DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
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Subject: **2016 Benefit Year HHS-Operated Risk Adjustment Data Validation (HHS-RADV) Protocol Updates**

We are pleased to release the updated HHS-operated Risk Adjustment Data Validation (HHS-RADV**)** protocols for the 2016 benefit year. The updates have been made as a result of the successful execution of the pilot for the 2015 benefit year. CMS engaged continuously with stakeholders to gather valuable feedback and based on the lessons learned in the initial pilot year, we are providing improvements for 2016 benefit year HHS-RADV. These improvements will reduce burden by eliminating some audit procedures and refining and clarifying processes. Due to these changes and the lessons learned from the initial pilot, CMS has converted the 2016 benefit year to a second pilot year.[1]

HHS-RADV promotes confidence in risk adjustment payment transfers by ensuring the integrity and quality of data provided from issuers operating in state markets under the HHS-operated risk adjustment program. The first pilot year provided tremendous insight into the HHS-RADV processes and we anticipate this second pilot year will provide the necessary experience to allow successful ongoing audit completion.

CMS has identified a number of process improvements and policy refinements from 2015 benefit year HHS-RADV that have been incorporated in the 2016 benefit year HHS-RADV protocols. The changes in the protocols are summarized below. Specifically, these changes are addressed in section five (5) of the protocols with the exception of inter-rater reliability (IRR), which is addressed in section six (6).

- 2016 benefit year HHS-RADV pilot year:
  - Issuers with total premiums of $15 million or less in the 2016 benefit year and issuers exiting the market in the 2017 benefit year are exempt from hiring an Initial Validation Audit (IVA) entity and submitting IVA results for 2016 benefit year HHS-RADV.

- IVA audit timeframe expansion:
  - In 2015 benefit year HHS-RADV, issuers and IVA Entities experienced widespread issues obtaining medical records in the pilot year. CMS has developed a timeline for 2016 HHS-RADV that provides issuers and IVA Entities additional time for medical record retrieval by releasing the IVA sample earlier,

[1] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/HHS-Operated-Risk-Adjustment-Data-Validation-HHS-RADV-%E2%80%93-2016-Benefit-Year-Implementation-and-Enforcement.pdf

simultaneously to issuers and IVA Entities, and allowing concurrent submission of the IRR results with the IVA results.

- Burden reduction for demographic and enrollment validation:
  - In the 2015 benefit year HHS-RADV pilot year, we required validation of demographic and enrollment data for the full sample of 200 enrollees. Beginning for 2016 benefit year HHS-RADV, CMS will select a subsample of 50 enrollees from the 200 enrollee sample for the IVA Entity to conduct demographic and enrollment validation.
  - IVA entities encountered challenges validating enrollment data on issuers' source systems. For 2016 benefit year HHS-RADV, CMS has clarified that issuers must provide mapping documentation that matches the unique Enrollee IDs in the full IVA sample of 200 to the actual enrollee in the source system.
  - CMS has also provided additional, clarifying guidance in the protocols on validating the demographic and enrollment data elements.
  - Similar to 2015 benefit year HHS-RADV, errors found from demographic and enrollment validation will not be used in error estimation.

Plan ID:

- The Plan ID validates the plan's metal level (and cost-sharing reduction [CSR] variant, if applicable), which is another component of risk adjustment transfers.
- CMS is requiring issuers to provide a mapping crosswalk between the issuer's source system and plan data submitted to the External Data Gathering Environment (EDGE) server.
- The IVA entity must validate that the enrollee is enrolled in the appropriate 16-digit Plan ID based on the issuer-provided crosswalk to the issuer's source system.

Premium:

- Premiums only need to be validated for subscriber enrollees in the demographic and enrollment subsample of 50 enrollees.
- CMS will randomly select a month during the enrollee's enrollment period for the IVA Entity to validate the premium.
- CMS has clarified the types of information from issuer systems that may be used to validate the subscriber premium.
- For small group market plans, the issuer will need to provide the IVA Entity with the necessary mapping of the enrollee's premium to the group premium in their source system. If a composite rating is used, then this information must be explained.

Rating Area:

- CMS is requiring IVA Entities to validate rating area against the subscriber's home address zip code and/or county; the employer company address would be used for validating rating area for small group enrollees.
- The issuer will need to provide the IVA Entity with the zip code and/or county to rating area mapping for their state.

- Elimination of claims data validation, except for non-EDGE claims:
  - Claims data validation is required for medical records linked to non-EDGE claims to verify that they are risk adjustment eligible.

- Medical record review requirements:
  - Removing requirement that medical record abstraction coding must be blind to Hierarchical Condition Categories (HCCs) from the EDGE server report. We will instead leave that decision up to the issuer, to determine whether or not to use blind coding.
  - Removing requirement to validate service code modifier.
  - Removing requirement to validate provider credentials on the medical record.

- IRR agreement standard:
  - CMS had originally intended to raise the IRR standard from 85% agreement to 95% agreement beginning for 2016 benefit year HHS-RADV; however, IRR standards will remain at the 85% agreement threshold to maintain consistency between pilot years.

CMS will use demographic and enrollment findings from 2016 benefit year HHS-RADV to determine if an issuer may have significant data errors and must improve their data extraction and transformation process for EDGE server submission. We thank the issuers and their IVA Entities for the hard work and dedication in the 2015 benefit year HHS-RADV audit that allowed your continued engagement and commitment to the process to implement refinements. We look forward to an even more successful pilot year for 2016 benefit year HHS-RADV.