DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: April 15, 2022

TO: **All Medicare Advantage Organizations, PACE Organizations, Medicare-Medicaid Plans, Section 1876 Cost Contractors, and Demonstrations**

FROM: Jennifer R. Shapiro, Director, Medicare Plan Payment Group

SUBJECT: Reminder of Existing Obligation to Submit Accurate Risk Adjustment Data [1]

This memo is a reminder to all Medicare Advantage (MA) organizations that submit risk adjustment data under 42 CFR 422.310 of their existing statutory, regulatory, and contractual obligations to submit accurate risk adjustment data, and correct their risk adjustment data based on their best knowledge, information, and belief.

Section 1853(a) of the Social Security Act requires the Secretary to make risk adjusted payments to MA organizations. Under Section 1853(a),the Secretary has the authority to require MA organizations to submit data the Secretary deems necessary to calculate MA risk adjustment payments. This authority has been implemented at 42 CFR 422.310, which requires submission of risk adjustment data by MA organizations. This includes the submission of "data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner." 42 CFR 422.310(b). MA organizations must submit data that conforms to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards, including the requirement in the International Classification of Diseases-Clinical Modification (ICD-CM) Guidelines for Coding and Reporting that diagnoses be properly documented in patients' medical records. *See* 42 CFR 422.310(d)(1); 45 CFR 162.1002(c)(2) and (c)(3). The diagnosis codes and other risk adjustment information that MA organizations submit directly affect the calculation of CMS payments to MA organizations. A diagnosis code that is not properly documented in a patient's medical record is not a valid basis for CMS risk adjustment payments to an MA organization. *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 869, 877 (D.C. Cir. 2021).[2] Misrepresentation to CMS about the accuracy of diagnosis codes and other risk adjustment

---

[1] The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

[2] The D.C. Circuit issued its mandate in *UnitedHealthcare* on November 1, 2021. Consequently, the Overpayment Rule remains in effect pending the disposition of any petition filed by Plaintiffs for further review.

information submitted to the agency may result in Federal civil action and/or criminal prosecution.

In accordance with the regulations at 42 CFR 422.503(b)(4)(vi) and 422.504(h) and (l) and MA organizations' contracts with CMS under the MA Program, MA organizations must implement effective compliance programs to prevent, detect, and correct fraud, waste, and abuse with respect to the submission of data to CMS; comply with Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law and the False Claims Act (31 U.S.C. 3729-3733); and certify (based on best knowledge, information, and belief) that the risk adjustment data they submit under 42 CFR 422.310 are "accurate, complete, and truthful." In addition, each MA organization also agrees "(b)ased on best knowledge, that it will submit data that are accurate, complete, and truthful" when signing the Electronic Data Interchange (EDI) agreement.[3]

Section 1128J(d) of the Social Security Act requires that overpayments received under title XVIII or XIX to which an entity is not entitled, must be reported and returned no later than 60 days after it was identified by the entity. Once an MA organization has identified that incorrect diagnosis data were submitted, the MA organization is responsible for deleting the incorrect diagnosis data through the established submission process (i.e., Risk Adjustment Processing System (RAPS) and/or Encounter Data Processing System (EDPS)) (42 CFR 422.310(d)(2)). The obligation to delete incorrect diagnosis data applies regardless of whether the MA organization identifies the incorrect diagnosis data prior to the risk adjustment deadline or after. The Part C/D Overpayment Rule, 42 CFR 422.326, implements the overpayment requirements of Section 1128J(d) and "establishes that, if a Medicare Advantage insurer has received a payment increment for a beneficiary's diagnosis and discovers that there is no basis for that payment in the underlying medical records, that is an overpayment that the insurer must correct by reporting it to CMS within sixty days for refund." *UnitedHealthcare*, 16 F.4th at 870 (upholding relevant portions of the C/D Overpayment Rule).

In instances where the organization identifies incorrect data after the final risk adjustment data submission deadline announced by CMS, but does not have the data available to submit to RAPS and/or EDPS, the organization should submit supporting documentation to the Risk Adjustment Overpayment Reporting (RAOR) module in HPMS giving an auditable estimate of the overpayment amount (including how the estimate was derived), the reason for the overpayment, and the reason the data is not available to submit. Please note, the RAOR module should not be used to submit letters addressing any other topics. When MA organizations correct diagnosis data, including the deletion of diagnosis codes, before the deadline for final reconciliation payments, CMS recalculates risk scores and adjusts payments through the final reconciliation payment process in accordance with 42 CFR 422.310(g)(2). CMS also periodically reruns risk score calculations and adjusts payments after it makes final reconciliation payments to MA organizations to account for instances in which MA organizations delete diagnosis data from a period for which the deadline for final reconciliation payments has closed (i.e., when they make "closed-period deletes" in RAPS and EDPS or submit auditable estimates to the RAOR module).

---

[3]https://www.csscoperations.com/internet/cssc4.nsf/files/2018_07_30%20EDI%20Agreement%20with%20OMB%20rev%20OSORA%20PRA.pdf/$FIle/2018_07_30%20EDI%20Agreement%20with%20OMB%20rev%20OSORA%20PRA.pdf

CMS intends to schedule reruns and adjust payments based on closed-period deletes and auditable estimates. CMS will provide advance notice to the MA organizations regarding the scheduling of these reruns and payment adjustments. Accordingly, MA organizations should continue to make closed-period deletes and submit auditable estimates to the RAOR module for prior payment years in accordance with their obligations referenced above.

Questions can be submitted to risk adjustment policy mailbox. Please specify, "Reminder of Existing Obligation to Submit Accurate Risk Adjustment Data" in the subject line. Thank you.