Session 48L, Understanding the ACA's RADV Audit Process

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SOA Antitrust Disclaimer
SOA Presentation Disclaimer
Understanding the ACA's RADV audit process

Maria Leth, ASA, MAAA
Director, Risk Adjustment and HEDIS Operations
Polling Question #1

What type of company do you work for?

- Insurance
- Consulting
- Regulator
- Other
Polling Question #2

How long have you supported ACA work (data submissions, risk adjustment analytics, audit support, etc)?

- Since inception
- Past 1-2 years
- Never
- Expect to in the future
AGENDA PART 1

- History 2014-2016
- Review of CMS Results
- RADV audit process
- Challenges
- Risks
History

2014 - 2016
**Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment Final Rule (45 C.F.R. Part 153) 3/23/2012:** Establishes the risk adjustment data validation standards.

**2014 Final NBPP 3/11/2013:** Provides additional standards for issuers, such as Issuers must conduct an initial validation audit (IVA) and that HHS must conduct a second validation audit (SVA) for benefit years 2014 and 2015, but HHS will not adjust payments and charges based on validation findings during the first two years of the program.

**RADV Whitepaper 6/22/2013:** This white paper focuses on the data validation process when the Department of Health and Human Services (HHS) is operating a risk adjustment program on behalf of a State.
Why such stringent audit requirements?

- CMS’ decision to leverage a distributed data model to administer the ACA programs.

- Issuers house their own Protected Health Information (PHI).

- Issuers submit data to their own EDGE Servers. An edge server is any server that resides on the “edge” between two networks. CMS runs programs and extracts summary level data necessary to administer the risk adjustment and reinsurance programs.
§ 153.630 Risk Adjustment Data Validation (RADV) standards

1. Sample selection
2. IVA: initial validation audit
3. SVA: second validation audit
4. Error estimation
5. Appeals
6. Payment
Program Area: HHS-Operated Risk Adjustment Data Validation (RADV)

Primary Category: General Audit Standards (IVA-SVA)

Secondary Category: Other

Question: When will the HHS-Operated Risk Adjustment Data Validation program (HHS-RADV) begin?

Answer: In the HHS Notice of Benefit and Payment Parameters for 2014 (78 FR 15410), CMS stated that in conducting the HHS-RADV program, it would adjust Risk Adjustment (RA) payments and charges based on the results of the HHS-RADV program in 2018 for 2016 benefit year data. CMS explained that issuers and auditors would have two (2) preliminary years in which to implement and test the HHS-RADV program, and adjust their audit procedures in response to that experience. RA payments and charges will continue to be adjusted in 2018 for 2016 benefit year data, in keeping with the original schedule.

However, CMS will not conduct HHS-RADV on 2014 data, originally one (1) of two (2) preliminary testing years. CMS will still conduct HHS-RADV in 2016 for 2015 benefit year data - thus, issuers and auditors will have one (1) preliminary testing year instead of two (2) in which to implement and test the HHS-RADV program, and adjust their audit procedures in response.
Inaugural Year of the Risk Adjustment Data Validation audit

- HHS-Operated Risk Adjustment Data Validation (HRADV) Webinar Training Series
  - Who should attend: Issuers of Marketplace and Non-Marketplace individual and small group plans, potential Initial Validation Audit (IVA) entities, Third Party Administrators (TPAs) and Support Vendors
  - Registration for all webinar series available at https://www.regtap.info/
  - Presentation Slides, Job Aids and Companion Guides are also available on the REGTAP website
  - HRADV Webinar Series I – weekly from 11/18/15 through 2/15/17
  - HRADV Webinar Series II – weekly from 3/1/17 through 5/31/17, then every two weeks until 1/10/18
  - HRADV Webinar Series III – every two weeks beginning 3/14/18

- HHS-RADV Audit Tool
  - Comprehensive User Guide
  - The audit tool is only available to the Issuer’s Senior Official (SO), Alternate SO and RADV Coordinators
  - Designate and attest to the IVA entity, manage RADV Coordinators, download Sampling Reports, submit IVA results, and access RADV Protocols, Guidance, Education materials, past Webinars and Announcements
Date: May 3, 2017

Subject: HHS-Operated Risk Adjustment Data Validation (HHS-RADV) – 2016 Benefit Year Implementation and Enforcement

CMS has assessed the results of the 2015 benefit year HHS-RADV pilot and received feedback from issuers and their initial validation audit (IVA) entities suggesting the need for an additional transition year to ensure the successful implementation of risk adjustment data validation. Therefore, CMS is converting 2016 benefit year HHS-RADV to a second pilot year, forgoing payment adjustments until 2017 benefit year HHS-RADV, and implementing process refinements that will reduce the burdens of HHS-RADV.
Review of CMS Results
For the 2015 benefit year, Medica had 7 Issuers, but one was below the threshold for the RADV audit; therefore, Medica had 6 Issuers as part of the 2015 RADV pilot audit.

CMS reviewed the IVA results submitted by Medica’s selected IVA entity and determined that there was sufficient agreement between the IVA and SVA results.

The 2015 benefit year pilot discovered a significant amount of medical record retrieval failures. As such, these results should not be interpreted to represent future error rates. To allow for more time for medical record retrieval and medical record review, CMS released the 2016 audit samples to Issuers approximately seven weeks earlier than the 2015 audit samples.

Issuers continually asked for national level error rates, but due to the significant amount of data gaps and variation across Issuers, no overall results were provided.
RADV audit process
RADV audit process

- Sample Selection
- RADV Protocols
- Secondary Validation Audit
- Error Estimation
- Appeals Process
- Payment Adjustment

- Hiring an IVA auditor
- Enrollment Screenshots
- Claim Screenshots*
- Member Crosswalk
- Medical Record Retrieval
- IVA Submission Approval

- Complete CMS Certification
- Enrollment Validations
- Claim Validations*
- Health Status Validations
- IVA Submission Package 1
- IVA Submission Package 2
RADV audit timeline: 2017 benefit year

May 2018
Sample Selection

June 2018 – January 2019
Initial Validation Audit

January 2019 – April 2019
Secondary Validation Audit
RADV audit timeline: 2017 benefit year continued

May 2019 – June 2019
Issuer Error Rates Released

June 2019
Payment Adjustments

June 2019 Appeals
Challenges
Challenges

1. Administrative Expense Burden
2. New Process
3. Ability to obtain enrollment and claim screenshots
4. Ability to obtain medical records
5. Coding Interpretations
Challenge #1

Administrative Expense Burden

External Expense

- Issuers are required to contract with a certified initial validation audit (IVA) firm.
  - In general, the IVA vendor fees are based on the number of Issuer IDs.
  - At a minimum, a health plan will have one Issuer ID per State.
- Issuers can incur additional expense burden if they contract with a vendor to support the medical record retrieval and first pass health status validation.

Internal Expense – resources and time

- Audit Lead / Data Submission validation team
- Enrollment and Claim operations
- Medical record retrieval and first pass health status validation
New Process

2015
- Limited time to complete the audit (the sample wasn’t released until July)
- New tools to learn (manual processes, automation builds, working out kinks), for both the health plan and the IVA vendors
- Medical record retrieval, and disagreements over interpretation of coding guidelines

2016
- Updates to CMS reports, tools and protocols
- Refined processes with IVA vendors
- Medical record retrieval, and disagreements over interpretation of coding guidelines
Challenge #3

Ability to obtain enrollment and claim screenshots

- Understanding the Source System(s)

- Originally CMS required the enrollment screenshots to be complete before a plan could begin the health status validation component of the audit. CMS later loosened their stance and allowed both to be completed in parallel.

- For the 2015 pilot audit, CMS required claim screenshots to validate the medical claim data submitted to the EDGE Server. CMS removed this requirement for the 2016 pilot audit, since the Dx codes are validated through the health status validation.
Challenge #4

Ability to obtain medical records

- Obtaining correct contact information for the provider medical record offices
  - Can be different from the billing office
  - Not typically captured on each claim
  - Can change from year to year (provider consolidations, addition of medical record retrieval vendors, new markets / new provider systems)

- Retrieving medical records in a timely manner
  - Not a top priority for providers (no incentive)
  - Multiple medical record requests for providers
  - Introduction of medical record retrieval vendors
  - Protected health information, especially for mental health / substance abuse providers
Challenge #5

Coding Interpretations

- Black and White coding documentation

- Clear coding documentation errors
  - Dx codes do not drive provider payments
  - Conditions pulled from member history when they are not actively being treated

- Grey areas for coding documentation
  - Clinical perspective
  - Coding perspective
Risks
1. Members and claims selected for the audit
   - Coding documentation is not error free
   - Provider payments are not driven by Dx coding

2. Transfer impact of RADV error rates relatively unknown
   - 2014 RADV pilot cancelled, no transfer impacts calculated
   - 2015 RADV pilot incomplete, no transfer impacts calculated
   - 2016 RADV pilot in progress, no transfer impacts calculated prior to starting the 2017 RADV

3. Issuer and membership changes
   - New Issuers and Exiting Issuers
   - Significant membership changes by Issuer from year to year
AGENDA PART 2

- Current Events
- Comparison to Medicare Advantage
- Challenges and criticisms
- Transfer Payment Adjustments
Understanding the ACA’s RADV audit process

Erica Rode, PhD, ASA, MAAA
25 JUNE 2018
Current events
2019 Notice of benefit and payment parameters

- Grouping of HCCs by failure rates
- Only adjust scores with material statistical deviation from an average
- Includes retroactive adjustment for those exiting the market
- Materiality thresholds:
  - $\leq 500$ billable member months (SG and IND combined) exempt from hiring IVA
  - $\leq 15$M in annual premium audited approximately every 3 years
- Sole issuers in a market, only high-cost risk pool transfers are audited
- Rules around mental health privacy

## Comparison to Medicare Advantage RADV

<table>
<thead>
<tr>
<th></th>
<th>ACA</th>
<th>Medicare Advantage¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Audit scope</strong></td>
<td>All carriers in the market²</td>
<td>30 contracts per year</td>
</tr>
<tr>
<td><strong>Audit impact</strong></td>
<td>Entire market</td>
<td>Audited contracts</td>
</tr>
<tr>
<td><strong>Conducted by</strong></td>
<td>(1) Independent contracted auditor (2) Secondary auditor from CMS</td>
<td>Medicare Recovery Audit Contractors</td>
</tr>
<tr>
<td><strong>Payment Adjustment Method</strong></td>
<td>Prospective risk score adjustment³</td>
<td>Prospective monthly payment adjustment</td>
</tr>
<tr>
<td><strong>Under-coding treatment</strong></td>
<td>Credited</td>
<td>Not credited</td>
</tr>
<tr>
<td><strong>Adjustment metric</strong></td>
<td>HCC failure rate reduced by population mean⁴</td>
<td>Overpayment reduced by FFS adjuster⁴</td>
</tr>
<tr>
<td><strong>Premium errors</strong></td>
<td>Adjustment if detrimental to other issuers</td>
<td>Not addressed</td>
</tr>
</tbody>
</table>

1. *Proposed policies (no payment adjustments to date)*
2. *Subject to materiality thresholds*
3. *With retrospective adjustment for carriers exiting the market*
4. *With no adjustment inside specified confidence intervals*
Challenges and criticisms
CMS and HHS RADV audits

- Claim-based diagnoses vs. clinically-based diagnoses
  - Non-equivalence
  - Model calibration
- Measuring coding differences vs compliance with rules
- Model changes
- Lack of transparency
- Sample size concerns
- Administrative burdens
- Timing
Graphic depictions of transfer formula ahead that may be disturbing to some ACA actuaries.
Transfer payment formula

Overview and definitions

\[ T_i = \left[ \frac{PLRS_i \times IDF_i \times GCF_i}{\sum_i (s_i \times PLRS_i \times IDF_i \times GCF_i)} \right] - \left[ \frac{AV_i \times ARF_i \times IDF_i \times GCF_i}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times GCF_i)} \right] \bar{P}_s \]

Where: Represents:

| PLRS \(_i\) | Plan liability risk score |
| IDF \(_i\) | Induced demand factor |
| GCF \(_i\) | Geographic cost factor |
| AV \(_i\) | Actuarial value |
| ARF \(_i\) | Allowable rating factor |
| s \(_i\) | Share of marketwide enrollment |
| P \(_s\) | Marketwide average premium for risk pool |
Transfer payment formula

Overview and definitions

\[ T_i = \left( \frac{\text{PLRS}_i \times \text{IDF}_i \times \text{GCF}_i}{\sum_i (s_i \times \text{PLRS}_i \times \text{IDF}_i \times \text{GCF}_i)} \right) \times \overline{P}_s - \left( \frac{\text{AV}_i \times \text{ARF}_i \times \text{IDF}_i \times \text{GCF}_i}{\sum_i (s_i \times \text{AV}_i \times \text{ARF}_i \times \text{IDF}_i \times \text{GCF}_i)} \right) \]

*Impacted by audit results*

<table>
<thead>
<tr>
<th>Where:</th>
<th>Represents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLRS&lt;sub&gt;i&lt;/sub&gt;</td>
<td>Plan liability risk score</td>
</tr>
<tr>
<td>IDF&lt;sub&gt;i&lt;/sub&gt;</td>
<td>Induced demand factor</td>
</tr>
<tr>
<td>GCF&lt;sub&gt;i&lt;/sub&gt;</td>
<td>Geographic cost factor</td>
</tr>
<tr>
<td>AV&lt;sub&gt;i&lt;/sub&gt;</td>
<td>Actuarial value</td>
</tr>
<tr>
<td>ARF&lt;sub&gt;i&lt;/sub&gt;</td>
<td>Allowable rating factor</td>
</tr>
<tr>
<td>s&lt;sub&gt;i&lt;/sub&gt;</td>
<td>Share of marketwide enrollment</td>
</tr>
<tr>
<td>P&lt;sub&gt;s&lt;/sub&gt;</td>
<td>Marketwide average premium for risk pool</td>
</tr>
</tbody>
</table>
## Transfer payments

2016 benefit year

<table>
<thead>
<tr>
<th>Market</th>
<th>Individual</th>
<th>Small Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average monthly premium</td>
<td>$391.86</td>
<td>$455.46</td>
</tr>
<tr>
<td>Absolute value of transfer payments as % of premium</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>Absolute value of transfer payments (PMPM)</td>
<td>$43.10</td>
<td>$27.33</td>
</tr>
</tbody>
</table>

## Transfer payments

2016 benefit year - Minnesota

<table>
<thead>
<tr>
<th>Market</th>
<th>Individual</th>
<th>Small Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total premium</td>
<td>$1,065,057,493</td>
<td>$1,244,695,370</td>
</tr>
<tr>
<td>Absolute value of transfer payments as % of premium</td>
<td>10.7%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Absolute value of transfer payments</td>
<td>$114,422,013</td>
<td>$28,266,011</td>
</tr>
</tbody>
</table>

Transfer payments
2016 benefit year - Minnesota

BCBSMN INC.,
$110 M

Medica Ins. Co., -$5 M

Group Health Plan Inc., -$18 M

HMO MN,
-$6 M

Medica Health Plans of WI, -$14 M

HealthPartners Ins. Co., -$55 M

PreferredOne Ins. Co., $5 M

UCare MN, -$17 M

Payment adjustments

Benchmark HCC failure rates

- HCC failure rate: The rate that HCC diagnoses reported on EDGE cannot be justified through chart reviews

\[
1 - \frac{\# \text{ of members with HCC validated}}{\# \text{ of members with HCC in EDGE}}
\]

- HCCs grouped into low, medium, and high failure rate – 1/3 of EDGE observations per group
- Prospectively adjust all coefficients in a group if the issuer failure rate is statistically significantly different than the nationwide average for the HCC group
Payment adjustments

- **Transfer Increase**
- **No**
- **Adjustment**
  - 95% confidence interval around group average
- **Transfer Decrease**

Issuer Failure Rate vs. Transfer Impact
Anatomy of a risk score

Claims-based variables:
- HCCs
- RxCs\(^1\)

Interactions:
- Severities
- Birth weights
- RxC\(^1\)/HCC Interactions

Demographics:
- Age and gender
- Enrollment duration

\(^1\)In 2018 and beyond
### HCC Failure Rates

#### Stratification

<table>
<thead>
<tr>
<th>Sample</th>
<th>Freq.</th>
<th>Failure Rate</th>
<th>Sample</th>
<th>Freq.</th>
<th>Failure Rate</th>
<th>Sample</th>
<th>Freq.</th>
<th>Failure Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC 156</td>
<td>5.7%</td>
<td>48.4%</td>
<td>HCC 142</td>
<td>5.4%</td>
<td>28.6%</td>
<td>HCC 023</td>
<td>4.4%</td>
<td>19.0%</td>
</tr>
<tr>
<td>HCC 012</td>
<td>3.5%</td>
<td>40.0%</td>
<td>HCC 160</td>
<td>4.6%</td>
<td>28.0%</td>
<td>HCC 045</td>
<td>3.3%</td>
<td>15.4%</td>
</tr>
<tr>
<td>HCC 131</td>
<td>3.7%</td>
<td>37.5%</td>
<td>HCC 075</td>
<td>3.3%</td>
<td>27.8%</td>
<td>HCC 127</td>
<td>7.4%</td>
<td>13.5%</td>
</tr>
<tr>
<td>HCC 088</td>
<td>4.3%</td>
<td>33.3%</td>
<td>HCC 056</td>
<td>2.0%</td>
<td>27.3%</td>
<td>HCC 047</td>
<td>3.3%</td>
<td>13.3%</td>
</tr>
<tr>
<td>HCC 020</td>
<td>7.2%</td>
<td>30.6%</td>
<td>HCC 030</td>
<td>3.1%</td>
<td>23.5%</td>
<td>HCC 161</td>
<td>5.4%</td>
<td>11.5%</td>
</tr>
<tr>
<td>HCC 130</td>
<td>8.9%</td>
<td>28.9%</td>
<td>HCC 008</td>
<td>6.3%</td>
<td>22.8%</td>
<td>HCC 074</td>
<td>3.0%</td>
<td>7.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HCC 002</td>
<td>3.1%</td>
<td>22.2%</td>
<td>HCC 009</td>
<td>3.3%</td>
<td>7.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HCC 021</td>
<td>2.6%</td>
<td>21.7%</td>
<td>HCC 253</td>
<td>3.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HCC 120</td>
<td>2.8%</td>
<td>20.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33.3%</td>
<td>35.3%</td>
<td><strong>Total</strong></td>
<td>33.3%</td>
<td>24.9%</td>
<td><strong>Total</strong></td>
<td>33.3%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

All values are for illustrative purposes only.
### Payment adjustments

#### HCC failure rates

<table>
<thead>
<tr>
<th>Rate Level</th>
<th>Average</th>
<th>Standard Deviation</th>
<th>No Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Failure Rate</strong></td>
<td>35%</td>
<td>3.0%</td>
<td>29% to 41%</td>
</tr>
<tr>
<td><strong>Medium Failure Rate</strong></td>
<td>25%</td>
<td>1.2%</td>
<td>23% to 27%</td>
</tr>
<tr>
<td><strong>Low Failure Rate</strong></td>
<td>12%</td>
<td>2.0%</td>
<td>8% to 16%</td>
</tr>
</tbody>
</table>

*All values are for illustrative purposes only*
Payment adjustments
Individual risk score adjustment

EDGE risk score = 7.629

<table>
<thead>
<tr>
<th>Failure Rate HCCs</th>
<th>10% Failure Rate</th>
<th>26% Failure Rate</th>
<th>40% Failure Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Failure Rate</td>
<td>1.246</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid Failure Rate</td>
<td>2.378</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Failure Rate</td>
<td>3.239</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Demographics: 0.766

Adjusted risk score = 7.034

Not Adjusted

All values are for illustrative purposes only
Payment adjustments

Final adjustment factors

- Individual adjustment factor = \( \frac{\text{HCC component of adjusted risk score}}{\text{HCC component of EDGE risk score}} \)

- Risk score adjustment = (EDGE HCC risk score) × (1 – Individual Adjustment)

- Weight together risk score adjustment and EDGE risk scores using risk strata

- Final issuer adjustment = \( \frac{\text{Weighted average risk score adjustment}}{\text{Weighted average EDGE score}} \)

- Applied to issuer’s PLRS in the subsequent year
Payment adjustments
Impact on transfer amounts

All values are for illustrative purposes only
Payment adjustments
Impact on transfer amounts

All values are for illustrative purposes only
Thank you

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