§411.1010) offered by an MA organization, and ends when the beneficiary is enrolled in an MA plan offered by the MA organization.

(ii) CMS does not make an adjustment unless the beneficiary certifies that, at the time of enrollment under the MA plan, he or she received from the organization the disclosure statement specified in §422.111.

(g) *Adjustment for national coverage determination (NCD) services and legislative changes in benefits.* If CMS determines that the cost of furnishing an NCD service or legislative change in benefits is significant, as defined in §422.109, CMS will adjust capitation rates, or make other payment adjustments, to account for the cost of the service or legislative change in benefits. Until the new capitation rates are in effect, the MA organization will be paid for the significant cost NCD service or legislative change in benefits on a fee-for-service basis as provided under §422.109(b).

(h) *Adjustments to payments to regional MA plans for purposes of risk corridor payments.* For the purpose of calculation of risk corridors under §422.458, MA organizations offering regional MA plans in 2006 and/or 2007 must submit, after the end of a contract year and before a date CMS specifies, the following information:

(1) Actual allowable costs (defined in §422.458(a)) for the previous contract year.

(2) The portion of the costs attributable to administrative expenses incurred in providing these benefits.

(3) The total costs for providing rebatable integrated benefits (as defined in §422.458(a)) and the portion of the costs that is attributable to administrative expenses in addition to the administrative expenses described in paragraph (h)(2) of this section.

[70 FR 4729, Jan. 28, 2005, as amended at 75 FR 44564, July 28, 2010]

### §422.310 Risk adjustment data.

(a) *Definition of risk adjustment data.* Risk adjustment data are all data that are used in the development and application of a risk adjustment payment model.

(b) *Data collection: Basic rule.* Each MA organization must submit to CMS (in accordance with CMS instructions) the 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. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.

(c) *Sources and extent of data.* (1) To the extent required by CMS, risk adjustment data must account for the following:

(i) Items and services covered under the original Medicare program.

(ii) Medicare covered items and services for which Medicare is not the primary payer.

(iii) Other additional or supplemental benefits that the MA organization may provide.

(2) The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the original Medicare program, even if they participate jointly in the same service.

(d) *Other data requirements.* (1) MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. CMS may specify abbreviated formats for data submission required of MA organizations.

(2) The data must be submitted electronically to the appropriate CMS contractor.

(3) MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service.

(4) MA organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data.

(e) *Validation of risk adjustment data.* MA organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data,

as required by CMS. There may be penalties for submission of false data.

(f) *Use of data.* CMS uses the data obtained under this section to determine the risk adjustment factors used to adjust payments, as required under §§ 422.304(a) and (c). CMS also may use the data for updating risk adjustment models, calculating Medicare DSH percentages, conducting quality review and improvement activities, and for Medicare coverage purposes.

(g) *Deadlines for submission of risk adjustment data.* Risk adjustment factors for each payment year are based on risk adjustment data submitted for items and services furnished during the 12-month period before the payment year that is specified by CMS. As determined by CMS, this 12-month period may include a 6-month data lag that may be changed or eliminated as appropriate. CMS may adjust these deadlines, as appropriate.

(1) The annual deadline for risk adjustment data submission is the first Friday in September for risk adjustment data reflecting items and services furnished during the 12-month period ending the prior June 30, and the first Friday in March for data reflecting services furnished during the 12-month period ending the prior December 31.

(2) CMS allows a reconciliation process to account for late data submissions. CMS continues to accept risk adjustment data submitted after the March deadline until January 31 of the year following the payment year. After the payment year is completed, CMS recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary. Risk adjustment data that are received after the annual January 31 late data submission deadline will not be accepted for the purposes of reconciliation.

[73 FR 48757, Aug. 19, 2008]

### § 422.311 RADV audit dispute and appeal processes.

(a) *Risk adjustment data validation (RADV) audits.* In accordance with § 422.2 and § 422.310(e), CMS annually conducts RADV audits to ensure risk adjusted payment integrity and accuracy.

(b) *RADV audit results.* (1) MA organizations that undergo RADV audits will be issued an audit report post medical record review that describes the results of the RADV audit as follows:

(i) Detailed enrollee-level information relating to confirmed enrollee HCC discrepancies.

(ii) The contract-level RADV payment error estimate in dollars.

(iii) The contract-level payment adjustment amount to be made in dollars.

(iv) An approximate timeframe for the payment adjustment.

(v) A description of the MA organization's RADV audit appeal rights.

(2) *Compliance date.* The compliance date for meeting RADV medical record submission requirements for the validation of risk adjustment data is the due date when MA organizations selected for RADV audit must submit medical records to CMS or its contractors.

(3) *Medical record review appeal.* MA organizations that do not agree with the medical record review determinations for audited HCCs may appeal the medical record review determinations of the initial validation contractor to CMS in accordance with paragraph (c)(2) of this section.

(c) *RADV audit dispute and appeal processes*—(1) *Attestation process*—(i) *Submission requirements for attestations.* MA organizations—

(A) May submit CMS-generated attestations from physician/practitioner(s) in order to dispute signature-related or credential-related RADV errors in accordance with the attestations provisions of this section.

(B) Are not obligated to submit attestations to CMS.

(ii) *RADV audit-related errors eligible for attestation process.* CMS will only accept an attestation to support a physician or outpatient medical record with a missing signature or missing credential or both.

(iii) *RADV audit-related errors and documentation ineligible for attestation process.*

(A) Attestations from providers for anything other than signature-related and credential-related errors will not be permitted.

(B) Inpatient provider-type medical records are not eligible for attestation.

(iv) *Manner and timing of a request for attestation.* (A) CMS will provide MA