

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE ADVANTAGE COMPLIANCE
AUDIT OF SPECIFIC DIAGNOSIS CODES
THAT PRESBYTERIAN HEALTH PLAN,
INC. (CONTRACT H3204)
SUBMITTED TO CMS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Amy J. Frontz
Deputy Inspector General
for Audit Services

August 2023
A-07-20-01197

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG) is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve. Established by Public Law No. 95-452, as amended, OIG carries out its mission through audits, investigations, and evaluations conducted by the following operating components:

Office of Audit Services. OAS provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. The audits examine the performance of HHS programs, funding recipients, and contractors in carrying out their respective responsibilities and provide independent assessments of HHS programs and operations to reduce waste, abuse, and mismanagement.

Office of Evaluation and Inspections. OEI's national evaluations provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. To promote impact, OEI reports also provide practical recommendations for improving program operations.

Office of Investigations. OI's criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs and operations often lead to criminal convictions, administrative sanctions, and civil monetary penalties. OI's nationwide network of investigators collaborates with the Department of Justice and other Federal, State, and local law enforcement authorities. OI works with public health entities to minimize adverse patient impacts following enforcement operations. OI also provides security and protection for the Secretary and other senior HHS officials.

Office of Counsel to the Inspector General. OCIG provides legal advice to OIG on HHS programs and OIG's internal operations. The law office also imposes exclusions and civil monetary penalties, monitors Corporate Integrity Agreements, and represents HHS's interests in False Claims Act cases. In addition, OCIG publishes advisory opinions, compliance program guidance documents, fraud alerts, and other resources regarding compliance considerations, the anti-kickback statute, and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: August 2023

Report No. A-07-20-01197

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources.

To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

For this audit, we reviewed one MA organization, Presbyterian Health Plan, Inc. (PHP), and focused on seven groups of high-risk diagnosis codes. Our objective was to determine whether selected diagnosis codes that PHP submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 211 unique enrollee-years with the high-risk diagnosis codes for which PHP received higher payments for 2017 through 2018. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$496,911.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Presbyterian Health Plan, Inc. (Contract H3204) Submitted to CMS

What OIG Found

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that PHP submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 198 of the 211 sampled enrollee-years, the medical records that PHP provided did not support the diagnosis codes and resulted in \$442,454 in net overpayments. As demonstrated by the errors found in our sample, PHP's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of our sample results, we estimated that PHP received at least \$2.2 million in net overpayments for 2017 and 2018. Because of Federal regulations (updated after we issued our draft report) that limit the use of extrapolation in Risk Adjustment Data Validation audits for recovery purposes to payment years 2018 and forward, we are reporting the overall estimated net overpayment amount but are recommending a refund of \$1.3 million (\$206,048 for the sampled enrollee-years from 2017 and an estimated \$1.1 million for 2018).

What OIG Recommends and PHP Comments

We recommend that PHP: (1) refund to the Federal Government the \$1.3 million of estimated net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

PHP did not concur with any of our recommendations. PHP said that we overstated the estimated net overpayments because we used a flawed audit process and extrapolation methodology. PHP acknowledged its responsibility regarding data accuracy but also said that it had effective compliance procedures in place. After reviewing PHP's comments, we maintain that our findings and recommendations are valid. We revised the amount in our first recommendation in accordance with CMS's updated regulations. We made no changes to our second and third recommendations.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective.....	1
Background.....	2
Medicare Advantage Program.....	2
Risk Adjustment Program.....	2
High-Risk Groups of Diagnoses.....	4
Presbyterian Health Plan, Inc.....	5
How We Conducted This Audit.....	6
FINDINGS.....	7
Federal Requirements.....	7
Most of the Selected High-Risk Diagnosis Codes That Presbyterian Health Plan, Inc., Submitted to CMS Did Not Comply With Federal Requirements.....	8
Incorrectly Submitted Diagnosis Codes for Acute Stroke.....	9
Incorrectly Submitted Diagnosis Codes for Acute Myocardial Infarction.....	10
Incorrectly Submitted Diagnosis Codes for Embolism.....	11
Incorrectly Submitted Diagnosis Codes for Lung Cancer.....	12
Incorrectly Submitted Diagnosis Codes for Breast Cancer.....	13
Incorrectly Submitted Diagnosis Codes for Colon Cancer.....	14
Incorrectly Submitted Diagnosis Codes for Prostate Cancer.....	14
Summary of Incorrectly Submitted Diagnosis Codes.....	15
The Policies and Procedures That Presbyterian Health Plan, Inc., Had To Prevent, Detect, and Correct Noncompliance With Federal Requirements Could Be Improved.....	15
Presbyterian Health Plan, Inc., Received Net Overpayments.....	16
RECOMMENDATIONS.....	16
PRESBYTERIAN HEALTH PLAN, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	17
Presbyterian Health Plan, Inc., Did Not Concur With the Office of Inspector General’s Recommendation That It Refund Estimated Net Overpayments.....	17

Presbyterian Health Plan, Inc., Comments	17
Office of Inspector General Response	18
Presbyterian Health Plan, Inc., Did Not Concur With the Office of Inspector General’s Recommendation To Perform Additional Audits Before and After the Audit Period ...	19
Presbyterian Health Plan, Inc., Comments	19
Office of Inspector General Response	20
Presbyterian Health Plan, Inc., Did Not Concur With the Office of Inspector General’s Recommendation That It Enhance Its Existing Compliance Procedures	21
Presbyterian Health Plan, Inc., Comments	21
Office of Inspector General Response	21

APPENDICES

A: Audit Scope and Methodology	23
B: Related Office of Inspector General Reports.....	27
C: Statistical Sampling Methodology	29
D: Sample Results and Estimates	32
E: Federal Regulations Regarding Compliance Programs That Medicare Advantage Organizations Must Follow	36
F: Presbyterian Health Plan, Inc., Comments	38

INTRODUCTION

WHY WE DID THIS AUDIT

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations based in part on the characteristics of the enrollees being covered. Using a system of risk adjustment, CMS pays MA organizations the anticipated cost of providing Medicare benefits to a given enrollee, depending on such risk factors as the age, gender, and health status of that individual. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources relative to healthier enrollees, who would be expected to require fewer health care resources. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS.¹ We are auditing MA organizations because some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

This audit is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS.² Using data mining techniques and considering discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. (For example, we consolidated 65 breast cancer diagnoses into 1 group.) This audit covered Presbyterian Health Plan, Inc. (PHP), for contract number H3204 and focused on seven groups of high-risk diagnosis codes for payment years 2017 and 2018.³

OBJECTIVE

Our objective was to determine whether selected diagnosis codes that PHP submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

¹ The providers code diagnoses using the International Classification of Diseases (ICD), Clinical Modification (CM), *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines). The ICD is a coding system that is used by physicians and other health care providers to classify and code all diagnoses, symptoms, and procedures.

² See Appendix B for a list of related Office of Inspector General (OIG) reports.

³ All subsequent references to "PHP" in this report refer solely to contract number H3204.

BACKGROUND

Medicare Advantage Program

The MA program offers beneficiaries managed care options by allowing them to enroll in private health care plans rather than having their care covered through Medicare's traditional fee-for-service program.⁴ Beneficiaries who enroll in these plans are known as enrollees. To provide benefits to enrollees, CMS contracts with MA organizations, which in turn contract with providers (including hospitals) and physicians.

Under the MA program, CMS makes advance payments each month to MA organizations for the expected costs of providing health care coverage to enrollees. These payments are not adjusted to reflect the actual costs that the organizations incurred for providing benefits and services. Thus, MA organizations will either realize profits if their actual costs of providing coverage are less than the CMS payments or incur losses if their costs exceed the CMS payments.

For 2020, CMS paid MA organizations \$317.1 billion, which represented 34 percent of all Medicare payments for that year.

Risk Adjustment Program

Federal requirements mandate that payments to MA organizations be based on the anticipated cost of providing Medicare benefits to a given enrollee and, in doing so, also account for variations in the demographic characteristics and health status of each enrollee.⁵

CMS uses two principal components to calculate the risk-adjusted payment that it will make to an MA organization for an enrollee: a base rate that CMS sets using bid amounts received from the MA organization and the risk score for that enrollee. These are described as follows:

- *Base rate*: Before the start of each year, each MA organization submits bids to CMS that reflect the MA organization's estimate of the monthly revenue required to cover an enrollee with an average risk profile.⁶ CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that an MA organization is paid for each of its enrollees.⁷

⁴ The Balanced Budget Act of 1997, P.L. No. 105-33, as modified by section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act, P.L. No. 108-173, established the MA program.

⁵ The Social Security Act (the Act) §§ 1853(a)(1)(C) and (a)(3); 42 CFR § 422.308(c).

⁶ The Act § 1854(a)(6); 42 CFR § 422.254 *et seq.*

⁷ CMS's bid-benchmark comparison also determines whether the MA organization must offer supplemental benefits or must charge a basic beneficiary premium for the benefits.

- *Risk score:* A risk score is a relative measure that reflects the additional or reduced costs that each enrollee is expected to incur compared with the costs incurred by enrollees on average. CMS calculates risk scores based on an enrollee's health status (discussed below) and demographic characteristics (such as the enrollee's age and gender). This process results in an individualized risk score for each enrollee, which CMS calculates annually.

To determine an enrollee's health status for purposes of calculating the risk score, CMS uses diagnoses that the enrollee receives from acceptable data sources, including certain physicians and hospitals. MA organizations collect the diagnosis codes from providers based on information documented in the medical records and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs).⁸ Each HCC has a factor (which is a numerical value) assigned to it for use in each enrollee's risk score.

As a part of the risk adjustment program, CMS consolidates certain HCCs into related-disease groups. Within each of these groups, CMS assigns an HCC for only the most severe manifestation of a disease in a related-disease group. Thus, if MA organizations submit diagnosis codes for an enrollee that map to more than one of the HCCs in a related-disease group, only the most severe HCC will be used in determining the enrollee's risk score.

For enrollees who have certain combinations of HCCs, CMS assigns a separate factor that further increases the risk score. CMS refers to these combinations as disease interactions. For example, if MA organizations submit diagnosis codes for an enrollee that map to the HCCs for lung cancer and immune disorders, CMS assigns a separate factor for this disease interaction. By doing so, CMS increases the enrollee's risk score for each of the two HCC factors and by an additional factor for the disease interaction.

The risk adjustment program is prospective. Specifically, CMS uses the diagnosis codes that the enrollee received for one year (known as the service year) to determine HCCs and calculate risk scores for the following calendar year (known as the payment year). Thus, an enrollee's risk score does not change for the year in which a diagnosis is made. Instead, the risk score changes for the entirety of the year after the diagnosis has been made. Further, the risk score calculation is an additive process: As HCC factors (and, when applicable, disease interaction factors) accumulate, an enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment program compensates MA organizations for the additional risk of providing coverage to enrollees expected to require more health care resources.

CMS multiplies the risk scores by the base rates to calculate the total monthly Medicare payment that an MA organization receives for each enrollee before applying the budget

⁸ During our audit period CMS calculated risk scores based on the Version 22 CMS-HCC model.

sequestration reduction.⁹ Thus, if the factors used to determine an enrollee’s risk score are incorrect, CMS will make an improper payment to an MA organization. Specifically, if medical records do not support the diagnosis codes that an MA organization submitted to CMS, the HCCs are unvalidated, which causes overstated enrollee risk scores and overpayments from CMS.¹⁰ Conversely, if medical records support the diagnosis codes that an MA organization did not submit to CMS, validated HCCs may not have been included in enrollees’ risk scores, which may cause those risk scores to be understated and may result in underpayments.

High-Risk Groups of Diagnoses

Using data mining techniques and discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. For this audit, we focused on seven high-risk groups:

- *Acute stroke*: An enrollee received one acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have that diagnosis on a corresponding inpatient or outpatient hospital claim. In these instances, a diagnosis of history of stroke (which does not map to an HCC) typically should have been used.
- *Acute myocardial infarction*: An enrollee received one diagnosis that mapped to the HCC for Acute Myocardial Infarction on only one physician or outpatient claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician or outpatient claim). In these instances, a diagnosis indicating a history of a myocardial infarction (which does not map to an HCC) typically should have been used.
- *Embolism*: An enrollee received one diagnosis that mapped to either the HCC for Vascular Disease or to the HCC for Vascular Disease With Complications (Embolism HCCs) on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf. An anticoagulant medication is typically used to treat an embolism. In these instances, a diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used.

⁹ Budget sequestration refers to automatic spending cuts that occurred through the withdrawal of funding for certain Federal programs, including the MA program, as provided in the Budget Control Act of 2011 (BCA) (P.L. No. 112-25 (Aug. 2, 2011)). Under the BCA, the sequestration of mandatory spending began in April 2013.

¹⁰ 42 CFR § 422.310(e) requires MA organizations (when undergoing an audit conducted by the Secretary) to submit “medical records for the validation of risk adjustment data.” For purposes of this report, we use the terms “supported” or “unsupported” to denote whether or not the reviewed diagnoses were evidenced in the medical records. If our audit determines that the diagnoses are supported or unsupported, we accordingly use the terms “validated” or “unvalidated” with respect to the associated HCC.

- *Lung cancer*: An enrollee received one lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period either before or after the diagnosis. In these instances, a diagnosis of history of lung cancer (which does not map to an HCC) typically should have been used.
- *Breast cancer*: An enrollee received one breast cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of breast cancer (which does not map to an HCC) typically should have been used.
- *Colon cancer*: An enrollee received one colon cancer diagnosis (that mapped to the HCC for Colorectal, Bladder, and Other Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of colon cancer (which does not map to an HCC) typically should have been used.
- *Prostate cancer*: An enrollee 74 years old or younger received one prostate cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of prostate cancer (which does not map to an HCC) typically should have been used.

In this report, we refer to the diagnosis codes associated with these groups as “high-risk diagnosis codes.”

Presbyterian Health Plan, Inc.

PHP is an MA organization based in Albuquerque, New Mexico. As of December 2018, PHP provided coverage under contract number H3204 to 40,941 enrollees. For the 2017 and 2018 payment years (audit period), CMS paid PHP approximately \$661 million to provide coverage to its enrollees.^{11, 12}

¹¹ The 2017 and 2018 payment year data were the most recent data available at the start of the audit.

¹² All of the payment amounts that CMS made to PHP and the overpayment amounts that we identified in this report reflect the budget sequestration reduction.

HOW WE CONDUCTED THIS AUDIT

Our audit included enrollees on whose behalf providers documented diagnosis codes that mapped to one of the seven high-risk groups during the 2016 and 2017 service years, for which PHP received increased risk-adjusted payments for payment years 2017 and 2018, respectively. Because enrollees could be classified into more than one high-risk group or could have high-risk diagnosis codes documented in more than 1 year, we classified these individuals according to the condition and the payment year, which we refer to as “enrollee-years.”

We identified 1,598 unique enrollee-years and limited our review to the portions of the payments that were associated with these high-risk diagnosis codes (\$2,621,919).¹³ We selected for audit a stratified sample of 211 enrollee-years as shown in Table 1.

**Table 1: Sampled Enrollee-Years
(Strata for Sample Design Based on High-Risk Groups)**

High-Risk Group	Number of Sampled Enrollee-Years		
	Payment Year 2017	Payment Year 2018	Total
1. Acute stroke	17	13	30
2. Acute myocardial infarction	27	3	30
3. Embolism	15	15	30
4. Lung cancer	13	18	31
5. Breast cancer	11	19	30
6. Colon cancer	13	17	30
7. Prostate cancer	12	18	30
Total for All High-Risk Groups	108	103	211

PHP provided medical records as support for the selected diagnosis codes associated with 209 of the 211 sampled enrollee-years.¹⁴ We used an independent medical review contractor to review the medical records to determine whether the HCCs associated with the sampled enrollee-years were validated. For the HCCs that were not validated, if the contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, or if we identified another diagnosis code (on CMS’s systems) that mapped to an HCC in the related-disease group, we included the financial impact of the resulting HCC (if any) in our calculation of overpayments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

¹³ The 1,598 unique enrollee-years and associated payments that we reviewed consisted of 908 enrollee-years (\$1,454,942) for payment year 2017 and 690 enrollee-years (\$1,166,977) for payment year 2018.

¹⁴ PHP could not locate medical records for the remaining 2 sampled enrollee-years.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the Federal regulations regarding MA organizations' compliance programs.

FINDINGS

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that PHP submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 13 of the 211 sampled enrollee-years, the medical records validated the reviewed HCCs. For the remaining 198 enrollee-years, however, either the medical records that PHP provided did not support the diagnosis codes or PHP could not locate the medical records to support the diagnosis codes and the associated HCCs were therefore not validated and resulted in \$442,454 in net overpayments.

As demonstrated by the errors found in our sample, PHP's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of our sample results, we estimated that PHP received at least \$2,237,662 in net overpayments for 2017 and 2018.¹⁵ Because of Federal regulations that limit the use of extrapolation in Risk Adjustment Data Validation (RADV) audits for recovery purposes to payment year 2018 and forward, we are reporting the overall estimated net overpayment amount but are recommending a refund of \$1,302,682 in net overpayments (\$206,048 for the sampled enrollee-years from 2017 and an estimated \$1,096,634 for 2018).¹⁶

FEDERAL REQUIREMENTS

Payments to MA organizations are adjusted for risk factors, including the health status of each enrollee (the Social Security Act § 1853(a)). CMS applies a risk factor based on data obtained from the MA organizations (42 CFR § 422.308).

¹⁵ To be conservative, we estimate net overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

¹⁶ After we had issued our draft report, CMS updated Federal regulations that limit the use of extrapolation in RADV audits to payment years 2018 and forward (88 Fed. Reg. 6643 (Feb. 1, 2023)). Therefore, for sampled enrollee-years from payment year 2017, we limited our calculation of net overpayments to the financial impact associated with these enrollee-years. For sampled enrollee-years from payment year 2018, we used the financial impact associated with the enrollee-years to estimate the total amount of overpayments for that year. See also footnotes 26 and 36 later in this report.

Federal regulations state that MA organizations must follow CMS’s instructions and submit to CMS the data necessary to characterize the context and purposes of each service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner (42 CFR § 422.310(b)). MA organizations must obtain risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service (42 CFR § 422.310(d)(3)).

Federal regulations also state that MA organizations are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes and that such data must conform to all relevant national standards (42 CFR §§ 422.504(l) and 422.310(d)(1)). In addition, MA organizations must contract with CMS and agree to follow CMS’s instructions, including the *Medicare Managed Care Manual* (the Manual) (see 42 CFR § 422.504(a)).

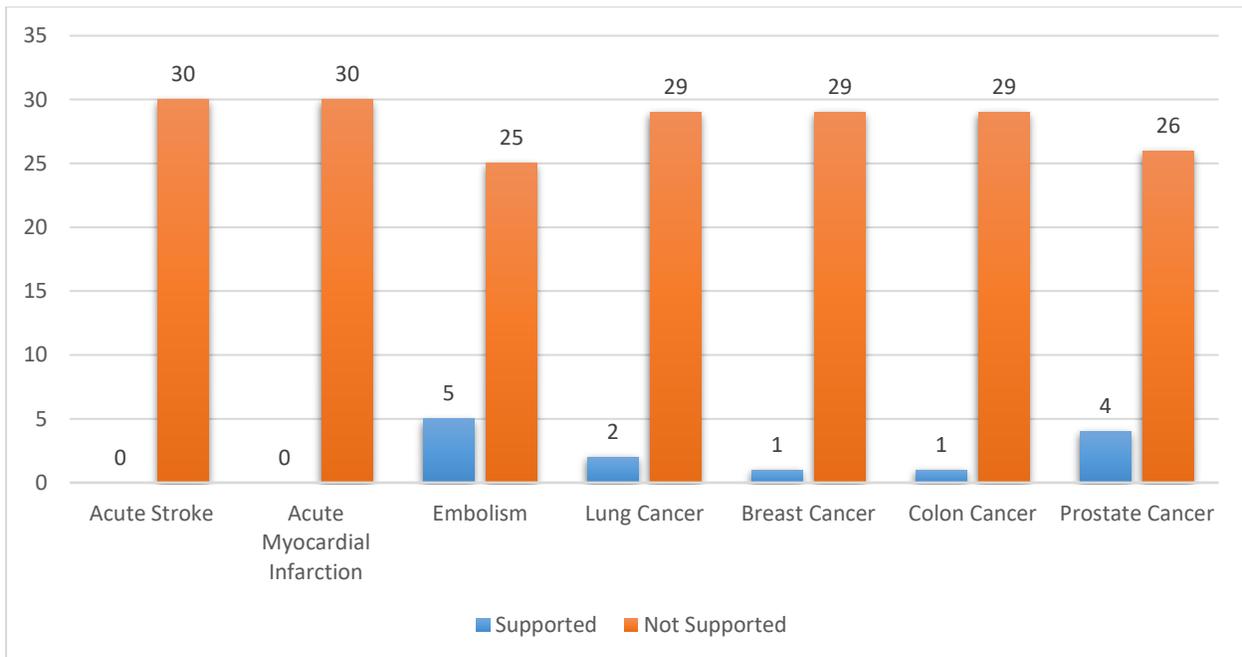
CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (the Manual, chap. 7 (last rev. Sept. 19, 2014)). Specifically, CMS requires all submitted diagnosis codes to be documented in the medical record and to be documented as a result of a face-to-face encounter (the Manual, chap. 7, § 40). The diagnosis must be coded according to the International Classification of Diseases, Clinical Modification, *Official Guidelines for Coding and Reporting* (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(c)(2)-(3)). Further, MA organizations must implement procedures to ensure that diagnoses come only from acceptable data sources, which include hospital inpatient facilities, hospital outpatient facilities, and physicians (the Manual, chap. 7, § 40).

Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS. Federal regulations also state that MA organizations must “adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS’ program requirements” Further, MA organizations must establish and implement an effective system for routine monitoring and identification of compliance risks (42 CFR § 422.503(b)(4)(vi)).

MOST OF THE SELECTED HIGH-RISK DIAGNOSIS CODES THAT PRESBYTERIAN HEALTH PLAN, INC., SUBMITTED TO CMS DID NOT COMPLY WITH FEDERAL REQUIREMENTS

Most of the selected high-risk diagnosis codes that PHP submitted to CMS for use in CMS’s risk adjustment program did not comply with Federal requirements. Specifically, as shown in the figure on the following page, the medical records for 198 of the 211 sampled enrollee-years did not support the diagnosis codes. In these instances, PHP should not have submitted the diagnosis codes to CMS and received the resulting net overpayments.

Figure: Analysis of High-Risk Groups



Incorrectly Submitted Diagnosis Codes for Acute Stroke

PHP incorrectly submitted diagnosis codes for acute stroke for all 30 sampled enrollee-years. Specifically:

- For 20 enrollee-years, the medical records indicated in each case that the individual had previously had a stroke, but the records did not justify an acute stroke diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no evidence of an acute stroke or any related condition that would result in an assignment of the submitted HCC or a related HCC. There is mention of a history of a stroke [diagnosis] but no description of residuals or sequelae that should be coded.”¹⁷ The history of stroke diagnosis code does not map to an HCC.

¹⁷ Residuals or sequelae are the late effects of an injury that can occur only after the acute phase of the injury or illness has passed.

- For 9 enrollee-years, the medical records in each case did not support an acute stroke diagnosis.¹⁸

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Ischemic or Unspecified Stroke]. There is documentation of a possible TIA (transient ischemic attack) [diagnosis] that does not result in an HCC.”¹⁹

- For the remaining 1 enrollee-year, PHP submitted an acute stroke diagnosis code (which was not supported in the medical records) instead of a diagnosis code for hemiplegia (which was supported in the medical records).²⁰ The independent medical review contractor stated that “there is no evidence of an acute stroke, however the patient has right hemiparesis from an old stroke . . . [which] would result in the assignment of [the] HCC [for Hemiplegia/Hemiparesis] and should have been assigned instead of the submitted HCC.”²¹ This error caused an underpayment.

As a result of these errors, the HCC for Ischemic or Unspecified Stroke was not validated, and PHP received \$50,249 in net overpayments (\$25,713 for 2017 and \$24,536 for 2018) for these 30 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Acute Myocardial Infarction

PHP incorrectly submitted diagnosis codes for acute myocardial infarction for all 30 sampled enrollee-years. Specifically:

- For 19 enrollee-years, the medical records indicated in each case that the individual had an old myocardial infarction diagnosis, but the records did not justify an acute myocardial infarction diagnosis at the time of the physician’s service.²²

¹⁸ For risk adjustment purposes, CMS uses only diagnoses that enrollees receive from acceptable data sources (a face-to-face encounter with a provider, physician, or other practitioner) (42 CFR § 422.310(d)(3); the Manual, chap. 7, §§ 40 and 120.1). For 1 of these enrollee-years, the medical record that PHP provided to support the reviewed HCC was an infusion note signed and credentialed by a registered nurse. Because this record did not meet CMS’s requirements for acceptable data sources, we could not validate the reviewed HCC.

¹⁹ A transient ischemic attack is a temporary period of symptoms similar to those of a stroke.

²⁰ Hemiplegia is defined as complete paralysis or loss of function of one-half of the body, including one leg and arm, because of injury or disease in the motor centers of the brain.

²¹ Hemiparesis is a less severe form of hemiplegia which, instead of affecting one-half of your body, affects particular muscles only.

²² An “old myocardial infarction” is a distinct diagnosis that represents a myocardial infarction that occurred more than 4 weeks previously, has no current symptoms directly associated with that myocardial infarction, and requires no current care.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Acute Myocardial Infarction]. There is documentation of [a] past medical history of myocardial infarction [diagnosis] that does not result in an HCC.”

- For 6 enrollee-years, the medical records in each case did not support an acute myocardial infarction diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, PHP should not have received an increased payment for the acute myocardial infarction diagnosis but should have received a lesser increased payment for the other diagnosis identified.
- For the remaining 5 enrollee-years, the medical records in each case did not support an acute myocardial infarction diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Acute Myocardial Infarction]. The medical documentation does not indicate certainty of a diagnosis of non-ST elevation (NSTEMI) myocardial infarction . . . which should not be coded as a current diagnosis.”²³

As a result of these errors, the HCC for Acute Myocardial Infarction was not validated, and PHP received \$36,459 in overpayments (\$31,055 for 2017 and \$5,404 for 2018) for these 30 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Embolism

PHP incorrectly submitted diagnosis codes for embolism for 25 of 30 sampled enrollee-years. Specifically:

- For 14 enrollee-years, the medical records in each case did not support a diagnosis that mapped to an Embolism HCC.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the]

²³ A non-ST-elevation myocardial infarction, often referred to as an NSTEMI or a non-STEMI, is a type of heart attack, which is a less severe form than an ST-elevation myocardial infarction (STEMI) because it inflicts less damage to the heart. The term “ST” refers to the flat section of an echocardiogram (ECG). When an individual has the most severe type of heart attack, this segment will no longer be flat on the ECG but will appear abnormally elevated.

HCC [for Vascular Disease]. There is documentation of deep vein thrombosis prophylaxis that does not result in an HCC.”²⁴

- For the remaining 11 enrollee-years, the medical records indicated in each case that the individual had previously had an embolism, but the records did not justify a diagnosis that mapped to an Embolism HCC at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Vascular Disease]. There is documentation of a past medical history of deep vein thrombosis [diagnosis] that does not result in an HCC.”

As a result of these errors, the Embolism HCCs were not validated, and PHP received \$53,723 in overpayments (\$27,416 for 2017 and \$26,307 for 2018) for these 25 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Lung Cancer

PHP incorrectly submitted diagnosis codes for lung cancer for 29 of 31 sampled enrollee-years. Specifically:

- For 17 enrollee-years, the medical records indicated in each case that the individual had previously had lung cancer, but the records did not justify a lung cancer diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Lung and Other Severe Cancers]. There is documentation of a past medical history of lung cancer [diagnosis] that does not result in an HCC.”

- For 7 enrollee-years, the medical records in each case did not support a lung cancer diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, PHP should not have received an increased payment for the lung cancer diagnosis but should have received a lesser increased payment for the other diagnosis identified.

²⁴ Deep vein thrombosis occurs when a blood clot forms in one or more of the deep veins of the body, usually in the legs. Prophylaxis is a preventative measure taken to maintain health and deter disease or another unwanted consequence.

- For the remaining 5 enrollee-years, the medical records in each case did not support a lung cancer diagnosis.²⁵

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Lung and Other Severe Cancers].”

As a result of these errors, the HCC for Lung and Other Severe Cancers was not validated, and PHP received \$179,316 in overpayments (\$70,180 for 2017 and \$109,136 for 2018) for these 29 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Breast Cancer

PHP incorrectly submitted diagnosis codes for breast cancer for 29 of 30 sampled enrollee-years. Specifically:

- For 24 enrollee-years, the medical records indicated in each case that the individual had previously had breast cancer, but the records did not justify a breast cancer diagnosis at the time of the physician’s service.

For example, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Breast, Prostate, and Other Cancers and Tumors]. There is documentation of a past medical history of breast cancer [diagnosis] that does not result in an HCC.”

- For the remaining 5 enrollee years, the medical records in each case did not support a breast cancer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Breast, Prostate, and Other Cancers and Tumors].”

As a result of these errors, the HCC for Breast, Prostate, and Other Cancers and Tumors was not validated, and PHP received \$31,238 in overpayments (\$11,737 for 2017 and \$19,501 for 2018) for these 29 sampled enrollee-years.

²⁵ For risk adjustment purposes, CMS uses only diagnoses that enrollees receive from acceptable data sources (a face-to-face encounter with a provider, physician, or other practitioner) (42 CFR § 422.310(d)(3); the Manual, chap. 7, §§ 40 and 120.1). For 1 of these enrollee-years, the medical record that PHP provided to support the reviewed HCC was a radiology report signed and credentialed by a radiologist. Because this record did not meet CMS’s requirements for acceptable data sources, we could not validate the reviewed HCC.

Incorrectly Submitted Diagnosis Codes for Colon Cancer

PHP incorrectly submitted diagnosis codes for colon cancer for 29 of 30 sampled enrollee-years. Specifically:

- For 23 enrollee-years, the medical records indicated in each case that the individual had previously had colon cancer, but the records did not justify a colon cancer diagnosis at the time of the physician's service.

For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that will result in the assignment of [the] HCC [for Colorectal, Bladder, and Other Cancers]. There is documentation of a past medical history of colon cancer [diagnosis] that does not result in an HCC."

- For 3 enrollee-years, the medical records in each case did not support a colon cancer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of a diagnosis that results in [the] HCC [for Colorectal, Bladder, and Other Cancers]."

- For 2 enrollee-years, the medical records in each case did not support the submitted colon cancer diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors, which is a less severe manifestation of the related-disease group. Accordingly, PHP should not have received an increased payment for the submitted colon cancer diagnoses. Rather, it should have received a lesser increased payment for the other diagnosis identified.
- For the remaining 1 enrollee-year, PHP could not locate any medical records to support the colon cancer diagnosis; therefore, the HCC for Colorectal, Bladder, and Other Cancers was not validated.

As a result of these errors, the HCC for Colorectal, Bladder, and Other Cancers was not validated, and PHP received \$62,039 in overpayments (\$27,940 for 2017 and \$34,099 for 2018) for these 29 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Prostate Cancer

PHP incorrectly submitted diagnosis codes for prostate cancer for 26 of 30 sampled enrollee-years. Specifically:

- For 20 enrollee-years, the medical records indicated in each case that the individual had previously had prostate cancer, but the records did not justify a prostate cancer diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Breast, Prostate, and Other Cancers and Tumors]. There is documentation of a past medical history of prostate cancer [diagnosis] that does not result in an HCC.”

- For 5 enrollee-years, the medical records in each case did not support a prostate cancer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in the assignment of [the] HCC [for Breast, Prostate, and Other Cancers and Tumors].”

- For the remaining 1 enrollee-year, PHP could not locate any medical records to support the prostate cancer diagnosis; therefore, the HCC for Breast, Prostate, and Other Cancers and Tumors was not validated.

As a result of these errors, the HCC for Breast, Prostate, and Other Cancers and Tumors was not validated, and PHP received \$29,430 in overpayments (\$12,007 for 2017 and \$17,423 for 2018) for these 26 sampled enrollee-years.

Summary of Incorrectly Submitted Diagnosis Codes

In summary and with respect to the seven high-risk groups covered by our audit, PHP received \$442,454 in net overpayments for the 198 sampled enrollee-years (\$206,048 for 2017 and \$236,406 for 2018).

THE POLICIES AND PROCEDURES THAT PRESBYTERIAN HEALTH PLAN, INC., HAD TO PREVENT, DETECT, AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS COULD BE IMPROVED

As demonstrated by the errors found in our sample, the policies and procedures that PHP had to prevent, detect, and correct noncompliance with CMS’s program requirements, as mandated by Federal regulations (42 CFR § 422.503(b)(4)(vi)), could be improved.

As part of its preventative measures, PHP had compliance procedures in place that consisted of a variety of provider-specific outreach efforts that provided clarification on coding matters. These outreach efforts included the distribution of a provider manual and newsletters. Furthermore, the outreach efforts included provider coding training. PHP’s preventative measures also included sampling a portion of the daily provider-submitted claims to ensure the diagnosis coding accuracy of those claims before their submission to CMS.

PHP's compliance procedures also included detection and correction measures designed to determine whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct. PHP routinely conducted diagnosis coding audits on a sample of previously submitted claims. If the coding audits identified any coding errors, PHP's policies and procedures provided guidance on how to submit the corrections to CMS. PHP also conducted multiple quality assurance analyses, which identified areas as having a higher risk of incorrect coding and which included measures to track coding accuracy at the provider and HCC level. PHP used the results of these analyses to evaluate and improve its compliance procedures.

In addition, PHP educated its coders on best coding practices. The education included coding guidance on how to classify conditions as acute, chronic, or historical. This guidance highlighted how to accurately code several of the high-risk areas that are identified in this audit (acute stroke, myocardial infarction, embolism, and cancers (active as opposed to historical)).

We acknowledge that PHP has compliance procedures that include measures designed to ensure that diagnosis codes, including some of the diagnoses that we classified as high risk, comply with Federal requirements. However, because we found that 198 of the 211 sampled enrollee-years were not supported by medical records, we believe that these procedures could be improved.

PRESBYTERIAN HEALTH PLAN, INC., RECEIVED NET OVERPAYMENTS

As a result of the errors we identified, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that PHP received at least \$2,237,662 in net overpayments for our audit period.

Because of Federal regulations that limit the use of extrapolation in RADV audits for recovery purposes to payment years 2018 and forward,²⁶ we are reporting the estimated net overpayment amount, but are recommending recovery of \$1,302,682 in net overpayments (\$206,048 for the sampled enrollee-years from 2017 and an estimated \$1,096,634 for 2018). (See footnote 16 and Appendix D for sample results and estimates.)

RECOMMENDATIONS

We recommend that Presbyterian Health Plan, Inc.:

- refund to the Federal Government the \$1,302,682 of estimated net overpayments;

²⁶ After we had issued our draft report, CMS updated Federal regulations that limit the use of extrapolation in RADV audits to payment years 2018 and forward (88 Fed. Reg. 6643 (Feb. 1, 2023)). RADV audits are conducted to verify that diagnoses submitted by MA organizations for risk-adjusted payment are supported by medical record documentation.

- identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and
- continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS’s risk adjustment program) and take the necessary steps to enhance those procedures.

PRESBYTERIAN HEALTH PLAN, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, PHP did not concur with any of our recommendations. According to PHP, we overstated the estimated net overpayments because we used a “flawed” audit process and extrapolation methodology. More specifically, PHP stated that we did not: (1) follow CMS’s established RADV audit process, (2) consider potential underpayments, or (3) account for a payment principle known as “actuarial equivalence.”

We reviewed the entirety of PHP’s comments and for the reasons detailed below, we maintain that our findings are valid. After we had issued our draft report, CMS updated its regulations for RADV audits to specify that extrapolated overpayments could only be recouped beginning with payment year 2018 (footnote 16). Because our audit period covered payment years 2017 and 2018, we revised the amount in our first recommendation. For sampled enrollee-years from payment year 2017, we limited our calculation of net overpayments to the financial impact associated with these enrollee-years. For sampled enrollee-years from payment year 2018, we used the financial impact associated with the enrollee-years to estimate the total amount of overpayments for that year. We made no changes to our second and third recommendations.

A summary of PHP’s comments and our responses follows. PHP’s comments appear in their entirety as Appendix F.

PRESBYTERIAN HEALTH PLAN, INC., DID NOT CONCUR WITH THE OFFICE OF INSPECTOR GENERAL’S RECOMMENDATION THAT IT REFUND ESTIMATED NET OVERPAYMENTS

Presbyterian Health Plan, Inc., Comments

PHP did not concur with our first recommendation—that it refund to the Federal Government the estimated net overpayments—because, it said, the methodologies we used were “flawed.” Specifically, PHP made the following points:

- PHP stated that we ignored CMS’s established RADV process and instead used a methodology that was “not promulgated through notice and comment rulemaking.” PHP also stated that it was “not clear” which audit procedures we followed as our

approach differed from that described in other reports that we have issued in this series of audits. In this regard, PHP noted that we used extrapolation to calculate the net overpayment amount for this audit, while other audits in this series were not subject to extrapolation. PHP also said that we, in response to previous questions about our methodologies, have stated that we do not have to mirror CMS's approach. To this point, PHP stated that we did not consider "various nuances of the [MA] program" and added that we do "not have the statutory and regulatory authority to unilaterally impose new substantive requirements for [MA organizations]." PHP said that therefore, our recommendation to refund estimated net overpayments to CMS should, "at a minimum, be based on the structure of the CMS RADV process."

- Additionally, PHP stated that our audit did not consider potential underpayments and was "designed to overstate" estimated net overpayments. In this regard, PHP acknowledged that we identified four instances of sampled enrollee-years in which the medical records supported another diagnosis in the same related-disease group. However, according to PHP, we "did not review or consider unreported and underreported diagnoses for the sampled [enrollee-years] in unrelated disease groups for which PHP should have been compensated." Furthermore, PHP stated that we should also have considered unreported and underreported diagnosis codes for other enrollee-years that were not in our sampling frame and that were associated with individuals who had potentially "lower probability diagnoses" or "no reported diagnoses." PHP added that if we had included these enrollee-years in our audit, "the outcome would be vastly different."
- PHP also stated that our audit methodology did not account for a payment principal known as "actuarial equivalence," because we did not apply an adjustment called a Fee-for-Service (FFS) Adjuster. PHP added that "[t]he methodology used by OIG [Office of Inspector General] creates an actuarial disconnect between [MA] payments and the [FFS] data upon which [MA] payment rates are based." PHP acknowledged that CMS recently published a proposed rule for RADV audits that does not include an FFS Adjuster, but said that "that rule is still a proposal and may not be finalized as proposed," and "[t]he RADV Guidance is the current CMS guidance on the subject, and the RADV Guidance was the existing guidance during the [a]udit [p]eriod."

Office of Inspector General Response

We disagree with PHP's assertion that our audit process and methodology were "flawed," and we disagree that our audit needed to follow CMS's established RADV audit procedures. Specifically:

- We did not ignore Federal requirements; rather, we designed our audit to comply with Federal requirements. We did not apply any new regulatory requirements that would be subject to notice and comment rulemaking, and therefore, our audit does not make substantive changes to a CMS-administered program. Furthermore, our audits do not

have to mirror CMS’s approach, or the methodologies used in previous audits. All of our audits are intended to provide an independent assessment of Department of Health and Human Services programs and operations in accordance with the Inspector General Act of 1978, 5 U.S.C. Ch. 4. We believe that our audit methodology provides a reasonable basis for our findings and recommendations.

- With respect to PHP’s comments regarding potential underpayments, our objective was to determine whether selected high-risk diagnosis codes that PHP submitted to CMS for use in CMS’s risk adjustment program complied with Federal requirements. Our objective did not extend to diagnosis codes “unreported or underreported” by PHP or to HCCs that were beyond the scope of our audit. A valid estimate of overpayments, given the objective of our audit, does not need to take into consideration all potential HCCs or underpayments within the audit period; this estimate addressed only the accuracy of the portion of payments related to the reviewed HCCs and did not extend to HCCs that were beyond the scope of this audit.
- Regarding PHP’s statement that we did not consider “actuarial equivalence” in our overpayment calculations, our audit methodology correctly applied CMS requirements to properly identify the net overpayment amount associated with the unvalidated HCCs for each sampled enrollee-year. Specifically, we used the results of the independent medical review contractor’s review to determine which HCCs were not validated and, in some instances, to identify HCCs that should have been used but were not used in the associated enrollees’ risk score calculations. We followed CMS’s risk adjustment program requirements to determine the payment that CMS should have made for each enrollee and to estimate net overpayments.

Additionally, after we issued our draft report, CMS stated that it “will not apply an adjustment factor (known as an FFS Adjuster) in RADV audits.”²⁷ To this point, we recognize that CMS—not OIG—is responsible for making operational and program payment determinations for the MA program. CMS will evaluate our recommendations and will adjust our net overpayment finding by whatever amount it determines necessary.

PRESBYTERIAN HEALTH PLAN, INC., DID NOT CONCUR WITH THE OFFICE OF INSPECTOR GENERAL’S RECOMMENDATION TO PERFORM ADDITIONAL AUDITS BEFORE AND AFTER THE AUDIT PERIOD

Presbyterian Health Plan, Inc., Comments

PHP did not concur with our second recommendation—that it perform additional reviews to determine whether similar instances of high-risk diagnoses occurred before or after the audit period. According to PHP, “this standard is neither feasible, nor consistent with obligations

²⁷ 88 Fed. Reg. 6643 (Feb. 1, 2023).

under law and the risk-adjusted nature of the [MA] program.” PHP also stated that this recommendation “implies a standard far beyond that which has been articulated by CMS and OIG.”

PHP said that CMS requires PHP to “take reasonable steps to ensure the ‘accuracy, completeness, and truthfulness’ of the risk adjustment data it submits based on its ‘best knowledge, information and belief’” (42 CFR § 422.504(l)(2)). PHP stated that it had a reasonably designed system in which it randomly selected, on a daily basis, claims to ensure that the diagnoses were supported in the medical record and that any unsupported diagnoses were deleted in real time. To this point, PHP also stated that it had “identified and deleted, during the [a]udit [p]eriod, hundreds of the same ‘high risk’ diagnosis codes” that PHP determined “were not supported by the medical records.”

Moreover, PHP stated that CMS has acknowledged that MA organizations “cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that [CMS], the OIG, and [the Department of Justice] believe is reasonable to enforce.” PHP acknowledged its responsibility regarding data accuracy but added that it receives “thousands of claims each day and cannot reasonably be expected to audit 100% of this data, which is the standard that would be required to identify and correct 100% of diagnosis code errors.”

In addition, PHP stated that it had “already been subject to contract-level RADV audits and the annual Medicare Part C Improper Payment Measure for certain years within the [a]udit [p]eriod and within the broader lookback period.”²⁸ PHP said that for this reason, our audits and our recommendations to perform additional audits “potentially are overlapping and duplicative with audits already completed or underway.”

After summarizing the reasons for its nonconurrence with our second recommendation, PHP added that it “will evaluate its legal obligations and will fully discharge those obligations.”

Office of Inspector General Response

We do not fully agree with PHP’s interpretation of the Federal requirements at 42 CFR § 422.504(l)(2). We recognize that CMS applies a “best knowledge, information and belief” standard when MA organizations certify the heavy volume of data that they submit to CMS for use in the risk adjustment program. We also acknowledge that CMS recognizes that MA organizations cannot reasonably be expected to know that every piece of data is correct.

Although PHP stated that during our audit period it took reasonable steps with respect to the accuracy of the data that it submitted to CMS, and stated that it had identified and deleted hundreds of the same high-risk diagnosis codes through its quality assurance program, our

²⁸ CMS conducts an annual Medicare Part C Improper Payment Measure activity for a sample of Medicare Part C enrollees to estimate the improper payments for the Medicare Part C program due to unsubstantiated risk adjustment data.

audit still revealed a significant error rate (198 of 211 enrollee-years) for the high-risk groups.²⁹ Federal regulations require MA organizations to implement procedures for “promptly responding to compliance issues as they are raised” and to “[correct] such problems promptly and thoroughly to reduce the potential for recurrence” (42 CFR § 422.503(b)(4)(vi)(G)) (Appendix E)). Accordingly, we believe that PHP is responsible for addressing more fully the issues that resulted in this significant error rate, both before and after our audit period.

We provided a list of the enrollee-years in our sampling frame to CMS to ensure that the individuals and the associated HCCs identified for this audit would be excluded from future CMS RADV audits. We believe that this audit methodology pre-empts any overlapping or duplicative audit findings.

PRESBYTERIAN HEALTH PLAN, INC., DID NOT CONCUR WITH THE OFFICE OF INSPECTOR GENERAL’S RECOMMENDATION THAT IT ENHANCE ITS EXISTING COMPLIANCE PROCEDURES

Presbyterian Health Plan, Inc., Comments

PHP did not concur with our third recommendation—that it continue to examine its existing compliance procedures for diagnoses that are at high risk for being miscoded and enhance those procedures as necessary. Specifically, PHP stated that it has “thorough and effective compliance procedures in place,” a fact that we acknowledged in our draft report. PHP said that its compliance program “is not ineffective just because errors exist,” and added that during the normal course of its compliance program, “[n]umerous changes have already been made since the time of the OIG audit.”

Finally, PHP stated that although it would “continue to assess and improve its compliance procedures, [it] does not concur with this recommendation to the extent it implies that PHP could or must implement a program that would eliminate all potential errors.”

Office of Inspector General Response

PHP’s comments on our third recommendation implied that we opined on the effectiveness of its entire compliance program. That was not our intention or our focus for this audit. Rather, we limited our audit to selected diagnoses that we determined to be at high risk for being miscoded. Our audit revealed a significant error rate for all of these high-risk groups. We acknowledge that PHP had compliance procedures in place to promote the accuracy of diagnosis codes submitted to CMS to calculate risk-adjusted payments, including some procedures related to the high-risk diagnosis codes that were the subject of this audit. Although PHP stated that it has made numerous changes to its compliance program and risk

²⁹ Our audit methodology included a step in which PHP verified that the enrollee-years included in our sampling frame met the requirements spelled out in our statistical sampling methodology (Appendix C). Before we selected our sampled enrollee-years, PHP did not inform us that it had reviewed and corrected any of the HCCs associated with the individuals in our sampling frame. Furthermore, PHP had not given us any documentation showing that, before we finalized our sampling frame, it made corrections for any of the individuals in the frame.

adjustment practices since our audit, this does not mean that PHP should not continue to examine and enhance its compliance procedures with respect to these high-risk groups of diagnoses. Improvement of PHP's existing procedures, based on the results of both this audit and PHP's internal audits, will assist PHP in attaining better assurance with regard to the "accuracy, completeness and truthfulness" of the risk adjustment data that it submits in the future. Accordingly, we maintain that our third recommendation remains valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid PHP \$661,147,526 to provide coverage to its enrollees for 2017 and 2018. We identified a sampling frame of 1,598 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes during the 2016 and 2017 service years; PHP received \$18,889,065 in payments from CMS for these enrollee-years for 2017 and 2018. We selected for audit 211 enrollee-years with payments totaling \$2,649,982.

The 211 enrollee-years included 30 acute stroke diagnoses, 30 acute myocardial infarction diagnoses, 30 embolism diagnoses, 31 lung cancer diagnoses, 30 breast cancer diagnoses, 30 colon cancer diagnoses, and 30 prostate cancer diagnoses. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$496,911 for our sample.

Our audit objective did not require an understanding or assessment of PHP's complete internal control structure, and we limited our review of internal controls to those directly related to our objective.

We performed audit work from February 2020 through August 2022.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- We reviewed applicable Federal laws, regulations, and guidance.
- We discussed with CMS program officials the Federal requirements that MA organizations should follow when submitting diagnosis codes to CMS.
- We identified, through data mining and discussions with medical professionals at a Medicare administrative contractor, diagnosis codes and HCCs that were at high risk for noncompliance. We also identified the diagnosis codes that potentially should have been used for cases in which the high-risk diagnoses were miscoded.
- We consolidated the high-risk diagnosis codes into specific groups, which included:
 - 74 diagnosis codes for acute stroke,
 - 38 diagnosis codes for acute myocardial infarction,
 - 85 diagnosis codes for embolism,
 - 24 diagnosis codes for lung cancer,
 - 65 diagnosis codes for breast cancer
 - 20 diagnosis codes for colon cancer, and

- 2 diagnosis codes for prostate cancer.
- We used CMS’s systems to identify the enrollee-years on whose behalf providers documented the high-risk diagnosis codes. Specifically, we used extracts from CMS’s:
 - Risk Adjustment Processing System (RAPS)³⁰ to identify enrollees who received high-risk diagnosis codes from a physician during the service years,
 - Risk Adjustment System (RAS)³¹ to identify enrollees who received an HCC for the high-risk diagnosis codes,
 - Medicare Advantage Prescription Drug System (MARx)³² to identify enrollees for whom CMS made monthly Medicare payments to PHP, before applying the budget sequestration reduction, for the relevant portions of the service and payment years (Appendix C),
 - Encounter Data System (EDS)³³ to identify enrollees who received specific procedures, and
 - Prescription Drug Event (PDE) file³⁴ to identify enrollees who had Medicare claims with certain medications dispensed on their behalf.
- We interviewed PHP officials to gain an understanding of: (1) the policies and procedures that PHP followed to submit diagnosis codes to CMS for use in the risk adjustment program and (2) PHP’s monitoring of those diagnosis codes to detect and correct noncompliance with Federal requirements.
- We selected for audit a stratified random sample of 211 enrollee-years (Appendix C).

³⁰ MA organizations use the RAPS to submit diagnosis codes to CMS.

³¹ The RAS identifies the HCCs that CMS factors into each enrollee’s risk score calculation.

³² The MARx identifies the payments made to MA organizations.

³³ The EDS contains information on each item (including procedures) and service provided to enrollees.

³⁴ The PDE file contains claims with prescription drugs that have been dispensed to enrollees through the Medicare Part D (prescription drug coverage) program.

- We used an independent medical review contractor to perform a coding review for the 211 enrollee-years to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements.³⁵
- The independent medical review contractor’s coding review followed a specific process to determine whether there was support for a diagnosis code and the associated HCC:
 - If the first senior coder found support for the diagnosis code on the medical record, the HCC was considered validated.
 - If the first senior coder did not find support on the medical record, a second senior coder performed a separate review of the same medical record:
 - If the second senior coder also did not find support, the HCC was considered to be not validated.
 - If the second senior coder found support, then a physician independently reviewed the medical record to make the final determination.
 - If either the first or second senior coder asked a physician for assistance, the physician’s decision became the final determination.
- We used the results of the independent medical review contractor, and CMS’s systems, to calculate overpayments or underpayments (if any) for each enrollee-year. Specifically, we calculated:
 - a revised risk score in accordance with CMS’s risk adjustment program and
 - the payment that CMS should have made for each enrollee-year.
- We estimated the total net overpayment made to PHP during the audit period.

³⁵ Our independent medical review contractor used senior coders all of whom possessed one or more of the following qualifications and certifications: Registered Health Information Technician (RHIT), Certified Coding Specialist (CCS), Certified Coding Specialist – Physician-Based (CCS-P), Certified Professional Coder (CPC), and Certified Risk Adjustment Coder (CRC). RHITs have completed a 2-year degree program and have passed an American Health Information Management Association (AHIMA) certification exam. The AHIMA also credentials individuals with CCS and CCS-P certifications and the American Academy of Professional Coders credentials both CPCs and CRCs.

- We calculated the recommended recovery amount in accordance with CMS’s regulations that limit the use of extrapolation in RADV audits for recovery purposes.³⁶ Specifically, we calculated the recommended recovery amount as the sum of the net overpayments identified for the sampled enrollee-years from payment year 2017 and the estimate of total overpayments made to PHP for the enrollee-years from payment year 2018.
- We discussed the results of our audit with PHP officials on May 23, 2022.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

³⁶ Federal regulations at 42 CFR § 422.311(a) state: “[T]he Secretary annually conducts RADV audits to ensure risk-adjusted payment integrity and accuracy.” Recovery of improper payments from MA organizations will be conducted in accordance with the Secretary’s payment error extrapolation and recovery methodologies. CMS may apply extrapolation to audits for payment year 2018 and subsequent payment years. 88 Fed. Reg. 6643, 6655 (Feb. 1, 2023).

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Excellus Health Plan, Inc. (Contract H3351) Submitted to CMS</i>	<u>A-07-20-01202</u>	7/10/2023
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Keystone Health Plan East, Inc. (H3952) Submitted to CMS</i>	<u>A-03-20-00001</u>	5/31/2023
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HumanaChoice (Contract H6609) Submitted to CMS</i>	<u>A-05-19-00013</u>	4/4/2023
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cigna-HealthSpring Life & Health Insurance Company, Inc. (Contract H4513) Submitted to CMS</i>	<u>A-07-19-01192</u>	3/28/2023
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That MCS Advantage, Inc. (Contract H5577) Submitted to CMS</i>	<u>A-02-20-01008</u>	3/24/2023
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Geisinger Health Plan (Contract H3954) Submitted to CMS</i>	<u>A-09-21-03011</u>	3/16/2023
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Cigna-HealthSpring of Tennessee, Inc. (Contract H4454) Submitted to CMS</i>	<u>A-07-19-01193</u>	12/22/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That BCBS of Rhode Island (Contract H4152) Submitted to CMS</i>	<u>A-01-20-00500</u>	11/16/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That California Physician's Service, Inc. (Contract H0504) Submitted to CMS</i>	<u>A-09-19-03001</u>	11/10/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HumanaChoice (Contract R5826) Submitted to CMS</i>	<u>A-05-19-00039</u>	9/30/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Highmark Senior Health Company (H3916) Submitted to CMS</i>	<u>A-03-19-00001</u>	9/29/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That BlueCross BlueShield of Tennessee, Inc. (Contract H7917) Submitted to CMS</i>	<u>A-07-19-01195</u>	9/29/2022
<i>Medicare Advantage Compliance Audit of Diagnosis Codes that Inter Valley Health Plan, Inc. (Contract H0545), Submitted to CMS</i>	<u>A-05-18-00020</u>	9/26/2022

Report Title	Report Number	Date Issued
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Regence BlueCross BlueShield of Oregon (Contract H3817) Submitted to CMS</i>	<u>A-09-20-03009</u>	9/13/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That WellCare of Florida, Inc., (Contract H1032) Submitted to CMS</i>	<u>A-04-19-07084</u>	8/29/2022
<i>Medicare Advantage Compliance Audit of Diagnosis Codes That Cigna HealthSpring of Florida, Inc. (Contract H5410) Submitted to CMS</i>	<u>A-03-18-00002</u>	8/19/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cariten Health Plan, Inc., (Contract H4461) Submitted to CMS</i>	<u>A-02-20-01009</u>	7/18/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Peoples Health (Contract H1961) Submitted to CMS</i>	<u>A-06-18-05002</u>	5/25/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Tufts Health Plan (Contract H2256) Submitted to CMS</i>	<u>A-01-19-00500</u>	2/14/2022
<i>Medicare Advantage Compliance Audit of Diagnosis Codes That SCAN Health Plan (Contract H5425) Submitted to CMS</i>	<u>A-07-17-01169</u>	2/3/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., (Contract H3359) Submitted to CMS</i>	<u>A-02-18-01029</u>	1/5/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UPMC Health Plan, Inc. (Contract H3907) Submitted to CMS</i>	<u>A-07-19-01188</u>	11/5/2021
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc. (Contract H2663) Submitted to CMS</i>	<u>A-07-17-01173</u>	10/28/2021
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Anthem Community Insurance Company, Inc. (Contract H3655) Submitted to CMS</i>	<u>A-07-19-01187</u>	5/21/2021
<i>Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc., (Contract H1036) Submitted to CMS</i>	<u>A-07-16-01165</u>	4/19/2021
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross Blue Shield of Michigan (Contract H9572) Submitted to CMS</i>	<u>A-02-18-01028</u>	2/24/2021
<i>Some Diagnosis Codes That Essence Healthcare, Inc., Submitted to CMS Did Not Comply With Federal Requirements</i>	<u>A-07-17-01170</u>	4/30/2019

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We identified PHP enrollees who: (1) were continuously enrolled in PHP throughout all of the 2016 or 2017 service year and January of the following year, (2) were not classified as being enrolled in hospice or as having end-stage renal disease status at any time during 2016 or 2017 or in January of the following year, and (3) received a high-risk diagnosis during 2016 or 2017 that caused an increased payment to PHP for 2017 or 2018, respectively.

We presented the data for these enrollees to PHP for verification and performed an analysis of the data included on CMS's systems to ensure that the high-risk diagnosis codes increased CMS's payments to PHP. After we performed these steps, our finalized sampling frame consisted of 1,598 enrollee-years.

SAMPLE UNIT

The sample unit was an enrollee-year, which covered either payment year 2017 or 2018.

SAMPLE DESIGN AND SAMPLE SIZE

The design for our statistical sample comprised of seven strata of enrollee-years. For the enrollee-years in each respective stratum, each individual received:

- an acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have that diagnosis on a corresponding inpatient or outpatient hospital claim (489 enrollee-years);
- a diagnosis (that mapped to the HCC for Acute Myocardial Infarction) on only one physician or outpatient claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician or outpatient claim (343 enrollee-years);
- a diagnosis (that mapped to an Embolism HCC) on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf (159 enrollee-years);
- a lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments related to the lung cancer diagnosis administered within a 6-month period before or after the diagnosis (31 enrollee-years);

- a breast cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments related to the breast cancer diagnosis administered within a 6-month period before or after the diagnosis (325 enrollee-years);
- a colon cancer diagnosis (that mapped to the HCC for Colorectal, Bladder, and Other Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (81 enrollee-years); or
- a prostate cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors), for an individual 74 years old or younger, on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (170 enrollee-years).

The specific strata are shown in Table 2.

Table 2: Sample Design for Audited High-Risk Groups

Stratum (High-Risk Groups)	Frame Count of Enrollee-Years	CMS Payment for HCCs in Audited High-Risk Groups	Sample Size
1 – Acute stroke	489	\$864,308	30
2 – Acute myocardial infarction	343	498,097	30
3 – Embolism	159	334,564	30
4 – Lung cancer	31	205,401	31
5 – Breast cancer	325	357,070	30
6 – Colon cancer	81	171,470	30
7 – Prostate cancer	170	191,009	30
Total	1,598	\$2,621,919	211

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by a beneficiary identification number and payment year, then consecutively numbered the items in each stratum in the stratified sampling frame. After generating 211 random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

Estimated Net Overpayments

We used the OIG, OAS, statistical software to estimate the total amount of net overpayments to PHP at the lower limit of the two-sided 90-percent confidence interval (Appendix D). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

Estimated Net Overpayments for Recommended Recovery

After we had issued our draft report, CMS updated Federal regulations that limit the use of extrapolation in RADV audits to payment years 2018 and forward (footnote 36). Therefore, we calculated the recommended recovery amount in accordance with CMS's regulations. Specifically, we calculated the recommended recovery amount as the sum of the net overpayments identified for the sampled enrollee-years from payment year 2017 and the estimate of total overpayments made to PHP for the enrollee-years from payment year 2018.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Details and Results for Payment Year 2017

Audited High-Risk Groups	Frame Size	CMS Payments for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)	Sample Size	CMS Payments for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)	Number of Sampled Enrollee-Years With Unvalidated HCCs	Net Overpayments for Unvalidated HCCs (for Sampled Enrollee-Years)*
1 – Acute stroke	249	\$429,517	17	\$29,116	17	\$25,713
2 – Acute myocardial infarction	285	402,672	27	36,167	27	31,055
3 – Embolism	101	212,115	15	30,653	13	27,416
4 – Lung cancer	13	84,039	13	84,039	13	70,180
5 – Breast cancer	150	167,339	11	11,737	11	11,737
6 – Colon cancer	30	66,492	13	30,159	12	27,940
7 – Prostate cancer	80	92,768	12	12,993	11	12,007
Total	908	\$1,454,942	108	234,864	104	\$206,048

* The acute stroke high-risk group was the only group that had a net overpayment for 2017.

Table 4: Sample Details and Results for Payment Year 2018

Audited High-Risk Groups	Frame Size	CMS Payments for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)	Sample Size	CMS Payments for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)	Number of Sampled Enrollee-Years With Unvalidated HCCs	Overpayments for Unvalidated HCCs (for Sampled Enrollee-Years)
1 – Acute stroke	240	\$434,791	13	\$24,537	13	\$24,536
2 – Acute myocardial infarction	58	95,425	3	5,404	3	5,404
3 – Embolism	58	122,449	15	33,595	12	26,307
4 – Lung cancer	18	121,362	18	121,362	16	109,136
5 – Breast cancer	175	189,731	19	20,529	18	19,501
6 – Colon cancer	51	104,978	17	36,184	17	34,099
7 – Prostate cancer	90	98,241	18	20,436	15	17,423
Total	690	\$1,166,977	103	262,047	94	\$236,406

**Table 5: Sample Details and Results
(Payment Years 2017 and 2018 Combined)**

Audited High-Risk Groups	Frame Size	CMS Payments for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)	Sample Size	CMS Payments for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)	Number of Sampled Enrollee-Years With Unvalidated HCCs	Net Overpayments for Unvalidated HCCs (for Sampled Enrollee-Years)*
1 – Acute stroke	489	\$864,308	30	\$53,653	30	\$50,249
2 – Acute myocardial infarction	343	498,097	30	41,571	30	36,459
3 – Embolism	159	334,564	30	64,248	25	53,723
4 – Lung cancer	31	205,401	31	205,401	29	179,316
5 – Breast cancer	325	357,070	30	32,266	29	31,238
6 – Colon cancer	81	171,470	30	66,343	29	62,039
7 – Prostate cancer	170	191,009	30	33,429	26	29,430
Total	1,598	\$2,621,919	211	\$496,911	198	\$442,454

* The net overpayment occurred in 2017 and was in the acute stroke high-risk group.

**Table 6: Estimated Net Overpayments in the Sampling Frame
(Payment Years 2017 and 2018 Combined)
(Limits Calculated at the 90-Percent Confidence Level)**

Point Estimate	\$2,372,638
Lower Limit	\$2,237,662
Upper Limit	\$2,507,614

**Table 7: Total Estimated Net Overpayments in the Sampling Frame
for Recommended Recovery
(Limits Calculated at the 90-Percent Confidence Level)**

	Net Overpayments for Sampled Enrollee- Years for 2017	Estimated Overpayments for Statistical Sample for 2018*	Total Net Estimated Overpayments
Point Estimate	\$206,048	\$1,137,343	\$1,343,391
Lower Limit	206,048	1,096,634	1,302,682
Upper Limit	206,048	1,166,977	1,373,025

* The computed upper limit of the 90-percent confidence interval for 2018 overpayments is greater than the total amount in the 2018 sampling frame. Therefore, the upper limit is being reported using the 2018 sampling frame total.

**APPENDIX E: FEDERAL REGULATIONS REGARDING COMPLIANCE PROGRAMS
THAT MEDICARE ADVANTAGE ORGANIZATIONS MUST FOLLOW**

Federal regulations (42 CFR § 422.503(b)) state:

Any entity seeking to contract as an MA organization must

(4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following

(vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum, include the following core requirements:

(A) Written policies, procedures, and standards of conduct that—

- (1) Articulate the organization's commitment to comply with all applicable Federal and State standards;
- (2) Describe compliance expectations as embodied in the standards of conduct;
- (3) Implement the operation of the compliance program;
- (4) Provide guidance to employees and others on dealing with potential compliance issues;
- (5) Identify how to communicate compliance issues to appropriate compliance personnel;
- (6) Describe how potential compliance issues are investigated and resolved by the organization; and
- (7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials

(F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The

system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MA organization, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.

- (G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.
- (1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.
 - (2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section.
 - (3) The MA organization should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee.



October 10, 2022

James I. Korn
 Regional Inspector General for Audit Services
 Office of Audit Services, Region VII
 601 East 12th Street, Room 0429
 Kansas City, MO 64106

RE: Presbyterian Health Plan, Inc. Response to OIG's Draft Report No. A-07-20-01197

Dear Mr. Korn:

Presbyterian Health Plan, Inc. ("PHP") appreciates the opportunity to submit this response to the United States Department of Health and Human Services ("HHS") Office of the Inspector General's ("OIG's") Draft Report for Audit No. A-07-20-01197 ("Draft Report").

In its Draft Report, OIG recommends that PHP (i) refund the Federal Government \$2,237,662 of estimated net overpayments ("Alleged Overpayment") for the 2017 and 2018 payment years (the "Audit Period"), (ii) identify, for the high-risk diagnoses included in the Draft Report, similar instances of noncompliance that occurred before or after the Audit Period and refund any resulting overpayments to the Federal Government, and (iii) continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that the diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to the Centers for Medicare & Medicaid Services ("CMS") for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures. As further discussed below, PHP does not concur with OIG's recommendations and respectfully submits that OIG should reconsider its recommendations.

A. PHP Does Not Concur with the Recommendation that PHP Refund to the Federal Government \$2,237,662 of Extrapolated Net Overpayments

PHP does not concur with OIG's recommendation that PHP should refund to the Federal government the Alleged Overpayment. For the reasons stated below, the Alleged Overpayment does not accurately reflect an overpayment to PHP under applicable law and guidance because OIG's audit process and extrapolation methodology is flawed and overstates any potential net overpayments.

(1) OIG ignores the established process for validation of risk adjustment data.

Medicare Advantage organizations' ("MAOs") are subject to an established process for CMS to validate risk adjustment data. CMS promulgated standards for CMS Risk Adjustment Data Validation ("RADV") audits through a notice and comment process which is intended to validate this data ("RADV Guidance")¹. OIG did not follow this RADV process. In fact, it's not clear which process OIG followed as its approach appears different among the MAOs that have been

¹ CMS, Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audit (Feb. 24, 2012).

reviewed by OIG in this “series of audits.”² For example, some MAOs were not subject to extrapolation (while PHP has been) and OIG’s approach to identification of high-risk areas varies among the audits.³

In OIG’s responsive comments when other audited MAOs have questioned OIG’s methodology, OIG has stated that it does not have to mirror CMS’s approach and that OIG’s audits are “intended to provide an independent assessment of HHS programs and operations in accordance with the Inspector General Act of 1978, 5 U.S.C. App.”⁴ However, we respectfully submit that OIG’s process does not appropriately take into consideration the various nuances of the Medicare Advantage program and that OIG does not have the statutory and regulatory authority to unilaterally impose new substantive requirements for MAOs.⁵

Therefore, any recommendation from OIG that PHP should refund money to CMS should, at a minimum, be based on the structure of the CMS RADV process and methodology rather than establishing a new process and methodology that is unknown to the MAOs, not consistent among MAOs, and not promulgated through notice and comment rulemaking.

(2) OIG did not consider underpayments in its audit.

To the extent overpayments exist, the Alleged Overpayment is designed to overstate the net overpayments. The methodology used by OIG is biased towards overpayment. The audit specifically targeted only certain “diagnoses that were at higher risk for being miscoded.”⁶ While we acknowledge that in four instances OIG took into consideration other diagnosis codes in a related disease group that were supported in the medical record, OIG’s process did not review or consider unreported and underreported diagnoses for the sampled members in unrelated disease groups for which PHP should have been compensated, as in done the CMS RADV audit process. OIG’s approach most likely overstates the overpayment within the sample and creates a fundamental unfairness given the sampled years are closed and PHP can no longer submit new

² Draft Report at 8.

³For some organizations, OIG recommended that the audited MAOs refund overpayment amounts based only on the purported errors identified in the sample. See e.g., HHS OIG Audit Report No. A-07-17-01170, *Some Diagnosis Codes That Essence Healthcare, Inc. Submitted to CMS Did Not Comply With Federal Requirements* (Apr. 2019), available at <https://oig.hhs.gov/oas/reports/region7/71701170.pdf> (“Essence Report”) at 3-4, 8; see also HHS OIG, Audit Report No. A-07-17-01173, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Coventry Health Care of Missouri, Inc. (Contract H2663) Submitted to CMS* (Oct. 2021), available at <https://oig.hhs.gov/oas/reports/region7/71701173.pdf> (“Coventry Report”) at 6, 14. For other organizations, OIG used extrapolated audit results to determine a recommended refund amount. See e.g., HHS OIG, Audit Report A-02-18-01028, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Blue Cross Blue Shield of Michigan (Contract H9572) Submitted to CMS* (Feb. 2021), available at <https://oig.hhs.gov/oas/reports/region2/21801028.pdf> (“BCBSM Report”) at 16, 24-25; see also HHS OIG, Audit Report No. A-07-19-01188, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that UPMC Health Plan, Inc. (Contract H3907) Submitted to CMS* (Nov. 2021), available at <https://oig.hhs.gov/oas/reports/region7/71901188.pdf> (“UPMC Report”) at 19, 40-41. Furthermore, OIG focused on a varying range of six to ten high-risk areas in each review without explanation of why different areas were selected for each organization. Within those high-risk areas, OIG’s approach to defining the sampled universe also varies. See e.g., UPMC Report at 4; Essence Report at 4; BCBSM Report at 4; Coventry Report at 4.

⁴ See HHS OIG Audit Report No. A-01-19-00500, *Medicare Advantage Audit of Specific Diagnosis Codes that Tufts Health Plan (Contract H2256) Submitted to CMS* (Feb. 2022), available at <https://oig.hhs.gov/oas/reports/region1/11900500.pdf>.

⁵ See *Azar v. Allina Health Services*, 139 S.Ct. 1804 (2019).

⁶ Draft Report at 11.

diagnosis codes for this sample, which is then further compounded by extrapolation of the error rate.

Further, OIG did not take into consideration the impact of unreported and underreported diagnosis codes at the contract level. By sampling only identified “high-risk” diagnoses, OIG did not take into account other members with lower probability diagnoses or members with no reported diagnoses. If the sample also included these additional members and underreported and unreported diagnosis codes were offset against any unsupported diagnoses codes, the outcome would be vastly different. The type of selective audit conducted by OIG does not align with the nature and realities of the Medicare Advantage program.

The methodology used by OIG to arrive at the Alleged Overpayment is flawed and overstates any potential overpayments because it did not take into account potential underpayments which would likely reduce the Alleged Overpayment amount. To more accurately identify any net overpayment to PHP, OIG should consider all potential offsetting underpayments for sampled members. Review of members excluded from sampling due to the lack of targeted diagnoses should also be addressed to ensure a more accurate risk adjusted payment amount.

(3) OIG’s extrapolation methodology does not appropriately account for the actuarial equivalence standard.

The extrapolation calculation set forth by OIG is not designed to result in an accurate representation of any overpayment to PHP. The methodology used by OIG creates an actuarial disconnect between Medicare Advantage payments and the fee-for-service (“FFS”) data upon which Medicare Advantage payment rates are based. By statute, CMS must set Medicare Advantage payment rates “to ensure actuarial equivalence” between Medicare Advantage and Medicare FFS.⁷ CMS has acknowledged the justification for a “FFS adjuster” in its RADV Guidance and has stated that it is necessary to satisfy the actuarial equivalence requirement. The data used for benchmark rate development and HCC risk score model development reflects unaudited FFS claims data. To the extent that FFS claims data also reflects unsupported diagnoses, then an overpayment would only occur if, and to the extent, the unsupported diagnosis rate for an MAO exceeds the amount that is already reflected in the benchmark rates and HCC model coefficients.

We acknowledge that CMS more recently published a proposed rule⁸ for RADV audits that does not include the FFS adjuster. However, that rule is still a proposal and may not be finalized as proposed. The RADV Guidance is the current CMS guidance on the subject, and the RADV Guidance was the existing guidance during the Audit Period. We also join other MAOs and industry experts in their conclusion that CMS’s proposal to eliminate the FFS adjuster is flawed, unreliable, and inconsistent with sound actuarial practice (see, e.g., Anthem, Inc. Comments to Seema Verma, Re: CMS–4185–P: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 (Aug. 28, 2019); Milliman White Paper: Medicare Advantage RADV FFS Adjuster: White Paper, August 23, 2019.).

⁷ 42 U.S.C. § 1395w-23(a)(1)(C)(i).

⁸ 85 Fed. Reg. 54982 at 55040 (Nov. 1, 2018)

B. PHP Does Not Concur with OIG’s Recommendation to Conduct Additional Audits of the Identified Diagnoses for Additional Time Periods

To the extent OIG’s recommendation imposes a standard that each existence of unsupported codes results in an obligation to conduct a full lookback audit, PHP respectfully submits that this standard is neither feasible, nor consistent with obligations under law and the risk-adjusted nature of the Medicare Advantage program.

CMS regulations require PHP to take reasonable steps to ensure the “accuracy, completeness, and truthfulness” of the risk adjustment data it submits based on its “best knowledge, information and belief.”⁹ OIG has acknowledged that this requirement “does not constitute an absolute guarantee of accuracy. Rather, it creates a duty on the [MAO] to put in place an information collection and reporting system reasonably designed to yield accurate information.”¹⁰ CMS has also recognized that MAOs “cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that [CMS], the OIG, and [the Department of Justice] believe is reasonable to enforce.”¹¹ OIG’s recommendation implies a standard far beyond that which has been articulated by CMS and OIG.

PHP has in fact put into place an information collection and reporting system reasonably designed to yield accurate information. On a daily basis, PHP’s quality assurance audits randomly selected claims to ensure that the diagnoses are supported in the medical record and any unsupported diagnoses are deleted in real time. In fact, through this quality assurance audit process, PHP identified and deleted, during the Audit Period, hundreds of the same “high risk” diagnosis codes audited by OIG when PHP’s process identified instances which were not supported by the medical records. Further, when PHP identifies potential trends, PHP investigates these trends, reviews and deletes unsupported diagnoses, and works with its provider organizations on education and other quality initiatives designed to improve coding accuracy and reverse identified trends.

PHP acknowledges its responsibility with respect to the accuracy of data submitted to CMS and to exercise reasonable diligence to determine if it has received an overpayment. However, PHP receives thousands of claims each day and cannot reasonably be expected to audit 100% of this data, which is the standard that would be required to identify and correct 100% of diagnosis code errors. Further, while OIG identified seven “high risk” diagnosis codes for purposes of its audit, this is not an exhaustive list of all potential high risk diagnosis codes. If PHP focuses only on so called high risk diagnosis codes, even then, a requirement that PHP identify, audit and correct 100% of all high risk diagnosis codes is not a reasonable expectation nor consistent with applicable law.

An assertion that PHP must retrospectively audit all plan years in the lookback period (including those that are closed and/or have been audited by CMS), when any discrepancies between the record and the reported codes are identified, disregards the nature of the Medicare Advantage program, the actuarial equivalence standard, and the specific instructions that the MAOs role is not to ensure 100% accuracy of the risk adjustment data submitted by such MAOs. The focus of PHP’s quality assurance program, and that of other MAOs, on identification and correction of the risk adjustment data in real-time and prior to final payment reconciliation of the plan year is designed to ensure accuracy of information while maintaining the actuarial integrity of the overall payment structure. Although PHP acknowledges there are circumstances when PHP must

⁹ 42 C.F.R. § 422.504(l)(2).

¹⁰ 64 Fed. Reg. 61893, 61900 (November 15, 1999)

¹¹ 65 Fed. Reg. 40169, 40268 (June 29, 2000).

conduct investigations and delete codes after the plan year's final run, it is not reasonable to assert that identification of unsupported codes in a designated sample of patients *automatically* confers on PHP the obligation to conduct investigations in other years.

Moreover, PHP has already been subject to contract-level RADV audits and the annual Medicare Part C Improper Payment Measure for certain years within the Audit Period and within the broader lookback period. The OIG audits and recommendations for further internal audits potentially are overlapping and duplicative with audits already completed or underway.

For these reasons, PHP does not concur with OIG's recommendation that PHP, without further consideration, is obligated to "identify, for the high-risk diagnoses included in [the Draft Report], similar instances of noncompliance that occurred before or after [the] audit period and refund any resulting overpayments to the Federal Government"¹². That said, PHP will evaluate its legal obligations and will fully discharge those obligations.

C. PHP Does Not Concur with the Recommendation for Enhanced Compliance Procedures

While PHP continues to improve its compliance procedures, PHP does not concur with OIG's recommendation for PHP to "continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures"¹³ to the extent this recommendation implies that PHP's current program is inadequate or that a program could ever result in 100% accuracy of data.

PHP has thorough and effective compliance procedures in place. Specifically, as OIG acknowledged in the Draft Report, PHP's relevant compliance procedures include: (i) provider-specific preventative outreach efforts that provide clarification on coding matters including provider coding training, (ii) a sampling of a portion of the daily provider-submitted claims to ensure the diagnosis coding accuracy of those claims before their submission to CMS, (iii) detection and correction measures designed to determine whether diagnosis codes submitted to CMS to calculate risk-adjusted payments are correct, (iv) routine diagnosis coding audits and guidance on how to submit corrections to CMS, (v) quality assurance analyses which are used to identify areas with a higher risk of incorrect coding and improve compliance procedures and included measures to track coding accuracy at the provider and HCC level, (vi) education to coders on best practices that included guidance on how to code several high-risk areas, and (vii) measures designed to ensure that diagnosis codes comply with Federal regulations including those identified as high risk in the Draft Report.¹⁴

PHP's compliance program is not ineffective just because errors exist. In fact, every year, PHP engages a third-party vendor to review the effectiveness of PHP's compliance program, and PHP implements recommended improvements following such annual review.

Further, in the normal course of carrying out PHP's compliance program, PHP routinely considers and continues to improve its compliance program and risk adjustment practices. Numerous changes have already been made since the time of the OIG audit in the normal course. For example, PHP maintains inter-departmental Risk Adjustment Coding Quality Assurance

¹² Draft Report at 16.

¹³ Draft Report at 16.

¹⁴ Draft Report at 15-16.

workgroups and through these workgroups has implemented a direct interface with network providers' EMR to make the HCC coding process more streamlined using analytics at the point-of-care and has implemented improved programs for partnership with provider organizations related to coding and documentation reviews and training.

While PHP will continue to assess and improve its compliance procedures, PHP does not concur with this recommendation to the extent it implies that PHP could or must implement a program that would eliminate all potential errors.

In conclusion, PHP is committed to an effective compliance program and takes seriously its compliance obligations. While PHP does not concur with OIG's findings in the Draft Report for those reasons set forth above, PHP will continue to assess and improve its risk adjustment program and will work with CMS to determine any repayment obligations and other corrective actions.

We thank you for the opportunity to comment on the Draft Report. If you have any questions or would like to discuss this letter, please do not hesitate to let me know.

Respectfully,

A handwritten signature in cursive script that reads "Alejandra Quintana-Clyde". The signature is written in dark ink on a light-colored background.

Alejandra Quintana-Clyde, MHA, CHC, CHPC
PHP Compliance Officer