2018 Benefit Year HHS Risk Adjustment Data Validation (HHS-RADV) Introduction

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March 6, 2019

HHS-RADV Webinar Series IV

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Session Agenda

- Session Guidelines
- Intended Audience
- Session Purpose
- HHS-RADV Acronyms, Timeline, and Definitions
- HHS-RADV Authority, Overview, and Processes
- HHS-RADV CMS, issuer, IVA Entity, and SVA Entity Responsibilities
- Question and Answer (Q&A)
- Next Steps
- Resources
- Closing Remarks

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Session Guidelines

- This is a 60-minute webinar session
- For questions related to content, please contact the RADV team at CCIIOACARADataValidation@cms.hhs.gov
- For questions regarding logistics and registration, please contact the Registrar at: (800) 257-9520

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Intended Audience

- Issuers subject to the HHS-RADV audit requirements under 45 CFR 153.630
- Initial Validation Audit (IVA) Entities
- Third Party Administrators (TPA) and support vendors

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Session Purpose

- Provide an overview of the HHS-RADV program background and standards as finalized in regulation
- Identify the HHS-RADV processes
- Describe the responsibilities of key Stakeholders
- Provide the HHS-RADV timeline and upcoming trainings

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HHS-RADV Acronyms

Common Acronyms

Acronym	Definition
CMS	Centers for Medicare & Medicaid Services
DDVC	Default Data Validation Charge
EDGE	External Data Gathering Environment
HHS	The Department of Health and Human Services
HHS-RADV	HHS-operated Risk Adjustment Data Validation
IRR	Inter-rater Reliability
IVA	Initial Validation Audit
PLRS	Plan average liability risk score
PPACA	Patient Protection and Affordable Care Act
RADC	Risk Adjustment Default Charge
RADV	Risk Adjustment Data Validation
REGTAP	Registration for Technical Assistance Portal
RXC	Prescription Drug Categories
SVA	Second Validation Audit

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HHS-RADV Timeline

HHS-RADV Timeline



To access the most HHS-RADV Timeline, please log in to REGTAP and visit the HHS-RADV Program Area page: www.REGTAP.info/hhsradv.php

or utilize the following web link: https://www.regtap.info/reg_librarye.php?i=2456

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HHS-RADV Definitions Stakeholders

HHS-RADV Stakeholders

HHS-RADV processes require active Stakeholder engagement:

HHS	Organization responsible for the HHS-RADV program
CMS	Agency designated by HHS to implement the Risk Adjustment (RA) program, including HHS-RADV
Issuer	Issuers subject to the HHS-RADV Audit: issuers offering RA covered plans during the benefit year being audited
IVA	Issuers retain an IVA Entity to perform the IVA
SVA	CMS retains an SVA Entity to perform the SVA

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HHS-RADV Authority

HHS-RADV Authority

- CMS operates the HHS-RADV program in accordance with the following regulations:
  - 45 CFR §153.350
  - 45 CFR §153.620
  - 45 CFR §153.630
  - 45 CFR §153.740
  - 45 CFR §156.1220

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HHS-RADV Authority (continued)

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- Section 1343 of the Patient Protection and Affordable Care Act (PPACA) establishes a permanent RA program, under which payments are collected from issuers that enroll relatively lower-risk populations and payments are made to issuers that enroll relatively higher-risk populations
- Under the HHS-operated RA program, which applies in states that elect not to operate RA, HHS validates a statistically valid sample of data for issuers that submit RA data each benefit year and provides an appeals process
  - HHS adjusts average actuarial risk based on the error rate found in the data validation process, resulting in adjustments to payments and charges based on the changes to average actuarial risk

HHS-RADV Authority (continued)

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- Issuers receiving a Risk Adjustment Default Charge (RADC) pursuant to 45 C.F.R. § 153.740(b), are exempt from the requirements of HHS-RADV in the state market risk pools for which the issuer is receiving a RADC
- Issuers who fail to engage an IVA entity or fail to submit the results of an IVA to HHS, will be assessed a Default Data Validation Charge (*DDVC) under 45 C.F.R. § 153.630(b)(10)



* ***Note***: In the 2020 Payment Notice Proposed Rule, we propose to formally adopt this acronym in regulation. We use the acronym in these slides to distinguish the DDVC from the RADC

HHS-RADV Authority (continued)

- Beginning with the 2018 benefit year HHS-RADV, HHS implemented a materiality threshold exemption stating that issuers with total annual premiums at or below $15 million statewide **would not** be subject to annual IVA (and SVA) requirements
- However, these issuers would be subject to random and targeted sampling that would include issuers below this materiality threshold being subject to an IVA approximately every three (3) years, barring any risk-based triggers that would warrant annual participation
  - Potential risk-based metrics may be issuers' prior HHS-RADV results and/or material changes in RA data submission, as measured by our quality metrics

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HHS-RADV Authority (continued)

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- Starting with the 2018 benefit year, the HHS-operated RA methodology takes into account certain prescription drug categories (RXCs) in the adult models for purposes of determining an enrollee's risk score
- Beginning for the 2018 benefit year RADV, IVA entities will be required to validate the RXCs of sampled enrollees
  - Additional details on the validation of RXCs will be presented in the near future

HHS-RADV Authority (continued)

- Beginning with the 2017 benefit year HHS-RADV issuers of RA covered plans with 500 billable member months or fewer statewide that elect to establish and submit External Data Gathering Environment (EDGE) data are exempt from the requirements to hire an IVA Entity and submit IVA results
- For the 2018 benefit year HHS-RADV, issuers with 500 billable member months or fewer statewide will not be subject to random sampling under the materiality threshold (discussed above) and would continue to be exempt from the requirements to hire an IVA Entity and submit IVA results
- A sole issuer in a state market risk pool in a benefit year is not required to conduct RADV for that state market risk pool; however, if the sole issuer participates in multiple risk pools in the state during that year, it would be subject to RADV for those risk pools with other issuers

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HHS-RADV Overview

Risk Adjustment Overview

- **What:** When operated by HHS a budget neutral program that transfers funds from plans with lower risk enrollees to plans with higher risk enrollees in a state market risk pool
- **Who participates:** Issuers of RA covered plans
- **How:** Criteria and methods developed by the Secretary of HHS, in consultation with states and issuers. When operated by HHS, calculations are performed consistent with the methodology established through notice with comment rulemaking

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HHS-RADV Overview

- A robust RA program requires high-quality data to calculate accurate risk scores, payments, and charges
- Data validation is an audit function that promotes confidence in budget-neutral transfers by ensuring the integrity and quality of data provided from issuers
- HHS-RADV is a data validation process essential to the operations of a credible RA program

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HHS-RADV Overview (continued)

- Key Components:
  - CMS selects a statistically valid sample of enrollees and associated data submitted to the issuer's EDGE server
  - Data validation of the selected sample is conducted by an IVA Entity selected by the issuer and reviewed by CMS
  - CMS selects an SVA Entity to validate a subsample of the original IVA sample

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HHS-RADV Overview (continued)

- Key Components (continued):
  - CMS calculates national metrics using issuers' failures rates from their IVA and SVA results to determine confidence intervals for groups of Hierarchical Condition Categories (HCCs) based on national failure rates
  - CMS uses those confidence intervals to determine which issuers are outliers in comparison to the national metrics
  - For an issuer that is determined to be an outlier, CMS calculates an issuer-level risk score error rate based on its HHS-RADV results
  - CMS generally applies that risk score error rate to the next benefit year's RA plan average liability risk score(s) (PLRSs)
  - CMS provides an HHS-RADV Discrepancy and Appeals process for issuers

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HHS-RADV Overview (continued)

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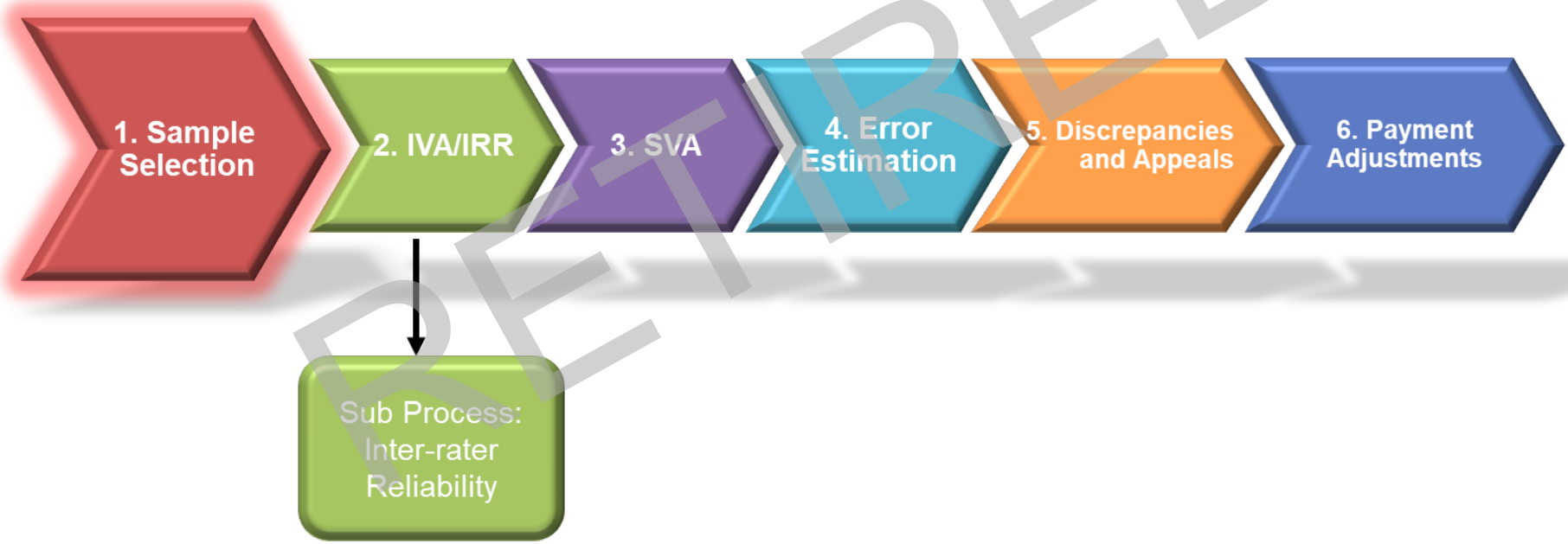
- CMS uses an automated system to facilitate the HHS-RADV processes known as the **HHS-RADV Audit Tool**
- Issuers and IVA Entities use the HHS-RADV Audit Tool to submit results for all RADV activities (IVA Entity designation, Inter-rater Reliability [IRR] submission, IVA Results Submission, Final Discrepancy Reporting and Appeals Submission)
- Issuers, IVA Entities, and the SVA Entity are required to register in the HHS-RADV Audit Tool
- Issuers are required to designate a person from their organization to serve as the **HHS-RADV Senior Official** (SO), to communicate with CMS regarding HHS-RADV activities and to serve as the primary user in the HHS-RADV Audit Tool

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HHS-RADV Processes

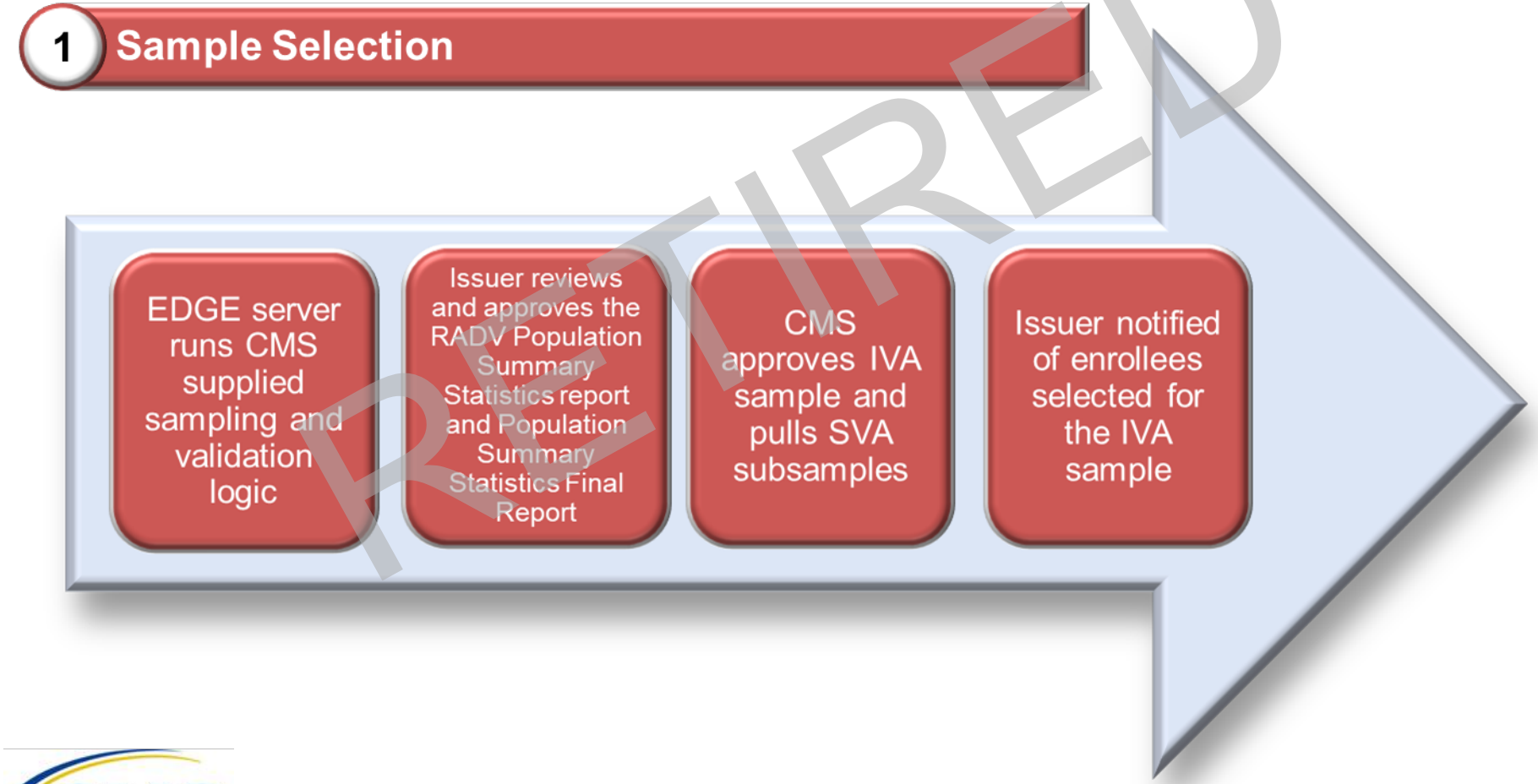
HHS-RADV Processes: Sample Selection

- Step 1: Sample Selection



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HHS-RADV Processes: Sample Selection (continued)



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HHS-RADV Processes: Sample Selection (continued)

1 Sample Selection

- CMS selects a sample size of enrollees so that the estimated risk score errors would be statistically sound and the enrollee-level risk score distributions would reflect enrollee characteristics for each issuer
- For the 2018 benefit year HHS-RADV IVA sample, CMS selects up to 200 enrollees per issuer for each state in which the issuer offers RA covered plans
  - Companies that offer plans in more than one (1) state will need to conduct the HHS-RADV process for each Health Insurance Oversight System Identification (HIOS ID) in each state in which they participate
- Following the EDGE server sampling logic execution and before CMS approves the IVA sample, the issuer will need to review and approve the RADV Population Summary Statistics (RADVPS) Report and the RADV Population Summary Statistics Final (RADVPSF) Report

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HHS-RADV Processes: Sample Selection (continued)

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1 Sample Selection

- An IVA sample size may differ based on the issuer's population size:
  - A maximum sample of 200 enrollees (up to two-thirds of the sampled enrollees will have one [1] or more HCCs)
  - An IVA sample with less than 200 enrollees may be selected for small issuers

HHS-RADV Processes: Sample Selection (continued)

1 Sample Selection

- Though the IVA will use a sample size of 200, the SVA will use subsamples of the IVA sample enrollees in the SVA process
  - An initial SVA subsample of 12 enrollees from the IVA sample
  - If needed, an expanded SVA subsample would include the initial SVA subsample and additional enrollees in the IVA sample
- The expanded SVA subsample will be used in the event a pairwise means test on the initial SVA subsample shows insufficient agreement between IVA and SVA results. This insufficient agreement will require the remaining IVA sample enrollees to be submitted to the SVA
  - **Pairwise Means Test**: A statistical means test, which is a hypothesis-testing procedure to determine if two (2) population means are different when there is a one (1)-to-one (1) correspondence between the values in the two (2) samples

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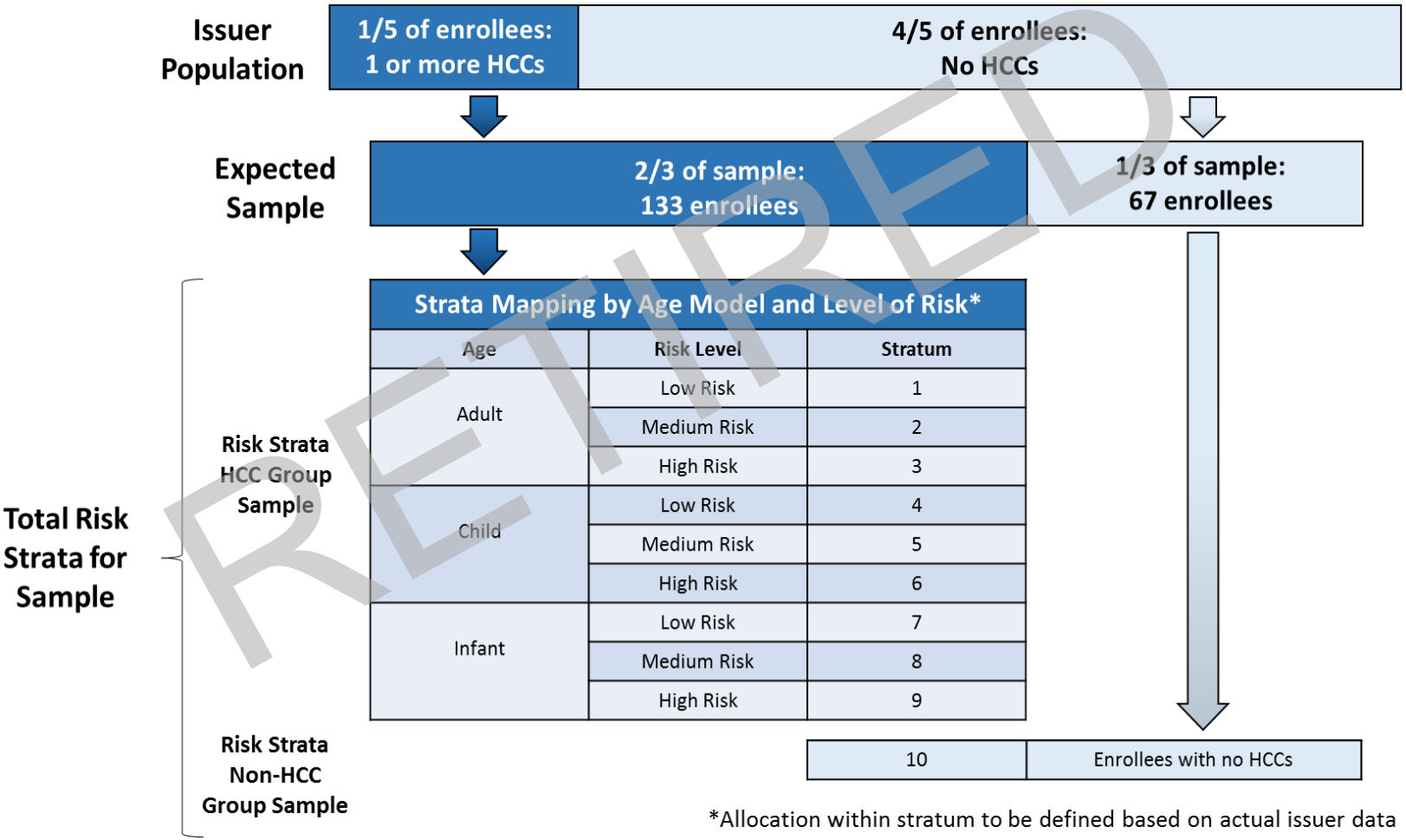
HHS-RADV Processes: Sample Selection (continued)

1 Sample Selection

- Population and Sampling Distribution
  - **Issuer Population:** Approximately one-fifth of all enrollees are expected to have at least one (1) HCC and four-fifths of the enrollees are expected to have no HCCs
  - **Expected Sample:**
    - Two-thirds (2/3) of the issuer's IVA sample enrollees with HCCs
    - One-third (1/3) of the issuer's IVA sample enrollees with no HCCs
- Risk Strata
  - **HCC Group Strata:** To account for risk score variation, each issuer's population of enrollees with HCCs will be divided into nine (9) strata based on risk score and sampled for the IVA sample by stratum
  - **Non-HCC Group Stratum**: The enrollees without HCCs in the issuer's population and selected for the IVA sample are assigned to stratum 10

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Population and Sampling Distribution



*Allocation within stratum to be defined based on actual issuer data

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Population and Sampling Distribution
(continued)

Example: Issuer ABC has a total enrollee population of 13,000. Table 1 shows the stratification of this population. Table 2 displays the issuer's sample distribution by stratum

Table 1 – Issuer ABC Population Stratified by Age and Risk Score Thirds

Issuer ID	Stratum	N (Pop. Freq.)
ABC	1 – Adult Low	1,200
ABC	2 – Adult Med.	300
ABC	3 – Adult High	100
ABC	4 – Child Low	400
ABC	5 – Child Med.	100
ABC	6 – Child High	100
ABC	7 – Infant Low	200
ABC	8 – Infant Med.	100
ABC	9 – Infant High	100
ABC	10 – No-HCC	10,400
	TOTAL	**13,000**

Table 2 – Issuer ABC Samples Stratified by Age and Risk Score Thirds

Issuer	Stratum	IVA Sample Size (200)	SVA Sample Size (100)
ABC	1	22	11
ABC	2	11	6
ABC	3	8	4
ABC	4	15	8
ABC	5	15	8
ABC	6	18	9
ABC	7	18	9
ABC	8	11	6
ABC	9	15	6
ABC	10	67	33
	TOTAL	**200**	**100**

Sample sizes may be higher due to rounding. Allocation within stratum defined based on actual Issuer data. Refer to the HHS-RADV Protocols § 4.2.1 Stratification for more information

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HHS-RADV Processes: Sample Selection

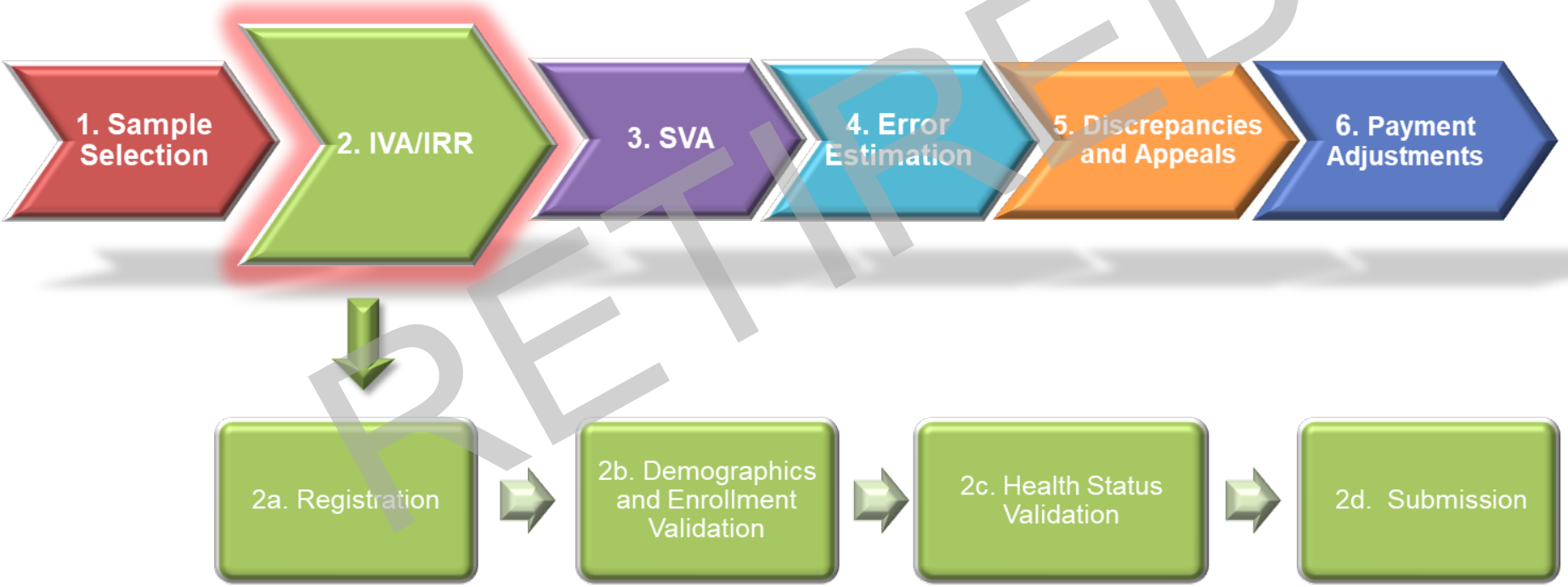
1 Sample Selection

- CMS will notify issuers when the IVA Sample Reports are finalized
  - **RADVPSF** (RADV Population Statistics Final) Report
  - **RADVIVAS** (RADV IVA Statistics) Report
  - **RADVDE** (RADV Detailed Enrollee) Report
  - **RADVEE** (RADV Enrollment Extract) Report
  - **RADVMCE** (RADV Medical Claim Extract) Report
  - **RADVSE** (RADV Supplemental Extract) Report
  - **RADVPCE** (RADV Prescription Claims Extract) Report
    - This is a **new report** for the 2018 benefit year HHS-RADV process
    - Details of this report will be discussed in a future webinar
- **Finalization of the IVA Sample Reports marks the start of the IVA process**

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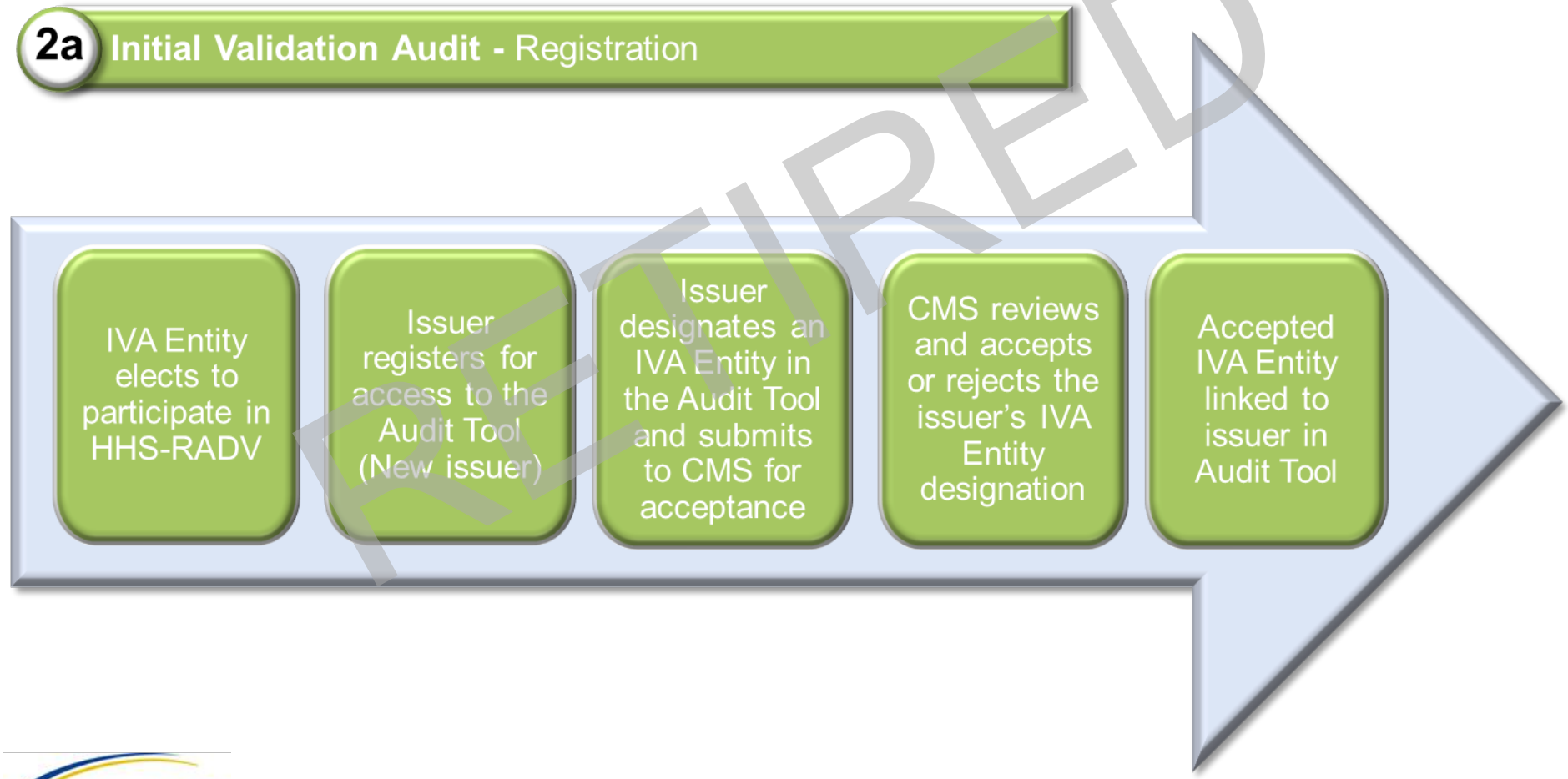
HHS-RADV Processes: IVA

- Step 2: IVA/IRR



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HHS-RADV Processes: IVA (continued)



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HHS-RADV Processes: IVA (continued)

2a Initial Validation Audit - Registration

- IVA Entity elects to participate in HHS-RADV
- Issuer registers for access to the HHS-RADV Audit Tool (new issuer only)
- Issuer designates an IVA Entity in the HHS-RADV Audit Tool
- CMS accepts or rejects the issuer's IVA Entity designation in the Audit Tool
- Accepted IVA Entity is linked to designating issuer in the Audit Tool
  - Additional details regarding the IVA Entity's responsibilities will be provided in the following section, Stakeholder Responsibilities

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HHS-RADV Processes: IVA (continued)

2a Initial Validation Audit - Registration

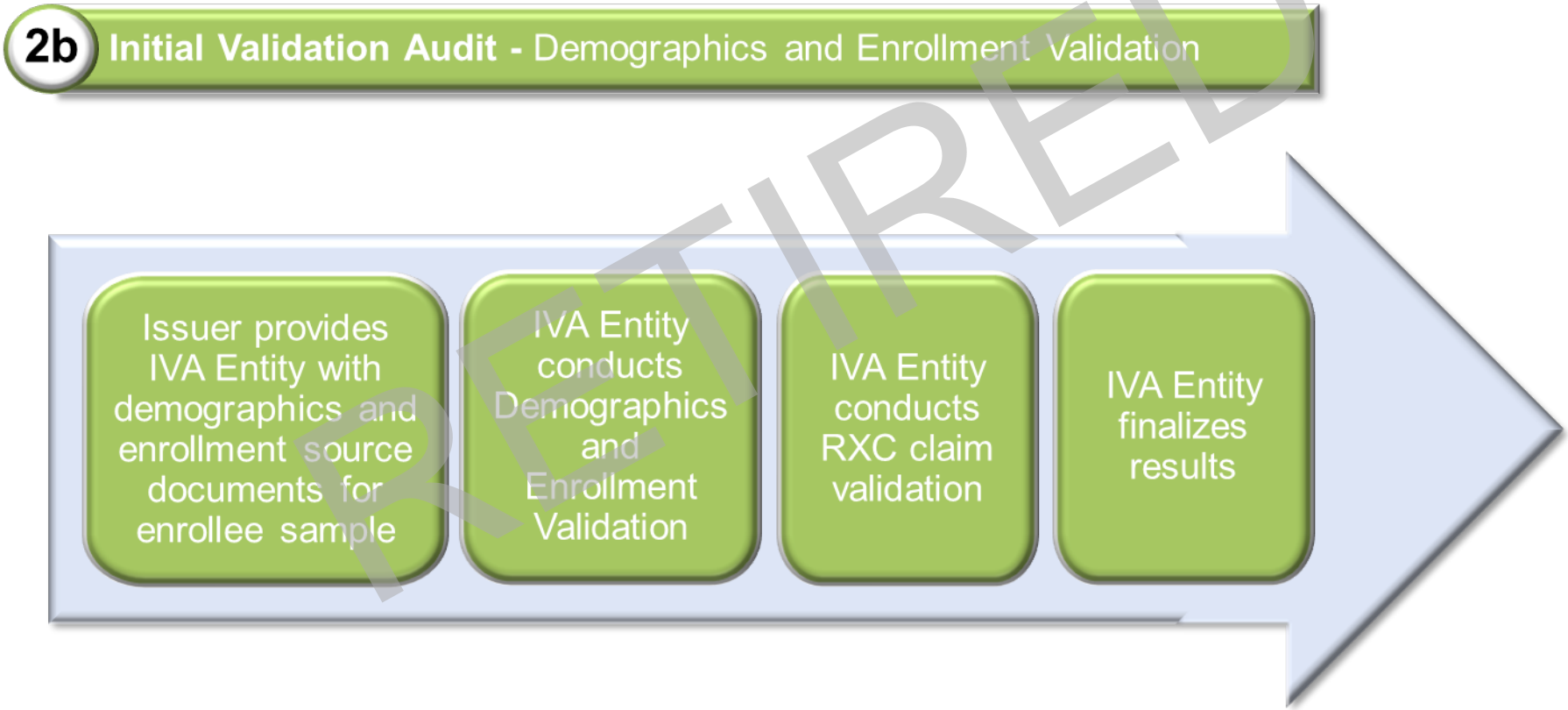
- Per §153.630, issuers must ensure that the designated IVA Entity meets the following criteria:

1. Reasonably capable of performing an IVA according to the standards established by HHS for such audit, and must ensure that the audit is so performed
2. Reasonably free of conflicts of interest, such that it is able to conduct the IVA in an impartial manner and its impartiality is not reasonably open to question
3. An IVA review of enrollee health status must be conducted by medical coders certified after examination by a nationally recognized accrediting agency for medical coding

CMS may reject an issuer's designation of an IVA Entity if the submitted IVA Entity does not meet regulatory requirements

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HHS-RADV Processes: IVA (continued)



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HHS-RADV Processes: IVA (continued)

2b Initial Validation Audit - Demographics and Enrollment Validation

- The issuer provides the IVA Entity with source enrollment documentation
  - The demographics and enrollment review will be used to validate that enrollment data submitted to the EDGE server is the same as the enrollment transactions stored with the issuer
- CMS will provide further guidance in an upcoming webinar training

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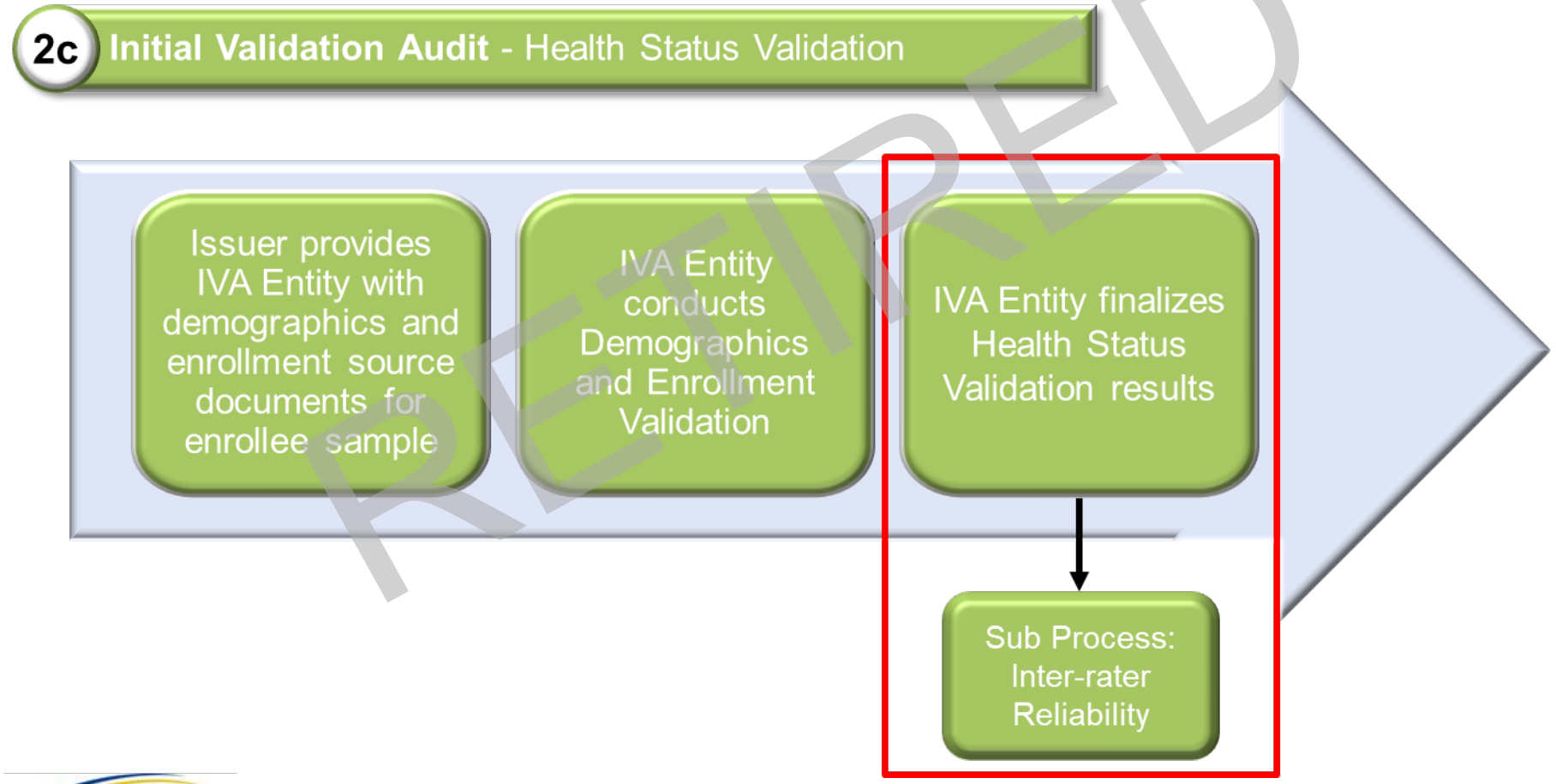
HHS-RADV Processes: IVA (continued)

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2b Initial Validation Audit – Adult RXC Claim Validation

- IVA Entity will validate adult RXC claims
- CMS will provide further guidance in an upcoming webinar training

HHS-RADV Processes: IVA (continued)



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HHS-RADV Processes: IVA (continued)

2c Initial Validation Audit - Health Status Validation

- The issuer provides the IVA Entity with source medical record documentation to validate issuer-submitted RA data for each sampled enrollee
- The review of enrollee health status must be conducted by **certified medical coders** accredited by a nationally recognized accrediting agency such as:
  - American Health Information Management Association (AHIMA)
  - American Academy of Professional Coders (AAPC)

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HHS-RADV Processes: IVA (continued)

2c Initial Validation Audit - Health Status Validation

- The risk score of each enrollee in the sample must be validated by having a Senior Coder confirm any HCC differences discovered during the IVA
- For purposes of this section, a Senior Coder is an individual certified as a medical coder by a nationally recognized accrediting agency who possesses at least **five (5) years** of experience in medical coding

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HHS-RADV Processes: IVA (continued)

2c Initial Validation Audit - Health Status Validation

- **IRR**
  - The IVA Entity must measure and report to the issuer and CMS, in a manner and timeframe specified by CMS, its IRR rates among its reviewers specific to the HHS-RADV audit
  - Each IVA Entity Primary Coder must achieve an IRR rate of at least 95 percent
  - The IRR process measures the degree of agreement among reviewers
  - The required IRR rate is the rate at which a senior reviewer's results for HCCs match the results of another reviewer
  - If the IRR rate is not met, either additional medical records must be sampled until the required accuracy rate is met or all medical records must be reviewed by a senior reviewer

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HHS-RADV Processes: IVA (continued)

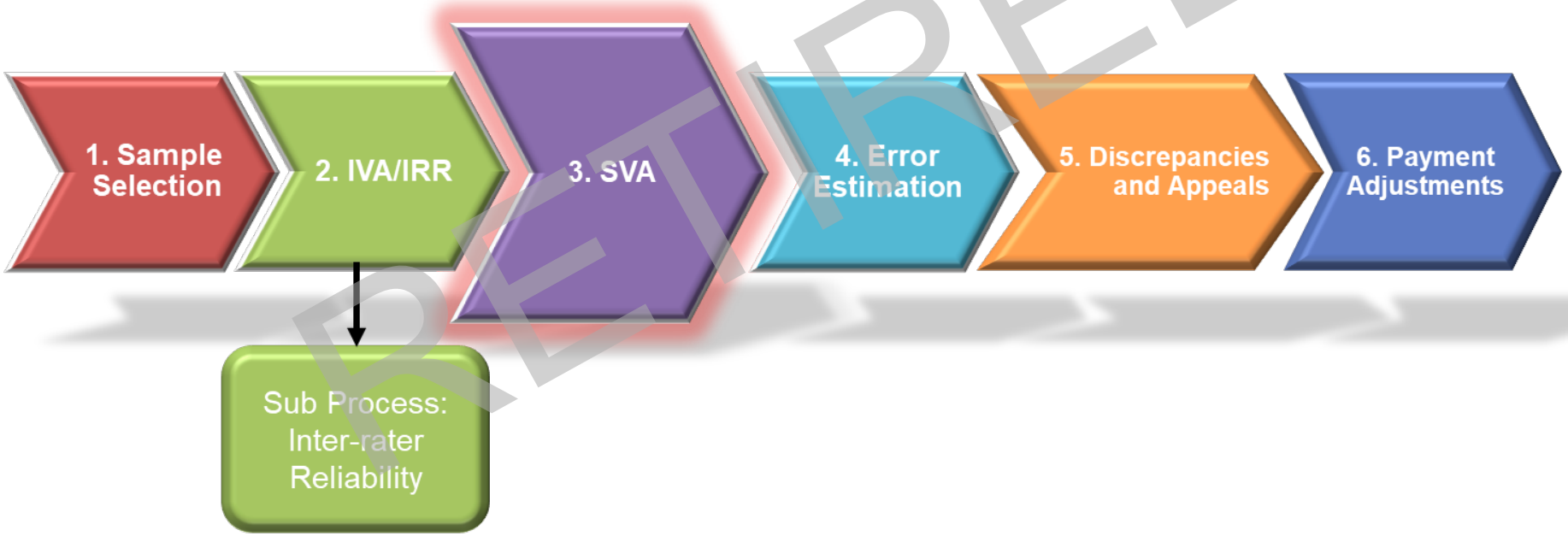
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2d Initial Validation Audit - Submission

- The IVA Entity provides CMS with the final IVA results and all requested supporting documentation for the SVA
- Following completion of the audit, the IVA Entity submits the following to the Audit Tool:
  - The IVA results
  - The requested supporting documentation
  - IRR results for Primary Coders

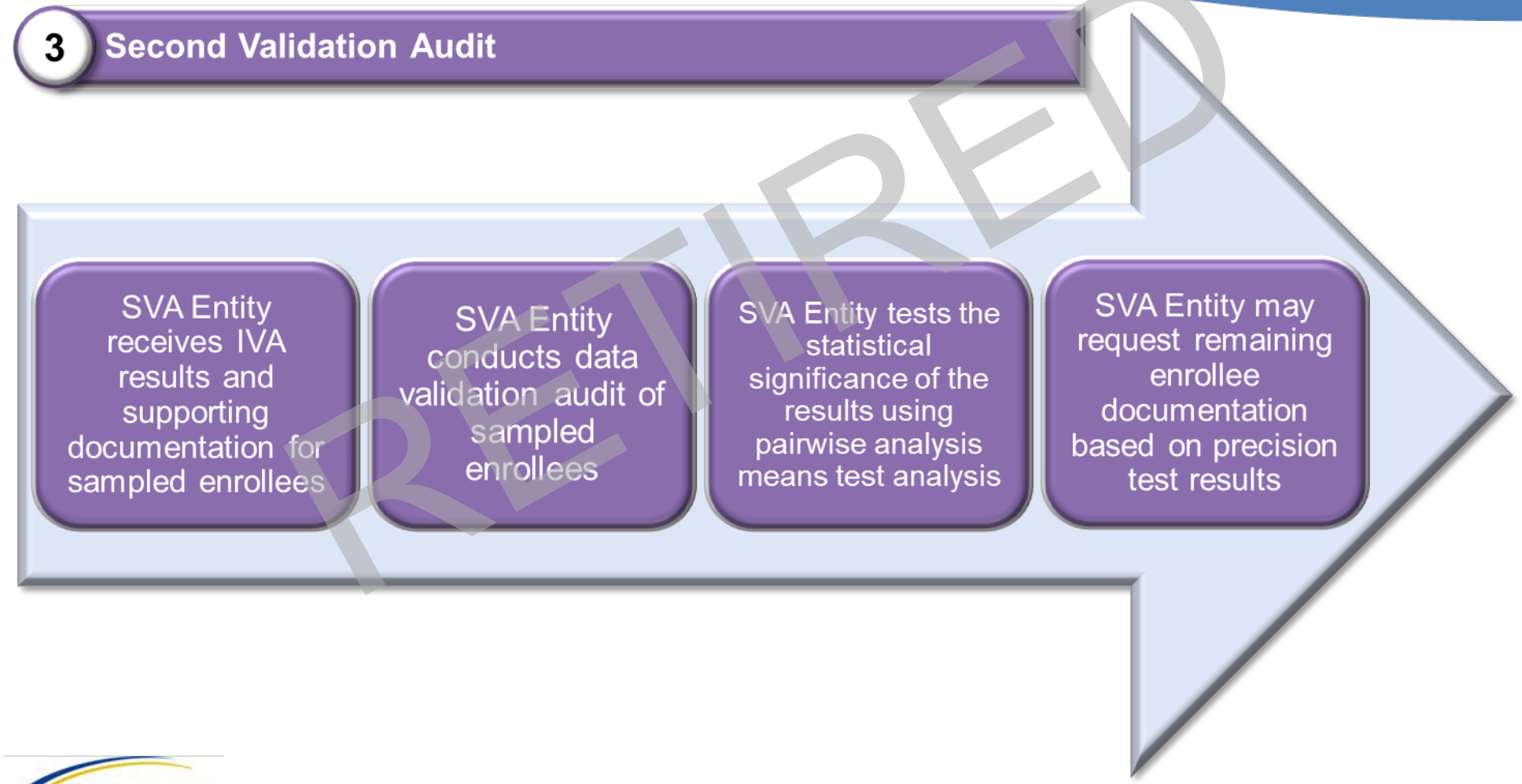
HHS-RADV Processes: SVA

- Step 3: SVA



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HHS-RADV Processes: SVA (continued)



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HHS-RADV Processes: SVA (continued)

3 Second Validation Audit

- Following the IVA, the SVA is conducted by an auditor retained by CMS to verify the accuracy of the IVA findings
- The SVA Entity will only review enrollee information that was originally presented during the IVA and submitted to the HHS-RADV Audit Tool
- The SVA Entity will re-perform the validation steps on the SVA subsample to verify the accuracy of the IVA Entity's results
- At the conclusion of the SVA, CMS evaluates the precision of Error Estimation Results, and may request the documentation for all remaining enrollees in the IVA Sample

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HHS-RADV Processes: SVA (continued)

3 Second Validation Audit

- The initial SVA subsample of enrollees per issuer is expected to be sufficiently large enough to determine if there is sufficient agreement between the IVA and SVA results by pairwise means testing
- The SVA Entity tests a small portion of subsampled enrollees and expands to review additional enrollees until one (1) of the following is determined:
  - All subsampled enrollees for the issuer are reviewed; or
  - The pairwise means tests indicates that there is sufficient agreement between IVA and SVA results
- If the pairwise means test concludes that the difference in the enrollees' risk scores between the IVA and SVA demonstrates that there is sufficient agreement between results, then the IVA results are used for error estimation

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HHS-RADV Processes: SVA (continued)

3 Second Validation Audit

- If the pairwise means test concludes that the difference in the enrollees' risk scores between the IVA and SVA demonstrates that there is **insufficient agreement** between results the SVA Entity will perform the validation steps on a larger subsample of the enrollees previously subject to the IVA, and the results from the larger SVA subsample would again be compared to the results of the IVA using the pairwise means test
  - If the final pairwise means test concludes that there **is sufficient agreement**, then CMS will apply the **IVA** results for error estimation using all enrollees selected for the IVA sample
  - If the final pairwise means test concludes that there **is insufficient agreement**, then CMS will apply the **SVA** results to modify the IVA results, which would be used for error estimation

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HHS-RADV Processes: SVA (continued)

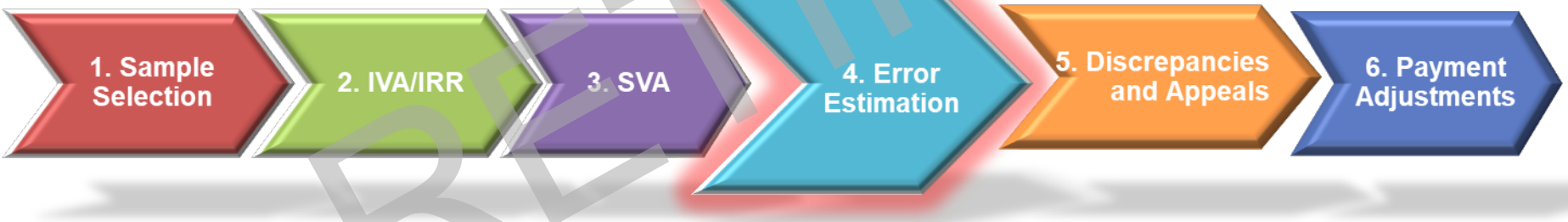
3 Second Validation Audit

- Following the conclusion of the SVA, Error Estimation is performed (see Step 4)
- CMS evaluates the precision of error rate estimates derived during the Error Estimation process, and may require additional enrollees be evaluated during the SVA process if poor precision is indicated
- The additional enrollees which may be requested by CMS are those enrollees from the IVA Sample which were not in the original SVA subsample
  - Example:
    - IVA Sample = 200 enrollees; SVA subsample = 100 enrollees
    - The additional request would be for the medical record documentation for the 100 enrollees not in the original SVA subsample

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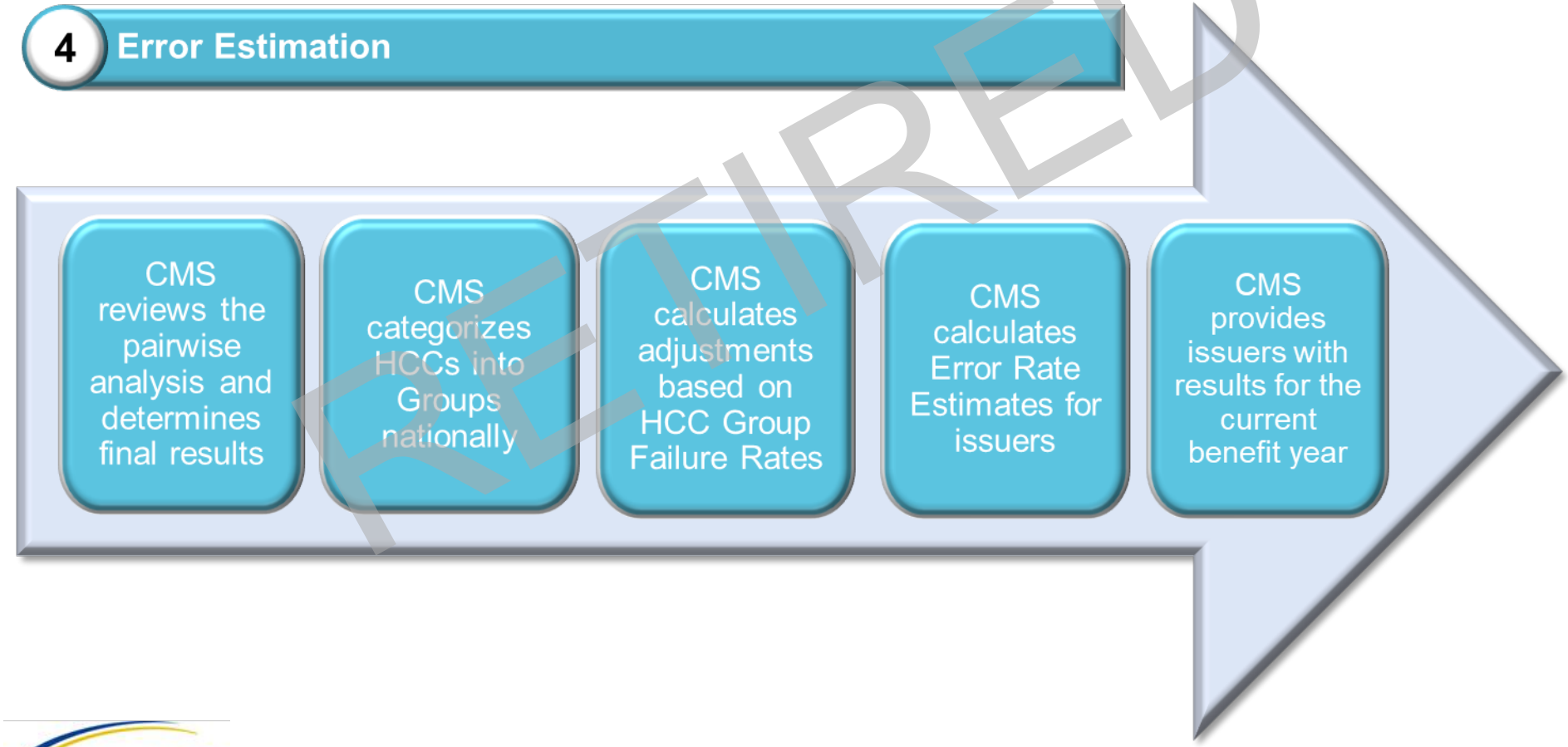
HHS-RADV Processes: Error Estimation

- Step 4: Error Estimation



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HHS-RADV Processes: Error Estimation (continued)



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HHS-RADV Processes: Error Estimation (continued)

4 Error Estimation

- Upon completion of the IVA and SVA, CMS will derive an issuer-level error rate for the benefit year under HHS-RADV review
- CMS compares the health status of an issuer's enrollee population based on data submissions for RA calculations against its peers and applies an adjustment to issuers who statistically deviate from the norm
- CMS utilizes what is known as the "HCC failure rate methodology" to identify outliers and calculate adjustment to enrollee risk scores
- Adjustments to enrollee risk scores for outlier issuers will result in an issuer risk score error rate

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HHS-RADV Processes: Error Estimation (continued)

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4 Error Estimation

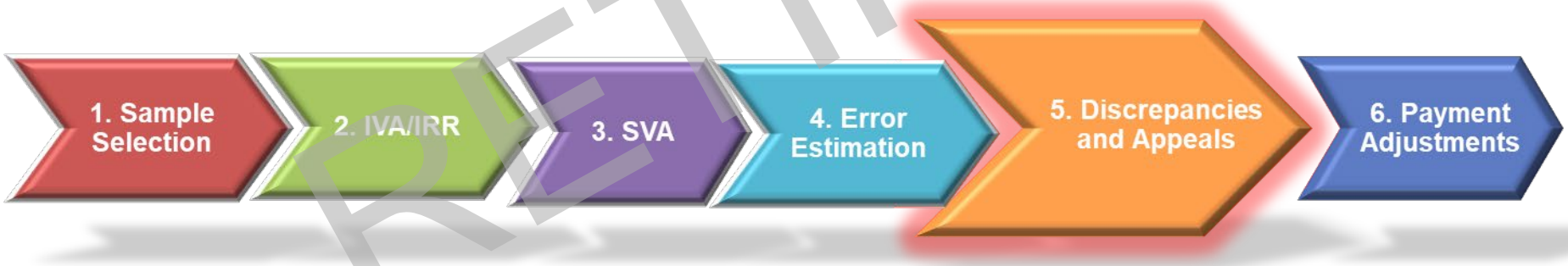
- There are four (4) primary steps to the HCC failure rate methodology under HHS-RADV:
  - Determine final enrollee results (either IVA or SVA)
  - Categorize HCCs into Groups nationally
  - Calculate enrollee-level risk score adjustments based on HCC Group Failure Rates for each issuer
  - Calculate error rate for each outlier issuer
- At the conclusion of the Error Estimation process, CMS will provide each issuer with enrollee and issuer specific results, including error rates for the applicable HHS-RADV benefit year



Note: Only issuers who are outliers in one (1) or more HCC groups will receive an error rate.

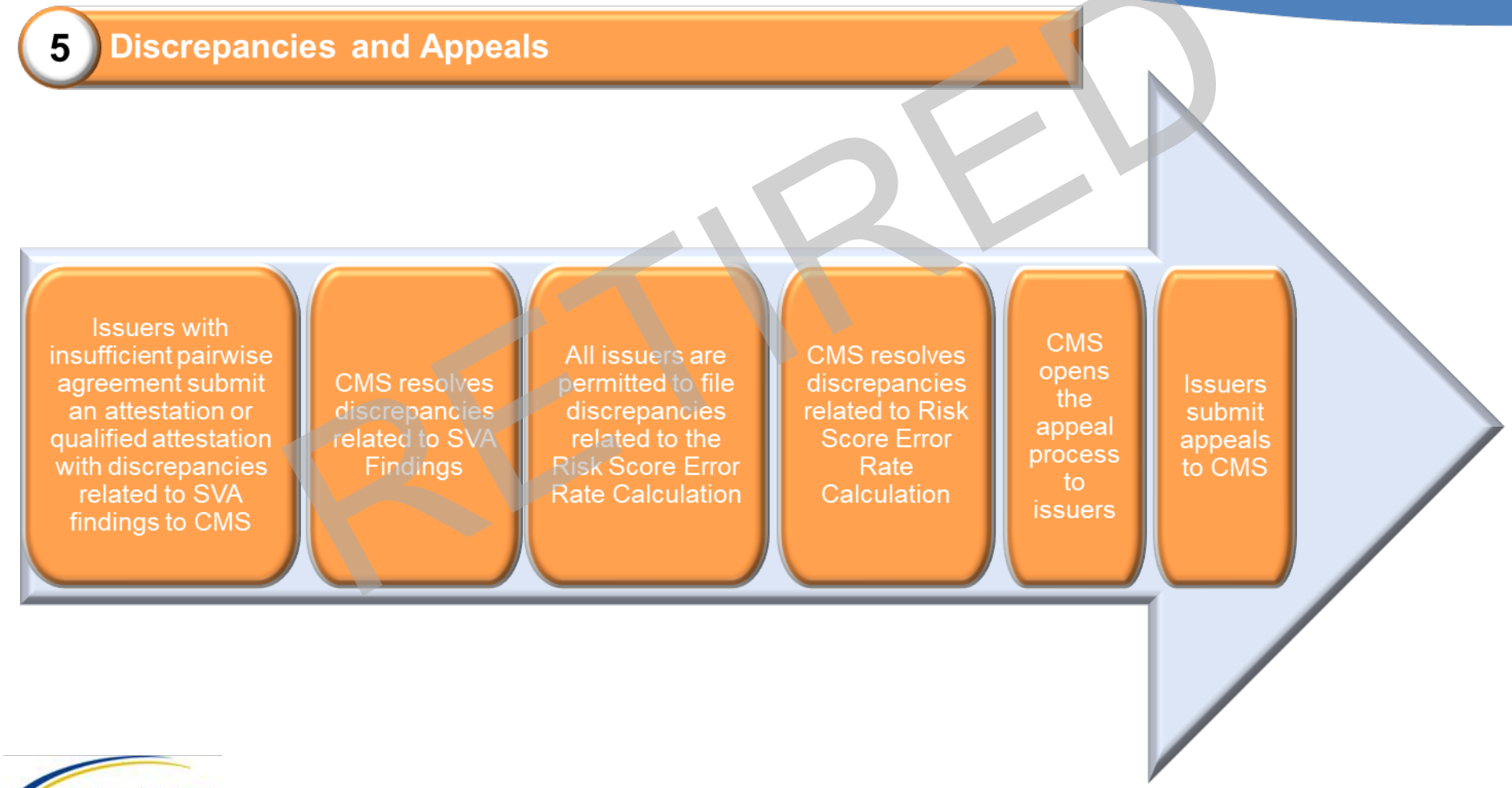
HHS-RADV Processes: Final Results Discrepancy and Appeals

- Step 5: Discrepancies and Appeals of SVA Findings (if applicable) and risk score error rate calculation



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HHS-RADV Processes: Discrepancies and Appeals (continued)



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HHS-RADV Processes: Discrepancies and Appeals (continued)

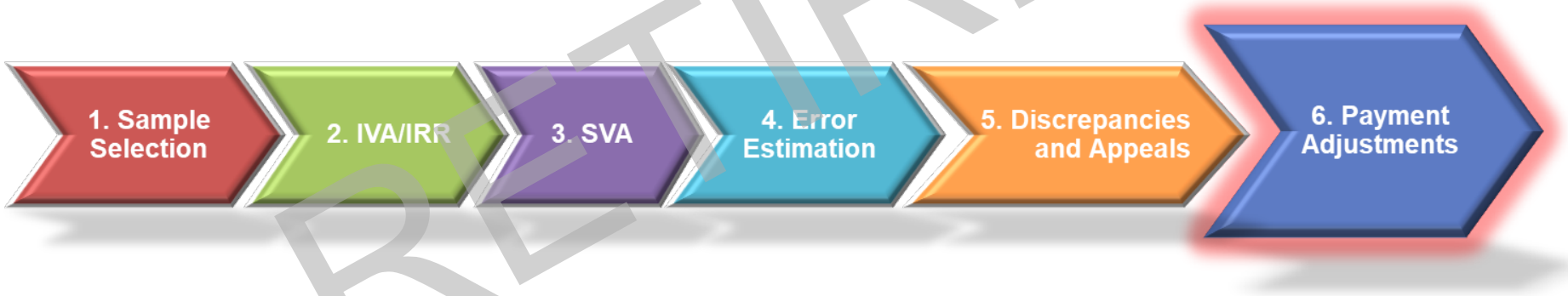
5 Discrepancies and Appeals

- Following the conclusion of the 2018 benefit year HHS-RADV audit, CMS will distribute SVA findings to issuers with insufficient pairwise agreement and risk score error rates based on audit findings to all issuers who participated in HHS-RADV
- If issuers disagree with the SVA findings or the calculation of a risk score error rate, they will have the opportunity to submit a discrepancy to CMS
- Issuers are not permitted to appeal the results of the IVA (including when the IVA results are used to calculate risk score error rates) because the IVA entity is under contract with the issuer and HHS does not produce the IVA results
- Additional details on the SVA Findings attestation and discrepancy reporting process, Risk Score Error Rate Calculation discrepancy reporting process, and appeals process will be forthcoming in future webinars

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HHS-RADV Processes: Payment Adjustments

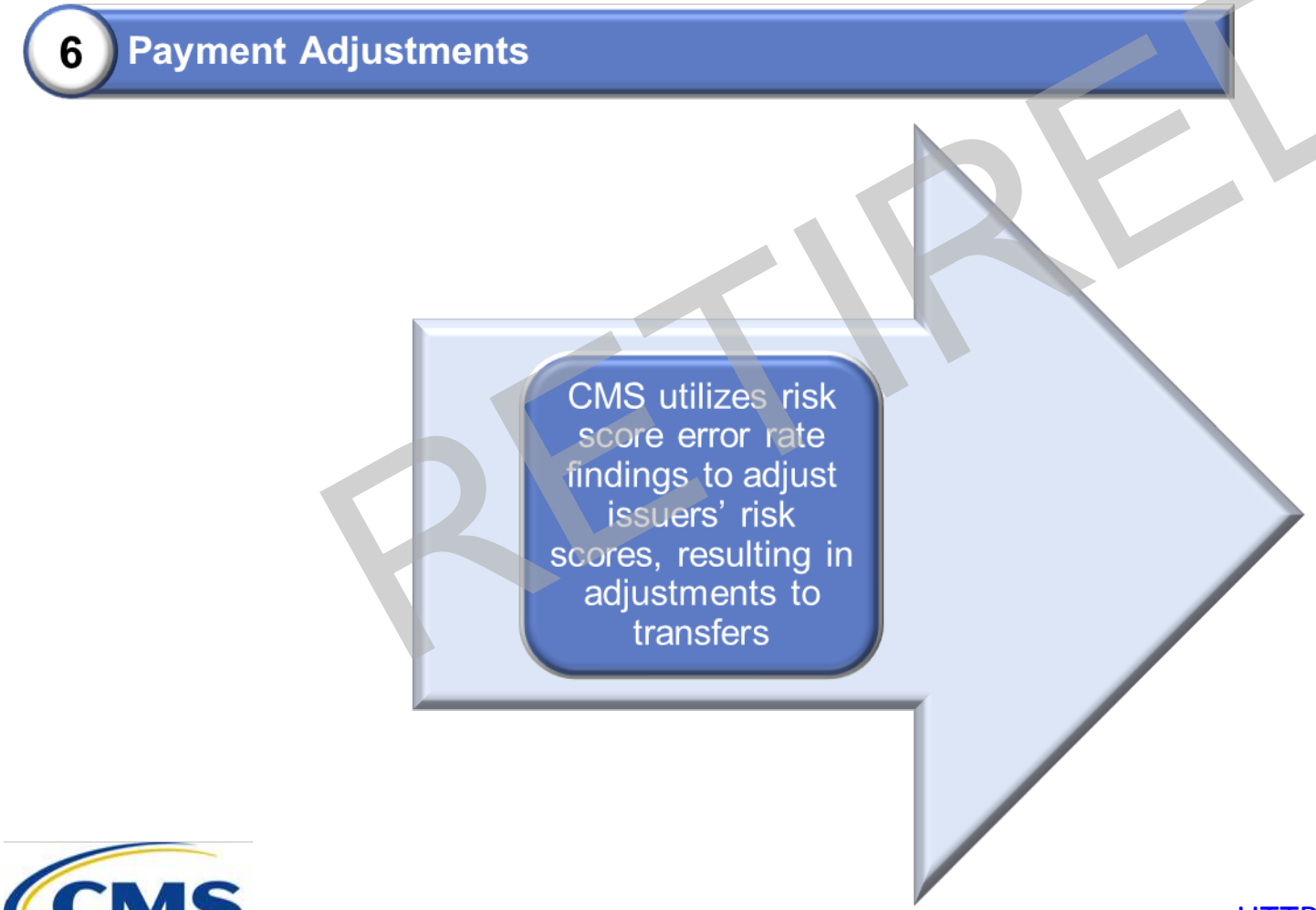
- Step 6: Payment Adjustments



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HHS-RADV Processes: Payment Adjustments (continued)



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HHS-RADV Processes: Payment Adjustments (continued)

6 Payment Adjustments

- CMS will generally use risk score error rate findings from the 2018 benefit year HHS-RADV to adjust the 2019 benefit year RA PLRS(s), resulting in adjusted 2019 benefit year RA transfers which are charged and paid in the summer of 2020
- Additional details on the payment adjustment process will be forthcoming in a future webinar

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HHS-RADV CMS Responsibilities

HHS-RADV Responsibilities: CMS

RETIRED

- Regulate the HHS-RADV process for HHS-operated RA program, including the issuance of regulations, guidance, and trainings
- Develop and implement the guidelines for issuers to follow for their respective EDGE servers
- Develop, implement, and provide access to the Audit Tool
- Adjust issuers' PLRS based on the IVA and SVA results
- Adjudicate issuers' discrepancies and appeals related to SVA findings and risk score error rate calculations

HHS-RADV Responsibilities: CMS (continued)

RETIRED

- Communicate all HHS-RADV updates to issuers, IVA Entities, and the SVA Entity
- Distribute an IVA sample of enrollees and their associated EDGE server data to issuers
- Review and accept the independent IVA Entity selected by the issuer to conduct the IVA
- Perform the SVA and apply the error estimation methodology using IVA or SVA results
- Facilitate discrepancy and appeals processes
- Apply error rates to risk scores for transfer adjustments

RETIRED

HHS-RADV Issuer Responsibilities

HHS-RADV Responsibilities: Issuer

RETIRED

- The information found on the following slides contains a high-level overview of issuer responsibilities and is intended to offer only a summary of technical legal standards
- Issuers should review the applicable statutes, regulations, Protocols, and other interpretive materials for complete and current information about the requirements that apply to them
- Additional information related to issuer responsibilities will be presented during a future webinar presentation

HHS-RADV Responsibilities: Issuer (continued)

RETIRED

- Identify a HHS-RADV Issuer SO to communicate with CMS regarding HHS-RADV activities and to serve as primary user in the Audit Tool, if you have not done so previously
  - The HHS-RADV Issuer SO is required to:
    - Maintain accounts for issuer staff to access the Audit Tool
    - Complete and submit the IVA Entity designation form via the Audit Tool
    - Validate issuer RADVPS report
    - Resolve any non-compliance issues related to the completion and submission of the IVA
    - Confirm the completeness of the IVA results prior to final submission to the Audit Tool
    - If applicable, submit discrepancies or appeals regarding SVA audit findings or the risk score error rate calculation

HHS-RADV Responsibilities: Issuer (continued)

RETIRED

- Engage an independent auditor to conduct the IVA and use the Audit Tool to submit IVA Entity designation
  - The IVA designation process will be presented at a future webinar
- Ensure that the selected IVA Entity is reasonably capable of performing the audit and meets the requirements of 45 CFR 153.630
- Attest that the selected IVA Entity is reasonably free of conflicts of interest, such that it is able to conduct the IVA in an impartial manner with its impartiality not reasonably open to question

HHS-RADV Responsibilities: Issuer (continued)

RETIRED

- Ensure that all IVA Entity regulatory and contractual obligations are met with respect to performing the IVA
- Link the EDGE server unique enrollee IDs to the actual enrollees
- Provide all claims, medical records, and enrollment documentation to the IVA Entity for sampled enrollees in a timely manner that aligns with audit submission and signoff timeframes
- Ensure that the IVA is completed in the manner and timeframe established by CMS
- Ensure the IVA results and requested supporting source documentation are submitted to CMS in the manner and timeframe specified

HHS-RADV Responsibilities: Issuer (continued)

- Discuss IVA findings with IVA Entity prior to submission and signoff in the HHS-RADV Audit Tool
  - Resolve disputes while maintaining the integrity of the IVA Entity's independence
- Initiate the HHS-RADV Attestation and Discrepancy Reporting process of SVA results or the risk score error rate calculations (if applicable)
- Attend HHS-RADV trainings
- Review applicable statues, regulations, published Protocols, Interface Control Document (ICD), Job Aids and all related HHS-RADV published documents
- Maintain an active account in the HHS-RADV Audit Tool

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HHS-RADV IVA Entity Responsibilities

HHS-RADV Responsibilities: IVA Entities

- The information found on the following slides contains a high-level overview of IVA Entities' responsibilities and is intended to offer only a summary of technical legal standards
- IVA Entities should review the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them
- Additional information related to IVA Entities and their responsibilities will be presented during a future webinar presentation

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HHS-RADV Responsibilities: IVA Entities (continued)

RETIRED

- Provide issuers with detailed information on qualifications, capabilities, and potential conflicts of interest
- Be reasonably free of conflicts of interest with the issuer consistent with the policies finalized in the final 2015 Payment Notice
- Attend HHS-RADV trainings
- Review applicable statues, regulations, published Protocols, ICD, Job Aids, and all related HHS-RADV published documents
- Maintain an active account in the HHS-RADV Audit Tool

HHS-RADV Responsibilities: IVA Entities (continued)

RETIRED

- Maintain appropriate personnel to conduct the IVA
  - Have appropriate personnel with proficient knowledge to review, evaluate, and understand:
    - Medical and Prescription Drug Claims Data
    - Demographics and Enrollment Data
    - Premium Amounts
  - Ensure certified medical coders have and maintain current certifications
  - Ensure that at least two (2) certified coders are available to perform medical record reviews, with at least one (1) Senior Coder
  - Ensure senior level coders are certified and have at least five (5) years experience for the 2018 benefit year HHS-RADV and beyond

HHS-RADV Responsibilities: IVA Entities (continued)

RETIRED

- Register in the HHS-RADV Audit Tool
- Create and maintain the data used to submit the IVA procedures and results
- Perform the IVA in an impartial manner
- Perform IRR assessments and submit IRR results to CMS
- Discuss IVA findings with the issuer prior to submission and signoff in the HHS-RADV Audit Tool
  - Resolve disputes while maintaining the integrity of the IVA Entity's independence
  - Enter audit results in the Audit Tool
- Submit enrollee source documentation for the SVA subsample
  - CMS strongly encourages the IVA Entity to redact specific issuer information so that the SVA Entity will not know the identity of the issuer being validated; however, redaction is not required

RETIRED

HHS-RADV SVA Entity Responsibilities

HHS-RADV Responsibilities: SVA Entity

- Register in the HHS-RADV Audit Tool
- Review and approve issuer SVA samples
- Extract subsamples from the IVA sample for the SVA review
- Perform demographics and enrollment information validation
- Perform the pairwise tests and error estimation
- Perform health status validation for medical record reviews and claims
- Conduct the SVA according to published Protocols, ICD, Job Aids, and all related HHS-RADV published documents
- Perform the IRR assessments
- Submit SVA findings and pairwise test results to CMS
- Provide the necessary information and other support to CMS for the SVA results and risk score error rate calculation discrepancy reporting and appeals process

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Q&A

RETIRED

- Type your question in the text box under the “Q&A” tab located to the left-hand panel of your screen
  - To submit your question, click “Submit”



If your question does not receive a response during this webinar session, please submit your question to the HHS-RADV team at CCIIOACARADataValidation@cms.hhs.gov

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Next Steps

Next Steps: Training Sessions

Topic	Date
2018 HHS-RADV Reports Updates, IVA Selection, and Conflict of Interest	March 13, 2019

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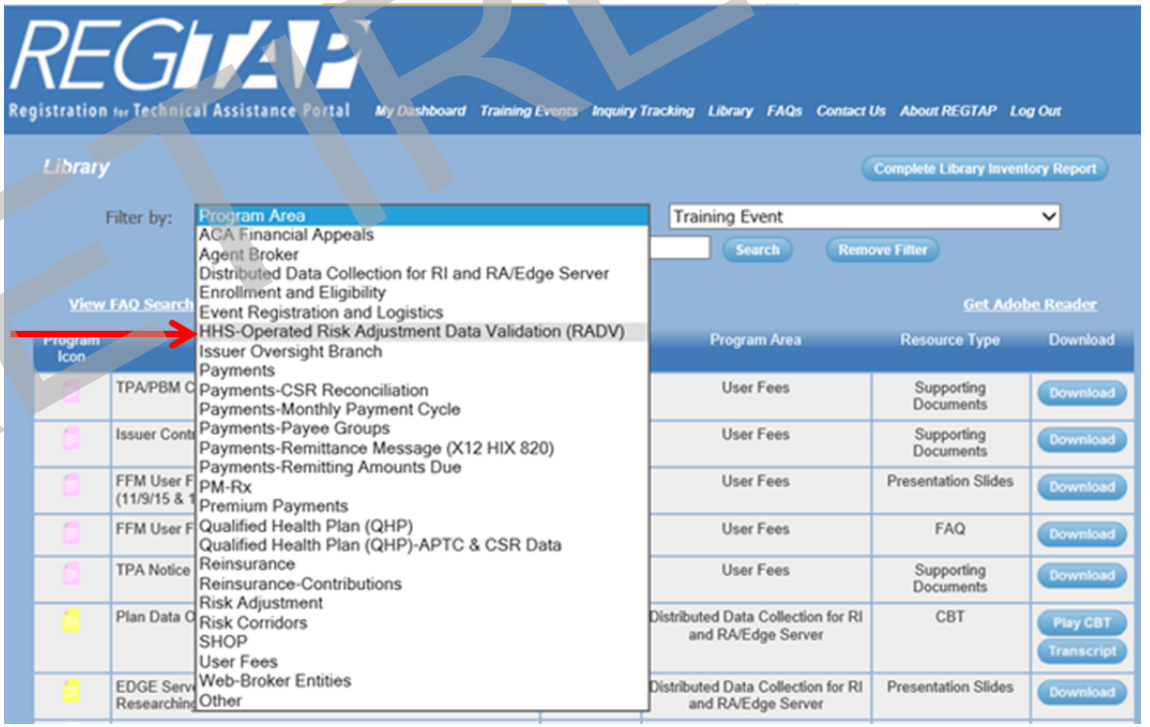
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Resources

Locating HHS-RADV Documents in REGTAP

Stakeholders can access additional documents at https://www.REGTAP.info in the REGTAP Library.

Under Program Area, select "**HHS Risk Adjustment Data Validation (HHS-RADV)**"



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Resources: Links

Resource	Resource Link
U.S. Department of Health & Human Services (HHS)	http://www.hhs.gov/
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov/
The Center for Consumer Information & Insurance Oversight (CCIIO) web page	http://www.cms.gov/cciio
Consumer website on Health Reform	http://www.healthcare.gov/
Registration for Technical Assistance Portal (REGTAP)	https://www.REGTAP.info
Patient Protection and Affordable Care Act (PPACA)	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html

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Resources: Links (continued)

Resource	Resource Link
HHS Notice of Benefit and Payment Parameters for 2014	http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf
HHS Notice of Benefit and Payment Parameters for 2015	http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf
HHS Notice of Benefit and Payment Parameters for 2016	http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf
HHS Notice of Benefit and Payment Parameters for 2017	https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf
HHS Notice of Benefit and Payment Parameters for 2018	https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf

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Resources: Links (continued)

Resource	Resource Link
HHS Notice of Benefit and Payment Parameters for 2019	https://www.gpo.gov/fdsys/pkg/FR-2018-04-17/pdf/2018-07355.pdf
Proposed HHS Notice of Benefit and Payment Parameters for 2020	https://www.govinfo.gov/content/pkg/FR-2019-01-24/pdf/2019-00077.pdf

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Resources: Contact Information

Resource	Contact Information
For RADV policy questions, contact the RADV Team.	CCIIOACARADataValidation@cms.hhs.gov
EDGE server questions, please contact your Financial Management (FM) Service Representative directly and copy the Centers for Medicare & Medicaid Services (CMS) Help Desk.	EDGE_server_data@cms.hhs.gov and copy CMS_FEPS@cms.hhs.gov
HHS-RADV Audit Tool	To contact us within the HHS-RADV Audit Tool, use the Inquiries tab and select “Submit Inquiry”

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Closing Remarks