Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF SPECIFIC DIAGNOSIS CODES THAT HEALTHFIRST HEALTH PLAN, INC., (CONTRACT H3359) SUBMITTED TO CMS

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

Amy J. Frontz
Deputy Inspector General
for Audit Services

January 2022
A-02-18-01029

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

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

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

Report in Brief
Date: January 2022
Report No. A-02-18-01029

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

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., (Contract H3359) 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 than to healthier enrollees, who would be expected to require fewer health care resources.

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

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

How OIG Did This Audit

We sampled 240 unique enrollee-years with the high-risk diagnosis codes for which Healthfirst received higher payments for 2015 through 2016. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $787,928.

What OIG Found

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that Healthfirst submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 155 of the 240 enrollee-years, the diagnosis codes that Healthfirst submitted to CMS were not supported in the medical records and resulted in net overpayments of $516,509.

These errors occurred because the policies and procedures that Healthfirst had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of our sample results, we estimated that Healthfirst received at least $5.2 million in net overpayments for these high-risk diagnosis codes in 2015 and 2016.

What OIG Recommends and Healthfirst Comments

We made a series of recommendations to Healthfirst, including that it: refund to the Federal Government the $5.2 million of net overpayments; identify, for the diagnosis codes described in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and continue its examination of existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.

Healthfirst objected to all of our recommendations; however, it did not object to any of the errors we identified. Instead, Healthfirst requested we limit our recommended recovery to the overpayments identified in our sample—not the extrapolated value of those overpayments. Healthfirst stated that OIG lacked the authority to use extrapolation to recommend a repayment and disagreed with our extrapolation methodology. It also stated that our audit methodology did not account for a payment principle known as "actuarial equivalence" and disagreed that it should perform audits of high-risk diagnoses or enhance its compliance program. After reviewing Healthfirst's comments, we maintain that our findings and recommendations are valid. No statutory authority limits our use of extrapolation to estimate a recovery and we correctly applied Federal requirements underlying the MA program.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/21801029.asp.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

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

This audit is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS.[2] Using data mining techniques and considering discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. (For example, we consolidated 27 major depressive disorder diagnoses into 1 group.) This audit covered Healthfirst Health Plan, Inc. (Healthfirst),[3] for contract number H3359[4] and focused on seven groups of high-risk diagnosis codes for payment years 2015 and 2016.

OBJECTIVE

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

[1] The providers code diagnoses using the International Classification of Diseases (ICD), Clinical Modification (CM), *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines). The ICD is a coding system that is used by physicians and other health care providers to classify and code all diagnoses, symptoms, and procedures. Effective October 1, 2015, CMS transitioned from the ninth revision of the ICD coding guidelines (ICD-9-CM) to the tenth revision (ICD-10-CM). Each revision includes different diagnosis code sets.

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

[3] Healthfirst Health Plan, Inc. is a subsidiary of Healthfirst, Inc.

[4] All subsequent references to "Healthfirst" in this report refer solely to contract number H3359.

BACKGROUND

Medicare Advantage Program

The MA program offers beneficiaries managed care options by allowing them to enroll in private health care plans rather than having their care covered through Medicare's traditional fee-for-service program.[5] Beneficiaries who enroll in these plans are known as enrollees. To provide benefits to enrollees, CMS contracts with MA organizations, which in turn contract with providers (including hospitals) and physicians.

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

For 2019, CMS paid MA organizations $273.8 billion, which represented 34 percent of all Medicare payments for that year.

Risk Adjustment Program

Federal requirements mandate that payments to MA organizations be based on the anticipated cost of providing Medicare benefits to a given enrollee and, in doing so, also account for variations in the demographic characteristics and health status of each enrollee.[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 amount for each geographic area to determine the base rate that an MA organization is paid for each of its enrollees.[8]

[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 *et seq*.

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

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

To determine an enrollee's health status for the purposes of calculating the risk score, CMS uses diagnoses that the enrollee receives from acceptable data sources, including certain physicians and hospitals. MA organizations collect the diagnosis codes that physicians document on the medical records and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs).[9] 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 (in either the Version 12 model or the Version 22 model), 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 (in the Version 12 model) for an enrollee that map to the HCCs for acute stroke, acute myocardial infarction, and chronic obstructive pulmonary disease (COPD), CMS assigns a separate factor for this disease interaction. By doing so, CMS increases the enrollee's risk score for each of the three HCC factors and by an additional factor for the disease interaction.

The risk adjustment program is prospective. Specifically, CMS uses the diagnosis codes that the enrollee received for 1 calendar year (known as the service year) to determine HCCs and calculate risk scores for the following calendar year (known as the payment year). Thus, an enrollee's risk score does not change for the year in which a diagnosis is made. Instead, the risk score changes for the entirety of the year after the diagnosis has been made. Further, the risk score calculation is an additive process—as HCC factors (and, when applicable, disease interaction factors) accumulate, an enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment

[9] CMS transitioned from one HCC payment model to another during our audit period. As part of this transition, for 2015, CMS calculated risk scores based on both payment models. CMS refers to these models as the Version 12 model and the Version 22 model, each of which has unique HCCs. CMS blended the two separate risk scores into a single risk score that it used to calculate a risk-adjusted payment. Accordingly, for 2015, an enrollee's blended risk score is based on the HCCs from both payment models. For 2016, CMS calculated risk scores on the Version 22 model.

program compensates MA organizations for the additional risk of providing coverage to enrollees expected to require more health care resources.

CMS multiplies the risk scores by the base rates to calculate the total Medicare monthly payment that an MA organization receives for each enrollee before applying the budget sequestration reduction.[10] Miscoded diagnoses submitted to CMS may result in HCCs that are not validated and incorrect enrollee risk scores, which may lead to improper payments (overpayments) from CMS to MA organizations. Conversely, correctly coded diagnoses that MA organizations do not submit to CMS may lead to improper payments (underpayments).

High-Risk Groups of Diagnoses

Using data mining techniques and discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. For this audit, we focused on seven high-risk groups:[11]

- *Acute stroke*: An enrollee received one acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim. A diagnosis of history of stroke (which does not map to an HCC) typically should have been used.

- *Acute heart attack*: An enrollee received one diagnosis that mapped to either the HCC for Acute Myocardial Infarction or to the HCC for Unstable Angina and Other Acute Ischemic Heart Disease (Acute Heart Attack HCCs) on only one physician claim but did not have that diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician's claim). A diagnosis for a less severe manifestation of a disease in the related-disease group typically should have been used.

- *Acute stroke and acute heart attack combination*: An enrollee met the conditions of both the acute stroke and acute heart attack high-risk groups in the same year.[12]

- *Embolism*: An enrollee received one diagnosis that mapped to either the HCC for Vascular Disease or to the HCC for Vascular Disease With Complications (Embolism

[10] Budget sequestration refers to automatic spending cuts that occurred through the withdrawal of funding for certain Federal Government programs, including the MA program, as provided in the Budget Control Act of 2011 (BCA) (P.L. No. 112-25 (8-2-2011)). Under the BCA, the sequestration of mandatory spending began in April, 2013.

[11] Unless otherwise specified, the HCCs described in this report have the same name under both the Version 12 and Version 22 models.

[12] We combined these enrollees into one group because an individual's risk scores could have been further increased if that enrollee also had a COPD diagnosis (which was not part of our audit). If our audit identified an error that invalidated either the acute stroke or acute heart attack HCC, then the disease interaction factor would also be identified as an error. By combining these enrollees in one group, we eliminated the possibility of including the disease interaction factor twice in overpayment calculations (if any).

HCCs) but did not have an anticoagulant medication dispensed on his or her behalf. An anti-coagulant medication is typically used to treat an embolism. A diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used.

- *Vascular claudication*: An enrollee did not receive a diagnosis related to vascular claudication (which maps to the HCC for Vascular Disease) for 2 years and then, in the subsequent year, received that diagnosis but had medication dispensed on his or her behalf that is frequently dispensed for a diagnosis of neurogenic claudication.[13] In these instances, the vascular claudication diagnoses may not be supported in the medical records.

- *Major depressive disorder*: An enrollee received one major depressive disorder diagnosis (which maps to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) during the service year but did not have an antidepressant medication dispensed on his or her behalf. In these instances, the major depressive disorder diagnoses may not be supported in the medical records.

- *Potentially mis-keyed diagnosis codes*: An enrollee received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition (which mapped to a possibly unvalidated HCC). For example, ICD-9 diagnosis code 250.00 (which maps to the HCC for Diabetes Without Complication) could be transposed as diagnosis code 205.00 (which maps to the HCC for Metastatic Cancer and Acute Leukemia and, in this example, would be unvalidated). Using an analytical tool that we developed, we identified 811 scenarios in which diagnosis codes could have been mis-keyed because numbers were transposed or other data entry errors occurred that could have resulted in the assignment of an unvalidated HCC.

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

Healthfirst Health Plan, Inc.

Healthfirst is an MA organization based in New York, New York. As of December 31, 2016, Healthfirst provided coverage under contract number H3359 to approximately 136,875

[13] Vascular claudication and neurogenic claudication are different diagnoses. Vascular claudication is a condition that can result in leg pain while walking and is caused by insufficient blood flow. Neurogenic claudication is a condition that can also result in leg pain but is caused by damage to the neurological system, namely the spinal cord and nerves.

enrollees. For the 2015 and 2016 payment years (audit period),[14] CMS paid Healthfirst approximately $3.3 billion to provide coverage to its enrollees.[15]

HOW WE CONDUCTED THIS AUDIT

Our audit included enrollees on whose behalf providers documented diagnosis codes that mapped to one of the seven high-risk groups during the 2014 and 2015 service years, for which Healthfirst received increased risk-adjusted payments for payment years 2015 and 2016, respectively. Because enrollees could be classified in more than one high-risk group or have high-risk diagnosis codes documented in more than 1 year, we classified these individuals according to the condition and the payment year, which we refer to as "enrollee-years." We identified 5,721 unique enrollee-years and limited our review to the portions of the payments that were associated with these high-risk diagnosis codes ($14,847,742). We selected for audit a sample of 240 enrollee-years, which comprised (1) a stratified random sample of 200 (out of 5,646) enrollee-years for the first 6 high-risk groups and (2) a non-statistical sample of 40 (out of 75) enrollee-years for the remaining high-risk group.

Table 1 details the number of sampled enrollee-years for each high-risk group.

Table 1: Sampled Enrollee-Years

High-Risk Group	Number of Sampled Enrollee-Years
1. Acute Stroke	49
2. Acute Heart Attack	30
3. Acute Stroke/Acute Heart Attack combination	11
4. Embolism	30
5. Vascular Claudication	35
6. Major Depressive Disorder	45
Total for Stratified Random Sample	**200**
7. Potentially Mis-keyed Diagnosis Codes	40
Total for All High-Risk Groups	**240**

Healthfirst provided medical records as support for the selected diagnosis codes associated with the 240 enrollee-years. We used an independent medical review contractor to review the medical records to determine whether the selected diagnosis codes that Healthfirst submitted to CMS were supported. If the contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, we included the financial impact of the resulting HCC (if any) in our calculation of overpayments.

[14] The 2015 and 2016 payment year data were the most recent data available at the start of the audit.

[15] All of the payment amounts that CMS made to Healthfirst and the overpayment amounts that we identified in this report reflect the budget sequestration reduction.

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

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that Healthfirst submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 85 of the 240 sampled enrollee-years, the medical records supported the diagnosis codes that Healthfirst submitted to CMS. However, for the remaining 155 enrollee-years, the diagnosis codes were not supported in the medical records.

These errors occurred because the policies and procedures that Healthfirst had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. As a result, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Healthfirst received at least $5.2 million in net overpayments for 2015 and 2016.[16]

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 42 CFR

[16] Specifically, we estimated that Healthfirst received at least $5,221,901 ($5,023,530 for the statistically sampled groups plus $198,371 for the group of potentially mis-keyed diagnosis codes) in net overpayments. To be conservative, we recommend recovery 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.

§ 422.310(d)(1)). In addition, MA organizations must contract with CMS and agree to follow CMS's instructions, including the *Medicare Managed Care Manual* (the Manual) (see 42 CFR § 422.504(a)).

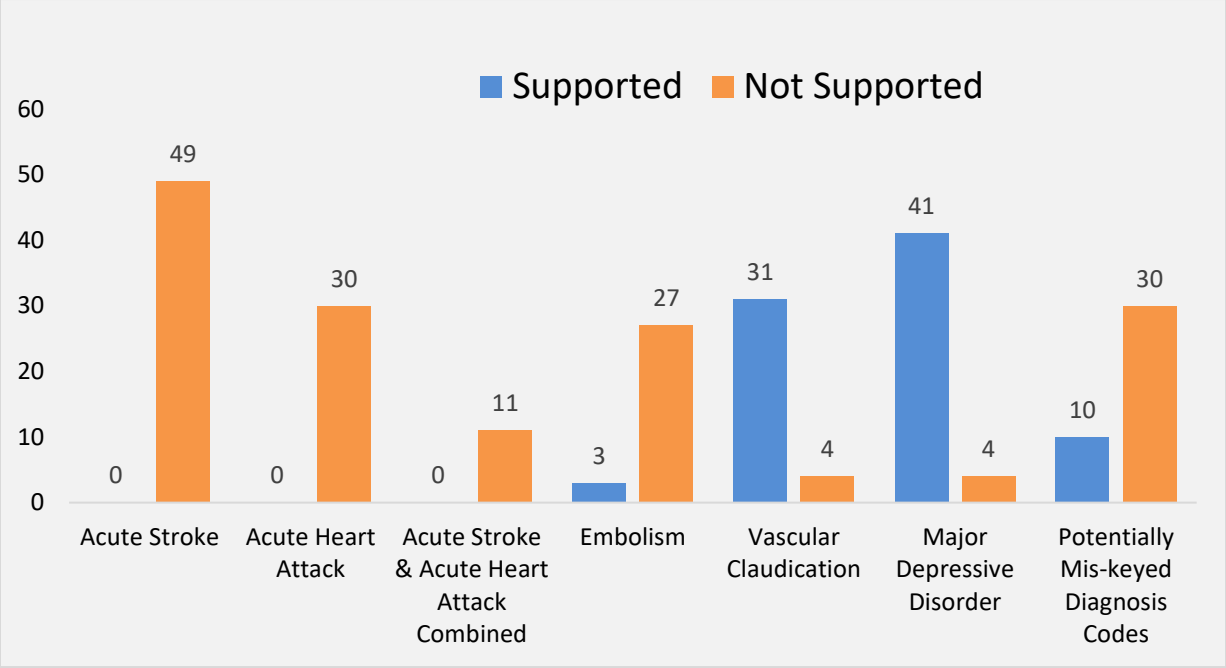
CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (the Manual, chap.7 (last rev. Sept. 19, 2014)). Specifically, CMS requires all submitted diagnosis codes to be documented in the medical record and to be documented as a result of a face-to-face encounter (the Manual, chap. 7, § 40). The diagnosis must be coded according to the ICD Coding Guidelines (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(b)(1) and (c)(2)-(3)). Further, 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 state that MA organizations must "adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS's program requirements . . . ." Further, MA organizations must establish and implement an effective system for routine monitoring and identification of compliance risks (42 CFR § 422.503(b)(4)(vi), See Appendix E).

MOST OF THE SELECTED HIGH-RISK DIAGNOSIS CODES THAT HEALTHFIRST SUBMITTED TO CMS DID NOT COMPLY WITH FEDERAL REQUIREMENTS

Most of the selected high-risk diagnosis codes that Healthfirst submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. As shown in the figure on the following page, the medical records for 155 of the 240 sampled enrollee-years did not support the diagnosis codes. In these instances, Healthfirst should not have submitted the diagnosis codes to CMS and received the resulting net overpayments.

Figure: Analysis of High-Risk Groups



Incorrectly Submitted Diagnosis Codes for Acute Stroke

Healthfirst incorrectly submitted diagnosis codes for acute stroke for all 49 sampled enrollee-years. Specifically:

- For 26 enrollee-years, the medical records indicated in each case that the individual had previously had a stroke, but the records did not justify an acute stroke diagnosis at the time of the physician's service.

  For example, for 1 enrollee-year, the medical record (for a service that occurred in 2014) indicated that the individual had an acute stroke in 1998. The independent medical review contractor noted that "there is no evidence of an acute stroke or any related condition that would result in an assignment of the submitted HCC [Ischemic or Unspecified Stroke] or a related HCC. There is mention of a history of a stroke [diagnosis] . . . ." The history of stroke diagnosis code does not map to an HCC.

- For 21 enrollee-years, the medical records did not contain sufficient information to support an acute stroke diagnosis.

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that will result in assignment of [the] HCC [for Ischemic or Unspecified Stroke]. The patient was admitted from [the] emergency room for suspected acute [Cerebrovascular Accident] which was ruled out at discharge."

- For the remaining 2 enrollee-years, Healthfirst did not provide any medical records to support the acute stroke diagnosis; therefore, the HCC for Ischemic or Unspecified Stroke was not validated.

As a result of these errors, the HCCs for Ischemic or Unspecified Stroke were not validated, and Healthfirst received $129,370 in overpayments for these 49 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Acute Heart Attack

Healthfirst incorrectly submitted diagnosis codes for acute heart attack for all 30 sampled enrollee-years. Specifically:

- For 19 enrollee-years, the medical records did not support an acute myocardial infarction diagnosis. However, we identified support for another diagnosis of a less severe manifestation of the related-disease group as detailed below:

    - For 14 enrollee-years, we identified support for an old myocardial infarction diagnosis.

        - For 8 enrollee-years, which occurred in payment year 2015, the old myocardial infarction diagnosis mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Healthfirst should not have received an increased payment for the acute myocardial infarction diagnosis. Rather, it should have received a lesser increased payment for the old myocardial infarction diagnosis.

            For example, for 1 enrollee-year, the independent medical review contractor noted that "there is no documentation of any condition that will result in the assignment of [the Unstable Angina and Other Acute Ischemic Heart Disease] HCC. There is documentation of history of myocardial infarction [diagnosis] that results in [the] HCC [for Angina Pectoris/Old Myocardial Infarction] which should have been assigned instead of the submitted HCC."

        - For 6 enrollee-years, which occurred in payment year 2016, the old myocardial infarction diagnosis did not map to an HCC.[17] Accordingly, Healthfirst should not have received an increased payment for acute myocardial infarction.

[17] In contrast to the enrollee-years that occurred in payment year 2015 (for which CMS used the Version 12 model), for payment year 2016, CMS used only the Version 22 model, which did not include an HCC for Old Myocardial Infarction, to calculate risk scores (footnote 9).

- For 2 enrollee-years, which occurred in payment year 2016, we identified support for an acute ischemic heart disease diagnosis, which mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Healthfirst should not have received an increased payment for the acute myocardial infarction diagnosis. Rather, it should have received a lesser increased payment for the acute ischemic heart disease diagnosis.

- For 2 enrollee-years, which occurred in payment year 2015, we identified support for both an old myocardial infarction diagnosis and an unspecified angina pectoris diagnosis,[18] both of which mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Healthfirst should not have received an increased payment for the acute myocardial infarction diagnosis. Rather, it should have received a lesser increased payment for the old myocardial infarction and unspecified angina pectoris diagnoses.

- For the remaining 1 enrollee-year, which occurred in payment year 2016, we identified support for an unspecified angina pectoris diagnosis, which mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Healthfirst should not have received an increased payment for the acute myocardial infarction diagnosis. Rather, it should have received a lesser increased payment for the unspecified angina pectoris diagnosis.

- For 10 enrollee-years, the medical records did not support either an acute myocardial infarction diagnosis or a diagnosis of a less severe manifestation of the related-disease group.

- For the 1 remaining enrollee-year, Healthfirst did not provide any medical records to support the acute myocardial infarction diagnosis; therefore, the HCC for Acute Heart Attack was not validated.[19]

As a result of these errors, the Acute Heart Attack HCCs were not validated, and Healthfirst received $49,653 in net overpayments for these 30 sampled enrollee-years.

[18] Angina pectoris is defined as a disease marked by brief sudden attacks of chest pain or discomfort caused by deficient oxygenation of the heart muscles, usually due to impaired blood flow to the heart.

[19] For this 1 enrollee-year, we found in CMS's Risk Adjustment Processing System (RAPS) and Encounter Data System (EDS) a diagnosis code submitted by Healthfirst that mapped to an HCC for a less severe manifestation of the related-disease group, which we included in our calculation of the overpayment.

Incorrectly Submitted Diagnosis Codes for Acute Stroke and Acute Heart Attack Combination

Healthfirst incorrectly submitted diagnosis codes for all 11 of the sampled enrollee-years for which physicians had documented conditions for both the acute stroke and acute heart attack high-risk groups in the same year (footnote 12).

For 10 enrollee-years, the medical records did not support either the acute stroke diagnosis, the acute myocardial infarction diagnosis, or both (table 2).

Table 2: Acute Stroke and Acute Heart Attack Combination Findings

Count of Enrollee-Years	Acute Stroke HCC		Acute Heart Attack HCC	
	Medical Record Validated HCC	Support for Different HCC Found	Medical Record Validated HCC	Support for Different HCC Found
4	No	No	No	Yes – Old Myocardial Infarction[20]
4	No	No	No	No
1	No	No	No	Yes – Angina Pectoris
1	No	No	Yes	N/A

For the one remaining enrollee-year, Healthfirst did not provide any medical records to support either diagnosis; therefore, the HCCs for Acute Heart Attack and Acute Stroke were not validated.[21]

As a result of these errors, the HCCs for either Ischemic or Unspecified Stroke, Acute Heart Attack, or both, were not validated, and Healthfirst received $46,496 in net overpayments for these 11 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Embolism

Healthfirst incorrectly submitted diagnosis codes for embolism for 27 of 30 sampled enrollee-years. Specifically:

- For 16 enrollee-years, the medical records did not contain sufficient information to support an embolism diagnosis.

[20] For these 4 enrollee-years, which occurred in payment year 2015, the old myocardial infarction diagnosis mapped to an HCC for a less severe manifestation of the related-disease group.

[21] For this enrollee-year, we found in CMS's RAPS a diagnosis code submitted by Healthfirst that mapped to an HCC for a less severe manifestation of the heart attack related-disease group, which we included in our calculation of the overpayment.

For example, for 1 enrollee-year, the independent medical review contractor noted that "there is no documentation of any condition that will result in the assignment of [an Embolism] HCC. There is documentation of deep vein thrombosis [diagnosis] as a working diagnosis that would not be coded based on outpatient guidelines of suspected/ruled out diagnoses."[22]

- For 7 enrollee-years, the medical records indicated in each case that the individual had previously had an embolism, but the records did not justify an embolism diagnosis at the time of the physician's service.

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

- For the remaining 4 enrollee-years, Healthfirst did not provide any medical records to support the embolism diagnoses; therefore, the Embolism HCCs were not validated.

As a result of these errors, the Embolism HCCs were not validated, and Healthfirst received $72,442 in overpayments for these 27 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Vascular Claudication

Healthfirst incorrectly submitted diagnosis codes for vascular claudication for 4 of 35 sampled enrollee-years. Specifically:

- For 3 enrollee-years, the medical records did not support a vascular claudication diagnosis.

  For example, for 1 enrollee-year, the independent medical review contractor noted that "there is no documentation of any condition that would result in the assignment of [the Vascular Disease] HCC."

- For the 1 remaining enrollee-year, Healthfirst did not provide any medical records to support the vascular claudication diagnosis; therefore, the HCC for Vascular Disease was not validated.

As a result of these errors, the HCCs for Vascular Disease were not validated, and Healthfirst received $8,738 in overpayments for these 4 sampled enrollee-years.

[22] ICD-9-CM Coding Guidelines, which were applicable for the reviewed diagnosis code, state that diagnoses documented as "suspected" or "rule out" should not be coded for outpatient services.

Incorrectly Submitted Diagnosis Codes for Major Depressive Disorder

Healthfirst incorrectly submitted diagnosis codes for major depressive disorder for 4 of 45 sampled enrollee-years. Specifically:

- For 2 enrollee-years, the medical records did not support a major depressive disorder diagnosis.[23]

  For example, for 1 enrollee-year, the independent medical review contractor noted that "there is no documentation of any condition that will result in the assignment of [the Major Depressive, Bipolar, and Paranoid Disorders] HCC. There is [an] assessment of anxiety [diagnosis] which does not result in an HCC."

- For the remaining 2 enrollee-years, Healthfirst did not provide any medical records to support the major depressive disorder diagnoses; therefore, the HCCs for Major Depressive, Bipolar, and Paranoid Disorders were not validated.

As a result of these errors, the HCCs for Major Depressive, Bipolar, and Paranoid Disorders were not validated, and Healthfirst received $11,438 in overpayments for these 4 sampled enrollee-years.

Potentially Mis-keyed Diagnosis Codes

Healthfirst submitted potentially mis-keyed diagnosis codes for 30 of 40 sampled enrollee-years. In each of these cases, the enrollee-years received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition.

- For 24 enrollee-years, the medical records did not support the diagnosis for the unrelated condition. Because of these errors, Healthfirst submitted unsupported diagnosis codes that mapped to unvalidated HCCs to CMS.

  For example, for 1 enrollee-year, Healthfirst submitted 107 diagnosis codes for acute myeloid leukemia (205.00) and only one diagnosis code for diabetes mellitus (250.00) to CMS. The independent medical review contractor limited its review to the diabetes mellitus diagnosis, for which it did not find support.

- For 3 enrollee-years, the medical records did not support the diagnosis for the unrelated condition. However, we identified support for another diagnosis that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Healthfirst should not have received an increased payment for the submitted diagnosis.

[23] For these 2 enrollee-years, the independent medical review contractor identified support for a diagnosis code for a milder form of depression, which does not map to an HCC.

Rather, it should have received a lesser increased payment for the other diagnosis identified.

For example, for 1 enrollee-year, the medical records did not support a dissection of aorta diagnosis, which maps to the HCC for Vascular Disease With Complications. The independent medical review contractor noted that "there is no documentation of any condition that will result in the assignment of [the Vascular Disease with Complications] HCC. There is documentation of abdominal aortic aneurysm [diagnosis,] which results in [the Vascular Disease] HCC [that] should have been assigned instead of the submitted HCC." Accordingly, Healthfirst should not have received payment for the dissection of aorta diagnosis. Rather, it should have received a lesser increased payment for the abdominal aortic aneurysm diagnosis.

- For the remaining 3 enrollee-years, Healthfirst did not provide any medical records to support the potentially mis-keyed diagnosis code; therefore, the HCCs associated with the potentially mis-keyed diagnosis codes were not validated.[24]

Appendix F contains the HCCs that were not validated for the 30 enrollee-years (Table 6) and the HCCs for the less severe manifestation of the related-disease group that were supported for the 4 enrollee-years (Table 7).

As a result of these errors, the HCCs associated with the potentially mis-keyed diagnosis codes were not validated, and Healthfirst received $198,371 in net overpayments for these 30 sampled enrollee-years.

THE POLICIES AND PROCEDURES THAT HEALTHFIRST USED TO DETECT AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS WERE NOT ALWAYS EFFECTIVE

The errors we identified occurred because the policies and procedures that Healthfirst had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations (42 CFR § 422.503(b)(4)(vi)), were not always effective.

Healthfirst had compliance procedures in place during our audit period to determine whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct. These procedures included a provider education program that was designed to promote accurate diagnosis codes, which provided instructions to its providers on the proper coding of several frequently miscoded diagnoses, one of which was acute stroke. In addition, Healthfirst's compliance procedures included routine internal medical reviews to compare diagnosis codes from a random sample of claims to the diagnoses that were documented on the associated medical records. However, these internal medical reviews did not focus on any

[24] For 1 enrollee-year, we found in CMS's RAPS and CMS's EDS a diagnosis code submitted by Healthfirst that mapped to an HCC for a less severe manifestation of the related-disease group, which we included in our calculation of the overpayment.

specific high-risk diagnosis codes, including those we identified as being at a higher risk for being miscoded. As a result, Healthfirst's compliance procedures to prevent and detect incorrect high-risk diagnoses during our audit period were not always effective. Additionally, Healthfirst was not always able to obtain medical records from its providers to support diagnosis codes submitted to CMS to calculate risk-adjusted payments.[25]

Healthfirst explained that, after our audit period, it revised its procedures for conducting internal medical reviews to include reviews of targeted diagnosis codes that we identified as being at a higher risk for being miscoded. In addition, Healthfirst updated its provider education program to include steps to notify providers of errors identified during the internal medical reviews, and provide them with guidance on how to avoid coding errors.

HEALTHFIRST RECEIVED NET OVERPAYMENTS

As a result of the errors we identified, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Healthfirst received at least $5,221,901 in net overpayments ($5,023,530 for the statistically sampled groups plus $198,371 for the group of potentially mis-keyed diagnosis codes) in 2015 and 2016. (See Appendix D for sample results and estimates).

RECOMMENDATIONS

We recommend that Healthfirst Health Plan, Inc.:

- refund to the Federal Government the $5,221,901 of estimated net overpayments;
- identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government;
- identify, for the potentially mis-keyed diagnosis codes described in this report, similar instances of noncompliance that occurred during our audit period but were not included in our non-statistical sample and refund any resulting overpayments to the Federal Government; and
- continue its examination of existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

[25] For example, Healthfirst stated that the records associated with some patients were not in the providers' electronic record systems or were not available because the associated physician or medical practice was no longer active.

HEALTHFIRST COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Healthfirst objected to all of our recommendations. However, it did not object to any of the errors we identified. Instead, Healthfirst requested we limit our recommended recovery to the overpayments identified in our sample rather than the extrapolated value of those overpayments. Specifically, Healthfirst stated that OIG lacked the authority to use extrapolation to recommend a repayment and disagreed with our extrapolation methodology. Moreover, Healthfirst argued that our audit methodology did not account for a payment principle known as "actuarial equivalence." Healthfirst also disagreed that it should perform additional audits of the high-risk diagnoses included in this report. Lastly, Healthfirst stated that, although it regularly evaluates its compliance programs, it believes its current compliance program is sufficient to meet its current obligations.

After reviewing Healthfirst's comments and for the reasons detailed below, we maintain that our findings and recommendations are valid.

A summary of Healthfirst's comments and our responses follows. Healthfirst's comments are included in their entirety as Appendix G.

HEALTHFIRST DID NOT AGREE WITH THE EXTRAPOLATION METHODOLOGY THAT THE OFFICE OF INSPECTOR GENERAL USED TO ESTIMATE OVERPAYMENTS

Healthfirst Comments

Healthfirst stated that OIG lacks the authority to base a recommendation for recovery on an extrapolation of individual overpayment amounts across a "broader universe." Specifically, Healthfirst referenced 42 U.S.C. § 1395ddd(f)(3), stating that it provides only "limited authority for CMS to extrapolate, and such authority is limited to *contractors* auditing *providers* under Medicare Parts A and B in limited circumstances not present here with respect to [MA organizations]" (emphasis in original). It further argued that there is "simply no statutory authority for the use of extrapolation of audit results of MAOs providing services under Part C."

Additionally, Healthfirst stated that CMS drafted regulations on extrapolation for 2011 through 2013; however, according to Healthfirst, nothing was published and there is no approved extrapolation methodology for the audit period (payment years 2015 and 2016). Healthfirst noted that using an unpublished extrapolation methodology is inconsistent with the Act's rulemaking requirements for notice and comment set forth in *Azar v. Allina Health Services*,[26] and therefore, "any purported authority for such extrapolation fails to comply with the required rule-making processes."

Healthfirst further claimed that retroactivity is prohibited by Federal law. Specifically, it stated that the Act "prohibits retroactive rules absent a statutory requirement, significant public

[26] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).

safety concern or other critical need [42 U.S.C. § 139hh(e)(1)(A)], none of which are present here." Additionally, Healthfirst noted that seeking records from providers to support HCCs for services provided in 2015 and 2016 is often difficult. Healthfirst stated that, for these reasons, it believes that "even if a valid rule authorizing extrapolation i[s] promulgated, it should not be applied retroactively, and that extrapolation by the OIG based on audit findings from 201[5]-2016 is similarly not permissible."

Healthfirst also stated that our methodology for calculating the extrapolated repayment amount is faulty. Healthfirst specifically referenced our use of the 90-percent confidence interval instead of, according to Healthfirst, the "statistically valid and more robust practice" of using the lower limit of the 95- or 99-percent confidence interval. Additionally, Healthfirst noted that CMS uses the lower limit of the 99-percent confidence interval level for calculating extrapolated repayment amounts for its Risk Adjustment Data Validation (RADV) audits. Healthfirst stated that, if it were permissible to extrapolate, OIG would have to use the lower limit of the 99-percent confidence interval to be consistent with CMS's practice for RADV audits.

Office of Inspector General Response

Healthfirst relies on 42 U.S.C. § 1395ddd(f)(3) to say that OIG has no authority to extrapolate. This conclusion is misguided. No statutory or other authority limits our ability to recommend a recovery to CMS based upon sampling and extrapolation. Extrapolation has long been recognized as a permissible method of calculating overpayments in Medicare. Further, current case law supports the use of extrapolation as a means to determine overpayments so long as the methodology used is statistically valid.[27, 28]

Healthfirst alleged that OIG cannot use extrapolation without publishing our methodology through notice-and-comment rulemaking. OIG disagrees. We also note that because we are not recommending the application of any new statutory or regulatory requirements, the criteria cited by Healthfirst that prohibit retroactivity is not applicable to this audit.

Additionally, our estimation methodology does not need to mirror CMS's estimation methodology. Our use of the lower limit of a two-sided 90-percent confidence interval provided a reasonably conservative estimate of the total amount overpaid to Healthfirst for the

[27] See *John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *12 (W.D. Pa. 2012), aff'd 555 F. App'x 188 (3d Cir. 2014); *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); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); and *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

[28] We properly executed our statistical sampling methodology in that we defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., the OIG, Office of Audit Services, statistical software RAT-STATS) to apply the correct formulas for the extrapolation.

enrollee-years and time period covered in our sampling frame. Further, we note that this approach, which is routinely used by the Department of Health and Human Services (HHS) for recovery calculations,[29] results in a lower limit (the estimated overpayment amount to refund) that is less than the actual overpayment amount 95 percent of the time.

HEALTHFIRST DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S APPLICATION OF CMS REQUIREMENTS FOR CALCULATING OVERPAYMENTS

Healthfirst Comments

Healthfirst stated that OIG's extrapolated calculation of overpayments violated certain CMS requirements mandated under the MA program. Specifically, Healthfirst stated that OIG's methodology did not account for a payment principle known as "actuarial equivalence," which, according to Healthfirst, is mandated by the Act.

Healthfirst cited the provision of the Act that mandates that risk-adjusted payments be made in a manner that ensures "actuarial equivalence" between CMS payments for health care coverage under MA and CMS payments under Medicare's traditional Fee-for-Service (FFS) program. Healthfirst stated that "CMS developed the [MA] risk adjustment model using unaudited [FFS] claims data from the traditional Medicare program, which CMS has acknowledged contain high levels of erroneous diagnoses. Accordingly, in order to ensure actuarial equivalence between the FFS and MA programs, CMS should measure overall rates of erroneous diagnoses in the [MA] program against the rates of erroneous diagnoses found within the traditional Medicare FFS program." It further stated that, in 2012, "CMS said that it would first identify a 'payment recovery amount' based on the value of supported and unsupported HCCs identified during its review. Then, 'to determine the final payment recovery amount, CMS [would] apply a Fee-for-Service Adjuster [(FFSA)] amount as an offset to the preliminary recovery amount . . . .'"

Healthfirst stated that "CMS departed from the principle that an FFSA is necessary by issuing a proposed rule in 2018 suggesting that diagnosis coding errors in unaudited traditional Medicare data do not systematically impact payments to [MA organizations] and released a corresponding study purporting to support this premise." Healthfirst added that this rule is not final and is still subject to the administrative rule-making process.

Healthfirst also noted that a Federal district court vacated a different MA rule implemented by CMS because "the rule violated the [Act's] actuarial equivalence mandate by defining

[29] HHS has used the two-sided 90-percent percent confidence level 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 FFS 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).

'overpayment' as the payment of funds to [MA organizations] based on unsupported diagnosis codes, while not applying the same documentation standards to the traditional Medicare data used to calculate payments to [MA organizations]."[30] Healthfirst noted that the Federal district court decision concluded "that CMS systematically devalues [MA organization] payments when it uses unaudited traditional Medicare data to set [MA organization] payment rates while measuring [MA organization] 'overpayments' based on audited patient records." Healthfirst cited to the opinion by the U.S. Court of Appeals for the D.C. Circuit, which ruled on the U.S. District Court's decision; specifically, Healthfirst highlighted that the Appeals Court held that "the actuarial-equivalence requirement does not pertain to the statutory overpayment-refund obligation . . . ." [31] However, Healthfirst noted that the court did not invalidate actuarial equivalence for use in RADV audits, for which the court stated "[w]e express no opinion on whether the actuarial equivalence requirement . . . requires such an adjuster in the [contract-level RADV audit . . .] context."

Healthfirst asserted that "the [MA] program requirements apply to OIG's audits" and that, without applying the FFSA, OIG's extrapolated repayment calculations violate the "actuarial equivalence" mandate. Accordingly, Healthfirst requested that OIG withdraw our overpayment calculation and limit any recovery to the specific encounters reviewed during this audit and for which the unsupported codes were found.

Office of Inspector General Response

Our audit methodology correctly applied CMS requirements to properly identify the overpayment amount associated with unsubstantiated HCCs for each sample item.

We used the results of the independent medical review contractor's 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 CMS's risk adjustment program requirements 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.

Healthfirst stated that we did not consider "actuarial equivalence" in our overpayment calculations. To this point, we recognize that CMS, not OIG, is responsible for making operational and program payment determinations for the MA program, including the application of any FFSA. Moreover, CMS has not issued any requirements that compel us to reduce our net overpayment calculations.[32] If CMS deems it appropriate to apply an FFSA, it will adjust our overpayment finding by whatever amount it determines necessary. Thus, we

[30] *UnitedHealthcare Ins. C. v. Azar II*, 330 F. Supp. 3d 173 (D.D.C. 2018).

[31] *United Healthcare Insurance Co. v. Becerra*, 9 F.4th 868 (D.C. Cir. 2021).

[32] In 2018, CMS proposed not to include an FFSA in any final RADV payment error methodology (Proposed Rule at 83 Fed. Reg. 54982, 55041).

believe that the steps that we followed for this audit provide a reasonable basis for our findings and recommendations, including our estimation of net overpayments.[33]

HEALTHFIRST DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S RECOMMENDATION TO PERFORM ADDITIONAL REVIEWS BEFORE AND AFTER THE AUDIT PERIOD

Healthfirst Comments

Healthfirst disagreed with our second recommendation—that Healthfirst perform additional reviews to determine whether similar instances of high-risk diagnoses occurred before or after the audit period and to refund any overpayments—because, according to Healthfirst, "[MA] regulations do not require the sort of audits that OIG recommends." In addition, Healthfirst stated that it does not have the information necessary to identify additional potentially mis-keyed diagnosis codes similar to those that we identified and for which we recommended that Healthfirst refund any resulting overpayments to the Federal Government (third recommendation).

Healthfirst stated that MA regulations "do not require [MA organizations] to ensure data perfection as the [d]raft [r]eport implies." In this respect, Healthfirst stated that "[t]he government has long acknowledged that [MA organizations] are not expected to submit perfect risk adjustment data" and that "OIG has issued non-binding guidance stating that [MA organizations] should establish an 'information collection and reporting system reasonably designed to yield accurate information.'" Moreover, Healthfirst stated that CMS recognizes that MA organizations submit encounter data "'in great volume from a number of sources'" and that for the certification of these data, CMS holds MA organizations responsible for making good faith efforts to certify their accuracy, completeness, and truthfulness.

In this respect, Healthfirst stated that our citations of Federal regulations for MA organizations like Healthfirst to monitor the data that they receive from providers and submit to CMS were misleading. Specifically, Healthfirst stated that our citations did not address the "broad discretion" that CMS provided to MA organizations to design their own compliance programs and did not "account for the qualified 'good faith' attestation standard that CMS explicitly adopted." Thus, according to Healthfirst, OIG's second recommendation "would dramatically expand the [MA] compliance program requirements."

[33] OIG audit findings and recommendations do not represent final determinations by CMS. 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.

Office of Inspector General Response

We do not agree with Healthfirst's interpretation of Federal requirements. We recognize that MA organizations have the latitude to design their own federally mandated compliance programs. We also recognize that CMS applies a "good faith attestation" standard when MA organizations certify the great volume of data that they submit to CMS for use in the risk adjustment program. However, contrary to Healthfirst's assertions, we believe that our second recommendation conforms to the requirements specified in Federal regulations (42 CFR § 422.503(b)(4)(vi) (see Appendix D)).

These Federal regulations state that MA organizations must "implement an effective compliance program, which must include measures that prevent, detect, and correct noncompliance with CMS' program requirements." Further, these regulations specify that Healthfirst's compliance plan "must, at a minimum, include [certain] core requirements," which include "an effective system for routine monitoring and identification of compliance risks . . . [including] internal monitoring and audits and, as appropriate, external audits to evaluate . . . compliance with CMS requirements and the overall effectiveness of the compliance program." These regulations also require MA organizations to implement procedures and a system for 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." Thus, CMS has, through the issuance of these Federal regulations, assigned the responsibility for dealing with potential compliance issues to the MA organizations.

We believe that the error rates identified in this report demonstrate that Healthfirst has compliance issues that need to be addressed. These issues may extend to periods of time beyond our scope. Accordingly, we maintain that our second recommendation is valid.

With regard to the potentially mis-keyed diagnosis codes, during the course of our audit work, we explained to Healthfirst officials how we selected each target area, including mis-keyed diagnosis codes. Additionally, after the issuance of our draft report we provided Healthfirst with a spreadsheet detailing the 811 scenarios that we identified in which diagnosis codes could have been mis-keyed. Therefore, Healthfirst has the information necessary to identify additional mis-keyed diagnosis codes similar to those that we identified. Accordingly, we maintain that our third recommendation is also valid.

HEALTHFIRST DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S RECOMMENDATION TO ENHANCE ITS EXISTING COMPLIANCE PROGRAM

Healthfirst Comments

Healthfirst noted that it made changes to its compliance program after the end of our audit period. Additionally, Healthfirst stated that it regularly evaluates its compliance programs to respond to regulatory changes and to identify opportunities for improvement. Healthfirst

stated that it believes its current compliance program is sufficient to meet its current obligations and requested that we withdraw our fourth recommendation.

Office of Inspector General Response

We limited our review to selected diagnoses and HCCs that we determined to be at high risk for noncompliance (i.e., miscoded). Our audit revealed a significant error rate for some of these areas. After our audit period, Healthfirst revised its procedures to include internal medical reviews of these high-risk diagnoses. The continued improvement of those procedures, based on the results of this audit, as well as the results of Healthfirst's internal medical reviews, will assist Healthfirst in attaining better assurance with regard to the "accuracy, completeness and truthfulness" of the risk adjustment data that it submits in the future. Accordingly, we maintain that our fourth recommendation is valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid Healthfirst $3,333,485,481 to provide coverage to its enrollees for 2015 and 2016. We identified a sampling frame of 5,721 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes during the 2014 and 2015 service years. Healthfirst received $107,579,597 in payments from CMS for these enrollee-years for 2015 and 2016. We selected for audit 240 enrollee-years with payments totaling $5,432,013.

The 240 enrollee-years included 49 acute stroke diagnoses, 30 acute heart attack diagnoses, 11 acute stroke diagnosis and acute heart attack diagnosis combinations, 30 embolism diagnoses, 35 vascular claudication diagnoses, 45 major depressive disorder diagnoses, and 40 potentially mis-keyed diagnoses. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $787,928 for our sample.

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

We performed audit work from August 2019 through September 2021.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- We reviewed applicable Federal laws, regulations, and guidance.

- We discussed with CMS program officials the Federal requirements that MA organizations should follow when submitting diagnosis codes to CMS.

- We identified, through data mining and discussions with medical professionals at a Medicare administrative contractor, diagnosis codes and HCCs that were at high risk for noncompliance. We also identified the diagnosis codes that potentially should have been used for cases in which the high-risk diagnoses were miscoded.

- We consolidated the high-risk diagnosis codes into specific groups, which included:

    - 6 diagnosis codes for acute stroke,
    - 35 diagnosis codes for acute heart attack,
    - 56 diagnosis codes for embolism,
    - 4 diagnosis codes for vascular claudication, and
    - 27 diagnosis codes for major depressive disorder.

- We developed an analytical tool that identified 811 scenarios in which either ICD-9 or ICD-10 diagnosis codes, when mis-keyed into an electronic claim because of a data transposition or other data entry error, could result in the assignment of an incorrect HCC to an enrollee's risk score. For each of the 811 occurrences, the tool identified a potentially mis-keyed diagnosis code and the likely correct diagnosis code. Accordingly, we considered the potentially mis-keyed diagnosis codes to be high risk.

- We used CMS's systems to identify the enrollee-years on whose behalf providers documented the high-risk diagnosis codes. Specifically, we used extracts from CMS's:

    - Risk Adjustment Processing System (RAPS)[34] to identify enrollees who received high-risk diagnosis codes from a physician during the service years,

    - Risk Adjustment System (RAS)[35] to identify enrollees who received an HCC for the high-risk diagnosis codes,

    - Medicare Advantage Prescription Drug System (MARx)[36] to identify the total Medicare payments that CMS calculated, before applying the budget sequestration reduction, for Healthfirst for the payment years, and

    - Prescription Drug Event (PDE) file[37] to identify enrollees who had Medicare claims with certain medications dispensed on their behalf.

- We interviewed Healthfirst officials to gain an understanding of (1) the policies and procedures that Healthfirst followed to submit diagnosis codes to CMS for use in the risk-adjustment program and (2) Healthfirst's monitoring of those diagnosis codes to identify and detect noncompliance with Federal requirements.

- We selected for audit a sample of 240 enrollee-years that included (1) a stratified random sample of 200 enrollee-years and (2) a non-statistical sample of 40 enrollee-years.

[34] MA organizations use the RAPS to submit diagnosis codes to CMS.

[35] The RAS identifies the HCCs that CMS factors into each enrollee's risk score calculation.

[36] The MARx identifies the payments made to MA organizations.

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

- We used an independent medical review contractor to perform a coding review for the 240 enrollee-years to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements.[38]

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

    - If the first senior coder found support for the diagnosis code on the medical record, the HCC was considered validated.

    - If the first senior coder did not find support on the medical record, a second senior coder performed a separate review of the same medical record:

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

        - If the second senior coder found support, then a physician independently reviewed the medical record to make the final determination.

    - If either the first or second senior coder asked a physician for assistance, the physician's decision became the final determination.

- We used the results of the independent medical review contractor to calculate overpayments or underpayments for each enrollee-year. Specifically, we calculated:

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

    - the payment that CMS should have made for each enrollee-year.

- We estimated the total net overpayment made to Healthfirst during the audit period.

- We discussed the results of our audit with Healthfirst officials.

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.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Anthem Community Insurance Company, Inc. (Contract H3655) Submitted to CMS	A-07-19-01187	5/21/2021
Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc., (Contract H1036) Submitted to CMS	A-07-16-01165	4/19/2021
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross Blue Shield of Michigan (Contract H9572) Submitted to CMS	A-02-18-01028	2/24/2021
Some Diagnosis Codes That Essence Healthcare, Inc., Submitted to CMS Did Not Comply With Federal Requirements	A-07-17-01170	4/30/2019

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We identified Healthfirst enrollees who (1) were continuously enrolled in Healthfirst throughout all of the 2014 or 2015 service year and January of the following year, (2) were not classified as being enrolled in hospice or as having end-stage renal disease status at any time during 2014 or 2015 or in January of the following year, and (3) received a high-risk diagnosis during 2014 or 2015 that caused an increased payment to Healthfirst for 2015 or 2016, respectively.

We presented the data for these enrollees to Healthfirst for verification and performed an analysis of the data included on CMS's systems to ensure that the high-risk diagnosis codes increased CMS's payments to Healthfirst. After we performed these steps, our finalized sampling frame consisted of 5,721 enrollee-years.

SAMPLE UNIT

The sample unit was an enrollee-year, which covered either payment year 2015 or 2016.

SAMPLE DESIGN

The design for our statistical sample was comprised of six strata of enrollee-years with either:

- an acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (1,071 enrollee-years);

- a diagnosis that mapped to an Acute Heart Attack HCC on only one physician claim but did not have that diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician claim (560 enrollee-years);

- an acute stroke diagnosis and a diagnosis that mapped to an Acute Heart Attack HCC in the same year and that met the criteria mentioned in the previous two bullets (11 enrollee-years);

- a diagnosis that mapped to an Embolism HCC but for which an anticoagulant medication was not dispensed (362 enrollee-years);

- a vascular claudication diagnosis (which maps to the HCC for Vascular Disease) on one claim during the service year (and did not occur during the 2 years that preceded the service year), but for which medication was dispensed for neurogenic claudication during the service year (1,547 enrollee-years); or

- a major depressive disorder diagnosis (which maps to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) on one claim during the service year but for which antidepressant medication was not dispensed (2,095 enrollee-years).

The specific strata are shown in Table 3.

Table 3: Sample Design for Audited High-Risk Groups

Stratum (High-Risk Groups)	Frame Count of Enrollee-Years	CMS Payment for HCCs in Audited High-Risk Groups*	Sample Size
1 – Acute Stroke	1,071	$2,712,635	49
2 – Acute Heart Attack	560	1,203,268	30
3 – Acute Stroke / Acute Heart Attack Combination	11	54,748	11
4 – Embolism	362	954,907	30
5 – Vascular Claudication	1,547	3,712,264	35
6 – Major Depressive Disorder	2,095	5,839,986	45
Total – First Six Strata	**5,646**	**$14,477,808**	**200**

*Rounded to the nearest whole dollar amount.

After we selected the 200 enrollee-years, we identified an additional group of 75 enrollee-years, from which we non-statistically selected 40 enrollee-years that represented individuals who received 1 of the 811 potentially mis-keyed diagnosis codes (which mapped to a potentially unvalidated HCC) and multiple instances of diagnosis codes for unrelated conditions that were likely keyed correctly. Thus, we selected for audit a total of 240 enrollee-years.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the items in each stratum in the stratified sampling frame. After generating 200 random numbers according to our sample design, we selected the corresponding frame items for review. We also systematically selected a non-statistical sample of 40 items from the potentially mis-keyed group. This resulted in at least 1 enrollee-year being selected from each HCC group.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate the total amount of net overpayments to Healthfirst 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. We also identified the net overpayments from the non-statistical sample of 40 potentially mis-keyed diagnosis codes and added that amount to the estimate for the statistical sample to obtain the total net overpayments.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 4: Sample Details and Results

Audited High-Risk Groups	Frame Size	CMS Payment for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)	Sample Size	CMS Payment for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)	Number of Sampled Enrollee-Years With Incorrect Diagnosis Codes	Net Overpayment for Unvalidated HCCs (for Sampled Enrollee-Years)
1 – Acute Stroke	1,071	$2,712,635	49	$129,370	49	$129,370
2 – Acute Heart Attack	560	1,203,268	30	63,009	30	49,653
3- Acute Stroke/ Acute Heart Attack Combination	11	54,748	11	54,748	11	46,496
4 – Embolism	362	954,907	30	79,669	27	72,442
5 – Vascular Claudication	1,547	3,712,264	35	82,178	4	8,738
6 – Major Depressive Disorder	2,095	5,839,986	45	126,317	4	11,438
Totals—First Six Strata	**5,646**	**$14,477,808**	**200**	**535,291**	**125**	**$318,137**
7 – Potentially Mis-keyed Diagnoses	75	$369,934	40	$252,638	30	$198,371
Totals – All	**5,721**	**$14,847,742**	**240**	**$787,928***	**155**	**$516,509***

* Difference in total is due to rounding.

Table 5: Estimated Net Overpayments in the Sampling Frame (*Limits Calculated at the 90-Percent Confidence Level)*

	Estimated Net Overpayment for Statistical Sample	Overpayment for Potentially Mis-keyed Diagnosis Group	Total Estimated Net Overpayments
Point Estimate	$5,593,899	$198,371	$5,792,270
Lower Limit	$5,023,530	$198,371	$5,221,901
Upper Limit	$6,164,268	$198,371	$6,362,639

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's 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.

APPENDIX F: BREAKOUT OF POTENTIALLY MIS-KEYED DIAGNOSIS CODES

Table 6: Potentially Mis-keyed Diagnosis Codes and Associated Overpayments

Number of Sampled Enrollee-years	One Diagnosis for a Condition (Determined To Be Incorrect)			Multiple Diagnoses for a Condition (Not Reviewed)		Net Overpayment
	Diagnosis Code	Diagnosis Code Description	Hierarchical Condition Category That Was Not Validated	Diagnosis Code	Diagnosis Code Description	
6	714.9	Unspecified Inflammatory Polyarthropathy	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	174.9	Malignant Neoplasm of Breast (Female), Unspecified	$20,123
4	205.00	Acute Myeloid Leukemia, Without Mention of Having Achieved Remission	Metastatic Cancer and Acute Leukemia	250.00	Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled	75,495
3	200.00	Reticulosarcoma, Unspecified Site, Extranodal and Solid Organ Sites	Lymphatic, Head and Neck, Brain, and Other Major Cancers (Version 12 model) and Lymphoma and Other Cancers (Version 22 model)	250.00	Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled	17,859
2	205.90	Unspecified Myeloid Leukemia, Without Mention of Having Achieved Remission	Lung, Upper Digestive Tract, and Other Severe Cancers (Version 12 model) and Lung and Other Severe Cancers (Version 22 model)	250.90	Diabetes With Unspecified Complication, Type II or Unspecified Type, Not Stated as Uncontrolled	16,752
2	482.0	Pneumonia Due to Klebsiella Pneumoniae	Aspiration and Specified Bacterial Pneumonias	428.0	Congestive Heart Failure, Unspecified	9,450

Number of Sampled Enrollee-years	One Diagnosis for a Condition (Determined To Be Incorrect)			Multiple Diagnoses for a Condition (Not Reviewed)		Net Overpayment
	Diagnosis Code	Diagnosis Code Description	Hierarchical Condition Category That Was Not Validated	Diagnosis Code	Diagnosis Code Description	
2	493.20	Chronic Obstructive Asthma, Unspecified	Chronic Obstructive Pulmonary Disease	493.02	Extrinsic Asthma With (Acute) Exacerbation	8,261
2	402.01	Malignant Hypertensive Heart Disease With Heart Failure	Congestive Heart Failure	402.10	Benign Hypertensive Heart Disease Without Heart Failure	7,027
1	205.02	Acute Myeloid Leukemia, in Relapse	Metastatic Cancer and Acute Leukemia	250.02	Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Uncontrolled	18,997
1	433.01	Occlusion and Stenosis of Basilar Artery With Cerebral Infarction	Ischemic or Unspecified Stroke	433.10	Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction	4,027
1	249.20	Secondary Diabetes Mellitus With Hyperosmolarity, Not Stated as Uncontrolled, or Unspecified	Diabetes With Acute Complications	294.20	Dementia, Unspecified, Without Behavioral Disturbance	3,988
1	482.1	Pneumonia Due to Pseudomonas	Aspiration and Specified Bacterial Pneumonias	428.1	Left Heart Failure	3,961

Number of Sampled Enrollee-years	One Diagnosis for a Condition (Determined To Be Incorrect)			Multiple Diagnoses for a Condition (Not Reviewed)		Net Overpayment
	Diagnosis Code	Diagnosis Code Description	Hierarchical Condition Category That Was Not Validated	Diagnosis Code	Diagnosis Code Description	
1	250.00	Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled	Diabetes Without Complication	205.00	Acute Myeloid Leukemia, Without Mention of Having Achieved Remission	3,768
1	209.21	Malignant Carcinoid Tumor of the Bronchus and Lung	Breast, Prostate, Colorectal and Other Cancers and Tumors (Version 12 model) and Breast, Prostate, and Other Cancers and Tumors (Version 22 model)	290.21	Senile Dementia With Depressive Features	2,385
1	E32.9	Disease of Thymus, Unspecified	Other Significant Endocrine and Metabolic Disorders	F32.9	Major Depressive Disorder, Single Episode, Unspecified	2,349
1	441.01	Dissection of Aorta, Thoracic	Vascular Disease With Complications	414.01	Coronary Atherosclerosis of Native Coronary Artery	1,969
1	441.00	Dissection of Aorta, Unspecified Site	Vascular Disease With Complications	414.00	Coronary Atherosclerosis of Unspecified Type of Vessel, Native or Graft	1,960
30						**$198,371**

Table 7: Hierarchical Condition Categories (HCCs) That Were Not Validated, But We Found Support for an HCC for a Less Severe Manifestation of the Related-Disease Group

Count of Enrollee-Years	More Severe Hierarchical Condition Category That Was Not Validated	Less Severe Hierarchical Condition Category That Was Supported
2	Vascular Disease With Complications	Vascular Disease
1	Aspiration and Specified Bacterial Pneumonias	Pneumococcal Pneumonia, Emphysema, Lung Abscess
1	Metastatic Cancer and Acute Leukemia	Breast, Prostrate, Colorectal and Other Cancers and Tumors (Version 12 model)/Breast, Prostate, and Other Cancers and Tumors (Version 22 model)

APPENDIX G: HEALTHFIRST COMMENTS

healthfirst
Health Insurance for New Yorkers

VIA Electronic Mail "Kiteworks" to brenda.tierney@oig.hhs.gov

October 18, 2021

Brenda M. Tierney
Regional Inspector General for Audit Services
Office Of Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza,
Room 3900
New York, NY 10278

RE: Report Number: A-02-18-01029

Dear Ms. Tierney:

Healthfirst Health Plan, Inc. ("Healthfirst") writes in response to the United States Department of Health and Human Services ("HHS") Office of Inspector General's ("OIG's") Draft Report for Audit No. A-02-18-01029 ("Draft Report"). For the reasons described below, Healthfirst respectfully requests that OIG withdraw its recommendations that Healthfirst (i) repay an extrapolated amount of $5,221,901 (and instead limit repayment to the $516,509 in erroneous payments that were actually identified) and (ii) conduct additional self-audits beyond OIG's sample for periods during, prior to and after OIG's audit period and calculate any repayments based on those audits. Healthfirst objects to OIG's recommendations because (A) extrapolation is not permitted, (B) even if permitted, the proposed extrapolation methodology is inconsistent with the legal and regulatory requirements underlying the Medicare Advantage ("MA") program, and (C) there are currently open CMS audits in process for periods preceding the OIG's audit period and thus any self-audit would be duplicative and premature.

A. The Recommended Repayment Amount is Based on Extrapolation, For Which OIG Has No Authority and Which is Calculated Incorrectly

OIG reviewed medical records from a sample of Healthfirst beneficiaries and found overpayments totaling $516,509. The remaining over $4.5 million dollars OIG seeks to recoup is based on OIG's proposed extrapolation of those specific individual overpayments across a broader universe. Thus, OIG proposes to essentially use a sample to calculate a contract-wide error rate for similar codes and recover "overpayments" on that larger amount. OIG lacks authority to base its recovery on such an extrapolation. The Social Security Act ("SSA") only provides limited authority for CMS to extrapolate, and such authority is limited to *contractors* auditing *providers* under Medicare Parts A and B in limited circumstances not present here with respect to Medicare Advantage Organizations ("MAOs").[1]
The applicable statute, entitled "LIMITATION ON USE OF EXTRAPOLATION," states:

> A [M]edicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless [CMS] determines that—
>
> (A) there is a sustained or high level of payment error; or

[1] 42 U.S.C. § 1395ddd(f)(3).

(B) documented educational intervention has failed to correct the payment error.

The language of that section does not provide CMS with authority to use extrapolation for anyone other than *providers and suppliers* under Medicare Parts A and B. There is simply no statutory authority for the use of extrapolation of audit results of MAOs providing services under Part C. [2]

While CMS purported to enact draft regulations regarding extrapolation for 2011, 2012 and 2013, they were never published with a prior notice and comment period.[3] More recently, CMS published for comment a methodology for audits of Part C contractors for 2020 and 2021, which have received substantial negative comments, in part based on the actuarial equivalence argument discussed in paragraph B below.

There is no published methodology whatsoever for the 2015 and 2016 audit period here, and therefore there was no opportunity for the public or the MAOs to understand the details of the methodology or make comments. Utilizing unpublished extrapolation methodology is inconsistent with the SSA requirements for notice-and-comment rulemaking as indicated by the Supreme Court in *Azar v. Allina Health Services.*[4] Thus any purported authority for such extrapolation fails to comply with the required rule-making processes.

In addition, the methodology OIG employs in its extrapolation is faulty. OIG used the lower bound of a 90% confidence interval to calculate the extrapolated repayment amount, rather than the statistically valid and more robust practice of using the lower bound of a 95% or 99% confidence interval.[5] In CMS's most recent disclosure of its own methodology for calculating extrapolated repayment amounts for its RADV audits, CMS stated that it uses the lower bound of a 99% confidence interval.[6] Accordingly, although we believe that extrapolation is impermissible here, Healthfirst respectfully requests that even if OIG were permitted to extrapolate, it would have to recalculate the extrapolated "overpayment" amount using the lower bound of the more statistically robust 99% confidence interval consistent with CMS practice for RADV audits.

---

[2] That this section is limited providers and suppliers under Medicare Parts A and B is clear from the context and from additional language in this section: "There shall be no administrative or judicial review under section 1869 [referring to appeal rights specific to Medicare Parts A and B], section 1878 [referring to additional appeal rights specific to certain providers of services under Part A], or otherwise, of determinations by [CMS] of sustained or high levels of payment errors under this paragraph." *See* America's Health Insurance Plans, Comments to the Proposed Rule (August 17, 2019), www.ahip.org/wp-content/uploads/AHIP_RADV_comments_FINAL_8_27_19.pdf at 25.

[3] CMS proposed its methodology for conducting RADV audits, including extrapolation, via the CMS website on December 20, 2010, instead of the Federal Register. *See* Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Re g. 54982, 55038 (proposed Nov. 1, 2018)

[4] 139 S. Ct. 1804 (2019).

[5] Federal Judicial Center, National Academies Press, Reference Manual on Scientific Evidence 245 (3d ed. 2011) ("The 95% confidence level is the most popular, but some authors use 99%, and 90% is seen on occasion.")

[6] Centers for Medicare and Medicaid Services, Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation for Contract-Level Audits, at 4 (Feb. 24, 2012)(to be codified at 42 C.F.R. Parts 422, 423, 438, and 498)(hereinafter *Notice of Error Calculation*)

B. The Recommended Extrapolated Repayment Amount is Incorrect Because it is Not Adjusted to Ensure Actuarial Equivalence to the Fee-For-Service Medicare Program as Required by Law

The SSA 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. Actuarial equivalence measures whether different benefit packages have "the same value, based on the estimated spending that would be incurred by the insurer."[7] Because the SSA ties Medicare Advantage compensation to the expected cost of providing traditional Medicare benefits to an enrollee of average risk, the "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 different health status.[8] 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.[9] CMS developed the Medicare Advantage risk adjustment model using unaudited Fee-for-Service ("FFS") claims data from the traditional Medicare program, which CMS has acknowledged contain high levels of erroneous diagnoses. Accordingly, in order to ensure actuarial equivalence between the FFS and MA programs, CMS should measure overall rates of erroneous diagnoses in the Medicare Advantage program against the rates of erroneous diagnoses found within the traditional Medicare FFS program.[10] CMS previously formally signaled its agreement with the requirement of measuring error rates in Medicare Advantage diagnoses against those in the traditional Medicare program. In 2012, CMS published a notice stating that it was adopting this requirement as part of its methodology for calculating recovery amounts for unsupported Hierarchical Condition Categories ("HCCs") identified during its RADV audits. Specifically, CMS said that it would first identify a "payment recovery amount" based on the value of supported and unsupported HCCs identified during its review.[11] Then, "to determine the final payment recovery amount, CMS [would] apply a Fee-for-Service Adjuster ('FFS Adjuster') amount as an offset to the preliminary recovery amount," and base the FFS Adjuster "on a RADV-like review of records submitted to support [traditional Medicare] claims data."[12]

This announcement reflected CMS's view (stated in internal CMS documents) that without applying an FFS Adjuster to calculated repayment amounts, audited MAOs are underpaid.[13] In a CMS presentation titled "Model Calibration Factor," for example, CMS explained that:

---

[7] U.S. Department of Health & Human Services, Payment for Medicare Advantage Plans: Policy Issues and Options (June 2009), *available at* https://aspe.hhs.gov/reports/payment-medicare-advantage-plans-policy-issues-options-0.
[8] 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").
[9] *See* 42 U.S.C. § 1395w-23(b)(4)(C), (D).
[10] *See generally* Wakely Consulting Group, Actuarial Report on CMS's 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), *available at* https://beta.regulations.gov/comment/CMS-2018-0133-0260).
[11] *Notice of Error Calculation, supra* note 6, at 3-4.
[12] *Id.* at 4–5.
[13] *See Azar*, 1:16-cv-00157-RMC (D.D.C. Oct. 2, 2017) (ECF 44-3) (Document authored by CMS titled "Model Calibration Factor"); Azar, 1:16-cv-00157-RMC (D.D.C. Oct. 2, 2017) (ECF 44-4) (Document authored by CMS titled "Three RADV Policy Issues").

> "[i]n RADV audits, we expect coding perfection from [MAOs]," while "[i]n [traditional] Medicare, some portion of diagnoses on [traditional Medicare] claims are not documented in medical records."[14]

As a result, for RADV audits, MAOs "are being held to a different (higher) standard for diagnoses"[15] absent an FFS adjuster.

CMS said that these different document standards matter because traditional Medicare data were used to calculate MA payments and the "[i]nclusion of undocumented diagnoses tends to reduce risk adjustment values."[16] CMS then used numerical examples to demonstrate that MAOs would be underpaid (i.e., MAOs' costs would exceed CMS reimbursement) if MAOs were audited to a standard of data perfection without properly calibrating the overpayment amount to account for traditional Medicare data errors.[17] CMS departed from the principle that a FFS adjuster is necessary by issuing a proposed rule in 2018[18] suggesting that diagnosis coding errors in unaudited traditional Medicare data do not systematically impact payments to MAOs[19] and released a corresponding study purporting to support this premise.[20] Healthfirst and numerous other parties, including actuarial and statistical experts, have submitted comments to CMS objecting to this approach and advocating for the use of a "fee-for-service adjuster" as originally proposed in connection with the proposed rule.[21]

In September 2018, a federal district court in *UnitedHealthcare Ins. Co. v. Azar II* ("*Azar*"), 330 F. Supp. 3d 173 (D.D.C. 2018), vacated CMS's Medicare Advantage Overpayment Rule because the rule violated the SSA's actuarial equivalence mandate by defining "overpayment" as the payment of funds to MAOs based on unsupported diagnosis codes, while not applying the same documentation standards to the traditional Medicare data used to calculate payments to MAOs.[22] In doing so, the court concluded that CMS systematically devalues MAO payments when it uses unaudited traditional Medicare data to set MAO payment rates while measuring MAO "overpayments" based on audited patient records.[23] CMS presented a study that purported to deny the need for a fee-for-service adjuster, but the court in *Azar*

---

[14] *Azar,* 1:16-cv-00157-RMC (D.D.C. Oct. 2, 2017) (ECF 44-3) at 6.
[15] *Id.*
[16] *Id.* at 7.
[17] *Id.* at 8–9.
[18] Notably, the 2018 proposed rule is not final and is still subject to administrative rulemaking process.
[19] Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program for All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54982 (proposed Nov. 1, 2018) (to be codified at 42 C.F.R. §§ 422, 423, 438, 498) (hereinafter "Proposed Rule").
[20] Centers for Medicare and Medicaid Services, *Fee for Service Adjuster & Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* (Oct. 26, 2018), *available at* https://tinyurl.com/ve3737d; CMS, *Addendum to the Fee-For-Service Adjuster Study* (June 28, 2019).
[21] *See* Public Comments on Proposed Rule (e.g., Anthem Letter dated August 28, 2019, supra n.12; Cigna Letter dated August 28, 2019, available at https://www.regulations.gov/document?D=CMS-2018-0133-0254; CVSHealth Letter dated August 28, 2019, available at https://www.regulations.gov/document?D=CMS-2018-0133-0259; Humana Letter dated August 28, 2019, available at https://www.regulations.gov/document?D=CMS-2018-0133-0257; Kaiser Permanente Letter dated August 28, 2019, available at https://www.regulations.gov/document?D=CMS-2018-0133-0267; UnitedHealth Group Letter dated August 28, 2019, available at https://www.regulations.gov/document?D=CMS-2018-0133-0263).
[22] *Azar*, 330 F. Supp. 3d at 187–90; *Azar*, Case No. 16-cv-157 (RMC), 2020 WL 417867 (D.D.C. Jan. 27, 2020).
[23] *Id.* at 186–87 ("[T]he 'expected' value of payments from CMS for healthcare costs [to MAOs] will be lower than the 'expected' payments CMS itself will make under traditional Medicare, since CMS does not audit or engage in similar self-examination for accuracy of its own records. The consequence is inevitable: while CMS pays for all diagnostic codes, erroneous or not, submitted to traditional Medicare, it will pay less for Medicare Advantage coverage because essentially no errors would be reimbursed.").

found that CMS's study "does not persuade" and concluded that the government had failed to "adequately respond" to criticisms of the study raised during litigation.[24] On January 27, 2020, the same court reaffirmed this position in denying the government's request to reconsider the court's prior holding.[25] The D.C. Circuit in *United Healthcare Insurance Co. v. Becerra*, 9 F.4th 868 (D.C. Cir. 2021), while overturning *Azar* in part, recognized the requirement of actuarial equivalence in conducting RADV audits. The *Becerra* court recognized that "the system-level adjustment that CMS said it would apply in the context of contract-level RADV audits came in direct response to concerns about actuarial equivalence." *Becerra*, 9 F.4th at 872. The court expressly limited its holding, striking down actuarial equivalence in the overpayment context: "we hold that the actuarial-equivalence requirement does not pertain to the statutory overpayment-refund obligation, or the Overpayment Rule challenged here . . .." *Id.* The Court, however, noted that it was *not* invalidating actuarial equivalence as applied to RADV audits, saying "[w]e express no opinion on whether the actuarial equivalence requirement . . . requires such an adjuster in the [contract-level RADV audit . . .] context." *Id. at n.* 1 (emphasis added). Notably, the Overpayment Rule itself applies only to known overpayments. *Id.* at 880. Any RADV audit can necessarily only identify individual overpayments, and it is therefore not proper to require repayment of extrapolated results across the contract without adjusting to account for the error rate in the FFS program in order to ensure actuarial equivalency (if such extrapolation is indeed ever proper, as discussed above).

These Medicare Advantage program requirements apply to OIG's audits and calculation of estimated repayment amounts for the same program. Thus, OIG's extrapolated repayment calculations, by failing to apply an FFS adjuster, violate the "actuarial equivalence" mandate that underpins the Medicare Advantage program.

Healthfirst accordingly requests that OIG withdraw its overpayment calculation and limit any recovery in this audit to the specific encounters that were reviewed during this audit and for which the unsupported codes were found.

C. Retroactivity Is Prohibited By Federal Law and Is Unnecessary and Unjustified

This audit relates to services provided in 2015 and 2016, necessarily requiring looking back to significantly prior periods. The SSA prohibits retroactive rules absent a statutory requirement, significant public safety concern or other critical need[26], none of which are present here. In addition, retroactivity poses major operational barriers for MAOs and providers. Seeking records from providers for services provided in 2015 and 2016 to support HCCs reported on claims related to those services is often difficult. Most provider records from that period and earlier were paper, and while many providers have now converted to electronic records, it is not likely that they converted their older paper records. Additionally, providers have often moved, closed their practices, or may be deceased; all of which makes obtaining supporting records difficult even they existed at the time the claims were submitted.

Both because retroactivity is prohibited and because, practically speaking, provider records are sparse if available for past periods, we believe that even if a valid rule authorizing extrapolation if promulgated, it should not be applied retroactively, and that extrapolation by the OIG based on audit findings from 2016-2016 is similarly not permissible.

---

[24] *Azar*, 2020 WL 417867, at *1, *5.

[25] *Id.*.

[26] 42 U.S.C. § 139hh(e)(1)(A): "A substantive change in regulations, manual instructions, interpretive rules, statements of policy, or guidelines of general applicability under this subchapter shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that- (i) such retroactive application is necessary to comply with statutory requirements; or (ii) failure to apply the change retroactively would be contrary to the public interest."

D. Healthfirst Requests that OIG Withdraw Its Recommendation that Healthfirst Undertake Additional Auditing for the Condition Categories Subject to OIG's Audit

OIG recommends that Healthfirst "identify, for the high-risk diagnoses included in [the Draft Report], similar instances of noncompliance that occurred before or after [the] audit period and refund any resulting overpayments to the Federal Government[.]"[27] As further set forth below, MAOs are not required to audit to the standard that OIG suggests. Medicare Advantage regulations do not require the sort of audits that OIG recommends and certainly do not require MAOs to ensure data perfection as the Draft Report implies. In fact, the *Becerra* court notes that "[n]othing in the Overpayment Rule obligates insurers to audit their reported data," a fact the court notes that CMS did not dispute. *Becerra* at 884. Even if Healthfirst were to undertake additional audits, OIG has not provided Healthfirst with the information necessary to identify additional "potentially miskeyed diagnoses" similar to those audited by OIG here. Further, the implementation of ICD-10 in 2016 introduced a more precise alpha-numeric coding system which greatly reduced the likelihood of miskeying errors, which would likely moot this category of errors with respect to that year and going forward.

The government has long acknowledged that MAOs are not expected to submit perfect risk adjustment data. For example, it has stated 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."[28] OIG has issued non-binding guidance stating that MAOs should establish an "information collection and reporting system reasonably designed to yield accurate information."[29] This guidance affords MAOs broad discretion in designing compliance mechanisms. As the federal district court acknowledged in *Azar*, there is a disconnect when the government "treats diagnosis codes as categorically valid for its own purposes under traditional Medicare," but then requires "Medicare Advantage insurers to certify 'based on best knowledge, information, and belief' that the information they provide to CMS, including all diagnosis codes, is 'accurate, complete, and truthful.'"[30]

This understanding is reflected in MAOs' annual data accuracy attestation requirements. MAOs are required to certify that their risk adjustment data is accurate based on their "best knowledge, information, and belief."[31] 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."[32] 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."[33] This "good faith" standard is not defined by CMS or OIG but it recognizes "that encounter data [can] come into [MAOs] in great volume from a number of sources, presenting significant verification challenges for the organizations."[34]

---

[27] Draft report at "Report in Brief".
[28] 65 Fed. Reg. 40169, 40268 (June 29, 2000).
[29] 64 Fed. Reg. 61893, 61900 (Nov. 15, 1999) (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").
[30] *Azar*, 330 F. Supp. 3d at 179–80.
[31] 42 C.F.R. § 422.504(l)(2).
[32] 64 Fed. Reg. at 61900.
[33] 65 Fed. Reg. at 40268.
[34] *Id.* Notably, OIG's Draft Report appears at times to conflate the source of diagnosis codes in a manner that suggests MAOs have more information than they actually do about the accuracy of the risk adjustment data submitted to CMS. See, e.g., Draft Report at 3 ("MA organizations collect the diagnosis codes that physicians document on the medical records and submit th[o]se codes to CMS."); id. at 12 ("Healthfirst had submitted diagnosis codes in which physicians had documented conditions. . . ."). Providers document patient encounters in their medical records and submit claims to MAOs with diagnosis codes based on those encounters. MAOs then

OIG's Draft Report makes two potentially misleading statements in this respect. First, the Draft Report states that "[f]ederal regulations state that [MAOs] must monitor the data that they receive from providers and submit to CMS."[35] As noted above, given the high volume of diagnosis codes that are submitted to MAOs through provider claims submissions, CMS gives MAOs broad discretion to design their own compliance and risk adjustment data accuracy programs. CMS has declined to require MAOs to implement any specific oversight measures, and certainly does not require verification of every code submitted by a provider. Second, the Draft Report also states that federal regulations "state that [MAOs] are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes."[36] This statement is misleading and not accurate because it suggests that the standard for accuracy, completeness and truthfulness is absolute and fails to account for the qualified "good faith" attestation standard that CMS explicitly adopted.

Accordingly, OIG's recommendation would dramatically expand the Medicare Advantage compliance program requirements.[37] CMS is certainly aware of industry-wide trends pertaining to the seven categories audited by OIG through CMS's years of RADV audits, communications with MAOs, and review of the traditional Medicare data it uses to calculate MAO payments. But CMS has not opted to take any steps to implement regulations in response to these trends, let alone the expansive steps OIG proposes in its Draft Report. Healthfirst therefore respectfully requests that OIG withdraw this recommendation.

E. Healthfirst Will Continue to Identify Opportunities to Enhance Its Existing RADV Compliance Program

As OIG acknowledges, Healthfirst has made significant changes to its RADV compliance program since the close of OIG's audit period. While Healthfirst regularly evaluates its compliance programs in order to both respond to regulatory changes and to identify opportunities for improvement, Healthfirst believes that its current RADV compliance program is sufficient to meet its current obligations. Accordingly, Healthfirst requests that OIG withdraw its recommendation that Healthfirst make changes to its existing RADV compliance program.

CONCLUSION

For the foregoing reasons, Healthfirst requests that OIG withdraw all recommendations, with the exception of the recommendation that Healthfirst repay actual overpayments in the amount of $516,509.

---

extract diagnosis codes from provider claims data to submit to CMS. Contrary to OIG's description in the Draft Report, the majority of the diagnosis codes MAOs submit to CMS come from the claims data submitted to MAOs by providers and are not identified by MAOs following a review of patient medical records. Recognizing that MAOs are not the original source of most risk adjustment data, CMS applies a "good faith" standard to the annual data accuracy attestation, having expressly acknowledged that MAOs are not guaranteeing through that attestation absolute accuracy. OIG's Draft Report, and in particular its audit recommendations, appear to be in direct conflict with this express guidance from CMS.

[35] Draft Report at 8.

[36] *Id.* at 7.

[37] The fact that the CMS compliance requirements are not more comprehensive and proscriptive is consistent with (1) the fact that HCC coefficients are based on unaudited traditional Medicare data and (2) the implausibility of expecting MAOs to audit more than a small subset of the vast amount of data submitted to CMS that is generated by healthcare providers who are neither employed by an MAO nor under the direction and control of the MAO.

Sincerely yours,

Linda V Tiano

Linda Tiano
Chief Legal Officer and General Counsel

cc: Pat Wang
President and Chief Executive Officer

Christine Logreira
Vice President, Regulatory Affairs

Nahum Kianovsky
Vice President, Deputy General Counsel