

CASE STUDY

IMPACT OF RADV – AN UPDATE & INSIGHT INTO STRATEGIC PRIORITIES

CMS has signaled plans to materially expand the scope and potential financial implications of risk adjustment audit processes. In so doing, CMS has ushered in a new era of heightened focus on practitioner coding accuracy, quality controls on risk-adjusted data submissions, and preparedness for response to regulatory audits within Medicare Advantage and Managed Medicaid health plans. MedAssurant has been assisting clients to prepare for RADV audits, and has gained important insight from that experience. This case study considers the things that health plans can do to prepare for, and maximize the likelihood of a good outcome from, a RADV audit.

BACKGROUND

With the incorporation of risk-adjusted payment into the Medicare Advantage program in recent years, the Centers for Medicare and Medicaid Services (CMS) made a bold effort to more tightly link health plan reimbursement to the clinical risk each health plan bore – and thereby to pay health plans appropriately for higher and more costly Medicare beneficiaries. With risk-adjusted payment came powerful – and positive – incentives to improve the capture of clinical data: the data needed to accurately and completely describe each member's risk (and therefore the revenue appropriate to each member).

In order to fulfill its oversight obligations regarding the accuracy of risk-adjusted reimbursement, CMS established Risk Adjustment Data Validation (RADV) audits of Medicare Advantage plans several years ago. In response to increasing pressure to expand its oversight over this growing healthcare coverage program, CMS heightened the intensity of the RADV audit process in 2008. With the launch of the RADV Calendar Year (CY) 2007 Payments Pilot Audit process on July 17th 2008, CMS materially expanded the scope and potential financial implications of the contract-level RADV audits. CMS not only increased the size of the audit to 200 members and 750 to 800 HCCs (Hierarchical Condition Categories; the unit of risk-adjustment in the Medicare Advantage program), but also indicated that adjustments to payments, based on audit findings, would no longer be limited only to the cases that were audited, but would be extrapolated to a plan's entire risk-adjusted reimbursement on a contract level basis. Finally, CMS indicated its intention to expand significantly the number of Medicare Advantage plans it audited. In so doing, the RADV CY 2007 Pilot Audit process signaled the beginning of a new era for plans contracting with CMS: one marked by a heightened focus on provider coding practices and claims data accuracy, quality controls on risk-adjusted data submissions, and health plan preparedness for regulatory audit response.

MEDASSURANT'S EXPERIENCE AND INSIGHT INTO THE RADV AUDIT PROCESS

In the last analysis, the RADV audit is an effort to assess the extent to which diagnoses (and associated HCCs) submitted to CMS can be substantiated by data derived from patient medical records; it is a means to establish concordance between clinical risk reflected in data submitted to CMS by the health plan, and the clinical risk as inferred from the patient medical record. Operationally, the RADV audit requires that health plans be able to retrieve medical records for patients for whom HCC's have been submitted, and that those medical records contain appropriate documentation to confirm the HCC submitted.

Historically, health plans have been challenged to identify, pursue, collect, and review medical records within the allotted RADV process time frame. Many health plans have sought a partner with the expertise and capacity to assist them to do

so. MedAssurant has been a partner to many health plans facing RADV audits. As a result, MedAssurant has gained a front-row seat to observe the process and impact of varying approaches within the industry.

The opportunity both to support clients, and through participation in audit response processes to learn from the experience of others, has provided deep insight into the factors that are important to success in the RADV audit process. Preparing in advance for a RADV audit is strongly correlated with the effectiveness of its execution. Critical success factors for the execution of the RADV audit span the primary functions of the organization: people, process, and technology. With regard to people, health plans should align appropriately skilled resources in advance of notification from CMS of a pending audit. These resources must encompass the spectrum of cross functional areas required to successfully respond. From data integration to medical record review to project management, each health plan's RADV team should be fully organized in advance. With regard to process, it is essential that health plans understand and plan the operational strategies and process flow required to respond to a contract-level audit – from chart chase selection to the submission of “one best chart.” The operational requirements to respond to contract level RADV audits are materially different from those of the past. Regarding technology, organizations must be efficient in integrating and managing data, identifying and selecting appropriate chart chase locations, and supplying the operational team the information necessary to pursue necessary medical records. Health plans need to organize and test their technology systems in advance to ensure they are ready.

CMS and Medicare Advantage plans will have to work together to ensure data accuracy while maintaining a realistic view of the complexities of medical record substantiation. CMS indicated that it will permit physician signature attestations – raising a broad range of quality improvement initiative goals and implementation challenges. Despite (or perhaps even because of) that, many questions remain, and “next steps” continue to unfold.

LOOKING FORWARD

Medicare Advantage and Managed Medicaid plans are responding to intensified pressure to assure the accuracy of their submissions to CMS by making risk-adjustment data quality, accuracy, and documentation compliance strategic priorities for their organizations. This strategic focus takes many forms. Many health plans are evaluating their internal readiness to respond to regulatory audits, and are seeking to prepare in advance the internal and external resources needed to enable a successful response to RADV processes. To evaluate risk exposure, some plans are conducting analyses of their claims submissions to ensure compliance as well as performing “mock RADVs” to evaluate exposure within their provider medical records. Prospectively, health plans are expanding their investment in practitioner education and training, while also identifying the systematic coding issues found within their current medical record base. In the long run, such investments are not only the best preparation for a RADV audit, but are also directly in line with enhancement of the infrastructure needed to improve the quality of data capture and review processes generally. These investments will improve the accuracy and precision of the data that are needed not only for RADV and risk-adjustment, but also for the many other health plan processes that depend upon detailed and comprehensive information about plan members.