a particular HCC.	https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf Focus on pages 100-109.

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THANK YOU!
QUESTIONS?

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