

WHITE PAPER

ACA RADV Is More Than a Compliance Requirement

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INTRODUCTION

Risk Adjustment Data Validation (RADV) is a key mechanism that the Centers for Medicare & Medicaid Services (CMS) uses to ensure that Affordable Care Act (ACA) risk adjustment payments are based on accurate information. Risk adjustment payments between issuers may be substantial, making the accuracy of the underlying diagnoses critical. RADV provides CMS with a process to validate a subset of diagnoses, determine whether an issuer's coding is an outlier relative to the industry, and consequently adjust previously calculated and reported risk adjustment transfers.

The RADV process will sample 200 members' risk adjustment data as submitted to CMS. An independent validation auditor (IVA) will then audit sampled members' medical records to validate submitted hierarchical condition categories (HCCs) and identify supported diagnosis codes and HCCs that were not initially submitted. The disconnect between supported diagnoses codes and those not initially submitted may be the result of RADV operational issues, including chart retrieval, provider collaboration, and other RADV operations rather than true diagnosis miscoding. If an issuer's data are identified as outliers relative to national RADV results, CMS will adjust the issuers' risk scores and resulting risk transfers according to RADV protocols. Given the zero-sum nature of ACA risk adjustment transfers, one issuer's risk adjustment transfer result affects every other issuer within a market.¹

RADV is more than a compliance exercise for issuers and should not be thought of simply as a regulatory audit. It can have a direct and potentially material impact on financial results. RADV should instead be treated as a multiyear financial and operational process embedded within an issuer's ACA risk adjustment program strategy and accruals.

This white paper describes key high-level concepts related to RADV: the complex RADV timeline, demonstration that RADV may be a significant financial risk, RADV methodology changes and implications for benefit year 2025, and critical operational considerations.

¹ An issuer's adjusted risk score will change the statewide risk metrics and each individual's relative risk, thereby affecting resulting risk adjustment transfers.

RADV IS A LONG-TAIL PROCESS

An important consideration for issuers is the timing of ACA RADV, which is performed annually and results in a time lag over multiple years for final risk adjustment amounts (post-RADV). CMS releases RADV results in July two years after the benefit year in question. For example, CMS released calendar year 2024 RADV results on July 15, 2026, with actual payments being made in the subsequent months.² This timing creates an important distinction between when an issuer recognizes underlying risk adjustment transfer estimates in their financials and when the final RADV impact is known and settled.

Those organizations that participate in the Wakely National Risk Adjustment Reporting (WNRAR) project receive estimated RADV results in February of each year (i.e., estimated 2024 RADV results are received in February 2026, several months before CMS releases their results). This early access is helpful for issuers finalizing accrual setting and price products for the following year.

RADV OUTLIER IMPACTS MAY BE SIGNIFICANT

A state is an outlier if at least one issuer has audited diagnosis validation results that are statistically far enough from the expected benchmark that CMS considers the issuer's risk score error material, rather than normal sampling variation. Not every state may be identified as an outlier through the RADV process. In 2024, 30 individual ACA markets and 28 small group ACA markets experienced a RADV adjustment (out of 50 states and DC);³ however, a state not identified as an outlier in 2024 could become an outlier in 2025, and vice versa.

For markets that were identified as an outlier in 2024, approximately 95% of issuers experienced a RADV adjustment between -1% and 1% of issuer premium. Outlier RADV adjustments, however, may be significant. For example, as **Table 1** shows, approximately 1.6% of individual issuers had an unfavorable RADV adjustment of at least 2% of premium.

In extreme cases, the impact could be even more substantial. For example, one individual issuer in Texas had an unfavorable RADV adjustment equal to approximately 11% of its premium. This disconnect causes a significant financial risk and may be difficult for issuers to absorb and plan accordingly. RADV adjustments can change the profitability and financial sustainability of a company multiple years after the incurred benefit year.

² On September 9, 2026, CMS released a notice about delays in payment transfers and the potential to adjust 2024 RADV results "after receiving several requests for reconsideration..."

³ Centers for Medicare & Medicaid Services. Premium Stabilization Programs. Available at: <https://www.cms.gov/marketplace/health-plans-issuers/premium-stabilization-programs>.

Table 1. Distribution of Issuers by RADV Adjustment (2024)⁴

RADV Impact (% of Premium)	Individual	Small Group
<-2%	1.6%	0.9%
-2% to -1%	0.8%	2.6%
-1% to 0%	31.0%	18.0%
0% to 1%	63.4%	76.7%
1% to 2%	1.1%	1.2%
>2%	2.1%	0.6%

ACA RADV IS CHANGING FOR 2025 BENEFIT YEAR

Beginning in benefit year 2025, three key ACA RADV changes are being implemented that will have downstream operational implications.

First, CMS will exclude members who do not have an HCC from the RADV sample of members audited. This change is intended to make the audit more precise by focusing on members with diagnosis codes that contribute to an issuer's risk score.

Second, CMS will replace the current source of the Neyman allocation data used for IVA sampling with three years of HHS-RADV data. CMS noted that this change is expected to result in a higher proportion of low- and medium-risk members included in the audit sample and a lower proportion of high-risk members. With the revision in sampling, CMS anticipates the administrative burden of the audit will be reduced, as low- and medium-risk members will likely have fewer medical charts to review than high-risk members.

Third, CMS is removing a statistical adjustment that previously reduced the effective sample size for issuers with limited membership in a state. These issuers will now be subject to a sample of 200 members with HCCs, or the number of members with HCCs in their population if fewer than 200. Rather than assuming a smaller issuer will face a proportionally smaller audit, issuers should understand that a substantial portion—or potentially all—of their members with relevant diagnoses could be subject to RADV review.

⁴ Excludes MA, NE, and NY. Limited to states with a RADV adjustment.

Because these changes primarily affect sampling methodology, they will also affect RADV operational requirements. While CMS noted the Neyman allocation changes may reduce administrative burden, the increase of members with HCCs being audited and the increase in members audited for smaller issuers may dilute impact. Issuers should prepare for increased workload as the number of members with HCCs being audited increases.

Issuers should be aware that sampling changes may also affect national benchmarking and failure rate confidence intervals. Although the effect is unknown, benchmarks may become more volatile, making it difficult to rely fully on historical results when estimating potential RADV impact.

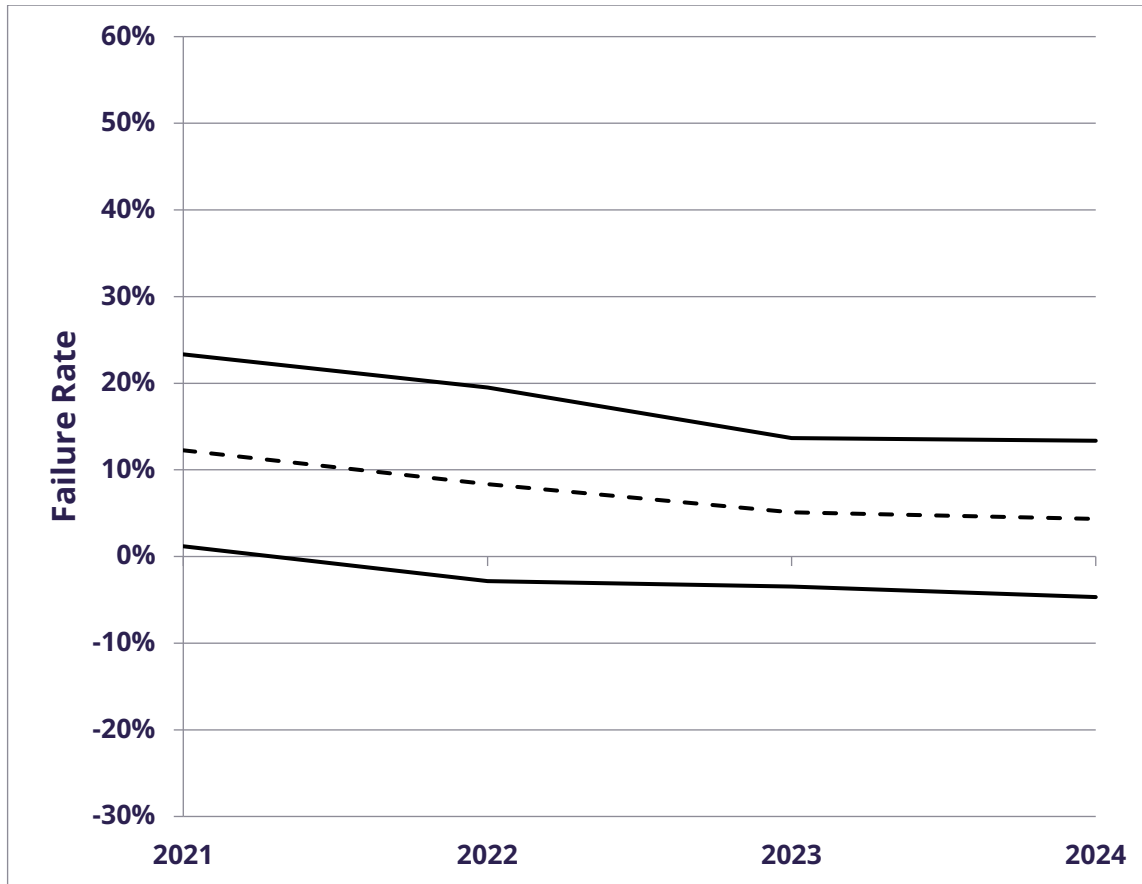
The 2025 changes reinforce the connection between coding, documentation, risk adjustment submissions, and eventual RADV results. Issuers should think about RADV earlier in the risk adjustment process as a result. Retrospective chart review efforts to identify documentation gaps may be considerably less effective than addressing those gaps during the normal risk adjustment cycle.

CMS has adjusted the ACA RADV process multiple times since inception. Furthermore, CMS has revised results post-release because of lawsuits and issuer inquiries. At the time of this writing, CMS just released notice of the potential to change the 2024 CMS RADV results. Issuers should stay current on methodology and regulatory changes and adapt operations accordingly. Strategies that worked historically may no longer be effective.

STATUS QUO OPERATIONS MAY BE INSUFFICIENT

In the ACA RADV process, members are stratified into low, medium, and high HCC groupings that are intended to separate records based on their risk adjustment impact. Each grouping has its own confidence interval boundaries, which are used to identify outliers. The same error rate can have a different financial impact on each grouping, so it is important to track each grouping individually rather than rely on an overall error rate.

Figure 1 on the next page illustrates the national confidence interval boundaries (solid lines) and mean (dotted line) for the medium HCC group for 2021 through 2024 ACA RADV.

Figure 1. Historical National Confidence Interval Movements (Medium HCC Group)

The decreasing trend in the national confidence interval means that issuers are required to improve (reduce) their RADV failure rates year over year to maintain their RADV results. Issuers within current HCC group confidence intervals that do not improve their RADV failure rates may be deemed outliers in future years. Maintaining the same operational approach to RADV annually may be insufficient to avoid unfavorable results. While not shown here, a similar pattern is observed for the low and high HCC groupings.

KEY RADV OPERATIONAL QUESTIONS

Issuers should develop an effective RADV strategy well before audit that accounts for general operations, long-tail process, accurate provider documentation and coding through data submission, internal validation, and audit response, which leads to several strategic and operational questions, including:

- Do you have a dedicated team focused on ACA RADV?
- Is your ACA RADV approach tailored to the ACA RADV program, or are you using the same approach as Medicare Advantage RADV?
- Are you collaborating with your selected IVA vendor to review every record and ensure alignment on findings?
- Is your selected vendor providing transparent RADV oversight and communicating actionable improvements?
- Are you proactively identifying and addressing documentation gaps before they become RADV findings?
- Are you strategically deploying chart retrieval and review resources?
- What processes can be established today to reduce future audit exposure?
- Are you retroactively reviewing RADV results, identifying improvement opportunities, and developing strategies for those improvements?
- How much RADV impact should be reflected in financial forecasts, accruals, and pricing assumptions?
- Are you staying up to date on upcoming changes to the RADV program?
- Are your operations scaling as your membership scales, or vice versa?
- Are you monitoring your performance against benchmarks by groupings?
- How are you measuring RADV success?

HOW WAKELY CAN HELP

Wakely can support issuers with end-to-end risk adjustment support. Specific to ACA RADV, Wakely can provide high-level oversight and exposure estimation throughout the process to identify risk, conduct a RADV-readiness assessment, train teams on industry best practices, assist with accruals, point to broader risk adjustment operational concerns, and help build sustainable solutions. Those organizations that participate in the WNRAR project receive estimated RADV results in advance of when results are released by CMS. Wakely's estimates have historically aligned well with CMS's findings.

Though not discussed in this white paper, Wakely can assist with Medicare Advantage RADV support as well.

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If you have any questions or want to follow up on any of the concepts presented here, please contact the authors.

ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

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