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Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services

Center for Consumer Information and Insurance Oversight

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Log of Updates to the 2017 Benefit Year Protocols

PPACA HHS Risk Adjustment Data Validation

Version 2.0

August 10, 2018

Page #	Section	Summary of Update
13-15 and 83	1.5 and 5.7	• Enhanced current language to emphasize the possibility of additional medical records requested (i.e., Package Three [3]) • Note added to indicate that Initial Validation Audit (IVA) Entities will have seven (7) calendar days from the time of the Package Three (3) request to submit additional records, inclusive of Issuer Senior Official (SO) sign off
31,58-59 and 125-126	4.5, 5.6.2 and 10	• Reference to Appendix A added in Section 5.6.2 to direct stakeholders to International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding guidelines • Reference to Appendix B added in Section 4.5 to direct stakeholders to Environmental Data Gathering Environment (EDGE) server Risk Adjustment Data Validation (RADV) resources
37	4.5.4	• Updated Link
48	5.5	• Clarified that, in order for enrollees to be eligible for Centers for Medicare & Medicaid (CMS) selection for Demographic & Enrollment (D&E) validations, enrollees must be enrolled for 30 continuous days in a calendar month with the issuer • Additional language added to indicate that in the event the requested enrollee target D&E sample size cannot be achieved, based on the CMS selection criteria, a smaller sample of enrollees may be selected by CMS • Language added to clarify D&E validation for enrollees with system generated EDGE enrollment periods
56-57 and 61	5.5.1.2 and 5.6.4	• Revised the cross-year claims section to note that the Risk Adjustment Data Validation Medical Claim Extract report claim logic has been updated for 2017 benefit year • Language added to clarify D&E validation for enrollees with system generated EDGE enrollment periods
58	5.6.1	• Additional language added to clarify the intent and use of the HHS-RADV Provider Medical Record Request Memo
62	5.6.5	• Revised paragraph to clearly outline the step-by-step process for linking a claim to a medical record • Section 5.6.5 - Emphasized the difference between “benefit year” and “coverage period” • Updated the terms: “paid adjudicated claim” to “paid/positively adjudicated claim” (global edit)
70-71	5.6.10	• Added language that a provider directory, under specific circumstances, may be submitted to validate provider credentials
71-72	5.6.10.1	• Updated date of signature guidance for clarity and to align with Medicare Advantage (MA) RADV guidance • Updated Acceptable Signature details and Table 18 to incorporate definitions and considerations derived from MA RADV, so that signature guidance is consistent across programs
77-78 and 68-69	5.6.12 and 5.6.8	• Language added to emphasize the use of professional judgement (i.e. CMS will not instruct IVA Entities on how to perform coding activities or how to specifically code different scenarios) • Medical Administration Record (MAR) included in list of documents that may be used in conjunction with other medical documentation to substantiate a diagnosis

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87-90	6.3	• Updated language on Table 20 to clarify that the IRR calculation must consider Hierarchical Condition Categories (HCCs) at an enrollee level • Distinguished “distinct” from “unique HCCs” per CMS feedback • Added examples and additional scenarios to demonstrate CMS recommended Inter-rater Reliability (IRR) calculation
95-111	7	• Removed bootstrap detail specific to the analysis of final error rates • Clarified bootstrap detail specific to the process of expanding the SVA Subsample to SVA200 • Clarified use of HHS-HCC hierarchy in determining the final SVA HCCs for an enrollee and provided an example
140-146	10	• Updated links in Appendix B: EDGE Server RADV Reports Resources • Added additional terms into the Appendix E: Glossary of Terms, Acronyms and Definitions