Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF DIAGNOSIS CODES THAT MMM HEALTHCARE, LLC, (CONTRACT H4003) SUBMITTED TO CMS

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Report in Brief
Date: August 2024
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Advantage Compliance Audit of Diagnosis Codes That MMM Healthcare, LLC, (Contract H4003) Submitted to CMS

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 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. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs). Thus, CMS makes higher payments for enrollees who receive diagnoses that map to HCCs.

For this audit, we reviewed the contract that MMM Healthcare, LLC, has with CMS with respect to the diagnosis codes that MMM submitted to CMS. Our objective was to determine whether MMM submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

How OIG Did This Audit

We selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2017. MMM provided medical records as support for 688 HCCs associated with these enrollees. We used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

What OIG Found

MMM did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. Although 580 of the 688 sampled enrollees' HCCs were supported in the medical records and therefore validated, the remaining 108 HCCs were not validated, which resulted in overpayments. These 108 unvalidated HCCs included 11 HCCs for which we identified other HCCs for less severe manifestations of the diseases. In addition, there were 11 HCCs for which the medical records supported diagnosis codes that MMM should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 688 HCCs. Rather, the risk scores should have been based on 602 HCCs (580 validated HCCs + 11 other HCCs + 11 additional HCCs). As a result, MMM received $165,312 in net overpayments. On the basis of our sample results, we estimated that MMM received approximately $59 million in net overpayments for 2017. Because of Federal regulations that limit the use of extrapolation in RADV audits for recovery purposes to payment years 2018 and forward, we are only recommending a refund of $165,312 in net overpayments for the sampled enrollees. These errors occurred because MMM's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could be improved.

What OIG Recommends and MMM Comments

We recommend that MMM refund to the Federal Government the $165,312 of net overpayments and continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments. MMM did not concur with our recommendations and did not agree with our findings for some HCCs in error identified in our draft report and provided additional information for our consideration. In addition, MMM stated that our findings and recommendations are inconsistent with HHS and CMS accuracy requirements, the realities of risk adjustment, and other CMS and OIG audits. MMM also disagreed with our assessment that its current risk adjustment compliance and education programs need improvement. MMM requested that we reconsider or withdraw our recommendations. After reviewing MMM's comments and the additional information provided, we reduced the number of HCCs in error and adjusted our calculation of net overpayments. We also reduced the recommended refund in in our first recommendation to $165,312. We maintain that our second recommendation remains valid.

The full report can be found on the OIG website.

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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 benefits to people enrolled in the Medicare program, depending on such risk factors as their age, gender, and health status. 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]

Incorrect diagnosis codes can lead to improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either an overpayment or an underpayment). An estimated 5.42 percent of payments to MA organizations for calendar year 2020 were improper, mainly because MA organizations submitted unsupported diagnosis codes to CMS.[2] Our previous audits have shown that MA organizations submitted diagnosis codes that did not comply with Federal requirements.

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.[3] We reviewed one MA organization, MMM Healthcare, LLC, (MMM) with respect to the diagnosis codes that MMM submitted to CMS for contract number H4003.[4]

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[1] The providers code diagnoses using the *International Classification of Diseases (ICD), Clinical Modification, 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] The Department of Health and Human Services Agency Financial Report, Fiscal Year 2022, estimated that 5.42 percent of the payments for the MA program were improper. This figure includes errors for both overpayments and underpayments. The error rate is determined in accordance with the Payment Integrity Information Act of 2019, P.L. No. 116-117 (Mar. 2, 2020), which repealed and replaced the Improper Payments Information Act of 2002, P.L. No. 107-300 (Nov. 26, 2002); the Improper Payments Elimination and Recovery Act of 2010, P.L. No. 111-204 (July 22, 2010); the Improper Payments Elimination and Recovery Improvement Act of 2012, P.L. No. 112-248 (Jan. 10, 2013); and the Fraud Reduction and Data Analytics Act of 2015, P.L. No. 114-186 (June 30, 2016). Similar to the Improper Payments Elimination and Recovery Improvement Act of 2012, the Payment Integrity Information Act of 2019 requires Federal agencies to: (1) review their programs and activities to identify programs that may be susceptible to significant improper payments, (2) test for improper payments in high-risk programs, and (3) develop and implement corrective action plans for high-risk programs.

[3] See Appendix B for a list of related Office of Inspector General reports.

[4] All subsequent references to "MMM" in this report refer solely to contract number H4003.

OBJECTIVE

Our objective was to determine whether MMM submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

BACKGROUND

Medicare Advantage Program

The MA program[5] allows people eligible for Medicare to enroll in private health care plans rather than Medicare's traditional fee-for-service program. For this report, we refer to these individuals 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 calendar year 2021, CMS paid MA organizations $349.9 billion, which represented 42 percent of all Medicare payments for that year.

Risk Adjustment Program

Federal requirements mandate that payments made to MA organizations be based on the anticipated cost of providing Medicare benefits to a given enrollee and that enrollee's demographic characteristics and health status.[6]

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.[7] CMS compares each bid to a specific benchmark

[5] 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.

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

[7] The Act § 1854(a)(6); 42 CFR § 422.254.

amount for each geographic area to determine the base rate that the MA organization is paid for each of its enrollees.[8]

- *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 a 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.[9] 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—based on similar clinical characteristics, severity of the disease or condition, and cost implications—into Hierarchical Condition Categories (HCCs). 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 a person enrolled in the MA program that map to the HCCs for lung cancer and immune disorders, CMS assigns a separate factor for the two diseases' interactions. 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. 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

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

[9] CMS required face-to-face encounters during our audit period. However, in April 2020, CMS issued a memorandum to MA organizations stating that diagnoses resulting from telehealth services can meet the face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication. This memorandum is available at https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf (accessed on Mar. 29, 2022).

the entirety of the year after the diagnosis has been made. Further, the risk score calculation is an additive process: As HCC 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 who are 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 sequestration reduction.[10] 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.[11] 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.

CMS designed its contract-level Risk Adjustment Data Validation (RADV) audits to be its primary corrective action on improper payments, which were estimated at 5.42 percent of payments to MA organizations for calendar year 2020. These CMS RADV audits are intended to verify whether diagnoses submitted by MA organizations for risk-adjusted payment are supported by medical record documentation.

MMM Healthcare, LLC

MMM is an MA organization based in San Juan, Puerto Rico. As of December 31, 2017, MMM provided coverage under contract number H4003 to approximately 204,000 enrollees. For our audit period (the 2017 payment year), CMS paid MMM approximately $1.4 billion to provide this coverage.[12] In June 2021, Anthem, Inc.—now called Elevance Health, Inc.—acquired MMM.

[10] Budget sequestration refers to automatic spending cuts that occur 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.

[11] 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 the reviewed diagnoses were evidenced in the medical records. In addition, we use the terms "validated" or "unvalidated" with associated HCCs that had supported or unsupported diagnoses.

[12] All payment amounts that CMS made to MMM, and the adjustment amounts that we identified in this report, reflect the budget sequestration reduction.

HOW WE CONDUCTED THIS AUDIT

Our audit focused on enrollees on whose behalf MMM submitted to CMS, for the 2016 service year, at least one diagnosis code that mapped to an HCC used in the enrollees' risk scores for the 2017 payment year. We identified a sampling frame of 110,934 enrollees, from which we selected a stratified random sample of 200 enrollees on whose behalf CMS made payments totaling $1,764,533 to MMM. MMM provided medical records as support for 685 of the 688 HCCs associated with 199 of the 200 sampled enrollees but did not provide any medical records for the remaining 3 HCCs (1 sampled enrollee).

We used an independent medical review contractor to review the medical records to determine whether the diagnosis codes validated the 685 HCCs. The contractor also reviewed these same records to determine whether any additional HCCs were validated by diagnosis codes that MMM did not submit but should have submitted.

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.

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

MMM did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, 580 of the 688 sampled enrollees' HCCs were validated;[13] however, the remaining 108 HCCs were not validated, which resulted in overpayments. These 108 unvalidated HCCs included 11 HCCs for which we identified other HCCs for less severe manifestations of the diseases. These other HCCs should have been included in the enrollees' risk scores (instead of the 11 unvalidated HCCs), which would have reduced the overpayments associated with the 108 unvalidated HCCs in our sample.[14]

[13] For 4 of these 580 sampled enrollees' HCCs, MMM officials informed us that they could not locate the associated medical record because the record had been destroyed in a natural disaster. CMS provides guidance for medical records that are unavailable because of "extraordinary circumstances" (*Contract-Level Risk Adjustment Data Validation CMS Submission Instructions*). Based on our assessment of the information provided by MMM, we determined that an extraordinary circumstance prevented MMM from locating the medical record for these HCCs, and we treated the sample items as non-errors.

[14] The less severe manifestations of the diseases for 11 HCCs led to overpayments for 10 HCCs and no payment effect for one HCC.

Second, in reviewing the medical record documentation that MMM submitted to us for the diagnosis codes associated with the sampled enrollees' HCCs, we identified support for diagnosis codes that MMM should have submitted to CMS but did not. If MMM had submitted these diagnosis codes, an additional 11 HCCs would have been included in the enrollees' risk scores. These risk scores would have increased, and CMS's payments to MMM would have been higher.

In summary, the risk scores for the 200 sampled enrollees should not have been based on the 688 HCCs. Rather, the risk scores should have been based on 602 HCCs (580 validated HCCs plus the 11 other HCCs associated with less severe manifestations of diseases plus the 11 additional validated HCCs that MMM did not submit to CMS). As a result, MMM received $165,312 in net overpayments. On the basis of our sample results, we estimated that MMM received at least $58,983,855 in net overpayments for 2017.[15] Because of Federal regulations that limit the use of extrapolation in RADV audits for recovery purposes to payment years 2018 and forward, we are reporting the overall estimated overpayment amount but are recommending a refund of $165,312 in net overpayments.[16]

As demonstrated by the errors found in our sample, MMM's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

FEDERAL REQUIREMENTS

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

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

[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 reviewed the sampled enrollees, 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)).

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. Sep. 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 (ICD), Clinical Modification (CM), *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines) (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(b)(1) and (c)(2)-(3)). In addition, the 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 require MA organizations to "adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements . . . ." In addition, MA organizations must establish and implement an effective system for routine monitoring and identification of compliance risks (42 CFR § 422.503(b)(4)(vi)).

See Appendix E for Federal regulations regarding compliance programs that MA organizations must follow.

MMM DID NOT SUBMIT SOME DIAGNOSIS CODES IN ACCORDANCE WITH FEDERAL REQUIREMENTS

MMM did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. Specifically, MMM either submitted some diagnosis codes that were not supported in the medical records or did not submit all of the correct diagnosis codes. Both types of errors caused CMS to calculate incorrect risk scores for 87 of the 200 sampled enrollees.[17]

Some of the Diagnosis Codes That MMM Submitted to CMS Were Not Supported in the Medical Records

The diagnosis codes that MMM submitted to CMS were not supported in the medical records for 108 of the 688 sampled enrollees' HCCs. The 108 HCCs were not validated and should not have been used in the enrollees' risk scores. These errors, which also included less severe manifestations of the diseases, caused net overpayments from CMS to MMM for 87 sampled enrollees.

[17] There was more than one type of error for some enrollees.

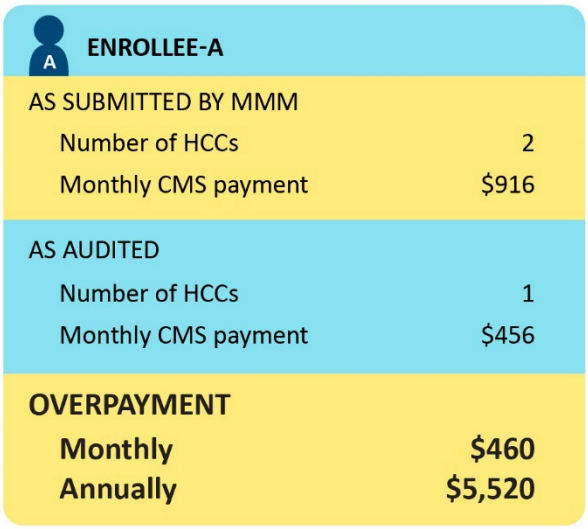
Medical Records Did Not Support Submitted Diagnosis Codes or Any Other Diagnosis Codes

For 94 of the 108 unvalidated HCCs (73 sampled enrollees), the medical records did not support either the diagnosis code that MMM submitted or any other diagnosis code that would have validated the HCC. These errors caused overpayments.

For example, for Enrollee A, MMM submitted a diagnosis code for "Malignant Neoplasm of Unspecified Part of Bronchus or Lung," which maps to the HCC for Lung and Other Severe Cancers. However, that diagnosis was not supported in the medical records that MMM provided to us. Our 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 shown in Figure 1, the diagnosis codes that MMM submitted to CMS on behalf of Enrollee A mapped to two HCCs, which CMS used to calculate a $916 monthly payment that it made to MMM. Because the Lung and Other Severe Cancers HCC was not validated, the CMS payment should have been based on one HCC, which would have resulted in a monthly payment of $456. This error caused a $5,520 overpayment for the year.

Figure 1: Overpayment Calculation for Enrollee A, Who Had an HCC That Was Not Validated



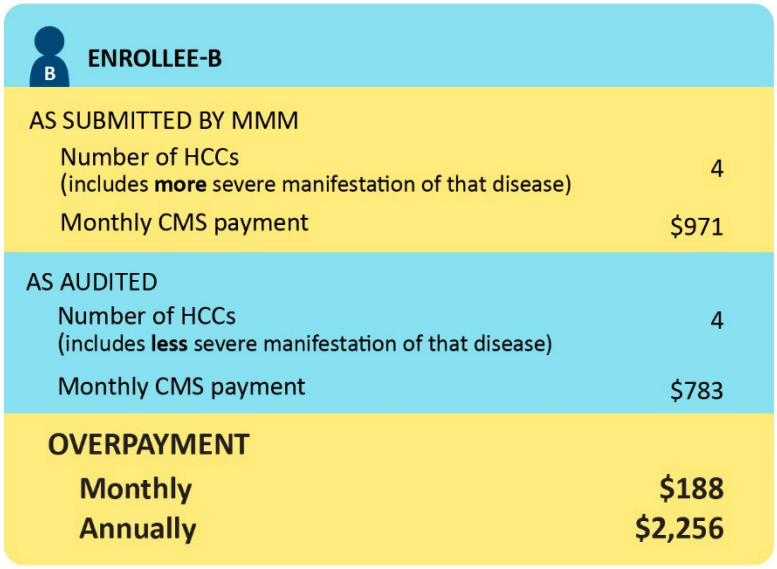
Medical Records Did Not Support Submitted Diagnosis Codes, but We Identified Other Hierarchical Condition Categories That Were Supported by Other Diagnosis Codes

For 11 of the 108 unvalidated HCCs (10 sampled enrollees), the medical records did not support the submitted diagnosis codes, which mapped to the more severe manifestations of the HCCs in the related-disease groups. However, we identified 11 other HCCs (that were supported by

other diagnosis codes) for less severe manifestations of the diseases. These HCCs should have been included in the enrollees' risk scores instead of the 11 unvalidated HCCs. These errors led to overpayments for 10 HCCs and had no payment effect for 1 HCC.

For example, for Enrollee B, the medical records did not support the diagnosis "Segment Elevation Myocardial Infarction Involving Right Coronary Artery." This diagnosis maps to an HCC that has a more severe manifestation of the HCC in the related-disease groups (Acute Myocardial Infarction). However, support existed for the diagnosis "Angina Pectoris, Unspecified," which maps to an HCC that was a less severe manifestation of the HCC in the related-disease group (Angina Pectoris). Accordingly, Enrollee B's risk score should have been based on the HCC with the less severe manifestation. As shown in Figure 2, this error caused a $2,256 overpayment for the year.

Figure 2: Overpayment Calculation for Enrollee B, Who Had an HCC for Less Severe Manifestation of a Disease That Should Have Been Used



Medical Records to Support Diagnosis Codes Were Not Provided for Three HCCs

For 3 of the 108 unvalidated HCCs (1 sampled enrollee), MMM did not provide any medical records as support for the diagnosis codes submitted to CMS. These errors caused an overpayment for this sampled enrollee.

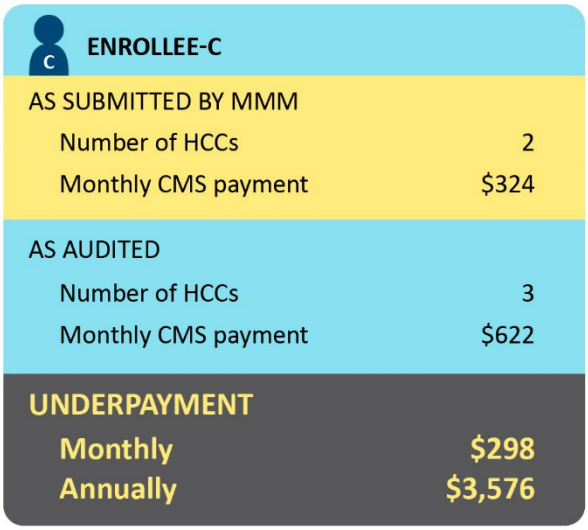
Diagnosis Codes That MMM Should Have Submitted but Did Not Submit to CMS

MMM did not submit all the correct diagnosis codes. Specifically, there were an additional 11 HCCs (10 sampled enrollees) for which the medical records supported diagnosis codes that should have been submitted to CMS but were not. Thus, these 11 additional HCCs should have

been included in the enrollees' risk scores. These errors caused underpayments from CMS to MMM.

For example, for Enrollee C, MMM did not submit a diagnosis code for "Hypertensive Heart Disease With Heart Failure." However, our independent medical review contractor, as part of its review of a different HCC, found support for the diagnosis documented in a medical record. This diagnosis code, which MMM should have submitted to CMS but did not, maps to the HCC for Congestive Heart Failure. As shown in Figure 3, this error caused a $3,576 underpayment.

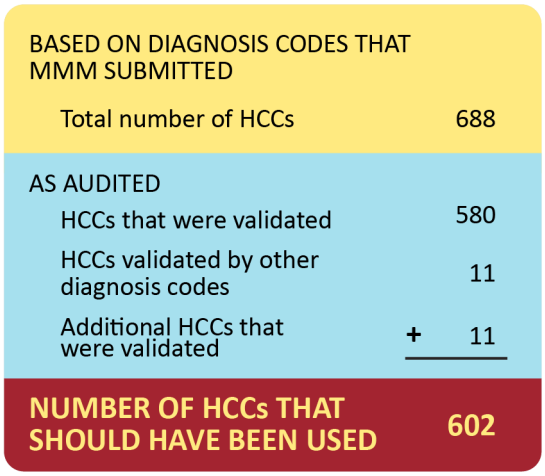
Figure 3: Underpayment Calculation for Enrollee C, Who Had an HCC That Was Validated From a Diagnosis Code That MMM Should Have Submitted but Did Not Submit to CMS



Summary of Diagnosis Codes Not Submitted in Accordance With Federal Requirements

Because MMM did not submit some diagnosis codes in accordance with Federal requirements for the 200 sampled enrollees, their risk scores should not have been based on the 688 HCCs but on the 602 validated HCCs. Figure 4 summarizes these differences.

Figure 4: Number of HCCs Used in Risk Scores Contrasted With Number of HCCs That Should Have Been Used in Risk Scores for the 200 Sampled Enrollees



Moreover, MMM received $165,312 in net overpayments (consisting of $180,974 of overpayments and $15,662 of underpayments) for the 200 sampled enrollees.

THE POLICIES AND PROCEDURES THAT MMM 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 MMM had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations at 42 CFR § 422.503(b)(4)(vi), could be improved.

MMM's compliance program, according to its officials, had several procedures designed to ensure that the organization submitted accurate diagnosis codes for use in CMS's risk adjustment program. To prevent healthcare providers from submitting inaccurate diagnosis codes and to encourage improvement with medical record documentation, MMM provided educational training sessions that were based on the best practices that it identified. To detect and correct inaccurate diagnosis codes that MMM had submitted to CMS, MMM had policies and procedures to perform medical record reviews for a sample of enrollees. MMM designed these internal reviews to (1) analyze provider-submitted diagnosis codes and (2) identify additional diagnosis codes that could be submitted to CMS. MMM used the results of these reviews to provide feedback to healthcare providers and submit corrections to CMS.

MMM officials also stated that they have plans to further enhance the organization's compliance program and oversight of activities, including Medicare risk adjustment compliance training for its staff members and health care providers and coding-specific training for its coders.

However, because the risk scores for the 200 sampled enrollees should have been based on 602 HCCs instead of 688 HCCs, we believe that MMM's policies and procedures associated with its compliance program could be improved.

MMM RECEIVED NET OVERPAYMENTS

On the basis of our sample results, we estimated that MMM received at least $58,983,855 in net overpayments for 2017.

Because of Federal regulations that limit the use of extrapolation in RADV audits for recovery purposes to payment years 2018 and forward, we are reporting the estimated net overpayment amount but are recommending a refund of only the $165,312 in net overpayments that MMM received for the 200 sampled enrollees.

RECOMMENDATIONS

We recommend that MMM Healthcare, LLC:

- refund to the Federal Government the $165,312 of net overpayments;[18] and

- continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

MMM COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, MMM did not concur with our recommendations and did not agree with some of our findings. Specifically, MMM did not agree with our findings for 39 HCCs identified as errors in our draft report and provided additional information for our consideration. In addition, MMM stated that our findings and recommendations are inconsistent with HHS and CMS data accuracy requirements, the realities of risk adjustment, and other CMS and OIG audits. MMM also disagreed with our assessment that its current risk adjustment compliance and education programs need improvement. MMM requested that we reconsider or withdraw our recommendations. MMM's comments appear as Appendix F.[19]

[18] OIG audit recommendations do not represent final determinations. Action officials at CMS will determine whether an overpayment exists and will recoup any overpayments consistent with its policies and procedures. In accordance with 42 CFR § 422.311, which addresses audits conducted by the Secretary (including those conducted by the OIG), if a disallowance is taken, MA organizations have the right to appeal the determination that an overpayment occurred through the Secretary's RADV appeals process.

[19] We excluded an attachment to MMM's comments (which MMM identified as "Appeals" in its comments) because it contained personally identifiable information. We are providing MMM's comments and the attachment in their entirety to CMS.

After reviewing MMM's comments and the additional information that it provided, we reduced the number of HCCs in error and adjusted our calculation of net overpayments. Accordingly, we reduced the recommended refund in our first recommendation from $202,179 to $165,312 for this final report. We maintain that our second recommendation remains valid.

A summary of MMM's comments and our responses follows.

MMM DID NOT CONCUR WITH OIG'S FIRST RECOMMENDATION TO REFUND NET OVERPAYMENTS

MMM Did Not Agree With Our Findings for Specific HCCs or With How We Summarized Our Findings

MMM Comments

MMM did not agree with our findings for 39 HCCs (34 sampled enrollees) and provided additional medical records and explanations as to why it believed these HCCs were validated.[20] MMM also objected to our statement in the draft report that it either submitted some diagnosis codes that were not supported in the medical records or that it did not submit all of the correct diagnosis codes for 94 of the 200 sampled enrollees.[21] Specifically, MMM requested that we reframe how we describe our findings because, "[a]s written, this could be misconstrued to mean that nearly half of the HCCs . . . were unsupported by medical record documentation."

Office of Inspector General Response

Our independent medical review contractor reviewed all the additional information that MMM provided for the 39 HCCs. After reviewing MMM's comments and additional information that it submitted, our contractor:

- found support and validated 21 HCCs and reversed its original decisions;
- reaffirmed that 15 HCCs were not validated and upheld its original decisions; and
- reaffirmed that 3 HCCs audited were not validated but found support for a diagnosis code that mapped to a less severe manifestation of the HCC in the related-disease group for each of the 3 HCCs.

Accordingly, we reduced the number of HCCs in error from 129 (as reported in our draft report) to 108 for this final report. We also revised our findings and reduced the associated monetary

[20] MMM submitted explanations and 8 new medical records (also with explanations) for the 39 HCCs.

[21] Our draft report identified 94 enrollees who had diagnosis codes that were not supported. After considering the information that MMM provided in response to our draft report, we have updated this final report to reflect that 87 enrollees had diagnosis codes that were not supported.

recommendation. Further, our independent medical review contractor performed a multifaceted quality review process during its initial medical record review and re-evaluation processes. In addition, the contractor performed a quality review on the determinations for which it either reversed its original decisions or identified an additional HCC and did not identify any systemic issues.

We disagree with MMM's statement that we implied that nearly half of the audited HCCs were unsupported. We clearly state, as updated for this final report, 580 of the 688 sampled enrollees' HCCs were validated. In this respect, we also clearly state that MMM had errors that caused incorrect payments for 87 of the 200 sampled enrollees.

MMM Had Concerns Related to OIG's Audit Methodology

MMM Comments

MMM had two concerns related to our audit methodology for reviewing medical records.

- MMM stated that our "audit methodology relies on a physician's determination when two coders disagree as to whether a medical record supports an HCC." Specifically, MMM said that our reliance "on the clinical judgment of a physician" to "clarify a coding question or resolve coder disagreement is inconsistent with CMS' approach to RADV audits." MMM stated that we "should have had coders review medical records, employing a 'senior coder' to resolve coding disagreements rather than a physician."

- MMM also said that "although it is unclear what specific diagnosis coding guidance [our independent medical review contractor] followed to review medical records, the [c]ontractor does not appear to have applied CMS' RADV Medical Record Reviewer Guidance in all instances." To illustrate its point, MMM explained that, for one of the sampled enrollees, our contractor did not apply CMS's guidance regarding "Vascular Doppler Studies interpreted by a cardiologist."

Office of Inspector General Response

We do not agree with either of the concerns that MMM raised. Our audit methodology is different from that of the CMS RADV audit methodology. Although our approach was generally consistent with the methodology used by CMS in its RADV audits, it did not mirror CMS's approach in all aspects, nor did it have to. The independent medical review contractor used both skilled coders and physicians (when necessary) to review medical record documentation in accordance with the relevant CMS guidance, which states, "reviewers should evaluate all listed

conditions . . . for consistency within the full provider documentation."[22] The coders and physicians did not, as MMM suggested, make clinical judgments but instead applied coding rules to accurately assign applicable ICD codes that translated to HCCs. Physician input did not constitute a clinical assessment; rather, it constituted an assessment of documented evidence in support of the assignment of diagnosis codes. We believe that the use of a physician to serve as the final decision maker (i.e., tiebreaker), was a reasonable method for determining whether the medical records adequately supported the submitted diagnosis codes.

With regard to the example that MMM provided, the independent medical review contractor reviewed the information that MMM provided in the attachment to its comments on our draft report for the 39 HCCs that MMM specifically disputed just above. The contractor explained to us that the HCC was validated with a newly submitted medical record from MMM. The contractor stated, "Decision to validate HCC . . . [for Vascular Disease] with newly submitted medical record. There is documentation of atherosclerosis of bilateral legs with claudication."

MMM Did Not Agree With OIG's Sampling and Estimation Methodology

MMM Comments

MMM noted several concerns with our statistical sampling methodology.

- MMM said that our methodology was skewed toward identifying overpayments in the audit sample. MMM stated that we did not review all medical records for the sampled enrollees and, instead, only reviewed medical records for HCCs already submitted to CMS for the audit period. MMM also said that we excluded enrollees for whom no risk adjustment data was submitted to CMS.

- MMM also stated that our audit methodologies were applied differently throughout our audits and that they also differed from CMS's RADV audits. MMM said that we are not being consistent and have used "different sampling frames, sampling designs, and sample sizes" throughout our audits of either specific diagnosis codes for high-risk groups or contract-level RADV audits, "leading to significant variation in the magnitude of [OIG]'s estimated extrapolated 'net overpayment' findings." In this respect, MMM noted the following departures from CMS's RADV audits:

    - MMM said that our stratification (selecting "50 enrollees from the first and second strata and 100 from the third stratum") was uneven; this departure from CMS's methodology ("sampling 67 enrollees from each stratum") likely increased the estimated extrapolated net overpayment finding. MMM mentioned that "increasing

[22] CMS, Contract-Level Risk Adjustment Data Validation, Medical Record Reviewer Guidance, in effect as of Mar. 20, 2019. Available online at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/Medical-Record-Reviewer-Guidance.pdf. Accessed on May 15, 2024.

the sample size increases the precision of an extrapolated estimate, such that an estimate derived from a [smaller sample of enrollees] would be expected to be less precise than an estimate derived from a [larger sample of enrollees] from the same population." MMM also stated that compared to CMS's even stratification, the uneven stratification that we applied likely raised the lower limit of the associated confidence interval on which we based the estimated extrapolated net overpayment finding.

- MMM also mentioned that our audit methodology arbitrarily increased the estimated extrapolated net overpayment finding because we used the lower limit of a 90-percent confidence interval instead of a 99-percent confidence interval, which is what CMS uses.

Office of Inspector General Response

We disagree with MMM's comments that our statistical sampling was skewed toward identifying overpayments and inconsistently applied. Specifically:

- Our objective was to determine whether MMM submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. In this regard, the identification of (1) all possible diagnosis codes that MMM could have submitted on behalf of the sampled enrollees and (2) enrollees for which MMM did not submit any risk-adjusting diagnosis codes for our sampling frame were beyond the scope of our audit.

  We requested that MMM provide us with the medical records for the audited HCCs. For outpatient and physician records, the independent medical review contractor performed a blind review to capture all HCCs.[23] For inpatient records, we requested that MMM provide us with an indication of where the support for the reviewed and possibly additional HCCs were in the medical record. If the independent medical review contractor was able to locate the corresponding support, then the HCCs were considered validated.

  CMS requires MA organizations like MMM to establish compliance programs and processes to ensure that they submit accurate diagnosis codes to CMS.[24] In this respect, when CMS updated the Federal regulations for RADV audits, CMS stated that "[t]hese processes should enable MAOs to identify not only instances where diagnoses submitted for risk adjustment payment are not supported by the medical record, but

[23] A blind review refers to identifying all diagnoses, including any diagnoses that led to an additional HCC, from these records.

[24] 42 CFR §§ 422.503 and 504.

also diagnoses that may not have been submitted to CMS."[25] MMM had policies and procedures to perform medical record reviews for a sample of enrollees. MMM designed these internal reviews to (1) analyze provider-submitted diagnosis codes and (2) identify additional diagnosis codes that could be submitted to CMS. Accordingly, MMM's medical record review process included steps to identify diagnosis codes that had not been submitted but should have been submitted to CMS.

For our audit period, CMS allowed MMM to make and submit adjustments up until February 2018 for claims for services rendered during the 2016 service year. To this point, CMS also stated in its update of the Federal regulations, "the purpose of RADV audits is not to reopen submission deadlines and for CMS to make additional payments. RADV audits identify overpayments after the final risk adjustment data submission deadline."

Further, and contrary to MMM's assertion, our extrapolation methodology is statistically supported. A valid estimate of net overpayments does not need to cover all potential diagnosis codes or underpayments within the audit period. Accordingly, our estimate of net overpayments does not extend to the diagnosis codes that were beyond the scope of our audit. In accordance with our objective, we properly executed our statistical sampling methodology in that we defined our sampling frame (MMM enrollees with at least one HCC) and sample unit, randomly selected our sample, applied relevant criteria to evaluate the sample, and used statistical sampling software to apply the correct formulas to estimate the net overpayments in the sampling frame made to MMM.

- Our audits, including the prior audits of other MA organizations that MMM refers to, 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. ch. 4. Although our approach was generally consistent with the methodology used by CMS in its RADV audits, we were not required to mirror CMS's approach to its RADV audits. Further, we have explained our audit methodologies in each of the reports that we issued to the MA organizations. With regard to MMM's specific comments:

    - The method of stratification and strata sizes are design choices made by the audit team, and those choices for this audit were statistically valid. Further, our sample was representative of the sampling frame in that we selected the items from each stratum using a simple random sample in which each item within each stratum had an equal probability of being selected. The legal standard for a sample size is that it must be sufficient to be statistically valid, not that it be the most precise

[25] 88 Fed. Reg. 6643, at 6652 (Feb. 1, 2023).

methodology.[26] Because absolute precision is not required, any imprecision in the sample may be remedied by identifying net overpayments at the lower limit, which was done in this audit.[27]

- Our policy is to recommend recovery at the lower limit of a two-sided 90-percent confidence interval. We believe that the lower limit of a two-sided 90-percent confidence interval provided a reasonably conservative estimate of the total amount overpaid to MMM for the enrollees and the time period covered in our sampling frame. Further, we note that this approach, which is routinely used by HHS for recovery calculations, results in a lower limit (the estimated overpayment amount to refund) that is designed to be less than the actual overpayment amount 95 percent of the time.[28]

MMM Stated that OIG's Estimation of Net Overpayments Should be Adjusted to Ensure Actuarial Equivalence

MMM Comments

MMM disagreed with our estimated extrapolated net overpayment finding because we did not make an adjustment to our calculations "to ensure actuarial equivalence as mandated by the [Act], which requires CMS to pay [MA organizations] an amount that is 'actuarially equivalent' to the expected cost that CMS would have otherwise incurred had it provided required Medicare benefits directly to the [MA organizations'] enrollees." To this point, MMM said that "it is not possible to determine whether MMM has received a net overpayment as a result of any diagnosis coding errors without considering diagnosis coding errors in traditional Medicare data."

MMM acknowledged that CMS published a final rule in 2023 that justified "not applying an adjustment to recoveries" because the actuarial equivalence requirements under the Act do not apply to the obligation for MA organizations to return improper payments when diagnosis

[26] *See John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012).

[27] *See Pruchniewski v. Leavitt*, 2006 U.S. Dist. LEXIS 101218 at *51-52 (M.D. Fla. 2006).

[28] HHS has used the two-sided 90 percent confidence interval when calculating recoveries in both the Administration for Child and Families and Medicaid programs. See, for example, *New York State Department of Social Services*, DAB No. 1358, 13 (1992); and *Arizona Health Care Cost Containment System*, DAB No. 2981, 4-5 (2019). In addition, HHS contractors rely on the one-sided 90 percent confidence interval, which is less conservative than the two-sided interval, for recoveries arising from Medicare Fee-For-Service overpayments. See, for example, *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); and *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 17-18 (E.D.N.Y. 2012).

codes are not supported in the medical records.[29] However, MMM stated that it disagreed with CMS's decision.

Office of Inspector General Response

Our audit methodology correctly applied CMS requirements to properly identify unsupported HCC submissions as overpayments. We used the results of the independent medical review to determine which HCCs were not substantiated and, in some instances, to identify HCCs that should have been used but were not used in the sampled enrollees' risk score calculations. We followed the requirements of CMS's risk adjustment program to determine the payment that CMS should have made for each enrollee. We used the overpayments and underpayments identified for each enrollee to estimate net overpayments. In this respect, we were cognizant of CMS's decision not to "apply an adjustment factor (known as a Fee-For-Service (FFS) Adjuster) in RADV audits." To this point, we recognize that CMS—not OIG—is responsible for making operational and program payment determinations for the MA program.

MMM Stated that OIG's Estimated Net Overpayment Finding Held It to a 100-Percent Accuracy Standard and is Inconsistent With the Recognized Realities of CMS's Payment Model

MMM Comments

MMM said the inclusion of an estimated net overpayment finding in this report is inconsistent with CMS and OIG guidance regarding "risk adjustment data accuracy obligations . . . which requires [MA organizations] to submit massive quantities of risk adjustment data each year." In this respect, MMM said that we are holding MMM to a 100-percent data accuracy standard that is inconsistent with the recognized realities of CMS's Medicare Advantage risk adjustment payment model. Moreover, MMM said, "CMS has stated that [MA organizations] 'will be held responsible for making *good faith efforts* to certify the accuracy, completeness, and truthfulness of encounter data submitted.'" MMM also stated that the OIG has issued guidance that gives MA organizations broad discretion in designing their compliance functions related to risk adjustment.

Office of Inspector General Response

We disagree with MMM that including an estimated net overpayment is inconsistent with prior CMS and OIG guidance. In this respect, we also do not fully agree with MMM's interpretation of the Federal requirements. Specifically, Federal regulations at 42 CFR § 422.503(b) state that MA organizations must "implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements." With regard to MMM's statement that verifying 100 percent of submitted risk adjustment data is inconsistent with the realities of CMS's risk-adjustment program, we too recognize that CMS

[29] CMS RADV Final Rule, 88 Fed. Reg. at 6656.

applies a "good faith" attestation standard when MA organizations certify the large volume of data that they submit to CMS for use in the risk adjustment program.[30]

We also acknowledge that MMM had compliance procedures in place to promote the accuracy of diagnosis codes submitted to CMS to calculate risk-adjusted payments during our audit period. However, including the estimated net overpayment finding ($59 million) provides context for our recommendation that MMM's compliance procedures need to be improved.

MMM Stated That OIG's Audit Focused on a Payment Year That Has Already Been Settled by CMS

MMM Comments

MMM stated that it was concerned with our recommended refund "because of its impact on a contract year that has already been settled." MMM also said "[a]n audit approach that recovers premiums from years that have been settled . . . undermines the models used to determine appropriate bid rates" and could possibly result in underpayments. MMM further stated that if "CMS recoups payments for a contract year that has already been settled, then the data and information used to determine bid rates for later years are flawed, as they do not take into account these later recoupments."

Office of Inspector General Response

Our 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. ch. 4. For this audit, our objective was to determine whether MMM submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. OIG audit findings and recommendations do not represent final determinations by CMS. CMS will determine whether an overpayment exists and will recoup any overpayments consistent with its policies and procedures. Similarly, any impact that CMS's potential recoupment might have on bid rate calculations is outside the scope of the audit.

MMM DID NOT CONCUR WITH OIG'S SECOND RECOMMENDATION TO CONTINUE TO IMPROVE ITS POLICIES AND PROCEDURES

MMM Comments

MMM did not concur with our second recommendation that it continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments. Specifically, MMM stated that its current compliance program was not subject to OIG's audit of 2016 dates of service. MMM also stated that OIG's determination that some HCCs were not validated does not

[30] 65 Fed. Reg. 40170, at 40268 (June 29, 2000).

demonstrate that MMM's policies and procedures need enhancement. MMM also stated that we do not "[cite any] deficiencies with the compliance functions in place to monitor risk adjustment data for that year." For these reasons, MMM requested that we withdraw this recommendation.

Office of Inspector General Response

We acknowledge that MMM had compliance procedures in place to promote the accuracy of diagnosis codes submitted to CMS to calculate risk-adjusted payments. However, based on the materiality of our findings—estimated net overpayments of approximately $59 million— we do not agree with MMM that our second recommendation should be withdrawn.

Federal regulations (42 CFR § 422.503(b)) require MA organizations like MMM to establish and implement an effective system for routine monitoring and identification of compliance risks. This regulation further explains that a compliance system should consider both internal monitoring and external audits. In this regard, we note that MMM has internal policies and procedures to ensure the accuracy of its risk adjustment submissions to CMS. MMM should continue to make improvements based on the materiality of findings, as previously mentioned. Our description of MMM's policies and procedures as "could be improved" to ensure compliance with CMS's program requirements serves to point directly to our second recommendation to continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements.

Accordingly, we believe that addressing this recommendation will assist MMM in attaining better assurance with regard to the accuracy and completeness of the risk adjustment data that it submits in the future. Thus, we maintain that our second recommendation is valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid MMM approximately $1.4 billion to provide coverage to approximately 204,000 enrollees in Puerto Rico for the 2017 payment year.[31] We identified a sampling frame of 110,934 enrollees who had at least 1 HCC in their risk scores; MMM received $885,528,826 in payments from CMS for these enrollees for 2017. We selected for audit a stratified random sample of 200 enrollees on whose behalf CMS made payments totaling $1,764,533 to MMM.

We reviewed MMM's internal controls for ensuring that the diagnosis codes it submitted to CMS for use in the risk adjustment program were in accordance with Federal requirements.

We performed audit work from November 2020 to August 2024.

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 interviewed MMM officials to gain an understanding of: (1) the policies and procedures that MMM followed to submit diagnosis codes to CMS for use in the risk adjustment program, and (2) MMM's monitoring of those submissions to prevent, detect, and correct noncompliance with Federal requirements.
- We reviewed MMM's policies and procedures to understand how MMM submitted diagnosis codes to CMS.
- We developed our sampling frame using data from CMS systems. Our sampling frame consisted of enrollees who had at least one HCC in their risk scores. To create this frame— and as explained further in Appendix C—we used data from the CMS:
    - Risk Adjustment Processing System, which MA organizations use to submit diagnosis codes to CMS;
    - Risk Adjustment System, which identifies the HCCs that CMS factors into each enrollee's risk score calculation;

[31] Payment year 2017 data were the most current data available when we started our audit.

- Medicare Advantage Prescription Drug System, which identifies the Medicare payments, before applying the budget sequestration reduction, made to MA organizations; and

- Encounter Data System, which identifies enrollees who received specific procedures.

- We selected a stratified random sample of 200 enrollees from the sampling frame (Appendix C).

- We obtained 501 medical records from MMM as support for the 685 HCCs associated with 199 of the 200 sampled enrollees. MMM did not provide any medical records for the remaining 3 HCCs associated with one sampled enrollee.

- We used an independent medical review contractor to determine whether the diagnosis codes in the medical records validated the 685 HCCs.

- The independent medical review contractor's coding review of the 501 medical records followed a specific process to determine whether there was support for a diagnosis code and associated HCC. Under the process:

  - 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 and then:

    - If the second senior coder also did not find support, the HCC was considered not validated.

    - If the second senior coder found support, 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.

  - For any diagnosis code that had not been previously submitted, the HCC was considered validated as an additional HCC if either: (1) both senior coders found support in the medical record or (2) one senior coder plus a physician did so.

- We reviewed available data from CMS's systems for the sampled enrollees to determine whether CMS's payments had been canceled or adjusted.

- We used the results of the independent medical review to calculate overpayments or underpayments (if any) for each sampled enrollee. Specifically, we calculated:

    - a revised risk score in accordance with CMS's risk adjustment program and

    - the Medicare payment, before applying the budget sequestration reduction, that CMS should have made for each enrollee.

- We used the overpayments and underpayments identified for each sampled enrollee to estimate total net overpayments.

- We provided the results of our audit to MMM officials on July 13, 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.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Advantage Compliance Audit of Diagnosis Codes That CarePlus Health Plans, Inc. (Contract H1019) Submitted to CMS	A-04-19-07082	10/26/2023
Medicare Advantage Compliance Audit of Diagnosis Codes That Health Net of California, Inc. (Contract H0562) Submitted to CMS	A-09-18-03007	9/22/2023
Medicare Advantage Compliance Audit of Diagnosis Codes That Inter Valley Health Plan, Inc. (Contract H0545), Submitted to CMS	A-05-18-00020	9/26/2022
Medicare Advantage Compliance Audit of Diagnosis Codes That Cigna HealthSpring of Florida, Inc. (Contract H5410) Submitted to CMS	A-03-18-00002	8/19/2022
Medicare Advantage Compliance Audit of Diagnosis Codes That SCAN Health Plan (Contract H5425) Submitted to CMS	A-07-17-01169	2/3/2022
Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc., (Contract H1036) Submitted to CMS	A-07-16-01165	4/19/2021

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 110,934 MMM enrollees who: (1) were continuously enrolled under contract number H4003 throughout the 2016 service year and in January 2017 and (2) had at least one HCC in their 2017 payment year risk scores. Because CMS adjusts its risk-adjusted payments in the calendar year after an enrollee is diagnosed, we restricted our population to individuals who were enrolled in—and thus diagnosed by—MMM during the 2016 service year.

Our sampling frame included enrollees who were:

- not classified as having hospice or end-stage renal disease (ESRD) status at any time during the 2016 service year through January 2017 and

- continuously enrolled in Medicare Part B coverage during the 2016 service year.

SAMPLE UNIT

The sample unit was one enrollee.

SAMPLE DESIGN

We used a stratified random sample. To identify the strata, we used a two-step process in which we first calculated a value we refer to as the monthly-weighted-health risk score. We computed the monthly-weighted-health risk score using the following formula:

[health-related portion of the enrollee's risk score]
x
[number of monthly 2017 capitation payments affected by the enrollee's risk score][32]

We classified the enrollees according to the magnitude of the risk-adjusted payments made on their behalf. A higher monthly-weighted-health risk score signified a higher amount of risk-adjusted payments on behalf of that enrollee for the year. We then ranked the 110,934 enrollees according to their monthly-weighted-health risk score from lowest to highest and separated them into 3 strata. The specific strata are shown in Table 1 on the following page.

[32] We excluded from this calculation months in 2017 for which enrollees were classified as having hospice or ESRD status.

Table 1: Strata Based on Monthly-Weighted-Health Risk Scores

Stratum	Sample Size	Number of Enrollees	Monthly-Weighted-Health Risk Score Range	Sampling Frame Dollar Total
1	50	36,937	0.136–14.062	$154,393,762
2	50	36,985	14.064–27.744	254,933,654
3	100	37,012	27.754–357.636	476,201,410
Total	**200**	**110,934**		**$885,528,826**

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the sample units in each stratum by the health-related portion of the risk score, the number of payment months, and a unique enrollee identifier number. We then consecutively numbered the sample units within each stratum. After generating the random numbers, we selected the corresponding sample units in each stratum.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of net overpayments to MMM 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.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Sampling Frame Dollar Total	Sample Size	Dollar Value of Sample	Number of Sampled Enrollees With Incorrect Diagnosis Codes	Dollar Value of Net Overpayments for Unvalidated HCCs for Sampled
1	36,937	$154,393,762	50	$198,766	16	$10,912
2	36,985	254,933,654	50	346,649	17	34,776
3	37,012	476,201,410	100	1,219,118	54	119,624
Total	**110,934**	**$885,528,826**	**200**	**$1,764,533**	**87**	**$165,312**

Table 3: Estimated Value of Net Medicare Overpayments in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$78,059,977
Lower limit	58,983,855
Upper limit	97,136,099

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.

July 7, 2023

BY EMAIL

Denise R. Novak
Assistant Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

RE: MMM's Response to HHS-OIG's Draft Report for Audit A-04-20-07090

Dear Ms. Novak:

MMM Healthcare, LLC ("MMM") writes to respond to the United States Department of Health and Human Services ("HHS") Office of Inspector General's ("OIG's") Draft Report for Audit No. A-04-20-07090 titled *Medicare Advantage Compliance Audit of Diagnosis Codes That MMM Healthcare, LLC, (Contract H4003) Submitted to CMS* ("Draft Report"). For the reasons described below, MMM respectfully requests that HHS-OIG withdraw its recommendations that MMM refund the Federal Government $202,179 in "net overpayments" and change its compliance procedures. MMM also asks HHS-OIG to reconsider its finding that MMM received estimated extrapolated "net overpayments" for Payment Year 2017 of $73,025,280. As written, these recommendations and findings are inconsistent with HHS and Centers for Medicare & Medicaid Services ("CMS") data accuracy requirements, the realities of risk adjustment, and other audits conducted by CMS and HHS-OIG. MMM therefore requests that HHS-OIG revise its Draft Report to address these issues.

I. MMM Requests That HHS-OIG Reconsider the Draft Report's Findings That Medical Records Do Not Substantiate Certain Audited HCCs

MMM has reviewed HHS-OIG's findings and disagrees with many of the determinations made by HHS-OIG's independent medical review contractor ("HHS-OIG's Contractor" or "Contractor") that certain HCCs were not supported by medical record documentation. MMM's review identified medical record support and coding guidance support, in addition to clinical support, for 39 of the enrollee-HCCs that HHS-OIG's Contractor did not validate. At the request of HHS-OIG, MMM is submitting its appeals for these HCCs and corresponding medical record documentation along with this response letter.[1]

In addition to reconsidering its findings for specific HCCs based on the appeals MMM has submitted, MMM urges HHS-OIG to reframe how it describes its findings in the Draft

[1] MMM is transmitting the appeals separately via secure file share.

Report. Specifically, HHS-OIG reports that "MMM either submitted some diagnosis codes that were not supported in the medical records or did not submit all of the correct diagnosis codes . . . for 94 of the 200 sampled enrollees." As written, this could be misconstrued to mean that nearly half of the HCCs submitted by MMM for the 200-enrollee sample audited by HHS-OIG were unsupported by medical record documentation. But as the Draft Report later clarifies, HHS-OIG's Contractor validated the vast majority of HCCs audited by HHS-OIG—559 of the 688 HCCs audited in the sample—after finding documented support for the HCCs in the medical records submitted by MMM. And MMM is appealing many of the HCCs that HHS-OIG's Contractor determined were not validated. MMM asks HHS-OIG to remove its enrollee-level finding or, at the very least, modify its description of its findings to provide clarity regarding the scope of the errors found by HHS-OIG's Contractor (e.g., "HHS-OIG's independent medical review contractor determined that most of the HCCs audited for the 200 sampled enrollees were correctly submitted to CMS for use in CMS' risk adjustment program, but for [] of the sampled enrollees, MMM submitted to CMS at least one diagnosis code for use in CMS' risk adjustment program that was not supported by medical record documentation.").

II. MMM Requests That HHS-OIG Recalculate Its Recommended Refund and Withdraw, or in the Alternative Recalculate, Its Estimated Extrapolated "Net Overpayment" Finding to Address Errors in HHS-OIG's Analysis of Certain Enrollee-Years, to Remove Biases, and to Ensure Actuarial Equivalence

Based on HHS-OIG's Contractor's medical record review, HHS-OIG concludes that MMM "received $202,179 in net overpayments" for the 200 sampled enrollees and recommends MMM refund this amount. HHS-OIG also applies an extrapolation methodology to all 2017 payments for H4003 and estimates MMM received "at least $73,025,280 in net overpayments" across the contract for the 2017 payment year. MMM respectfully submits that HHS-OIG's recommended refund and estimated extrapolated "net overpayment" are incorrect for the reasons set forth below.

A. *HHS-OIG's Contractor's Determinations Should Be Reconsidered for the 39 HCCs MMM Is Appealing*

As noted in Part I, MMM is appealing 39 HCCs that HHS-OIG's Contractor determined were not validated. MMM respectfully asks HHS-OIG to reconsider its Contractor's determinations with respect to those HCCs and recalculate HHS-OIG's recommended refund for the 200 sampled enrollees. MMM also asks HHS-OIG, to the extent it does not withdraw its estimated extrapolated "net overpayment" finding, to similarly revise this estimate to account for these appeals.

B. *HHS-OIG's Audit Methodology Improperly Incorporates a Physician's Judgment into Diagnosis Coding Determinations and Appears to Apply Diagnosis Coding Guidance That Differs from CMS' RADV Coding Guidelines*

MMM also challenges HHS-OIG's refund recommendation and estimated extrapolated "net overpayment" finding because HHS-OIG's audit methodology improperly

relies on a physician's judgment to make final diagnosis coding determinations and appears to apply diagnosis coding guidance that differs from CMS' Risk Adjustment Data Validation ("RADV") Medical Record Reviewer Guidance.

First, HHS-OIG's audit methodology relies on a physician's determination when two coders disagree as to whether a medical record supports an HCC. Relying on the clinical judgment of a physician who did not author a medical record to clarify a coding question or resolve coder disagreement is inconsistent with CMS' approach to RADV audits. CMS has stated that "CMS RADV reviewers are *certified coders*" and explained that a "senior *coder*" is "tasked with researching questions, confirming invalid cases from initial levels of coders, and conducting a second level of coding." [2] Similar to CMS, HHS-OIG only should have had coders review medical records, employing a "senior coder" to resolve coding disagreements rather than a physician. [3] If HHS-OIG had done so, MMM believes that the number of HCCs that HHS-OIG's Contractor deemed not valid would be reduced.

Second, although it is unclear what specific diagnosis coding guidance HHS-OIG's Contractor followed to review medical records, the Contractor does not appear to have applied CMS' RADV Medical Record Reviewer Guidance in all instances. The coding standards used by the Contractor impact the audit findings and could explain a number of the issues HHS-OIG describes in the Draft Report.[4] For instance, for appeal strata sample number 3-153, HHS-OIG's Contractor does not appear to have applied CMS' RADV Medical Record Reviewer Guidance, which notes that acceptable provider documentation includes Vascular Doppler Studies interpreted by a cardiologist. [5] In the medical record MMM submitted to support this HCC—a "Vascular Laboratory" (a diagnostic study) report—the interpreting provider, a cardiologist, documented atherosclerotic disease under "Right Leg,"

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[2] CMS, Contract-Level 15 Risk Adjustment Data Validation, Medical Record Reviewer Guidance, In effect as of 01/10/2020, Version 2.0, at 14, 72 (Jan. 1, 2020) (emphasis added); *see also* CMS, ICD-10-CM Official Coding Guidelines for Coding and Reporting FY 2017, at 13 (effective October 1, 2016), https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf ("The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.").

[3] MMM is submitting 39 appeals along with this response to the Draft Report and believes that each appeal is fully supported by applicable diagnosis coding guidance. MMM also is submitting clinical support for certain appeals, despite disagreeing with HHS-OIG's methodology of applying clinical standards when validating HCCs, because it is MMM's understanding that HHS-OIG relied on such standards as part of its audit methodology. MMM believes, however, that the diagnosis coding support included in its appeals are alone sufficient to validate the HCCs.

[4] *See* Draft Report at 7-11.

[5] "Diagnostic Testing (with or without interventional procedures) with acceptable provider interpretation [–] Acceptable Examples include: Cardiology and Vascular Surgeons … Vascular Doppler Study interpretation-not performed by Diagnostic Radiologists[.]" CMS, Contract-Level 15 Risk Adjustment Data Validation, Medical Record Reviewer Guidance In effect as of 01/10/2020, Version 2.0, at 34 (Jan. 1, 2020), https://www.cms.gov/files/document/medical-record-reviewer-guidance-january-2020.pdf. MMM is citing to CMS' Contract-Level 15 RADV Medical Record Reviewer Guidance because it is the most recent guidance released by CMS.

"Left Leg," and "Summary." If the Contractor had followed CMS' RADV Medical Record Reviewer Guidance, it would have determined that the medical record submitted by MMM supports ICD-10-CM code I70.209 and v22 HCC 108.

To the extent HHS-OIG's Contractor did not follow CMS' RADV Medical Record Reviewer Guidance, HHS-OIG's findings and recommendations are inconsistent with CMS' RADV audits, leaving MMM to guess what coding standard HHS-OIG applied. Moreover, HHS-OIG's application of different coding standards than those applied by CMS during its RADV audits leads to fundamental unfairness between those Medicare Advantage Organizations ("MAOs") audited by HHS-OIG and those audited by CMS and uncertainty about the medical record documentation necessary to support diagnosis coding in the Medicare Advantage program. MMM asks HHS-OIG to reassess any impacted findings and recommendations and apply CMS' RADV Medical Record Reviewer Guidance before finalizing its report.

C. *HHS-OIG's Methodology Was Skewed Toward Finding "Overpayments"*

MMM also contests HHS-OIG's recommended refund and estimated extrapolated "net overpayment" finding because HHS-OIG's audit sample was skewed toward identifying "overpayments." Specifically, HHS-OIG's audit did not involve a review of all medical records from the sampled years for the enrollees included in the audit sample, but instead sought to review only medical records that supported HCCs already on file with CMS for the audited enrollees in the audited year.[6] This methodology ignored the fact that there may be additional supported HCCs not previously submitted to CMS in other medical records for the sampled year for each enrollee.

HHS-OIG's audit population also was skewed by excluding enrollees for whom no risk adjustment data was submitted to CMS. This methodology ignored the fact that there may be supported HCCs not submitted to CMS for those enrollees and created an additional systematic bias toward identifying "overpayments."

Because the sampling methodology was skewed improperly toward identifying "overpayments," HHS-OIG's recommended refund and estimated extrapolated "net overpayment" calculations are likely inflated and its estimated extrapolated "net overpayment" calculation is statistically biased. To address these biases, MMM respectfully requests that HHS-OIG revise its refund recommendation and revise, if HHS-OIG opts not to withdraw, its estimated extrapolated "net overpayment" finding.

D. *HHS-OIG's Differing Audit Methodologies Render Its Recommended Refund and Estimated Extrapolated "Net Overpayment" Finding Arbitrary and Capricious*

MMM further contests HHS-OIG's recommended refund and estimated extrapolated "net overpayment" finding because HHS-OIG's application of differing methodologies across its audits creates a fundamental unfairness among audited MAOs and between audited and

[6] *See* Draft Report at 5.

unaudited MAOs. As HHS-OIG's published audit reports reflect, HHS-OIG applies different audit methodologies to the contract-years it audits, its audit methodologies differ from those applied by CMS, and HHS-OIG does not audit every MAO in a particular contract year. These differences among audited MAOs and between audited and unaudited MAOs creates significant variation in HHS-OIG's estimated extrapolated "net overpayment" findings across MAOs, with no "net overpayments" estimated for contracts not audited in a particular year and HHS-OIG's estimated extrapolated "net overpayments" findings for audited contracts ranging from $0 to $197.7M.[7] These variations in audit methodologies make it difficult for MAOs to anticipate and predict audit outcomes and lead to unfair payment inconsistencies between MAOs based simply on whether a contract happens to be selected for a particular type of audit, for a particular contract year, or for an audit at all.

Across its audits, HHS-OIG uses different sampling frames, sampling designs, and sample sizes—and among its so-called "high-risk" condition audits, focuses on different "high-risk" conditions—leading to significant variation in the magnitude of HHS-OIG's estimated extrapolated "net overpayment" findings. These differences are clear when comparing HHS-OIG's contract-level audits to its so-called "high-risk" condition audits. For instance, for its contract-level audits, HHS-OIG requires MAOs to provide medical records to support all HCCs associated with sampled enrollees, whereas for its "high-risk" condition audits, HHS-OIG only requires MAOs to submit medical records associated with the audited "high-risk" conditions. As another example, HHS-OIG's contract-level audits may concern a single contract year, whereas HHS-OIG's "high-risk" condition audits often span two contract years.

These inconsistencies in sampling design exist even across HHS-OIG's so-called "high-risk" condition audits. For instance, HHS-OIG has chosen to "focus" on inconsistent sets of so-called "high-risk" conditions across these audits, electing to audit lung and colon cancer diagnoses in one "high-risk" audit, while excluding these conditions from other "high-risk" condition audits. As another example, the total number of "high-risk" condition groups can vary from one HHS-OIG "high-risk" condition audit to another, with one audit focusing on seven "high-risk" condition groups and another on ten. Because HHS-OIG determines its sample sizes for these audits based in part on the number of "high-risk" condition groups audited, considerable differences in the number of enrollees sampled can arise simply due to the number of "high-risk" condition groups HHS-OIG chooses to audit.

Differences between HHS-OIG's audit methodologies and those applied by CMS—specifically, the stratification of the samples and the confidence intervals used to estimate extrapolated "net overpayments"—also result in fundamental unfairness to those MAOs audited by HHS-OIG. In its audit of MMM, HHS-OIG's decision to stratify its audit population unevenly resulted in HHS-OIG's recommended refund being approximately $34,000 more than what would be expected under a proportional sampling of enrollees, like the approach CMS has taken in its RADV audits. As background, HHS-OIG applied a

[7] *See Centers for Medicare and Medicaid Services (CMS)*, U.S. Dep't of Health and Hum. Servs. Office of Inspector Gen., https://oig.hhs.gov/reports-and-publications/oas/cms.asp (cataloging all HHS-OIG audit reports, which include HHS-OIG's estimated extrapolated "net overpayment" findings and recommendations).

stratified sampling design where the 200 enrollees in its sample frame were stratified into one of three strata based on their respective risk scores—the smallest, middle, and largest terciles of risk scores within the targeted enrollee population. While stratifying into three strata by risk score is consistent with CMS' RADV audits, HHS-OIG elected to depart from CMS' methodology when allocating sample enrollees across the three strata. Whereas CMS has evenly allocated sample enrollees across its strata (i.e., sampling 67 enrollees from each stratum), HHS-OIG chose to draw 50 enrollees from the first and second strata and 100 from the third stratum. As a result, a disproportionately large portion (50%) of HHS-OIG's sample was drawn from the enrollees with the highest risk scores, which increases HHS-OIG's recommended refund for the sample relative to what would be expected had the sample consisted of enrollees drawn at an equal rate according to the risk score distribution, as reflected in the tables below.

HHS-OIG Report - Appendix D - Table 2: Sample Results

Stratum	Sample Size [A]	Number of Sampled Enrollees with Incorrect Diagnosis Codes [B]	Dollar Value of Net Overpayments for Unvalidated HCCs for Sampled Enrollees [C]	Average Finding Per Enrollee Sampled [D] = [C]/[A]
Stratum 1	50	17	$ 11,467.00	$ 229.34
Stratum 2	50	18	$ 37,434.00	$ 748.68
Stratum 3	100	59	$ 153,278.00	$ 1,532.78
	200	**Recommended Refund -->**	**$ 202,179.00**	**$ 1,010.90**

Estimated Sample Findings Under An Equally Distributed Sample Size

Stratum	Equally Distributed Sample Size [E]	Average Finding Per Enrollee [Taken From OIG Sample Results - D]	Estimated Dollar Value of Net Overpayments for Unvalidated HCCs for Sampled Enrollees [F] = [D]* [E]	Average Finding Per Enrollee Sampled [G] = [F]/[E]
Stratum 1	66	$ 229.34	$ 15,136.44	$ 229.34
Stratum 2	67	$ 748.68	$ 50,161.56	$ 748.68
Stratum 3	67	$ 1,532.78	$ 102,696.26	$ 1,532.78
	200	**Estimated Adjusted Recommended Refund -->**	**$ 167,994.26**	**$ 839.97**

Difference	**$ 34,184.74**	**$ 170.92**

HHS-OIG's uneven stratification also likely increased its estimated extrapolated "net overpayment" finding. The precision of an extrapolated estimate is directly related to sample size and the variation between enrollees. All else being equal, increasing the sample size increases the precision of an extrapolated estimate, such that an estimate derived from a

sample of 50 enrollees would be expected to be less precise than an estimate derived from a sample of 100 enrollees from the same population. A sample size of 100, or any number larger than 50—the number of enrollees sampled from the other two strata—results in a relative increase in the precision of the extrapolated estimate coming from that third stratum, which in turn narrows the confidence interval around the estimate and raises the lower bound of that interval from what it would have been if the third stratum sample size was instead 50 enrollees.[8] Relative to the 67-67-67 strata split applied by CMS, therefore, the 50-50-100 breakdown applied by HHS-OIG in its audit of MMM likely raised the lower bound of the associated confidence interval on which HHS-OIG based its estimated extrapolated "net overpayment" finding.

Another difference in HHS-OIG's audit methodology that arbitrarily increased its estimated extrapolated "net overpayment" finding is its reliance on the lower bound of a 90% confidence interval. Historically in its RADV audits, CMS has used the lower bound of a 99% confidence interval to determine extrapolated estimates. As a confidence interval increases, the lower bound decreases and the upper bound increases, broadening the gap between the lower and upper bounds. As a result, the lower bound of a 90% confidence interval will be greater than the lower bound of a 99% confidence interval, yielding a larger estimated extrapolated "net overpayment" finding. HHS-OIG's selection of the 90% confidence interval (as opposed to 99%), especially when combined with the uneven stratification of its sample, raised the lower bound, which increased the estimated extrapolated "net overpayment" finding relative to the estimate that would be found when applying CMS' RADV audit methodology. HHS-OIG's decision to deviate from CMS' RADV audit methodology, therefore, results in differences in estimated extrapolated "net overpayments" for a contract year simply based on whether the MAO was audited by HHS-OIG or CMS and not based on any discernable differences in the quality of MAOs' risk adjustment data.

HHS-OIG's varying audit methods created differences among MAOs audited by HHS-OIG, between those audited by HHS-OIG and CMS, and between audited MAOs and unaudited MAOs, and those differences arbitrarily and capriciously impacted HHS-OIG's recommended refund and estimated extrapolated "net overpayment" finding here. For these additional reasons, MMM asks that HHS-OIG revise its refund recommendation and revise, if it does not withdraw, its estimated extrapolated "net overpayment" finding.

E. *If Not Withdrawn, HHS-OIG's Estimated Extrapolated "Net Overpayment" Should Be Adjusted to Ensure Actuarial Equivalence*

MMM also challenges HHS-OIG's estimated extrapolated "net overpayment" finding because it has not been adjusted to ensure actuarial equivalence as mandated by the Social

[8] The increase from 67 to 100 enrollees in the third stratum likely had a greater impact on the lower bound of the confidence interval than the decrease from 67 to 50 enrollees in the first two strata. This is because in HHS-OIG's audit of MMM, the stratum from which the 100 enrollees were sampled (i.e., the stratum with the largest risk scores) had no upper bound limitation to the largest risk scores, and therefore likely had the most amount of variation between its enrollees as compared to the other two strata. This increased variation in the third stratum relative to the other two suggests that increasing the sample size in this stratum raised the lower bound even as the sample size in the first and second strata decreased.

Security Act ("SSA"), which requires CMS to pay MAOs an amount that is "actuarially equivalent" to the expected cost that CMS would have otherwise incurred had it provided required Medicare benefits directly to the MAOs' enrollees. CMS' Final Rule,[9] published in the Federal Register on February 1, 2023 (the "RADV Rule"), does not alter MMM's firmly held position that it is not possible to determine whether MMM has received a net overpayment as a result of any diagnosis coding errors without considering diagnosis coding errors in traditional Medicare data, particularly when estimating contract-level overpayments via extrapolation, as HHS-OIG has done here with its estimated extrapolated "net overpayment" finding.

Actuarial equivalence measures whether different benefit packages have "the same value, based on the estimated spending that would be incurred by the insurer."[10] Because the SSA ties Medicare Advantage compensation to the expected cost of providing traditional Medicare benefits to an enrollee of average risk, the SSA's "actuarial equivalence" mandate requires CMS to base risk-adjusted payments on actuarially sound calculations of the expected cost of providing traditional Medicare benefits to enrollees with differing health statuses.[11] That conclusion is confirmed by the SSA's separate requirement that CMS report to Congress on the "actuarial soundness" of the agency's proposed risk adjustment methodology.[12] Because CMS developed the Medicare Advantage risk adjustment model using unaudited fee-for-service claims data from the traditional Medicare program—which CMS has acknowledged contain a high volume of diagnosis codes that are not supported by medical record documentation—CMS must account for those traditional Medicare data errors when measuring whether similar errors in Medicare Advantage enrollees' data result in overpayments to MAOs.[13]

CMS initially acknowledged the need to adjust recoveries to ensure actuarial equivalence.[14] In its recent RADV Rule, however, CMS reversed course, justifying not applying an adjustment to recoveries because "the 'actuarial equivalence' requirements" under the SSA "do not apply to the obligation to return improper payments for MAO

[9] Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, PACE, Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 ("CMS' RADV Rule"), 88 Fed. Reg. 6643 (Feb. 1, 2023).

[10] U.S. Dep't of Health & Hum. Serv., Payment for Medicare Advantage Plans: Policy Issues and Options (June 2009), https://aspe.hhs.gov/reports/payment-medicare-advantage-plans-policy-issues-options-0.

[11] 42 U.S.C. § 1395w-24(a)(5)(A), (a)(6)(A)(i)-(iii); *see also UnitedHealthcare Ins. Co. v. Azar*, No. 16-cv-157 (D.D.C. Dec. 4, 2017), ECF No. 57-1 (acknowledging, in the government's motion for summary judgment, that there must be equivalence "between the average payments that CMS would expect to make on behalf of a given beneficiary under traditional . . . Medicare, and the payments made to [MAOs] for covering an individual with those same characteristics").

[12] *See* 42 U.S.C. § 1395w-23(b)(4)(C), (D).

[13] *See generally* Wakely Consulting Group, Actuarial Report on CMS' November 1, 2018 Proposed Rule (Aug. 27, 2019) (enclosure to Letter from Anthony Mader, Vice President, Public Policy, Anthem, Inc., to Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Servs. (Aug. 28, 2019), https://downloads.regulations.gov/CMS-2018-0133-0267/attachment_4.pdf).

[14] *See, e.g.*, CMS, Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Feb. 24, 2012).

diagnosis codes that are unsupported by medical records."[15] But MMM—along with many other MAOs across the healthcare industry[16]—disagrees with CMS' decision to finalize the RADV Rule without an adjustment and believes that the SSA requires the application of an actuarially sound methodology to account for errors in traditional Medicare when determining whether an MAO has been overpaid based on diagnosis coding errors. Consistent with this belief, MMM asks HHS-OIG to withdraw its estimated extrapolated "net overpayment" finding from the Draft Report or adjust it after applying an actuarially sound methodology to account for similar errors in traditional Medicare data.

F. *HHS-OIG's Estimated Extrapolated "Net Overpayment" Finding Holds MMM to a 100% Accuracy Standard and Is Inconsistent with the Recognized Realities of CMS' Medicare Advantage Payment Model*

MMM also respectfully requests that HHS-OIG withdraw the estimated extrapolated "net overpayment" finding in its Draft Report given that CMS' RADV Rule states "CMS will only collect the non-extrapolated overpayments identified in the CMS RADV audits and [HHS-OIG] audits between PY 2011 and PY 2017."[17] Including an estimated extrapolated "net overpayment" finding in HHS-OIG's Draft Report, particularly one that is not adjusted to account for similar errors in traditional Medicare data, also is inconsistent with prior CMS and HHS-OIG guidance on MAOs' risk adjustment data accuracy obligations and the realities of CMS' Medicare Advantage payment model, which requires MAOs to submit massive quantities of risk adjustment data each year.

Prior to its recent RADV Rule, CMS had long acknowledged that MAOs are not expected to submit perfect risk adjustment data. For example, CMS 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 U.S. Department of Justice] believe is reasonable to enforce."[18] This understanding also is reflected in MAOs' annual data accuracy attestation obligations, which require MAOs to certify that their Medicare risk adjustment data is accurate based on their "best knowledge, information, and belief."[19] CMS has stated that MAOs "will be held responsible for making *good faith efforts* to certify the accuracy, completeness, and truthfulness of encounter data submitted."[20] This "good faith" standard is not defined by CMS, but CMS has recognized "that encounter data [can] come into [MAOs] in great volume from a number of sources, presenting significant verification challenges for the organizations."[21] Moreover, CMS has acknowledged that "[t]he requirement that the CEO or CFO certify as to the accuracy, completeness and truthfulness of data, based on best knowledge, information and belief, does not constitute an absolute guarantee of accuracy."[22]

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[15] CMS RADV Rule, 88 Fed. Reg. at 6656; *see generally* Medicare Program; Reporting and Returning of Overpayments, 79 Fed. Reg. 29844 (May 23, 2014).

[16] *See* CMS' RADV Rule, 88 Fed. Reg. at 6646-47.

[17] *Id*. at 6644.

[18] Medicare Program: Medicare+Choice Program, 65 Fed. Reg. 40169, 40268 (June 29, 2000).

[19] 42 C.F.R. § 422.504(*l*)(2).

[20] 65 Fed. Reg. at 40268 (emphasis added).

[21] *Id.*

[22] Publication of OIG's Compliance Program Guidance, 64 Fed. Reg. 61893, 61900 (Nov. 15, 1999).

Consistent with this guidance, HHS-OIG has issued non-binding guidance that affords MAOs broad discretion in designing compliance functions related to risk adjustment, stating that MAOs should establish an "information collection and reporting system reasonably designed to yield accurate information."[23] But estimating a contract-wide "net overpayment" based on HHS-OIG's Contractor's determination that some HCCs submitted by MMM for the sampled enrollees were not validated, particularly without any adjustment to account for errors in traditional Medicare data, is inconsistent with CMS' and HHS' prior guidance that MAOs will not be held to a perfection standard.

Nor does the perfection standard reflected in the Draft Report take into account the realities and limitations of CMS' Medicare Advantage risk adjustment payment model. The practice of medicine is subjective, with differences in opinion among providers about when to diagnose conditions, how to treat them, and what to document in the medical record. Consistent with this reality, CMS generally does not mandate the use of specific diagnostic criteria, but instead permits providers to use their own clinical judgment when diagnosing conditions.[24] Similarly, certified coders can and do reasonably disagree on a range of coding issues even when using their best judgment while reviewing medical records to determine which diagnosis codes are supported by medical record documentation. In fact, HHS-OIG's own audit methodology contemplates this reality—a physician reviewer resolved any disagreements between the two coders who reviewed the medical records submitted by MMM for this audit.[25] Moreover, diagnosis coding standards often can be vague and ambiguous, resulting in inconsistent diagnosis coding across the healthcare industry based on different, reasonable interpretations of the vague and ambiguous standards. CMS acknowledged this ambiguity in its most recent Advance Notice, noting that certain diagnoses under the ICD-9 Guidelines do not have "well-specified diagnostic coding."[26]

For these reasons and the others articulated in this letter, MMM respectfully requests that HHS-OIG withdraw its estimated extrapolated "net overpayment" finding so that MMM is not held to a 100% data accuracy standard that is inconsistent with the recognized realities of CMS' Medicare Advantage risk adjustment payment model.

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[23] *Id*. (noting also that MAOs "should exercise due diligence to ensure that these systems are working properly" but that "[t]he exact methods used . . . can be determined by the organization," and that these methods "should ordinarily [include] sample audits and spot checks of this system to verify whether it is yielding accurate information").

[24] *See* CMS, ICD-10-CM Official Coding Guidelines for Coding and Reporting FY 2017, at 13 (effective October 1, 2016), https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf ("The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis."). This longstanding principle has been reiterated in every subsequent publication of the ICD-10-CM Official Coding Guidelines.

[25] *See* Draft Report at 14 ("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 and then . . . If the second senior coder found support, a physician independently reviewed the medical record to make the final determination.").

[26] CMS, Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies ("Advance Notice") 47 (Feb. 1, 2023).

G. *An Audit Approach That Recovers Premiums from Years That Have Been Settled (2016 Dates of Service/2017 Payment Year) Undermines the Models Used to Determine Appropriate Bid Rates*

MMM also is concerned with HHS-OIG's recommended refund because of its impact on a contract year that has already been settled. An audit approach that recovers premiums from years that have been settled (here, 2016 dates of service/2017 payment year) undermines the models used to determine appropriate bid rates. When MAOs set bid rates each year, they use historic spending, background information, summaries of revenues and expenses, allowed costs, cost service categories, plan demographics, and quality ratings, among other considerations, to estimate the premiums needed from CMS to cover the average beneficiary enrolled in a particular Medicare Advantage plan. With the guidance of actuaries, MAOs are methodical about the bid rates offered and rely on heavily reviewed methodologies. If CMS recoups payments for a contract year that has already been settled, then the data and information used to determine bid rates for later years are flawed, as they do not take into account these later recoupments. As such, the process of recoupment after a contract year has been settled undermines the MAO's ability to accurately set bid rates and has the potential to result in the MAO's underpayment.

III. MMM Requests That HHS-OIG Withdraw Its Recommendation That MMM Make Changes to Its Existing Compliance and Education Programs

Despite finding that medical records substantiate a vast majority of the audited HCCs, HHS-OIG recommends that MMM "continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments." For the reasons described below, MMM asks that HHS-OIG reconsider this recommendation.

A. *MMM's Current Compliance Program Was Not Subject to HHS-OIG's Audit of 2016 Dates of Service*

MMM requests that HHS-OIG withdraw this recommendation because HHS-OIG's audit was limited to 2016 dates of service, and the Draft Report notes that MMM had policies and procedures in place at that time to support the submission of accurate risk adjustment data. Other than the HCCs that HHS-OIG's Contractor found to not be validated, the Draft Report cites no deficiencies with the compliance functions in place to monitor risk adjustment data for that year. To the extent the Draft Report can be read to include findings about MMM's current compliance program, there is no basis for such findings. It is beyond the scope of the audit as described in the Draft Report to arrive at a recommendation for current practices, which were not subject to HHS-OIG's audit.

B. *HHS-OIG's Determination That Some HCCs Were Not Validated Does Not Demonstrate That MMM's Policies and Procedures Need Enhancement*

HHS-OIG seems to infer, simply by virtue of the fact that HHS-OIG's Contractor found that some HCCs it audited were not supported by medical record documentation (a finding that MMM is appealing with respect to many HCCs), that MMM's compliance and

education programs must have been deficient. But as noted in Part II.F of this letter, a perfection standard is inconsistent with the recognized realities of risk adjustment, as CMS and HHS-OIG have long acknowledged. Thus, simply because HHS-OIG's Contractor identified some data inaccuracies—particularly through a skewed audit sample, see Part II.C—does not mean that MMM's compliance or education programs were or are deficient when measured by existing Medicare Advantage program guidance.

Because HHS-OIG has identified no flaws in MMM's compliance and education programs, MMM respectfully requests that HHS-OIG withdraw this recommendation.

IV. Conclusion

For the reasons explained herein, MMM does not concur with HHS-OIG's proposed recommendations and respectfully requests that HHS-OIG reconsider or withdraw each one. MMM also asks HHS-OIG to reconsider its findings with respect to the HCCs that MMM has appealed and its estimated extrapolated "net overpayment." MMM welcomes the opportunity to further discuss HHS-OIG's findings and anticipated recommendations. MMM reserves all rights to challenge any current or revised recommendations and findings.

Sincerely,

Myra I Plumey Rivera, CHC; CHPC
Chief Compliance Officer
MMM Holdings, LLC