Payment Year 2014
Medicare Advantage (MA) Contract-Specific Risk Adjustment Data Validation (RADV)

Payment Error Calculation Methodology

March 04, 2026

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1 Purpose

This document communicates the Centers for Medicare & Medicaid Services (CMS) payment error calculation (PEC) methodology for payment year (PY) 2014 contract-specific Risk Adjustment Data Validation (RADV) audits.[1]

2 Background

Section 1853(a)(1)(C) of the Social Security Act (the Act) requires that CMS calculates risk adjusted payments made to Medicare Advantage (MA) organizations. Risk adjustment strengthens the MA program by ensuring that appropriate payments are made to MA organizations based on the health status and demographic characteristics of their enrolled beneficiaries. MA organizations submit enrollees' diagnosis data[2] to CMS until the final risk adjustment data submission deadline for each payment year. Information about how CMS calculated PY 2014 risk adjusted payments—including risk adjustment factors and CMS hierarchical condition categories (CMS-HCCs)—was published in the Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (April 1, 2013).[3] Detailed information about MA risk adjustment and enrollee risk score calculation is published each year by CMS and applies to future payment years.[4]

CMS conducts RADV audits pursuant to 42 CFR Sections 422.2 and 422.310(e). Section 422.310(e) requires MA organizations to submit medical records (MRs) to CMS for validation of risk adjustment data. Contract-specific RADV audits are CMS' main corrective action to identify overpayments made to MA organizations when the documentation in MRs does not support the diagnoses reported by MA organizations for the calculation of risk adjusted payments.[5]

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[1] In the past, CMS referred to an MA contract-level RADV audit (now referred to as a contract-specific RADV audit) using the acronym CONXX, where XX referred to the two digit payment year. The acronym may still be used in CMS systems for a limited time until CMS can make terminology updates.

[2] Payments to MA organizations for a given PY are required to be substantiated by diagnoses documented in medical records from face-to-face encounters with dates of service in the year prior to the PY (i.e., data collection year) from an acceptable data source, and coded according to International Classification of Diseases (ICD) coding guidelines (Medicare Managed Care Manual, Chapter 7- Risk Adjustment).

[3] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/announcement2014.pdf

[4] https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents. These documents comprise the MA and Medicare+Choice (M+C) advance notices of methodological changes; announcements issued with MA or M+C rates; and special reports.

[5] In issuing these results, CMS notes the following: As part of the RADV audits for PY 2014, agency auditors reviewed MRs to determine whether MA organizations had submitted diagnosis codes in accordance with the ICD Guidelines for Coding and Reporting. However, the agency auditors who reviewed the MRs did so under constraints that MR coders typically do not face. For example, the auditors were limited to reviewing only the specific MRs submitted by MA organizations, and they could not query providers for clarification or collect additional records. The auditors also could not adapt their procedures to address specific MA organization and

For PY 2014, CMS selected a sample of enrollees and calculated an overpayment amount using the methodology described in this paper. Note that when PY 2014 RADV audits were initiated, CMS established a sampling methodology with some of the audited contracts having sampled enrollees from two different groups (or tiers). After initiating these audits, CMS published a final rule (CMS-4185-F2) communicating that it will only collect non-extrapolated overpayments for PY 2014 RADV audits.[6] Accordingly, the PEC methodology described in this paper is for calculating non-extrapolated overpayments related to sampled enrollees, regardless of their initial group (tier) designation.

3 Payment Error Calculation Methodology

RADV audits confirm the presence of diagnoses in valid MR documentation, submitted by an MA organization, that map to CMS-HCCs used for risk adjusted payments. A risk adjustment discrepancy is identified when any of the following conditions are true:

- The audited CMS-HCC was not supported by diagnoses found in valid MRs during the RADV audit process.[7]
- No valid MRs were submitted for the sampled enrollee.
- No MRs were submitted for the sampled enrollee.

A RADV audit report issued by CMS will communicate a determination for each audited CMS-HCC. Table 1 lists and explains the possible outcomes for audited CMS-HCCs for PY 2014 RADV audits.

provider practices, such as pre-population of problem lists and past medical histories. To account for these limitations, auditors were provided with internal guidance for applying the ICD Guidelines in the unique context of RADV. This guidance instructed auditors to make various assumptions, on a limited basis, that favored validating the diagnosis codes submitted by plans, particularly in situations that otherwise would have necessitated querying the provider. However, based on the experience gained in conducting audits to date, the agency has determined that this additional guidance is unnecessary, and in certain instances, may have led to results inconsistent with the ICD Guidelines that the guidance was intended to reflect. The agency therefore does not intend to use such guidance for RADV audits of contracts for PYs after 2015. While CMS made certain coding accommodations in the course of performing the 2014 RADV audits due to the constraints of the process, such accommodations were limited to the context of the RADV audit process and did not (and do not) change CMS' longstanding requirement in the ordinary risk adjustment process that all diagnosis codes submitted must be documented in the MR as the result of a face-to-face visit from an acceptable source, and be coded according to the ICD Guidelines and Coding Clinics for ICD-09-CM.

[6] 88 FR 6643 (February 1, 2023)

[7] An audited CMS-HCC is one that was derived from diagnosis code data, self-reported by an MA organization for the audited MA contract, and the basis for risk adjustment payment(s).

Table 1: Possible Outcomes for Audited CMS-HCCs

Audit Outcome Label	Audit Outcome Description
Confirmed	The audited CMS-HCC was validated by a diagnosis found in a valid MR for the enrollee.
Confirmed - Higher	The audited CMS-HCC is included in a hierarchy and a diagnosis, found in a valid MR submitted for the enrollee, validated a higher level of CMS-HCC within the hierarchy.
Discrepant	The audited CMS-HCC could not be validated.
Discrepant - Lower	The audited CMS-HCC is included in a hierarchy, and only a lower level of CMS-HCC within the hierarchy was validated by a diagnosis found in a valid MR submitted for the enrollee.
Administrative Exception - Hardship	CMS granted an administrative exception for the audited CMS-HCC as a result of approving a hardship exception request from the MA organization.
Administrative Exception - Data Update	CMS granted an administrative exception for the audited CMS-HCC because diagnoses that mapped to the audited CMS-HCC were deleted from the MA System of Records.
Administrative Exception - Other	CMS granted an administrative exception for the audited CMS-HCC for one or more reasons not previously mentioned, such as the audited CMS-HCC was involved in an audit or investigation conducted by another government agency or office.
Additional CMS-HCC	CMS identified a diagnosis code during MR review that maps to an additional CMS-HCC not previously submitted by the MA organization and subsequently used as a basis for risk adjusted payment(s).

All enrollee risk scores calculated during a RADV audit use the published model(s) for the relevant PY, including relevant normalization, coding intensity adjustment, and frailty factors (if applicable). CMS uses data from its Systems of Records and post-RADV MR review results of audited CMS-HCCs to calculate payment errors for sampled enrollees.[8] For PY 2014, ICD-9-CM diagnosis codes that were

[8] Data from CMS Systems of Records that contributes to MA PECs may include items such as the following: Health Insurance Claim Number (HICN), Date of Birth, Sex, Original Reason for Entitlement Code (OREC), and Medicaid Dual Status. A CMS contract-specific RADV audit focuses on the health conditions (i.e., diagnoses) self-reported by an MA organization for the purpose of receiving risk adjusted payments, not on confirming other data/factors from CMS Systems of Records that impact payments.

deleted by the MA organization and other enrollee demographic data updates in CMS Systems of Records as of January 2023 were accounted for in the PEC.

3.1 Payment Error Calculation for Each Sampled Enrollee

CMS calculated the RADV enrollee payment error amount for each enrollee selected in the RADV audit sample by completing the following steps:

1. Applying MR selection logic (see Appendix A) to choose the best, valid MR, submitted by the MA organization for RADV, that supports each audited CMS-HCC.[9]
2. Running the sampled enrollee's diagnosis codes, which are abstracted by CMS from valid MRs selected in #1 above, and other necessary demographic data for the enrollee sourced from CMS Systems of Records, through the relevant PY's published MA payment model(s) to determine the RADV enrollee risk score.[10]
3. Calculating RADV monthly enrollee risk payment amounts by multiplying the RADV enrollee risk score (after normalization, adjustment, and applicable blending) by the appropriate county rate[11] for months in which the sampled enrollee was covered by the MA organization and did not have End Stage Renal Disease (ESRD) or hospice status.
4. Summing the RADV monthly enrollee risk payment amounts and applying any other relevant payment components[12] and adjustments to determine the RADV enrollee risk payment amount.
5. Calculating RADV enrollee monthly payment error by subtracting each month's RADV monthly enrollee risk payment amount from the original monthly payment amount that was previously received by the MA organization.
6. Summing the RADV enrollee monthly payment error amounts for the PY to determine the RADV enrollee payment error.

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[9] Any sampled enrollees and/or audited CMS-HCCs for which CMS granted an MA organization hardship exception requests will not adversely impact overpayment calculations.

[10] If CMS abstracts a diagnosis code (that maps to a CMS-HCC) that was not previously submitted by the MA organization for risk adjusted payment prior to the final risk adjustment data submissions deadline, and the diagnosis code was on an MR chosen by the MR selection logic (see Appendix A), then CMS included the additional CMS-HCC when calculating a specific sampled enrollee's RADV enrollee risk score. Note, however, that the crediting of additional CMS-HCCs can only offset overpayment amounts and can never result in additional risk payments to an MA organization, since this would circumvent the final risk adjustment data submission deadlines described at § 422.310(g)(2)(ii). Further, an MA organization is not permitted to appeal additional CMS-HCC determinations found under the RADV audit for which it did not receive credit (79 Fed. Reg. 29932, May 23, 2014).

[11] The county rate is the Part A and/or Part B risk rate(s) used in MARx to calculate the monthly payment for an enrolled MA beneficiary. The risk rates are determined based on the county benchmark, the MA organization's bid, STAR ratings, and other factors specific to the plan and/or beneficiary.

[12] Other relevant payment components may include rebates, premiums, Medicare Medical Savings Account (MSA) deposits, Medicare Secondary Payer (MSP) adjustments, or potentially other factors.

Note that the RADV enrollee payment error amount can be positive, $0, or negative. When positive, an overpayment condition exists related to the sampled enrollee.

If CMS grants an MA organization an administrative exception for a sampled enrollee, an oversampled enrollee[13], if available, may be substituted in their place. When administrative exceptions are granted for sampled enrollees, an "N/A" indicator will be displayed in the audit report showing that the enrollee is not part of the PEC.[14] For more information about how administrative exceptions are displayed in the audit report, refer to the *Payment Year (PY) 2014 Medicare Advantage (MA) Contract-Specific Risk Adjustment Data Validation (RADV) Audit Report Data Dictionary* in the CDAT Plan Portal.

3.2 Total Overpayment Amount to be Collected

The PY 2014 RADV total overpayment amount to be collected is the sum of the RADV enrollee payment error amounts for all sampled enrollees. If the sum is greater than $0, an overpayment condition exists and CMS will initiate collection activities. If the sum is equal to or less than $0, then no overpayment exists. In this scenario, because the purpose of a RADV audit is to identify overpayments after the final risk adjustment data submission deadline (and not to reopen the submission deadline for CMS to make additional payments), a RADV audit will not result in additional payments being made to an MA organization.

4 RADV and the Requirement to Self-Report and Return Overpayments

In accordance with section 1128J(d) of the Act and 42 CFR 422.326, an MA organization is required to report and return any plan-identified overpayments within 60 days of being identified. However, as a contract selected for a CMS PY 2014 RADV audit and in accordance with 42 CFR 422.326(d), please suspend the reporting of overpayments to the Risk Adjustment Overpayment Reporting (RAOR) module in Health Plan Management System (HPMS) and the submission of data corrections in the Risk Adjustment Processing System (RAPS) for PY 2014 for enrollees included in this audit's sampling frame (which includes the sampled enrollees) until further notice. For plan-identified overpayments related to enrollees who are in an audited MA contract but are not included in the sampling frame for a RADV audit, the MA organization is required to report and return any potential overpayment to CMS in accordance with section 1128J(d) of the Act and 42 CFR 422.326.

5 CMS Email Support Resources

RADV points of contact (POCs) for an audited MA contract may request technical support regarding use of the CDAT system by sending an email to the CDAT Technical Support Email Box at RADVCONTechsupport@radvcdat.com. Individuals with general questions about CMS' MA contract-specific RADV audits may send an email to radv@cms.hhs.gov.

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[13] CMS included oversampled enrollees in the sampling methods for the PY 2014 RADV audit for some contracts. In certain instances, the results from an oversampled enrollee were applied if an MA organization was granted an administrative exception for all audited CMS-HCCs for a sampled enrollee.

[14] Any audited CMS-HCCs for which CMS has granted an MA organization an administrative exception will not adversely impact overpayment calculations.

Appendix A: Medical Record Selection Logic

CMS used the logic below to choose the valid MR that best supported each audited CMS-HCC. CMS generally relied on the MA organization's ranking of MRs but deviated from the MA organization's ranking when doing so resulted in a more beneficial audit finding for the MA organization for a given audited CMS-HCC (i.e., when a lower ranked MR substantiated a higher manifestation of an audited hierarchical CMS-HCC, and a higher ranked MR did not). For each audited CMS-HCC, CMS considered the MA organization's MR rankings and chose the highest ranked MR with the best result as the single best MR for the audited CMS-HCC, in the following order:

1. The MR confirmed a higher manifestation of an audited hierarchical CMS-HCC.
2. The MR confirmed the audited CMS-HCC.
3. The MR did not confirm the audited CMS-HCC but confirmed a lower manifestation of an audited hierarchical CMS-HCC.

If no MR substantiated the audited CMS-HCC, then the CMS-HCC was determined to be discrepant.

The single best MR was used by CMS when calculating the overpayment. Note that in #1 and #2, above, if additional CMS-HCCs were identified by CMS in the single best MR, then they were credited to the MA organization.