DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP

DATE: June 20, 2017

TO: All Medicare Advantage Organizations, PACE Organizations, Medicare-Medicaid Plans, Section 1833 Cost Contractors and Section 1876 Cost Contractors, and Demonstrations

FROM: Cheri Rice, Director
Medicare Plan Payment Group /s/

SUBJECT: RAPS Submission of Data Collection Year Diagnosis Codes

To calculate risk scores for a given payment year, CMS uses diagnosis data from the prior year (i.e., data collection period). In some instances, beneficiaries are enrolled in a plan with a different parent organization during the data collection period than in the payment year. CMS is aware that there are circumstances when Medicare Advantage plans enroll beneficiaries who have switched from a plan operated by another parent organization that had reported an especially low volume of diagnoses for those beneficiaries. In order to mitigate these circumstances, CMS is specifying that organizations are able to submit diagnosis codes to RAPS for years when a beneficiary was enrolled in a plan of a different parent organization (but not if the beneficiary was in Fee-for-Service Medicare the year before).

Please note that this guidance in no way creates an obligation for any organization to provide diagnoses data to another organization. Organizations should take into account any operational, burden, or legal considerations when determining how to proceed. In addition, we remind Medicare Advantage and other organizations that all risk adjustment and other applicable regulations and laws apply to the submission of these diagnoses, including requirements to report and return overpayments, just as they do when submitting diagnoses for beneficiaries who were enrolled in their own plan in the prior year.

If you have any questions, please email the RiskAdjustment@cms.hhs.gov mailbox, with the subject line “RAPS submission of data collection year diagnosis codes.”