RADV

RISK ADJUSTMENT VALIDATION AUDIT

Florida Blue
Your local Blue Cross Blue Shield

Objectives

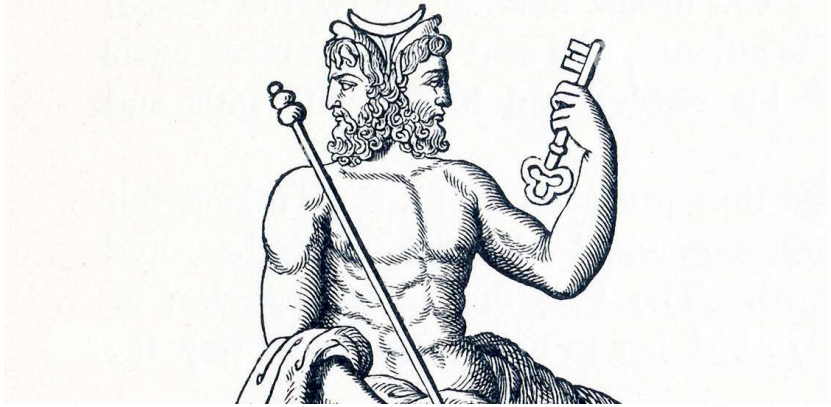
- Introduction and History
- Complications
- Future
- Options

Cheesy Opening

What your CFO thinks about RADV

What CMS thinks about RADV

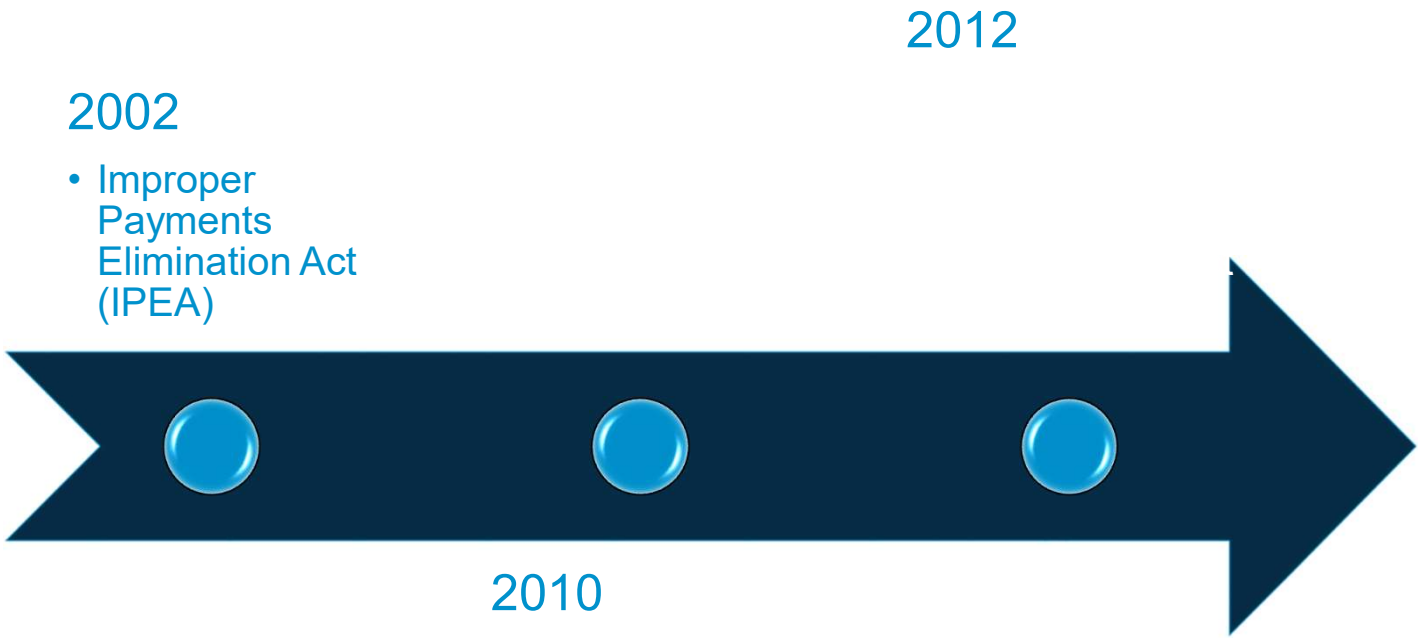
What the courts think about RADV



What you think about RADV

History

Regulations at 42 C.F.R. 422.2, 422.310 (e) and 422.311 govern the RADV process



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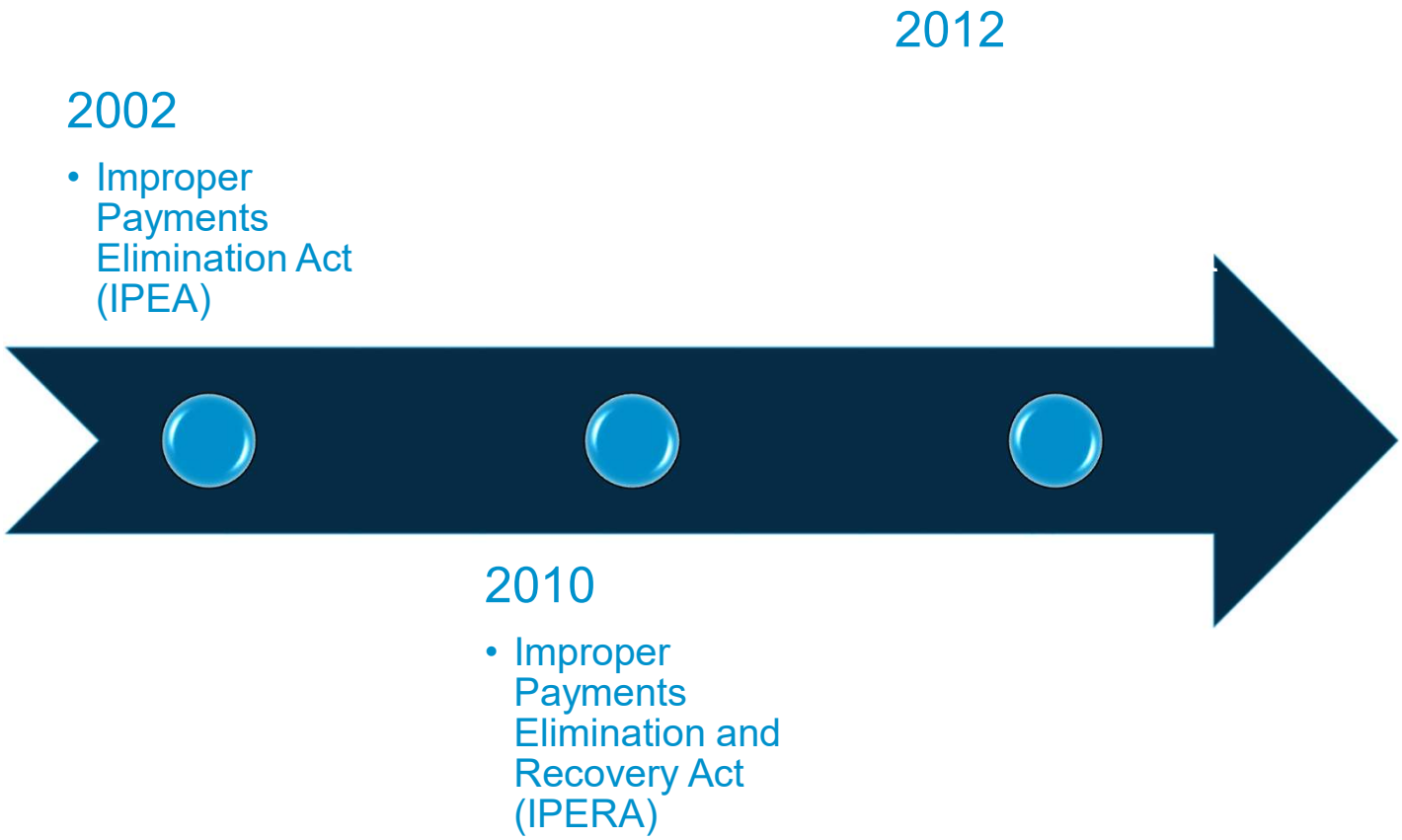

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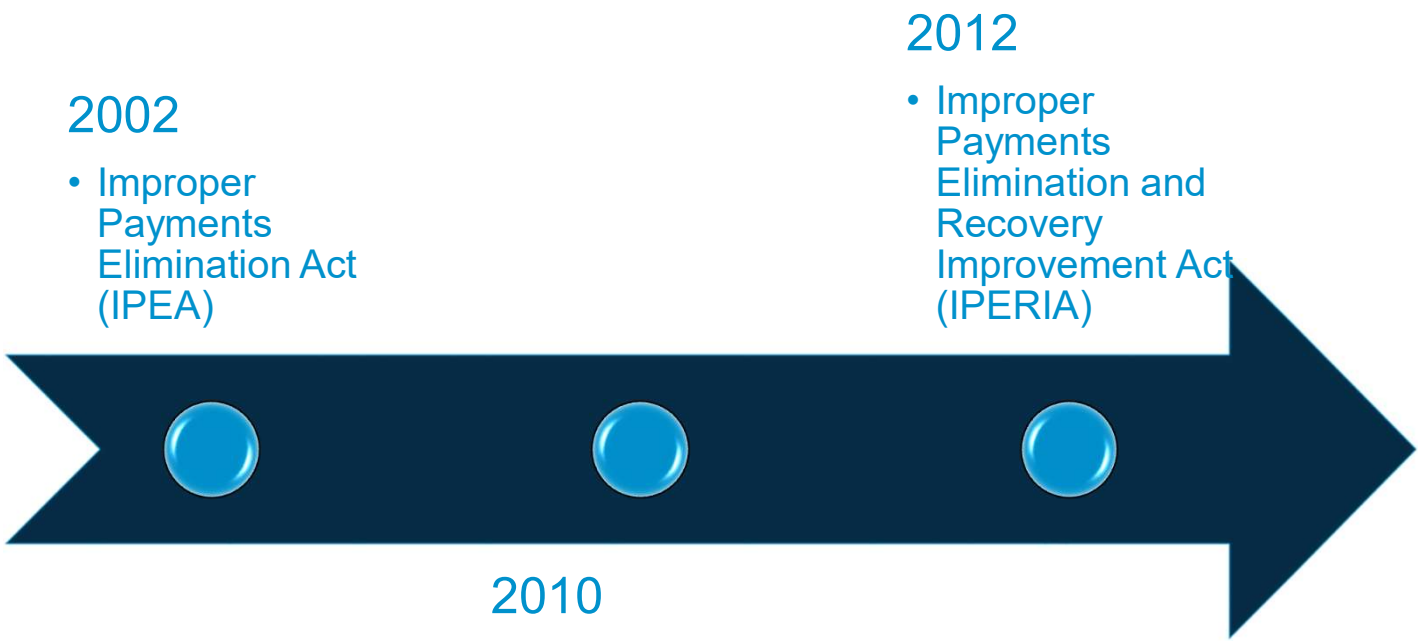
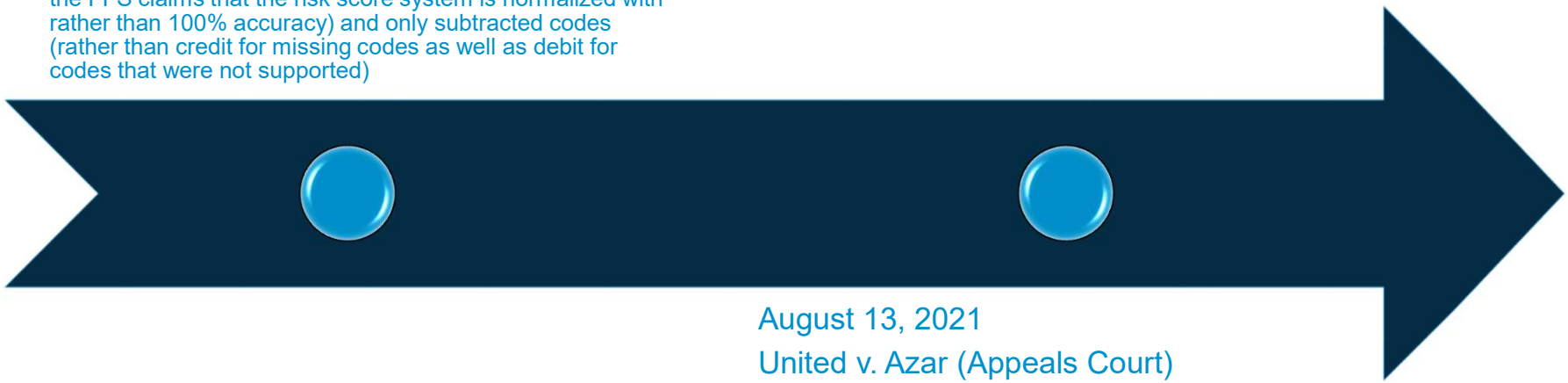

2002
• Improper Payments Elimination Act (IPEA)
2010
• Improper Payments Elimination and Recovery Act (IPERA)
2012
• Improper Payments Elimination and Recovery Improvement Act (IPERIA)

Court Cases

August 1, 2018

United v. Azar (Take 1)

- RADV process cited as “arbitrary, capricious” since it did not consider FFS normalization (the concept, originally included in RADV, that plans should be compared to the error rate of the FFS claims that the risk score system is normalized with rather than 100% accuracy) and only subtracted codes (rather than credit for missing codes as well as debit for codes that were not supported)



August 13, 2021

United v. Azar (Appeals Court)

- United’s claim has “no legal or factual basis”; actuarial equivalence applies to the risk model itself, not the RADV process.
- There is a lack of “parallelism between the context and effects of , on one hand, unsupported diagnoses in the traditional Medicare data CMS uses to model generally applicable risk factors and, on the other, the specific errors the Overpayment Rule targets

2018 Proposed Rule

From BCBSA

Oct 21. 2021: Postponed until Nov 1, 2022

Background:

- On Nov.1, 2018, CMS published a Proposed Rule announcing potential changes to the MA RADV audit program, including:

Extrapolation methodology: In the Proposed Rule, CMS announced that it intends to recover overpayments based on extrapolated findings from samples. CMS would use a small sample, up to 201 enrollees, and extrapolate those results to a contract-level recovery. BCBSA's position is that extrapolation of the findings from the sample to the contract level is inappropriate.

Retroactive application of new methodology to old audits: CMS proposed to apply the finalized methodologies to audits dating back to the 2011 payment year and all subsequent years. BCBSA's position is that these audits should be closed out without settlement due to the time that has elapsed and the unfairness of applying new rules retroactively.

Eliminating the FFS adjuster: CMS proposed eliminating the use of a previously proposed FFS adjuster. It is broadly agreed that the underlying FFS Medicare data (that MA payment relies on) contains errors because is not validated. CMS has previously taken the position that it must account for the flaws in the unaudited FFS data when it audits MA plans to ensure that, in accordance with statutory requirements, payment in MA is actuarially equivalent to payment in FFS. The FFS adjuster has been, and is still, the subject of litigation. BCBSA's position is that the agency must account for the flaws in the FFS data in some way; elimination of the FFS adjuster as proposed violates the statutory mandate of actuarial equivalence.

Extrapolation

From BCBSA

Extrapolation methodology: In the Proposed Rule, CMS announced that it intends to recover overpayments based on extrapolated findings from samples. CMS would use a small sample, up to 201 enrollees, and extrapolate those results to a contract-level recovery. BCBSA's position is that extrapolation of the findings from the sample to the contract level is inappropriate.

Typical situation is 33 member sample, extrapolated across all enrollment at the contract level.

Retroactive Application

From BCBSA

Retroactive application of new methodology to old audits: CMS proposed to apply the finalized methodologies to audits dating back to the 2011 payment year and all subsequent years. BCBSA's position is that these audits should be closed out without settlement due to the time that has elapsed and the unfairness of applying new rules retroactively.

The questions around error rates, whether codes could be deleted as well as added and comparisons with our without FFS normalization means this (most difficult) standard and method would be applied to audits for all years and dramatically increase retrospective plan liability.

FFS Adjuster

From BCBSA

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In a publicly available Milliman paper (from August 23, 2019), they comment that FFS error rates are estimated at 8% to 21%. Industry rates are generally comparable.

What's an Actuary to Accrue?

There is no absolute agreement on best practice. It is a plan by plan decision that should be made in coordination with the CFO and any reserving committees.

1. An annual accrual for all years should be considered
   - Most don't do this
   - Some consider it a risk due to admit liability
   - Alternative is to accrue only when selected for audit; similar issues in place for either
2. It is reasonable to consider accruing with our without a FFS adjusted in place
3. If you accrue, you should do separately for all contracts and consider a "likelihood of selection" factor
4. Assumed level of error could use prior results or results of a mock audit
5. It is reasonable to update once a year or adjust as new information comes in
6. Few are yet accruing OIG audits, but a plan could/should consider those in conjunction or separately from the RADV audit

Cheesy Ending

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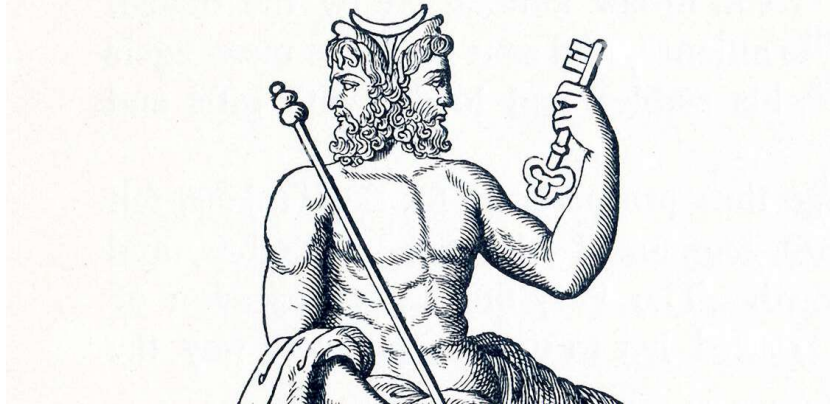
What the courts think about RADV



What CMS thinks about RADV

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