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Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services

Center for Consumer Information and Insurance Oversight

Log of Updates to the 2017 Benefit Year Protocols

PPACA HHS Risk Adjustment Data Validation

Version 1.0

May 21, 2018

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Page #	Section	Summary of Update
Global	Global	• Updated references from benefit year 2016 to benefit year 2017 or made benefit year agnostic. • All instances of “sub-sample” were standardized to “subsample” or “SVA subsample.” • All references to “pilot year” were removed. • Appendices (EDGE Server HHS-RADV sampling reports) were updated to reflect the new HHS-RADV reports. • Global changes to update “Marketplace” to “Exchange” as reflected in the 2018 and 2019 Payment Notices. • Language updated to indicate that IVA Entities are not abstracting hierarchical condition categories (HCCs); they are abstracting diagnoses that are assigned HCCs. • Language updated to include criteria from 2019 Payment Notice. • All references to “ACA” were updated to “PPACA.”
6 and 7	Preface and 1.1	• The objective of the HHS-RADV program was revised to better clarify the intent and goals of the HHS-RADV program.
6 and 7	Preface and 1.1	• Section language was updated to indicate benefit year 2017 is a payment year. • New language was included to introduce the new HCC Failure Rate Methodology used to calculate error rates. • Added clarification for exemptions from HHS-RADV and issuers in liquidation.
8-12 and 18	1.3, 1.3.5.1 and 2.5	• Language was updated to articulate roles and responsibilities that are specific to the HHS-RADV program and divided into “Programmatic” and “Audit Tool.” • Additional language discussing the Issuer and IVA Entity Senior Official and Coordinator roles was added. • Section 1.3.5.1 – Primary and Senior Reviewer roles and responsibilities were updated. • Clarifications around the Conflict of Interest (COI) Attestation were added.
13-14	1.5	• HHS-RADV Timeline was updated to reflect benefit year 2017 activities. • Benefit year 2016 hurricane guidance references were removed. • Updated to include Submission of Package three (3) Medical Records.
28-30	4.3	• Updated section to align with new Error Estimation approach and CMS selection of 200 enrollee sample size. • Updated Precision Confidence Level section and removed Sample Size Formulas and Overall Sample Size sections.
31-37	4.5	• Section 4.5.1 – RA Report – RADVPS was updated to clarify the difference between the RADVPS and RADVPSF Reports. • Section 4.5.2 – RADV Report – RADVPSF was added to describe the new report for the benefit year 2017 HHS-RADV Sampling Report Run. • Section 4.5.4 – Sampling Discrepancy Reporting was added to provide information on submitting RA Report and HHS-RADV Sampling Report discrepancies.
44	5.2.3	• The Audit workpaper definition and language were updated to clearly articulate the intent of workpapers and what they may be used for. • Clarifying language was added to indicate that issuers may submit workpapers to IVA Entities to identify an RA discrepancy.
48	5.5	• Demographic and Enrollment (D&E) language was updated to indicate that CMS reserves the right to further analyze D&E data and impose civil monetary penalties (CMPs), if appropriate, as stated in the 2019 Payment Notice.

50-55	5.5.1.1	• Clarifying language added around the validation of D&E data elements.
56	5.5.1.2	• Language was updated to clarify requirements for newborn verifications.
58	5.6.2	• Language was updated to clarify that CMS cannot assist in retrieving medical records and documentation. • Updated language to provided information on where to locate the Medical Record Provider Request memo in the Audit Tool.
61-64	5.6.5 and 5.6.5.1	• Language was updated to clarify acceptable date(s) of medical records. • Language was updated to indicate that dates of service align to medical records and Statement Covers From and Through dates align to claim values.
64-66	5.6.7	• Table 6 and 7 – Allowable Bill Type Codes for Institutional Claims Table was updated to reflect the allowable and non-allowable bill type codes for RA data submission. • The Mental Health or Behavioral Health Records section was updated to align to the 2019 Payment Notice.
72-76	5.6.11	• The Chronic Condition examples were updated to provide additional clarity after reviewing Benefit year 2016 submitted documentation.
76-80 and 82-83	5.6.12 and 5.7.1	• Language updated to clarify the package escalation process for IVA Entities to reduce IVA Entity's burden to re-review enrollee medical records. • Language updated to clarify requirements for submission of Final Diagnosis versus Senior and Primary Diagnosis Codes.
80-81	5.6.12.1	• Updated to reflect the impact of finding HCCs not previously reported to the EDGE server under the new HCC Failure Rate Methodology and the impact.
80-81	5.6.12.1	• Language updated to include clarifying language for using death summaries to support HCCs and diagnoses submitted to the EDGE server.
82-83	5.7.1	• Language updated to provide clarification on the option for issuers and IVA Entities to include an 'Other Map' workpaper document to outline enrollees in Strata 1-9 whose medical records were not obtained.
85-90	6.0	• Section 6.0 – Inter-rater Reliability (IRR) was updated with a new IRR Methodology which incorporates a 95% threshold to pass IRR. • Language updated to allow for IVA Entities to implement their own IRR methodology, with the understanding that they must submit their IRR methodology to CMS.
7-8, 12-13 and 92-107	1.1, 1.4.4 and 7.0	• Section 7.0 – Error Estimation was updated to reflect the new HCC Failure Rate Methodology. • Section 1.1 – Purpose section updated to introduce the new HCC Failure Rate Methodology. • Section 1.4.4 – Error Estimation Summary was updated to reflect the new HCC Failure Rate Methodology.
98-100	7.3.3	• Section 7.3.3 was updated to align with the Payment Notice.
12 and 109-111	1.4 and 8.0	• Section 1.4 was updated to include an introductory paragraph which provides a summary of the HHS-RADV Final Results Discrepancy and Administrative Appeals process. • Section 8.0 – HHS-RADV Final Results Discrepancy and Administrative Appeals Section was added to the Protocols to align with payment year processes.
125-135		• Added Appendix D – Error Estimation Example.