

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE ADVANTAGE COMPLIANCE  
AUDIT OF DIAGNOSIS CODES THAT  
SCAN HEALTH PLAN (CONTRACT  
H5425) SUBMITTED TO CMS**

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February 2022  
A-07-17-01169

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## Report in Brief

Date: February 2022

Report No. A-07-17-01169

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



### Why OIG Did This Audit

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

To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs). CMS makes higher payments for enrollees who receive diagnoses that map to HCCs.

For this audit, we reviewed one of the contracts that SCAN Health Plan (SCAN) has with CMS with respect to the diagnosis codes that SCAN submitted to CMS. Our objective was to determine whether SCAN submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

### How OIG Did This Audit

We selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. SCAN provided medical records as support for 1,577 HCCs associated with the 200 enrollees. We used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

## Medicare Advantage Compliance Audit of Diagnosis Codes That SCAN Health Plan (Contract H5425) Submitted to CMS

### What OIG Found

SCAN did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, although most of the diagnosis codes that SCAN submitted were supported in the medical records and therefore validated 1,413 of the 1,577 sampled enrollees' HCCs, the remaining 164 HCCs were not validated and resulted in overpayments. These 164 unvalidated HCCs included 20 HCCs for which we identified 20 other HCCs for more and less severe manifestations of the diseases. Second, there were an additional 21 HCCs for which the medical records supported diagnosis codes that SCAN should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,577 HCCs. Rather, the risk scores should have been based on 1,454 HCCs (1,413 validated HCCs plus 20 other HCCs plus 21 additional HCCs). As a result, we estimated that SCAN received at least \$54.3 million in net overpayments for 2015. As demonstrated by the errors found in our sample, SCAN's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

### What OIG Recommends and SCAN's Comments

We recommend that SCAN refund to the Federal Government the \$54.3 million of net overpayments and continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

SCAN disagreed with our findings and with both of our recommendations, which SCAN believed contained errors and were unsupported. Specifically, SCAN stated that our independent medical review contractor erred in its determinations by not validating certain HCCs. In addition, SCAN stated that our report was seriously flawed because of, among other things, errors in the approaches that we used to identify the sample of SCAN enrollees for audit and for extrapolation. After reviewing SCAN's comments and the additional information that it provided, we revised the number of unvalidated HCCs and, accordingly, the recommended refund, for this final report. We also revised the wording of our second recommendation. We followed a reasonable audit methodology, properly executed our sampling methodology, and correctly applied applicable Federal requirements underlying the MA program.

## TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective.....	1
Background.....	2
Medicare Advantage Program.....	2
Risk Adjustment Program.....	2
SCAN Health Plan.....	4
How We Conducted This Audit.....	4
FINDINGS.....	5
Federal Requirements.....	6
SCAN Did Not Submit Some Diagnosis Codes in Accordance With Federal Requirements.....	7
Some of the Diagnosis Codes That SCAN Submitted to CMS Were Not Supported in the Medical Records.....	7
Diagnosis Codes That SCAN Should Have Submitted but Did Not Submit to CMS.....	10
Summary of Diagnosis Codes Not Submitted in Accordance With Federal Requirements.....	11
The Policies and Procedures That SCAN Used To Prevent, Detect, and Correct Noncompliance With Federal Requirements Could Be Improved.....	12
SCAN Received Net Overpayments.....	12
RECOMMENDATIONS.....	12
SCAN COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	12
SCAN Did Not Agree With Certain Hierarchical Condition Category Determinations.....	13
SCAN Comments.....	13
Office of Inspector General Response.....	13

SCAN Did Not Agree That the Office of Inspector General’s Sampling Methodology Was Either Random or Representative of SCAN’s Enrollment .....	14
SCAN Comments .....	14
Office of Inspector General Response .....	15
SCAN Stated That the Office of Inspector General’s Audit Methodology and Overpayment Calculations Did Not Reflect All CMS Requirements .....	17
SCAN Comments .....	17
Office of Inspector General Response .....	17
SCAN Stated That the Office of Inspector General Should Not Have Extrapolated Its Overpayments .....	18
SCAN Comments .....	18
Office of Inspector General Response .....	20
SCAN Did Not Agree With the Office of Inspector General’s Assessment of Its Compliance Program .....	21
SCAN Comments .....	21
Office of Inspector General Response .....	22

## APPENDICES

A: Audit Scope and Methodology .....	23
B: Statistical Sampling Methodology .....	26
C: Sample Results and Estimates .....	28
D: Federal Regulations Regarding Compliance Programs That Medicare Advantage Organizations Must Follow .....	29
E: SCAN Comments .....	31

## INTRODUCTION

### WHY WE DID THIS AUDIT

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

Incorrect diagnosis codes can lead to improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either an overpayment or an underpayment). An estimated 7.87 percent of payments to MA organizations for calendar year 2017 were improper, mainly due to MA organizations submitting unsupported diagnosis codes to CMS.<sup>2</sup> Our previous audits have shown that MA organizations submitted diagnosis codes that did not comply with Federal requirements.

This audit is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS. We reviewed one MA organization, SCAN Health Plan (SCAN), with respect to the diagnosis codes that SCAN submitted to CMS for contract number H5425.<sup>3</sup>

### OBJECTIVE

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

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

<sup>2</sup> The Department of Health and Human Services' (HHS's) [FY \[Federal fiscal year\] 2019 Agency Financial Report](#) estimated that 7.87 percent of the payments for the MA program were improper. This figure includes errors for both overpayments and underpayments. The error rate is determined in accordance with the Improper Payments Elimination and Recovery Improvement Act of 2012, P.L. No. 112-248 (Jan. 10, 2013), which requires Federal Agencies to: (1) review their programs and activities to identify programs that may be susceptible to significant improper payments, (2) test for improper payments in high-risk programs, and (3) develop and implement corrective action plans for high-risk programs.

<sup>3</sup> All subsequent references to "SCAN" in this report refer solely to contract number H5425.

## BACKGROUND

### Medicare Advantage Program

The MA program<sup>4</sup> 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 (FFS) program. 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 generally 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 \$274 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.<sup>5</sup>

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.<sup>6</sup> CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that the MA organization is paid for each of its enrollees.<sup>7</sup>

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<sup>4</sup> 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.

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

<sup>6</sup> The Act § 1854(a)(6); 42 CFR § 422.254.

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



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

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

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. Accordingly, a diagnosis code can map to either a Version 12 model HCC, a Version 22 model HCC, or to both models. For example, the diagnosis code for “Acute kidney failure, unspecified” maps to the Version 12 model HCC for Renal Failure and the Version 22 model HCC for Acute Renal Failure.

CMS blended the risk scores from both models into a single risk score for each enrollee. Thus, the total number of HCCs associated with an enrollee’s risk score is based on the HCCs from both payment models.

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.<sup>9</sup>

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<sup>8</sup> CMS required face-to-face encounters during our audit period. However, in April 2020, CMS issued a memorandum to MA organizations stating that diagnoses resulting from telehealth services can meet the face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication. This memorandum is available online at <https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf> (accessed on Aug. 26, 2020).

<sup>9</sup> In some instances, CMS has assigned the same factors for certain HCCs in a related-disease group. For example, the factor for the HCC for Drug/Alcohol Psychosis is the same as the factor for the HCC for Drug/Alcohol Dependence. These two HCCs (Version 12) are in the same related-disease group.

The risk adjustment program is prospective; CMS uses the diagnosis codes that the enrollee received for one year (known as the service year) to determine HCCs and calculate risk scores for the following 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 accumulate, an enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment program compensates MA organizations for the additional risk for providing coverage to enrollees who are expected to require more health care resources.

CMS multiplies the risk scores by the base rates to calculate the total monthly Medicare payment that an MA organization receives for each enrollee before applying the budget sequestration reduction.<sup>10</sup> 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).

CMS designed its contract-level Risk Adjustment Data Validation (RADV) audits to be its primary corrective action on improper payments, which were estimated at 7.87 percent of payments to MA organizations for 2017. These CMS RADV audits verify that diagnoses submitted by MA organizations for risk-adjusted payment are supported by medical record documentation.

## **SCAN Health Plan**

SCAN, an MA organization with headquarters in Long Beach, California, has several geographically based Medicare Part C contracts with CMS. As of December 31, 2015, SCAN provided coverage under contract number H5425 to approximately 179,000 enrollees in California. For our audit period (the 2015 payment year), CMS paid SCAN approximately \$1.9 billion to provide this coverage.<sup>11</sup>

## **HOW WE CONDUCTED THIS AUDIT**

Our audit focused on enrollees on whose behalf SCAN submitted to CMS, for the 2014 service year, at least one diagnosis code that mapped to an HCC used in the enrollees' risk scores for the 2015 payment year. We identified a sampling frame of 93,437 enrollees from which we selected a stratified random sample of 200 enrollees on whose behalf CMS made payments totaling \$3,250,217 to SCAN. SCAN provided medical records as support for 1,577 HCCs (total of both HCC payment models) associated with the 200 enrollees.

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

<sup>11</sup> All of the payment amounts that CMS made to SCAN and the adjustment amounts that we identified in this report reflect the budget sequestration reduction.

We used an independent medical review contractor to review the medical records to determine whether the diagnosis codes validated the 1,577 HCCs. The contractor reviewed these same records to determine whether any additional HCCs were validated by diagnosis codes that SCAN did not submit but should have submitted.

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

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

## FINDINGS

SCAN did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

First, 1,413 of the 1,577 sampled enrollees' HCCs were validated; however, the medical records did not validate the remaining 164 HCCs and resulted in overpayments. These 164 unvalidated HCCs included 20 HCCs for which we identified 20 other HCCs for more and less severe manifestations of the diseases. These 20 other HCCs should have been included in the enrollees' risk scores (instead of the 20 unvalidated HCCs), which would have reduced the overpayments associated with the 164 unvalidated HCCs in our sample.<sup>12</sup>

Second, in reviewing the medical record documentation for the diagnosis codes associated with the 1,577 sampled enrollee HCCs, we identified support for diagnosis codes that SCAN should have submitted to CMS but did not. If SCAN had submitted these diagnosis codes, an additional 21 HCCs would have been included in the enrollees' risk scores. These risk scores would have increased, and CMS's payments to SCAN would have been higher.

In summary, the risk scores for the 200 sampled enrollees should not have been based on the 1,577 HCCs. Rather, the risk scores should have been based on 1,454 HCCs (1,413 validated HCCs plus 20 other HCCs associated with more and less severe manifestations of diseases plus 21 additional validated HCCs that SCAN did not submit to CMS). On the basis of our sample results, we estimated that SCAN received at least \$54,318,154 in net overpayments for 2015.

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<sup>12</sup> The less severe manifestations of the diseases for 18 HCCs led to net overpayments for 16 HCCs and no payment effect for 2 HCCs. The more severe manifestations for two HCCs led to a net underpayment for one HCC and no payment effect for one HCC.

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

## **FEDERAL REQUIREMENTS**

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

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

Federal regulations also state that MA organizations are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes and add that if any related entity, subcontractor, or contractor generates such data, that entity is similarly responsible (42 CFR § 422.504(l)). CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (*Medicare Managed Care Manual* (the Manual) (last rev. Sept. 19, 2014), chap. 7).

CMS requires all submitted diagnosis codes to be documented in the medical record and to be documented as a result of a face-to-face encounter (the Manual, chap. 7, § 40). The diagnosis must be coded according to the International Classification of Diseases (ICD), Clinical Modification, *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines) (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(b)(1) and (c)(2)-(3)). 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' 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), Appendix D).

## **SCAN DID NOT SUBMIT SOME DIAGNOSIS CODES IN ACCORDANCE WITH FEDERAL REQUIREMENTS**

SCAN did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. Specifically, SCAN either submitted some diagnosis codes that were not supported in the medical records or did not submit all of the correct diagnosis codes; both types of errors caused CMS to calculate incorrect risk scores for 71 of the 200 sampled enrollees.<sup>13</sup>

### **Some of the Diagnosis Codes That SCAN Submitted to CMS Were Not Supported in the Medical Records**

The diagnosis codes that SCAN submitted to CMS were not supported in the medical records for 164 of the 1,577 sampled enrollees' HCCs. The 164 HCCs were not validated and should not have been used in the enrollees' risk scores. These errors, which also included more and less severe manifestations of the diseases, caused net overpayments from CMS to SCAN for 71 sampled enrollees.

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

For 143 of the 164 HCCs (59 sampled enrollees), the medical records did not support either the diagnosis code that SCAN submitted or any other diagnosis code that would have validated the HCC. These errors caused overpayments.

For example, for Enrollee A, SCAN submitted a diagnosis code for "Morbid obesity," which maps to the Version 22 model HCC named Morbid Obesity. However, that diagnosis was not supported in the submitted medical records. Our independent medical review contractor stated that "there is no documentation of any condition that will result in assignment of [a diagnosis] code that translates to the assignment of [the HCC for Morbid Obesity]. There is no mention of Morbid obesity in the [medical] records submitted. The [Body Mass Index] value listed is well within the normal range . . . which does not result in [an] HCC."

As shown in Figure 1 on the following page, the diagnosis codes that SCAN submitted to CMS on behalf of Enrollee A mapped to four HCCs, which CMS used to calculate a \$983 monthly payment that it made to SCAN. Because the Morbid Obesity HCC was not validated, the CMS payment should have been based on three HCCs, which would have resulted in a monthly payment of \$907. This error caused a \$912 overpayment for the year.

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<sup>13</sup> There was more than one type of error for some enrollees.

**Figure 1: Overpayment Calculation for Enrollee A, Who Had HCCs That Were Not Validated**

AS SUBMITTED BY SCAN	
Number of HCCs	4
Monthly CMS Payment	\$983
AS AUDITED	
Number of HCCs	3
Monthly CMS Payment	\$907
OVERPAYMENT	
<b>Monthly</b>	<b>\$76</b>
<b>Annually</b>	<b>\$912</b>

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


For 20 of the 164 HCCs (13 sampled enrollees), the medical records did not support the diagnosis codes that SCAN submitted. However, we identified 20 other HCCs (that were supported by other diagnosis codes) for more and less severe manifestations of the diseases. These 20 other HCCs should have been included in the enrollees’ risk scores (instead of the 20 unvalidated HCCs). Including the 20 other HCCs would have reduced the overpayments associated with the 164 unvalidated HCCs in our sample (footnote 12).

For 18 of the 20 submitted HCCs (11 sampled enrollees), the diagnosis codes that SCAN submitted mapped to a more severe manifestation of the HCCs in the related-disease group but were not supported in the medical records. However, there were other diagnosis codes, which mapped to 18 other HCCs for less severe manifestations, that should have been used in the enrollees’ risk scores. These errors led to net overpayments for 16 HCCs and no payment effect for 2 HCCs.

For example, for Enrollee B, the medical records did not support the diagnosis “Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled.” This diagnosis maps to HCCs that are both more severe manifestations of the HCCs in those related-disease groups (Diabetes With Renal or Peripheral Circulatory Manifestation for the Version 12 model and Diabetes With Chronic Complications for the Version 22 model). However, there was support for the diagnosis “Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled,” which maps to HCCs that were both less severe manifestations of the HCCs in those related-disease groups (Diabetes Without Complication for both the Version 12 and 22 models). Accordingly, Enrollee B’s risk score should have been based on the HCCs with the less severe manifestation instead of the HCCs with the more severe manifestation.

As shown in Figure 2, this error caused a \$1,728 overpayment for the year.

**Figure 2: Overpayment Calculation for Enrollee B, Who Had HCCs for a Less Severe Manifestation of a Disease That Should Have Been Used Instead of HCCs for a More Severe Manifestation of That Disease**

<b>AS SUBMITTED BY SCAN</b>		
Number of HCCs (Includes <b>More</b> Severe Manifestation of That Disease)	5	
Monthly CMS Payment	\$770	
<b>AS AUDITED</b>		
Number of HCCs (Includes <b>Less</b> Severe Manifestation of That Disease)	5	
Monthly CMS Payment	\$626	
<b>OVERPAYMENT</b>		
<b>Monthly</b>	<b>\$144</b>	
<b>Annually</b>	<b>\$1,728</b>	


For 2 of the 20 submitted HCCs (2 sampled enrollees), SCAN did not submit diagnosis codes that mapped to the most severe manifestation of the HCCs in the related-disease groups. Instead, SCAN submitted only the diagnosis codes that mapped to the less severe manifestations. If SCAN had submitted the correct diagnosis codes, the more severe HCCs would have been used instead of the less severe HCCs in the risk scores. These errors led to a net underpayment for one HCC and no payment effect for one HCC.

For example, for Enrollee C, SCAN submitted a diagnosis of “Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled,” which maps to the Version 12 model HCC for Diabetes Without Complication (and is a less severe manifestation of the HCCs in that related-disease group).<sup>14</sup> However, our independent medical review contractor found support for the diagnosis “Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled,” which maps to the Version 12 HCC for Diabetes With Neurologic or Other Specified Manifestation (and is a more severe manifestation of the HCCs in that related-disease group). Accordingly, Enrollee C’s risk score should have been based on the HCC with the more severe manifestation instead of the HCC with the less severe manifestation.

<sup>14</sup> For Enrollee C, because of the differences in the two CMS payment models, the usage of the less severe manifestation HCC instead of the more severe manifestation HCC occurred only in the Version 12 payment model. As such, the Version 22 model HCCs are not addressed in this example.

As shown in Figure 3, this error caused a \$1,080 underpayment for the year.

**Figure 3: Underpayment Calculation for Enrollee C, Who Had an HCC for a More Severe Manifestation of a Disease That Should Have Been Used Instead of an HCC for a Less Severe Manifestation of That Disease**

<b>AS SUBMITTED BY SCAN</b>		
HCC for Diabetes Without Complications ( <b>Less</b> Severe Manifestation of That Disease)		
Monthly CMS Payment Attributed to HCC	\$55	
<b>AS AUDITED</b>		
HCC for Diabetes With Neurologic or Other Specified Manifestation ( <b>More</b> Severe Manifestation of That Disease)		
Monthly CMS Payment Attributed to HCC	\$163	
<b>UNDERPAYMENT</b>		
<b>Monthly</b>	<b>\$108</b>	
<b>Annually</b>	<b>\$1,080</b>	

#### *Medical Record With Other Issue That Caused Unsupported Diagnosis Code*

One of the HCCs (one sampled enrollee) was not validated because the medical record diagnosis did not result from a face-to-face encounter with a provider, supplier, physician, or other practitioner. This error caused an overpayment.

#### **Diagnosis Codes That SCAN Should Have Submitted but Did Not Submit to CMS**

SCAN did not submit all of the correct diagnosis codes. Specifically, there were an additional 21 HCCs (10 sampled enrollees) for which the medical records supported diagnosis codes that SCAN should have submitted but did not submit to CMS and that should have been used in the enrollees' risk scores. These errors caused underpayments from CMS to SCAN.

For example, for Enrollee D, SCAN did not submit a diagnosis code for "Congestive Heart Failure, Unspecified." However, our independent medical review contractor, as part of its review of a different HCC, found support for this diagnosis documented in a medical record. This diagnosis code, which SCAN should have submitted but did not submit to CMS, maps to and validates both the Version 12 model HCC for Congestive Heart Failure and the Version 22 model HCC also named Congestive Heart Failure.

As shown in Figure 4 on the following page, this error caused a \$4,236 underpayment.



**Figure 4: Underpayment Calculation for Enrollee D, Who Had HCCs That Were Validated From a Diagnosis Code That SCAN Should Have Submitted but Did Not Submit to CMS**

AS SUBMITTED BY SCAN	
Number of HCCs	2
Monthly CMS Payment	\$478
AS AUDITED	
Number of HCCs	4
Monthly CMS Payment	\$831
UNDERPAYMENT	
<b>Monthly</b>	<b>\$353</b>
<b>Annually</b>	<b>\$4,236</b>

**Summary of Diagnosis Codes Not Submitted in Accordance With Federal Requirements**

Because SCAN did not submit some diagnosis codes in accordance with Federal requirements for the 200 sampled enrollees, their risk scores should not have been based on the 1,577 HCCs. Rather, their risk scores should have been based on the 1,454 validated HCCs. Figure 5 summarizes these differences.

**Figure 5: Number of HCCs Used in Risk Scores Contrasted With Number of HCCs That Should Have Been Used in Risk Scores for the 200 Sampled Enrollees**

BASED ON DIAGNOSIS CODES THAT SCAN SUBMITTED	
Total Number of HCCs	1,577
AS AUDITED	
HCCs That Were Validated	1,413
HCCs Validated by Other Diagnosis Codes	20
Additional HCCs That Were Validated	+ 21
<b>NUMBER OF HCCS THAT SHOULD HAVE BEEN USED</b>	<b>1,454</b>

## **THE POLICIES AND PROCEDURES THAT SCAN USED TO PREVENT, DETECT, AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS COULD BE IMPROVED**

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

SCAN had a compliance program to ensure that it submitted accurate diagnosis codes for use in CMS's risk adjustment program. SCAN had procedures to prevent the submission of incorrect diagnosis codes to CMS, which included provider education on how to document and report accurate diagnosis codes on its claims. SCAN's compliance program also had procedures to detect and correct inaccurate coding. In some cases, after SCAN received claims from its providers, it requested medical records from providers and reviewed the accuracy of the diagnoses that the providers reported on the claims. However, because the risk scores for the 200 sampled enrollees should have been based on 1,454 HCCs instead of 1,577 HCCs, we believe that SCAN's policies and procedures could be improved, which could help reduce the occurrence of similar errors in subsequent periods.

### **SCAN RECEIVED NET OVERPAYMENTS**

SCAN received \$217,634 of net overpayments (consisting of \$237,284 of overpayments and \$19,650 of underpayments) for the 200 sampled enrollees (Appendix C). On the basis of our sample results, we estimated that SCAN received at least \$54,318,154 of net overpayments for 2015.

### **RECOMMENDATIONS**

We recommend that SCAN Health Plan:

- refund to the Federal Government the \$54,318,154 of net overpayments and
- continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

### **SCAN COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, SCAN disagreed with our findings and both of our recommendations, which SCAN stated were "plagued by errors and [were] unsupported." Specifically, SCAN stated that our independent medical review contractor erred in its determinations by not validating certain HCCs. In addition, SCAN stated that our report was seriously flawed because of, among other things, "the errors in the approaches [that we] used to identify the sample of SCAN [enrollees] for audit and for extrapolation." Accordingly, SCAN stated that our monetary recommendation was without merit and should be based solely on

the net overpayments associated with the audited sample items, rather than on the extrapolated results.

We reviewed SCAN's comments and the additional information that it provided and, accordingly, revised our findings and our calculation of net overpayments. In addition, our draft report did not consider the effects of sequestration and therefore did not reduce the net overpayment by 2 percent. After consideration of SCAN's comments and budget sequestration, we reduced the first recommendation from \$66,997,864 to \$54,318,154 for this final report. We also revised the opening phrase of our second recommendation.

A summary of SCAN's comments and our responses follows. SCAN's comments appear as Appendix E. We excluded an attachment (which SCAN identified as Appendix A in its comments) that contained personally identifiable information. We are separately providing SCAN's comments and attachments in their entirety to CMS.

## **SCAN DID NOT AGREE WITH CERTAIN HIERARCHICAL CONDITION CATEGORY DETERMINATIONS**

### **SCAN Comments**

SCAN, in the additional information that it provided, identified 59 HCCs that it believed were supported and that we should reconsider for 30 sampled enrollees.

Specifically, SCAN stated that it had an independent "Certified Coding Specialist" perform a "detailed medical record review" and gave us the results of that review, which contained specific references to previously submitted medical records and which, SCAN believed, validated 56 of the 59 HCCs. The additional information also included 10 previously unsubmitted medical records that SCAN believed validated 18 of the 56 HCCs.

For the remaining three HCCs, SCAN agreed with our independent medical review contractor's determinations that the more severe manifestations of the related-disease groups were not validated; however, SCAN provided additional information that it believed validated three other HCCs with less severe manifestations within the related-disease groups.<sup>15</sup>

### **Office of Inspector General Response**

Our independent medical review contractor reviewed all of the additional information that SCAN provided and validated 28 of the 56 HCCs but did not find support in the medical records to validate the remaining 28 HCCs. Consequently, we reduced the number of unvalidated HCCs

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<sup>15</sup> In its comments on our draft report, SCAN identified 60 HCCs for us to reconsider for 31 sampled enrollees; however, through later correspondence SCAN clarified that 1 of the enrollees that it identified as having a less severe manifestation within the related-disease group did not require our reconsideration. We therefore reconsidered 59 HCCs for 30 sampled enrollees.

from 192 in our draft report to 164 for this final report. With respect to the 3 HCCs with more severe manifestations of the related-disease groups that SCAN agreed were not validated (and which were included in the 164 unvalidated HCCs), our contractor validated 2 HCCs with less severe manifestations within the related-disease groups. Accordingly, we revised our findings and the associated monetary recommendation from \$66,997,864 to \$54,318,154 (which also reflects the budget sequestration reduction).

## **SCAN DID NOT AGREE THAT THE OFFICE OF INSPECTOR GENERAL'S SAMPLING METHODOLOGY WAS EITHER RANDOM OR REPRESENTATIVE OF SCAN'S ENROLLMENT**

### **SCAN Comments**

SCAN stated that our sampling methodology “was neither random nor representative of [SCAN’s] enrolled population.” In this regard, SCAN made two related points:

- SCAN said that we “inappropriately defined” our sampling frame in that we limited it to enrollees “who had at least one HCC.” Specifically, SCAN said that we failed “to consider the [enrollees] for whom SCAN did not [submit] a qualifying diagnosis [to CMS] but who had a condition documented in the medical record.” As a result, according to SCAN, our “sampling methodology excluded [enrollees] for whom SCAN was most likely underpaid” and overstated the overpayment calculations.
- SCAN also stated that the manner in which we selected our sample caused us to overstate our overpayment calculations. SCAN noted that we ranked the enrollees in the sampling frame according to their monthly-weighted-health risk score from lowest to highest and then divided the sampling frame into three strata that each contained approximately the same numbers of enrollees.<sup>16</sup> SCAN stated that our approach, which differed from CMS’s current approach, skewed the “audited sample towards [enrollees] who were more likely to have had overpayments than underpayments.”
  - SCAN added “that [our] sample design was inherently flawed as it created, by design, a stratum [the third stratum] of enrollees with a very large variance of risk scores and associated payments.” According to SCAN, this stratum, which “accounted for the majority of the payments [and HCCs], by design, did not contain enrollees with ‘homogeneous’ risk scores or payments.”
  - SCAN said that we exacerbated our skewed results because we selected 50 percent of the sampled enrollees from this third stratum.

To support these assertions, SCAN provided the results of several analyses, including a test of “whether the average value of a particular variable for the sampled items is statistically different from the average value of the corresponding variable for items in

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<sup>16</sup> We discuss the monthly-weighted-health risk score and the composition of the sampling frame in Appendix B.

the population.” SCAN stated that for all of the enrollees, it tested the payments that CMS made, the risk scores, the health portion of the risk scores, and the number of risk-adjusted payments and “found that the audited sample was **not representative** of [SCAN’s] enrolled population . . . for [the third] stratum.” (Emphasis in original.)

Thus, according to SCAN, our sampling methodology was “fatally flawed and unreliable” and did not support our extrapolation of net overpayments.

### **Office of Inspector General Response**

We designed an appropriate sampling methodology that supports our extrapolation of net overpayments. The following points detail why we disagree with SCAN’s assertions regarding our sampling frame design and sample selection methodology:

- Our objective was to determine whether SCAN submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. The inclusion, in our sampling frame, of enrollees for whom SCAN did not submit a qualifying diagnosis code to CMS was beyond the scope of our audit.

Moreover, SCAN had ample time and procedures in place to identify and submit any qualifying diagnosis codes to CMS. Specifically, CMS allowed SCAN to identify and submit diagnosis codes for its enrollees for 13 months beyond the year in which the medical services were rendered. In some cases, after SCAN received claims from its providers, it requested medical records from providers and reviewed the accuracy of the diagnoses that the providers reported on the claims. SCAN designed these procedures to detect and correct inaccurate coding. Accordingly, SCAN’s medical record review process included steps to identify diagnosis codes that had not been submitted but should have been submitted to CMS. For our audit period, CMS allowed SCAN to make and submit adjustments up until February 2016 for claims for services rendered during the 2014 service year. Accordingly, we believe the scope of our audit—enrollee-years with at least one HCC—is wholly appropriate.

We designed our audit to determine whether the diagnosis codes that SCAN submitted to CMS for use in the risk adjustment program were adequately supported—and thus complied with Federal requirements—in the medical records. Although our approach was generally consistent with the methodology used by CMS in its RADV audits, it did not mirror CMS’s approach in all aspects.

Contrary to SCAN’s assertion, a valid estimate of net overpayments does not need to cover all potential diagnosis codes or underpayments within the audit period. Accordingly, our estimate of net overpayments does not extend to the diagnosis codes that were beyond the scope of review. In accordance with our objective, we properly executed our statistical sampling methodology in that we defined our sampling frame (SCAN enrollees with at least one HCC) and sample unit, randomly selected our sample,

applied relevant criteria to evaluate the sample, and used statistical sampling software to apply the correct formulas to estimate the net overpayments made to SCAN.

- Our sample was representative of the sampling frame in that we selected the items from each stratum using a simple random sample in which each item within each stratum had an equal probability of being selected.
  - Although the third stratum accounted for the majority of the payments, our estimate of net overpayments accounted for the weighting of each stratum.
  - Stratified random sampling designs result in an unbiased estimate of net overpayments, regardless of the number of items selected from each stratum.

Further, we analyzed the variables that SCAN tested (the payments that CMS made, the risk scores, the health portion of the risk scores, and the number of risk-adjusted payments) using the same statistical software that we used to estimate SCAN's total net overpayments. Specifically, we computed two-sided 90-percent confidence intervals for each of these variables using the 200 sampled enrollees. We found that the lower limit estimates were less than the actual values for the sampling frame for the total payments, the risk scores, and the health portion of the risk scores. The lower limit estimate for the number of risk-adjusted payments was slightly higher (by 0.51 percent) than the actual number of risk-adjusted payments in the sampling frame.

Thus, we disagree with SCAN's assertion that our audited sample was not representative of SCAN's enrolled population. To the contrary, we: (1) correctly implemented an appropriate stratified random sampling design and estimation procedure, (2) further found that the 90-percent confidence lower limit estimates computed from the selected stratified random sample were reasonable for all four SCAN-tested variables, and (3) therefore confirmed the robustness and appropriateness of our sampling methodology.

Finally, due to the randomness of the sampling process, the composition of the sample may differ from the composition of the sampling frame. We account for such differences by using the lower limit of a two-sided 90-percent confidence interval as our basis to recommend refunds of net overpayments. Lower limits calculated in this manner are designed to be less than the actual frame totals (i.e., actual overpayments) 95 percent of the time. If the estimated amount is higher than the actual amount, we expect that difference to be small.

Accordingly, we made no changes to our first recommendation in response to SCAN's comments on our sampling methodology.

## **SCAN STATED THAT THE OFFICE OF INSPECTOR GENERAL'S AUDIT METHODOLOGY AND OVERPAYMENT CALCULATIONS DID NOT REFLECT ALL CMS REQUIREMENTS**

### **SCAN Comments**

SCAN stated that our audit methodology and overpayment calculations did not reflect the application of a CMS requirement known as the fee-for-service adjuster (FFSA).

SCAN stated that “CMS [in 2012] concluded that, prior to determining the final payment recovery [overpayment] amount in the RADV audit context, [an FFSA] amount must first be applied as an offset to the preliminary recovery amount.”<sup>17</sup> According to SCAN, CMS identified the need to make this offset because of the process that CMS used to calibrate the monthly payments made to MA organizations. Specifically, SCAN stated that CMS set the monthly payment rates with diagnosis codes listed on Traditional (FFS) Medicare claims, but those diagnoses were “not validated by medical record documentation. This lack of validation causes actuarial inequivalence, i.e., underpayments, when adjusting payments to [MA organizations] based upon auditing diagnosis codes . . . .” Further, SCAN said, “[t]hese underpayments are exacerbated by RADV payment error recoveries.”<sup>18</sup>

SCAN acknowledged “that CMS [in 2018] conducted a study that suggested an FFSA may not be necessary.”<sup>19</sup> SCAN added, though, that this study has been “widely criticized” and that “industry stakeholders emphasized that an FFSA is, in fact, necessary to ensure actuarial equivalence, and that CMS’ technical analysis was flawed in its design . . . .” Moreover, SCAN said that CMS’s “failure to finalize a RADV methodology based on a flawed study is indicative of the fact that CMS still considers an FFSA to be a relevant factor when determining overpayment calculations.”

### **Office of Inspector General Response**

Our audit methodology reflected CMS requirements to properly equate unvalidated HCCs with overpayments.

We used the results of the independent medical review to determine which HCCs were not validated and, in some instances, to identify HCCs that should have been used but were not used in the sampled enrollees’ risk score calculations. We followed the requirements of CMS’s risk adjustment program to determine the payment that CMS should have made for each

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<sup>17</sup> SCAN referenced CMS’s “Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits” (Feb. 24, 2012).

<sup>18</sup> We note that “RADV payment error recoveries” are essentially the same as the extrapolated overpayments identified in this report.

<sup>19</sup> SCAN referenced CMS’s “Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits” (Oct. 26, 2018).

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

SCAN commented that we did not consider actuarial equivalence in our overpayment calculations. CMS, not the Office of Inspector General (OIG), is responsible for making operational and program payment determinations for the MA program, including the application of any FFSA requirements. Moreover, CMS has not issued any requirements that compel us to reduce our net overpayment calculations.<sup>20</sup> If CMS deems it appropriate to apply an FFSA, it will adjust our overpayment finding by whatever amount it determines necessary. Thus, we believe that the steps that we followed for this audit provided an accurate estimate of net overpayments.<sup>21</sup>

## **SCAN STATED THAT THE OFFICE OF INSPECTOR GENERAL SHOULD NOT HAVE EXTRAPOLATED ITS OVERPAYMENTS**

### **SCAN Comments**

SCAN stated that we should not have extrapolated the net overpayments for the sampled enrollees to the sampling frame. Specifically, SCAN stated that the percentage of net overpayments that we identified for the sampled enrollees (5.66 percent) “does not warrant extrapolation.”<sup>22</sup> In this regard, SCAN stated that both the number of HCCs in error and the associated net overpayments were “below any likely threshold that would support extrapolation.” SCAN said that instead, it should refund only the total net overpayments identified for the sampled enrollees. To support its position, SCAN offered the following assertions:

- SCAN stated that we based our audit methodology on the assumption that SCAN should “have a zero percent error rate.” SCAN said this assumption was “not an appropriate or a realistic benchmark” and that it stands in contrast to the expectations that CMS has of its medical record reviewers. Specifically, SCAN stated that CMS’s “Inter-Rater Reliability Guidelines, which address the targeted accuracy of coding by medical record reviewers, has a required accuracy rate” of 95 percent. “Therefore, even in guidelines

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<sup>20</sup> In 2018, CMS proposed “not to include an FFS Adjuster in any final RADV payment error methodology” (Proposed Rule at 83 Fed. Reg. 54982, 55041.)

<sup>21</sup> 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.

<sup>22</sup> SCAN calculated the percentage of net overpayments (5.66 percent) by dividing the net overpayments that it identified for the sampled enrollees by the total payments that CMS made for these enrollees. However, using SCAN’s formula with our updated net overpayment calculations, we calculated a rate of 6.70 percent (\$217,634 of net overpayments for the sampled enrollees divided by \$3,250,217 of total payments).



meant to direct reviews performed by certified coders, CMS does not target a zero-error benchmark.”

- SCAN stated that “CMS previously concluded that, prior to determining the final payment recovery amount in the RADV audit context, [an FFSA] must first be applied as an offset to the preliminary recovery amount” (footnote 17). To this point, SCAN said that “[a]bsent CMS providing an actual FFSA, SCAN believes that the Improper Payments Rate is an appropriate proxy for the FFSA.”<sup>23</sup> Accordingly, SCAN said that because our extrapolated calculation of SCAN’s actual point estimate rate of 7.21 percent is “well below” the 12.7-percent improper payments rate for 2014 FFS (Traditional Medicare) payments, an extrapolation is not warranted.<sup>24</sup>
- SCAN said that the percentage of HCCs that were not validated for the sampled enrollees (6.97 percent)<sup>25</sup> was “substantially below” the percentage of diagnosis codes that were not validated (27 percent) on CMS’s Comprehensive Error Rate Testing (CERT) report. According to SCAN, “[t]he CERT program and the 2014 Improper Payments report [provided] information on the number of [Medicare Part A inpatient and Part B] claims” that contained diagnosis code errors. Moreover, SCAN stated that CMS used these “diagnosis codes for [MA] risk adjustment payment purposes.” Thus, according to SCAN, the CERT report does not support our extrapolation of net overpayments.
- SCAN also noted that the individual HCCs that CMS included in its FFSA study generally had higher percentages of error than the percentages of error that we identified for the same HCCs for the sampled enrollees.<sup>26</sup> For example, SCAN demonstrated that CMS’s study found 30.1 percent of the Congestive Heart Failure HCCs to be in error while our audit found 11.5 percent of the same HCCs to be in error. Moreover, SCAN identified 12 HCCs that it said represented over 80 percent of the HCCs for the sampled enrollees and said that we identified error rates for 10 of those 12 HCCs that were lower than the

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<sup>23</sup> CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare FFS program. As a part of that program, CMS calculated a national improper payment rate.

<sup>24</sup> SCAN calculated the point estimate rate (7.21 percent) by dividing the point estimate that we calculated and identified in our draft report by the sampling frame dollar value. However, using SCAN’s formula and the point estimate calculated for this final report, we calculated 6.26 percent (\$79,339,853 divided by \$1,267,300,812).

<sup>25</sup> SCAN calculated the percentage of HCCs that were not validated (6.97 percent) by dividing the number of HCCs not validated by the total number of reviewed HCCs for the sampled enrollees. This formula was based on the premise that the sampled enrollees had 110 unvalidated HCCs (which did not include errors associated with more and less severe manifestations of the diseases). We therefore calculated the percentage of unvalidated HCCs to be 10.40 percent (all 164 unvalidated HCCs divided by 1,577 reviewed HCCs).

<sup>26</sup> SCAN noted that CMS’s 2018 FFSA study (footnote 19) reviewed medical records for claims that were included in the 2008 CERT program. SCAN also stated that the study provided information to determine the percentage of errors by HCC.

error rates that CMS identified in its study. Accordingly, SCAN stated that this analysis “shows that extrapolation is not appropriate.”

In summary, SCAN said that “the net total potential overpayments . . . that may be due [to] CMS in connection with the audited sample are at most [\$186,188].”<sup>27</sup>

### **Office of Inspector General Response**

We disagree with SCAN that, for the sampled enrollees, there were not enough errors to justify our extrapolation of net overpayments to the sampling frame. SCAN’s statements about the percentage of net overpayments in error and the comparisons it drew to support its assertions are not relevant to our decision to extrapolate. We made that decision based on the number of errors that we identified in the enrollees’ risk scores; this decision is in accordance with long-established OIG statistical sampling methodology. In this regard, we believe that the extrapolated net overpayments, shown at the lower limit of a two-sided 90-percent confidence interval, provide a reasonably conservative estimate of the total amount overpaid to SCAN for the enrollee-years and time period covered in our sampling frame. This approach, which is routinely used by OIG for recovery calculations,<sup>28</sup> results in a lower limit (the estimated overpayment amount to refund) that is less than the actual overpayment amount 95 percent of the time. Thus, SCAN’s comparisons do not compel us to deviate from our sampling methodology and we continue to believe that our audit results warrant an extrapolation of net overpayments to the sampling frame.

We properly executed our statistical sampling methodology in that we defined our sampling frame (SCAN enrollees with at least one HCC) and sample unit, randomly selected our sample, applied relevant criteria to evaluate the sample, and used statistical sampling software to apply the correct formulas (based on the number of errors and the payments in error) to estimate the net overpayments made to SCAN.

Accordingly, we made no additional changes to our first recommendation.

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<sup>27</sup> SCAN, through later correspondence, clarified that it had identified \$186,188 of net overpayments (instead of \$188,169 as stated in its comments).

<sup>28</sup> For example, HHS has used the two-sided 90-percent confidence level when calculating recoveries in both the Administration for Child and Families and Medicaid programs. See, e.g., *New York State Department of Social Services*, DAB No. 1358, 13 (1992); *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, e.g., *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, 17-18 (E.D.N.Y. 2012).

## SCAN DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S ASSESSMENT OF ITS COMPLIANCE PROGRAM

### SCAN Comments

In its comments on our second recommendation, SCAN stated that our assessment of its compliance program was unfounded and stated that it disagreed “with [our] boilerplate declaration that SCAN’s policies and procedures ‘were not always effective.’” Specifically, SCAN said that our assessment is a standard finding in our audit reports and is inconsistent with the results of this audit because “most of the audited HCCs were, in fact, supported and validated” by our independent medical review contractor. To this point, SCAN said that our report “evidences the general effectiveness of SCAN’s compliance program policies and procedures.” Moreover, SCAN stated that if we took the “position that any errors, regardless of how many, evidence a failure in the effectiveness of compliance program policies and procedures, that position is impractical . . . . [A]s [SCAN believes], CMS itself does not target a zero-error benchmark.”

SCAN said that it routinely evaluates “its compliance program policies and procedures to identify appropriate improvement opportunities consistent with CMS requirements and expectations.” To this point, SCAN identified some of the “key process improvements” that it said it implemented to its policies and procedures between 2014 and 2019. SCAN also stated that it agreed with our statement “that an effective compliance program should be subject to periodic reviews for appropriate enhancements.” To demonstrate its commitment to this position, SCAN included the following information related to its compliance program:

- a third-party independent assessment of its compliance program,
- a description of how its compliance program adheres to Federal requirements,
- a description of the comprehensive coding accuracy training programs for providers and SCAN’s staff,
- a list of training and education topics that SCAN covers with its providers and the credentials that SCAN requires of staff performing medical record reviews, and
- a description of monitoring and auditing activities that SCAN performs of its contracted providers to assess and measure the level of coding accuracy.

Accordingly, SCAN stated that it “has effective policies and procedures . . . to prevent, detect, and correct non-compliance with CMS program requirements.”

## Office of Inspector General Response

We acknowledge that SCAN has taken steps in recent years to improve its policies and procedures. However, based on the materiality of our findings—overpayments of at least \$54.3 million—we do not agree with SCAN that our assessment of its compliance program was unfounded.

Federal regulations at 42 CFR § 422.503(b) require MA organizations like SCAN to establish and implement an effective system for routine monitoring and identification of compliance risks. This regulation further explains that a compliance system should consider both internal monitoring and external audits. Although we have not reviewed the effectiveness of the improvements that SCAN said it has made to its policies and procedures, we note SCAN's statement that it made these changes to ensure accuracy of its risk adjustment submissions to CMS. We also concluded that SCAN could make improvements. Specifically, the percentage of HCCs for the sampled enrollees in error (6.97 percent according to SCAN and 10.40 percent according to our revised findings (footnote 25)) and the number of sampled enrollees with at least 1 incorrect HCC included in their risk score (71 of 200 or 35.5 percent (Appendix C)) demonstrates that SCAN's compliance program could be improved. Thus, SCAN should consider the results of this audit to reduce the occurrence of similar errors in subsequent periods and to identify appropriate improvement opportunities consistent with CMS requirements and expectations.

With respect to SCAN's statements about its policies and procedures and our audit findings, we changed our description of SCAN's policies and procedures for preventing, detecting, and correcting noncompliance with CMS's program requirements from "not always effective" to "could be improved." Further, we have revised our second recommendation for SCAN to "continue to improve" its policies and procedures.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

CMS paid SCAN approximately \$1.9 billion to provide coverage to approximately 179,000 enrollees in California for the 2015 payment year.<sup>29</sup> We identified a sampling frame of 93,437 enrollees who had at least 1 HCC in their risk scores; SCAN received \$1,267,300,812 in payments from CMS for these enrollees for 2015. We selected for audit a stratified random sample of 200 enrollees on whose behalf CMS made payments totaling \$3,250,217 to SCAN.

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

We performed audit work from February 2017 to August 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 interviewed SCAN officials to gain an understanding of: (1) the policies and procedures that SCAN followed to submit diagnosis codes to CMS for use in the risk adjustment program, and (2) SCAN's monitoring of those submissions to prevent, detect, and correct noncompliance with Federal requirements.
- We reviewed SCAN's policies and procedures to understand how SCAN submitted diagnosis codes to CMS.
- We developed our sampling frame using data from CMS systems. Our sampling frame consisted of enrollees who had at least 1 HCC in their risk scores. To create this frame, and as explained further in Appendix B, we used data from the CMS:
  - Risk Adjustment Processing System, which MA organizations use to submit diagnosis codes to CMS;
  - Risk Adjustment System, which identifies the HCCs that CMS factors into each enrollee's risk score calculation; and

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<sup>29</sup> Payment year 2015 data were the most current data available when we started our audit in 2017.

- Medicare Advantage Prescription Drug System, which identifies the Medicare payments, before applying the budget sequestration reduction, made to MA organizations.
- We selected a stratified random sample of 200 enrollees from the sampling frame (Appendix B).
- We obtained 767 medical records from SCAN as support for the 1,577 HCCs associated with the 200 sampled enrollees.
- We used an independent medical review contractor to determine whether the diagnosis codes in the medical records validated the 1,577 HCCs.
- The independent medical review contractor’s coding review of the 767 medical records followed a specific process to determine whether there was support for a diagnosis code and associated HCC. Under the process:
  - If the first senior coder found support for the diagnosis code on the medical record, the HCC was considered validated.
  - If the first senior coder did not find support on the medical record, a second senior coder performed a separate review of the same medical record and then:
    - If the second senior coder also did not find support, the HCC was considered 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.
  - For any diagnosis code that had not been previously submitted, the HCC was considered validated as an additional HCC if either: (1) both senior coders found support in the medical record or (2) one senior coder plus a physician did so.
- We reviewed available data from CMS’s systems for the sampled enrollees to determine whether CMS’s payments had been canceled or adjusted.
- We used the results of the independent medical review to calculate overpayments or underpayments (if any) for each enrollee. Specifically, we calculated:
  - a revised risk score in accordance with CMS’s risk adjustment program and

- the Medicare payment, before applying the budget sequestration reduction, that CMS should have made for each enrollee.
- We used the overpayments and underpayments identified for each enrollee to estimate net overpayments.
- We provided the results of our audit to SCAN officials on June 9, 2020, and provided updated results on October 19, 2021.

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

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

Our sampling frame included only SCAN enrollees who: (1) were continuously enrolled under contract number H5425 throughout all of the 2014 service year and January 2015 and (2) had at least one HCC in their 2015 payment year risk scores. Because CMS adjusts its risk-adjusted payments in the calendar year subsequent to when a beneficiary is diagnosed, we restricted our population to individuals who were enrolled—and thus diagnosed—at SCAN during the 2014 service year.

Our sampling frame did not include enrollees who were:

- classified as having hospice or end-stage renal disease (ESRD) status at any time during the 2014 service year through January 2015 or
- not continuously enrolled in Medicare Part B coverage during the 2014 service year.

There were 93,437 enrollees in our sampling frame.

### SAMPLE UNIT

The sample unit was one enrollee.

### SAMPLE DESIGN

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

$$\begin{aligned} & \text{[health-related portion of the enrollee's risk score]} \\ & \quad \times \\ & \text{[number of monthly 2015 capitation payments affected by the enrollee's risk score]}^{30} \end{aligned}$$

We classified the enrollees according to the magnitude of the risk-adjusted payments made on their behalf. A higher monthly-weighted-health risk score signified a higher amount of risk-adjusted payments on behalf of that enrollee for the year. We then ranked the 93,437 enrollees according to their monthly-weighted-health risk score from lowest to highest and separated them into 3 strata. The specific strata are shown in Table 1 on the following page.

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<sup>30</sup> We excluded from this calculation months in 2015 for which beneficiaries were classified as having hospice or ESRD status.



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

<b>Stratum</b>	<b>Sample Size</b>	<b>Number of Enrollees</b>	<b>Monthly-Weighted-Health Risk Score Range</b>	<b>Sampling Frame Dollar Total</b>
1	50	31,181	0.081–6.589	\$215,086,354
2	50	31,111	6.590–14.775	355,212,834
3	100	31,145	14.784–177.180	697,001,624
<b>Total</b>	<b>200</b>	<b>93,437</b>		<b>\$1,267,300,812</b>

**SOURCE OF THE RANDOM NUMBERS**

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

**METHOD FOR SELECTING SAMPLE ITEMS**

We consecutively numbered the sample units within each stratum. After generating the random numbers, we selected the corresponding sample units in each stratum.

**ESTIMATION METHODOLOGY**

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

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Results**

<b>Stratum</b>	<b>Frame Size</b>	<b>Sampling Frame Dollar Total</b>	<b>Sample Size</b>	<b>Dollar Value of Sample</b>	<b>Number of Sampled Enrollees With Incorrect Diagnosis Codes</b>	<b>Dollar Value of Net Overpayments for Sampled Enrollees</b>
1	31,181	\$215,086,354	50	\$347,496	12	\$(2,476)
2	31,111	355,212,834	50	561,514	18	39,677
3	31,145	697,001,624	100	2,341,207	41	180,433
<b>Total</b>	<b>93,437</b>	<b>\$1,267,300,812</b>	<b>200</b>	<b>\$3,250,217</b>	<b>71</b>	<b>\$217,634</b>

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

Point estimate	\$79,339,853
Lower limit	54,318,154
Upper limit	104,361,552

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

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

Any entity seeking to contract as an MA organization must . . . .

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

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

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

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

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

## APPENDIX E: SCAN COMMENTS



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December 23, 2020

Patrick J. Cogley  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of the Inspector General  
Office of Audit Services, Region VII  
601 East 12th Street, Room 0429  
Kansas City, MO 64106

Re: Draft Report Number: A-07-17-01169  
Medicare Advantage Compliance Audit of Diagnosis Codes That SCAN Health Plan  
(Contract H5425) Submitted to CMS

Dear Mr. Cogley:

SCAN Health Plan (hereafter, "SCAN") is in receipt of the above-referenced Department of Health and Human Services Office of the Inspector General ("OIG") draft audit report (the "Draft Report") related to diagnosis submissions to the Centers for Medicare and Medicaid Services ("CMS") for risk adjustment payment purposes under Medicare Advantage Contract H5425 (the "Contract") for payment year 2015. We appreciate the extension of time given to us by the OIG to respond to the Draft Report's preliminary findings and recommendations and the additional information provided by the OIG regarding the sampling methodology used in connection with this audit.

### **EXECUTIVE SUMMARY**

SCAN disagrees with the Draft Report's preliminary findings and recommendations, which are plagued by errors and are unsupported.

As an initial matter, the OIG's independent medical review contractor erred in determining that the medical records submitted by SCAN in connection with the OIG's audit of the Contract did not validate certain audited hierarchical condition categories ("HCCs") and, therefore, wrongly invalidated those HCCs. Based on SCAN's review, the medical record documentation provided by SCAN fully supports basing the sampled enrollees' risk scores on 1490 HCCs and not 1,434 as indicated in the Draft Report.

SCAN also does not concur with the OIG's preliminary recommendation that SCAN should return \$66,997,864 in net overpayments to CMS. This recommendation is without merit for several reasons, including that:

- Zero errors is not an appropriate benchmark for extrapolation, and SCAN's sample error rate is below any reasonable proxy for an error rate that would support extrapolation;
- The Draft Report's methodology and calculations do not reflect the applicable CMS requirements for the 2015 payment year; and
- Contrary to statements in the Draft Report, the audited sample was neither random nor representative of the Contract's enrolled population and, therefore, was not appropriate for extrapolation. Thus, the net total potential overpayments under the Contract that may be due CMS in connection with the audited sample are at most \$188,169, in stark contrast to the Draft Report's unsupported recommended overpayment recovery.

The Draft Report's comments regarding SCAN's compliance program are also unfounded, and SCAN disagrees with the OIG's boilerplate declaration that SCAN's policies and procedures "were not always effective." This is a standard finding in audit reports issued by the OIG and, in SCAN's case, the finding is inconsistent with the Draft Report's acknowledgement that most of the audited HCCs were, in fact, supported and validated.<sup>1</sup> If anything, the Draft Report's findings confirm SCAN's commitment to compliance with its obligations as a Medicare Advantage organization ("MAO"), and confirm that SCAN has effective policies and procedures (detailed more fully in Section III below) to prevent, detect, and correct non-compliance with CMS program requirements.

For these reasons, and as explained more fully below, SCAN submits that the OIG should make substantial changes to the Draft Report's preliminary findings and recommendations before a final audit report is issued. The errors by the OIG's independent medical review contractor, as well as the errors in the approaches used to identify the sample of SCAN members for audit and for extrapolation, among other things, resulted in a Draft Report that is seriously flawed.

## **I. The Draft Report's Findings Are Erroneous And Unsupported**

### **A. Introduction**

The stated objective of the audit was to determine whether SCAN submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with federal requirements. As noted above, the Draft Report found that most of the diagnosis codes submitted by SCAN were supported in the enrollees' medical records. Moreover, with respect to "some" diagnosis codes that the Draft Report claims were not submitted in accordance with federal requirements, the Draft Report found that the medical record documentation submitted by SCAN supported 26 other HCCs for more or less severe disease manifestations as well as 23 additional HCCs that SCAN could have but did not submit to CMS, i.e., underpayments. Furthermore, SCAN's review of the allegedly unsupported HCCs shows that the OIG's independent medical review contractor

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<sup>1</sup> Per the Draft Report, "**most** of the diagnosis codes that SCAN submitted were supported in the medical records". Draft Report at Report in Brief (emphasis added).

made numerous errors in invalidating audited HCCs. Thus, the Draft Report's findings actually demonstrate SCAN's adherence to CMS risk adjustment requirements.

B. The Draft Report's Preliminary Finding that 192 HCCs Were Not Supported Is Erroneous

SCAN had a detailed medical record review conducted of the 200 sampled enrollees. This review was performed by a Certified Coding Specialist who independently reviewed the medical records submitted by SCAN to the OIG, and validated results with a second Certified Coding Specialist for a number of records. This review identified support (either direct coding support or clinical support as further detailed for each HCC in the documentation submitted with this response) for 56 of the HCCs the OIG's independent medical review contractor invalidated. Similar support was identified for four additional HCCs in the same hierarchy as an HCC that the OIG's contractor invalidated.<sup>2</sup>

SCAN has provided, at Appendix A, a list of the invalidated HCCs together with a description of and citation to the medical record that supports the HCC.

**II. The OIG's Sample Is Not Appropriate For Extrapolation**

SCAN does not concur with the Draft Report's recommendation that any alleged overpayments should be extrapolated. SCAN also objects to the Draft Report's sampling methodology, which resulted in an audit sample that was neither random nor representative of the Contract's enrolled population.

A. The Draft Report's Audit Results and Payment Error Calculation Are Flawed and Overstate the Size of the Potential Overpayment

Adjusting the Draft Report's net overpayment calculation to account for the errors made by the OIG's independent medical record contractor, the potential overpayment decreases from \$258,197 to \$188,169, as shown in Table 1.

**Table 1: Revised Sample Overpayment**

The OIG Net Overpayments	\$ 258,197
<i>LESS: Appealed HCCs</i>	\$ (70,028)
<b>Total</b>	<b>\$ 188,169</b>

<sup>2</sup> One of these four additional HCCs relates to "Enrollee A" who is discussed on page 7 of the Draft Report. The medical record documentation submitted by SCAN to the OIG supported ICD-9-CM 515, Post-Inflammatory Pulmonary Fibrosis, which maps to HCC 112.

This revised amount reflects a 5.66% overpayment rate (i.e., \$188,169/\$3,325,627) for the audited sample, which, as discussed below, is not appropriate to extrapolate.

**B. Extrapolation of the Sample Error Rate Is Not Appropriate**

Extrapolation is not appropriate here for the reasons discussed below.

**1. Zero errors is not an appropriate or realistic benchmark**

The Draft Report assumes that SCAN should have a zero percent error rate. This is not an appropriate or realistic benchmark for a number of reasons including but not limited to:

- CMS has acknowledged there are diagnosis coding errors in the Medicare fee-for-service (“FFS”) data<sup>3</sup> upon which the HCC model is calibrated. The imbalance between applying a zero error rate standard to risk adjustment data validation (“RADV”) audits of MAOs results in MA payments not being actuarially equivalent to the costs incurred in Medicare fee-for-service in violation of 42 U.S.C. § 1395w-23(a)(1)(C)(i).
- CMS’ Inter-Rater Reliability Guidelines, which address the targeted accuracy of coding by medical record reviewers, has a required accuracy rate of 95%.<sup>4</sup> Therefore, even in guidelines meant to direct reviews performed by certified coders, CMS does not target a zero-error benchmark.

**2. The OIG failed to apply a FFS Adjuster before extrapolation**

CMS previously concluded that, prior to determining the final payment recovery amount in the RADV audit context, a Fee-for-Service Adjuster (“FFSA”) amount must first be applied as an offset to the preliminary recovery amount.<sup>5</sup> CMS identified the need for an FFSA since the CMS-HCC Risk Adjustment model is calibrated on Medicare FFS diagnoses that are not validated by medical record documentation. This lack of validation causes actuarial inequivalence, i.e., underpayments, when adjusting payments to MAOs based upon auditing diagnosis codes, which

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<sup>3</sup> In the Medicare Fee-For-Service 2014 Improper Payments Report, CMS estimated 87.3% of Medicare FFS dollars were paid correctly. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Medicare-FeeForService-2014-Improper-Payments-Report>. CMS therefore acknowledged that there was a 12.7% Improper Payment Rate in 2014. The report also provided detail on the diagnosis code errors that were part of the improper payments and included in the Comprehensive Error Rate Testing (“CERT”).

<sup>4</sup> 82 Fed. Reg. 51052, 51077 (Nov. 2, 2017).

<sup>5</sup> Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Feb. 24, 2012). A copy is included as Attachment 1.



are the focus of RADV audits. These underpayments are exacerbated by RADV payment error recoveries.

Under CMS' 2012 RADV methodology, the weighted enrollee annual payment error will be summed across all enrollees in the sample to determine an estimated payment error for the MA contract. This is known as the "point estimate." If the point estimate is above zero, the payment recovery amount will be determined as follows:

First, a preliminary payment recovery amount for the contract will be set at the lower bound of the 99 percent [confidence interval] for the contract's point estimate. Second, to determine the final payment recovery amount, CMS will apply [an FFSA] amount as an offset to the preliminary recovery amount. If the [FFSA] amount is greater than the preliminary recovery amount, the final recovery amount is equal to zero.<sup>6</sup>

SCAN acknowledges that CMS subsequently conducted a study that suggested an FFSA may not be necessary.<sup>7</sup> However, that study has been widely criticized. For example, industry stakeholders emphasized that an FFSA is, in fact, necessary to ensure actuarial equivalence, and that CMS' technical analysis was flawed in its design, including inconsistently normalizing their model in evaluating the FFSA and underestimating the level of diagnosis coding errors present in FFS claims data.<sup>8</sup> The CMS study methodology was further criticized as inconsistent with standard risk adjustment methodology, relying on assumptions that are not reflective of actual diagnosis coding error rates or of the underlying claims distribution in the FFS and MA populations, and appearing to be designed to minimize differences in payment under the two models.<sup>9</sup>

Even after conducting the study, CMS indicated that extrapolation may only be appropriate to sub-cohorts (e.g., enrollees for whom a particular HCC or one of a related set of HCCs, such as the three diabetes HCCs, was reported).<sup>10</sup> The Draft Report's proposed extrapolation is not limited to a sub-cohort.

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<sup>6</sup> *Id.* at p. 4.

<sup>7</sup> Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits (Oct. 26, 2018), available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/FFS-Adjuster-Executive-Summary.pdf>.

<sup>8</sup> E.g., Rob Pipich, *Medicare Advantage RADV FFS Adjuster: White Paper*, MILLIMAN (Aug. 23, 2019) (available at [https://www.milliman.com/-/media/milliman/importedfiles/ektron/medicare\\_advantage\\_radv\\_ffs\\_adjuster\\_8-23-2019.ashx](https://www.milliman.com/-/media/milliman/importedfiles/ektron/medicare_advantage_radv_ffs_adjuster_8-23-2019.ashx)).

<sup>9</sup> Sean Creighton, *The FFS Adjuster Matters for Accurate Medicare Advantage Payment: An Examination of the Methodology and Evidence Behind a Regulatory Proposal to Eliminate the Adjuster*, RISE HEALTH (Dec. 11, 2019) (available at [https://www.risehealth.org/insights-articles/the-ffs-adjuster-matters-for-accurate-medicare-advantage-payment-an-examination-of-the-methodology-and-evidence-behind-a-regulatory-proposal-to-eliminate-the-adjuster/#\\_ftn1](https://www.risehealth.org/insights-articles/the-ffs-adjuster-matters-for-accurate-medicare-advantage-payment-an-examination-of-the-methodology-and-evidence-behind-a-regulatory-proposal-to-eliminate-the-adjuster/#_ftn1)).

<sup>10</sup> 83 Fed. Reg. 54982, 55039 (Nov. 1, 2018).

CMS has yet to make a final decision on extrapolation.<sup>11</sup> CMS' failure to finalize a RADV methodology based on its flawed study is indicative of the fact that CMS still considers an FFSA to be a relevant factor when determining overpayment calculations.

**3. SCAN's sample error rate is below any likely threshold that would support extrapolation**

SCAN's error rate of 5.66% does not warrant extrapolation. Using any reasonable error rate as a proxy, including those described below, SCAN's error rate is below any likely threshold that would support extrapolation.

*a. SCAN's sample error rate is below the Improper Payments Rate*

As referenced *supra* in footnote 3 above, CMS acknowledged a 12.7% Improper Payments Rate for 2014 FFS Payments. Absent CMS providing an actual FFSA, SCAN believes that the Improper Payments Rate is an appropriate proxy for the FFSA. CMS' FFSA methodology applies the lower bound of a 99% confidence interval to the extrapolated overpayment point estimate and compares the lower bound to the FFSA to determine if extrapolation is appropriate. Here, the Draft Report's extrapolated calculation of SCAN's actual point estimate of 7.21% is well below the 12.7% Improper Payments Rate. Therefore, by definition, the lower bound of a 99% confidence interval is also below the Improper Payments Rate with the result that no extrapolation is warranted.<sup>12</sup>

*b. SCAN's sample error rate is below the CERT Report Diagnosis Code Error Rate*

The Improper Payments Rate is developed as part of the CERT program. The CERT program and the 2014 Improper Payments report also provide information on the number of claims reviewed that specifically contained diagnosis code errors. The report provides this information separately for Part A inpatient and Part B claims, both of which are used in identifying diagnosis codes for Medicare Advantage risk adjustment payment purposes. The combined error rate for the claims sampled in these two areas (55,337 claims in total) was 27%.

The Draft Report found that 1,411 of the 1,577 audited HCCs were validated, and SCAN has identified an additional 56 sample items that were fully supported resulting in an error rate of 6.97% for the sample. This rate is substantially below the error rate from the 2014 CERT report for similar claim types with diagnosis errors. Therefore, the CERT report does not support extrapolation of SCAN's error rate.

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<sup>11</sup> 84 Fed. Reg. 15680, 15683 (April 16, 2019) (CMS did not finalize its RADV proposal in the final rule).

<sup>12</sup> The Draft Report's extrapolation calculation used a 90% confidence interval instead of a 99% confidence interval, which resulted in a rate of 5.18%, which is also below the Improper Payments Rate. Moreover, adjusting the Draft Report's sample overpayment for the wrongly invalidated HCCs results in these extrapolated rates being even lower.

c. A comparison of SCAN's sample error rate to the FFS Adjuster Study Error Rate by HCC and Claim shows that extrapolation is not appropriate

CMS issued a Technical Appendix as part of its evaluation of the FFSA.<sup>13</sup> The Technical Appendix contained additional detail on the review of medical records that CMS performed on claims that had been part of the 2008 CERT review. While the study contained numerous flaws that have been identified by MAOs and the industry,<sup>14</sup> it provides counts of the number of diagnosis code errors and CMS' estimate of how this translated into error rates by HCC.

Table 3 provides a comparison of the HCC level error rates from SCAN's sample and the 2008 CERT data used in the FFSA study for any HCCs that had 20 or more observations in SCAN's sample.

**Table 3: Comparing SCAN Sample to FFSA Study**

HCC Description	HCC	SCAN			CY2008 CERT		
		HCC Count	HCC w/ Errors	Error Rate	HCC Count	HCC w/ Errors	Error Rate
Renal Failure	131	95	1	1.1%	604	220	36.4%
Vascular Disease	105	84	4	4.8%	444	147	33.1%
Polyneuropathy	71	65	3	4.6%	81	38	46.9%
Major Depressive, Bipolar, and Paranoid Dis	55	58	3	5.2%	448	232	51.8%
Chronic Obstructive Pulmonary Disease	108	57	3	5.3%	484	96	19.8%
Congestive Heart Failure	80	52	6	11.5%	519	156	30.1%
Specified Heart Arrhythmias	92	51	3	5.9%	900	377	41.9%
Diabetes with Renal or Peripheral Circulato	15	46	1	2.2%	104	17	16.3%
Breast, Prostate, Colorectal and Other Canc	10	27	12	44.4%	790	346	43.8%
Drug/Alcohol Dependence	52	25	2	8.0%	16	7	43.8%
Diabetes with Neurologic or Other Specifie	16	23	5	21.7%	123	25	20.3%
Rheumatoid Arthritis and Inflammatory Cor	38	20	2	10.0%	219	58	26.5%

As shown in Table 3, SCAN's error rate is well below the CERT data error rate for 10 of the 12 HCCs included. For the other two HCCs, SCAN's error rate was higher than the CERT error rate by a very small margin: HCC 10 is 0.6% higher than the CERT error rate and HCC 16 is 1.4% higher.

Importantly, the 12 HCCs shown in Table 3 account for over 80% of the HCC observations in SCAN's sample.

C. The OIG's Sampling Frame, Sample Selection, and Weighting Are Not Representative of the Contract's Enrolled Population and Overestimates the Potential Overpayment by Excluding Members for Whom SCAN Was Most Likely Underpaid

<sup>13</sup> FEE FOR SERVICE ADJUSTER AND PAYMENT RECOVERY FOR CONTRACT LEVEL RISK ADJUSTMENT DATA VALIDATION AUDITS, CMS (Oct. 26, 2018) (*available at* <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Resources>); Technical Appendix (*available at* <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/FFS-Adjuster-Technical-Appendix.pdf>).

<sup>14</sup> See *supra* n. 8 & n. 9.

## **1. The sampling frame was inappropriately defined and therefore does not support extrapolation**

According to the Draft Report,<sup>15</sup> the sampling frame used in the audit of the Contract was limited to SCAN enrollees who:

- were continuously enrolled under the Contract throughout all of the 2014 service year and January 2015;
- had at least one HCC reported in their 2015 payment risk scores;
- were not classified as having hospice or end-stage renal disease status at any time during the 2014 service year through January 2015; and
- were continuously enrolled in Medicare Part B coverage during the 2014 service year.

Limiting the sampling frame to members who had at least one HCC in their 2015 payment risk score fails to consider the members for whom SCAN did not report a qualifying diagnosis but who had a condition documented in the medical record.<sup>16</sup> By excluding members who SCAN did not report to have an HCC, the OIG's sampling methodology excluded members for whom SCAN was most likely underpaid. This limitation in the audited sample is inconsistent with the Draft Report's recognition of the importance of potential underpayments in calculating the error rates in the OIG's analysis. In addition to the members included in the audited sample, potential underpayments also existed among the Contract's enrolled population, and are the only type of diagnosis code payment error for those members for whom no HCCs were reported.

In addition, failing to include in the sampling frame members for whom SCAN did not report an HCC and who did not have a condition documented in the medical record that would map to an HCC, is also flawed as it overstates the potential overpayment. That is, the sampling frame fails to account for those members who SCAN correctly reported as without an HCC-mapping condition.

Because members without any reported HCCs were excluded from the audited sample (including those members with related underpayments), the Draft Report's payment error rate incorrectly over represents overpayments and is therefore an inappropriate basis for extrapolation.

## **2. The resulting sample selection led to an overstated payment error rate**

In order to select a sample, the OIG isolated members who met the sampling criteria described above, and then stratified the sampled member population based on a two-step

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<sup>15</sup> Draft Report at p. 16.

<sup>16</sup> The likelihood of this occurrence is confirmed by the Draft Report, which identified 23 HCCs among the audited sample for which the medical records supported diagnosis codes that SCAN could have submitted to CMS for risk adjustment payment purposes, but did not submit.

process. In step one, the OIG calculated a value referred to as the “monthly-weighted-health risk score.” The OIG classified the members according to the magnitude of the risk-adjusted payments made for them by CMS. In step two, the OIG ranked the members in the sample according to their monthly-weighted-health risk score from the lowest to highest and separated them into three strata. After the members were equally divided into three strata, the OIG randomly chose 200 members, 50 of whom were chosen from the lowest risk strata, 50 from the middle-tiered risk strata, and 100 from the highest risk strata.

As discussed under Section II.C.1 above, the sample design itself, which differs from the current CMS RADV approach, skewed the audited sample towards members who were more likely to have had overpayments than underpayments since the sample excluded members who did not have a reported HCC. This skewed result was exacerbated by the OIG selecting 50% of the audited sample from members “[with on average the highest number of HCCs] (i.e., the high risk strata)” even though these members represented only 33.3% of the sampling frame.<sup>17</sup>

In order for the results of an audit sample to be reliably extrapolated to the population, the sample itself must be both random and representative of the population. As demonstrated by the above and as further discussed in Section II.C.3 below, the Draft Report’s sample was neither random nor representative of the Contract’s enrolled population.

### **3. The sample frame is not representative of the Contract’s enrolled population, which is a prerequisite to extrapolation**

SCAN engaged FTI Consulting, a global business advisory firm with over 6,000 employees worldwide and a dedicated healthcare practice whose work product is regularly reviewed by regulatory agencies and enforcement bodies including the OIG, the Department of Justice, CMS, state Attorneys General, state Medicaid agencies and various accreditation bodies such as the Joint Commission and NCQA, to perform statistical tests to assess whether the sample frame used for purposes of this audit was representative of the Contract’s enrolled population. As detailed below, FTI found that the sample was **not** representative of the Contract’s enrolled population.

#### *a. The Audited Sample Was Not Representative of the Contract’s Enrolled Population for Stratum 3*

The sample used for any extrapolation must be representative of the universe as a whole in order to produce a reliable extrapolation estimate.<sup>18</sup> FTI performed statistical tests to evaluate whether the sample drawn by the OIG was statistically representative of the Contract’s enrolled

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<sup>17</sup> Draft Report at p. 16.

<sup>18</sup> See, e.g., TRANSMITTAL 828, CMS (Sept. 28, 2018) (editing the Medicare Program Integrity Manual to “help ensure that a statistically representative sample of the claim universe is drawn that yields an unbiased estimate of an overpayment.”); *United States ex rel. Martin v. Life Care Ctrs. of Am., Inc.*, 114 F. Supp. 3d 549, 567 (Sept. 29, 2014) (“as long as the statistical sample is a valid sample that is representative of the universe of claims, the natural disparity between the claims does not preclude using sampling and extrapolation as evidence”).

population from which the sample was drawn. Even if a sample is randomly selected, it is possible that such a sample is not representative of the population from which it was drawn. For example, in a health outcomes study, the average height of a randomly selected sample of individuals from a population of people can be much higher (or lower) than the average height of the individuals in the population. In that situation, any findings with respect to the height of individuals included in the sample will be biased towards taller (or shorter) people and cannot be reliably extrapolated to the entire population because the individuals in the sample are not representative of the population with respect to height.

FTI performed statistical tests of representativeness on the stratified audited sample using the generally accepted statistical software package, Stata.<sup>19</sup> These tests are designed to determine if an audited sample was representative of the population from which the sample was drawn with respect to a particular characteristic.<sup>20</sup> In particular, FTI performed the T-test for the equality of means, which tests whether the average value of a particular variable for the sampled items is statistically different from the average value of the corresponding variable for items in the population. FTI performed the T-test for the equality of means on each of the following variables:

- MARXPMT
- BlendedRASRiskScore
- HealthRelatedRiskScore
- RS\_NumPMT

FTI found that the audited sample was **not representative** of the Contract's enrolled population with respect to any of the four variables for stratum 3. As a result, the overpayment determinations from the sample cannot be reliably extrapolated to the Contract's enrolled population for stratum 3. Moreover, FTI found that the averages of all four variables were statistically-significantly higher in the sample than in the enrolled population. This means that the **sample for stratum 3 was biased towards enrollees with higher payments and higher risk scores.**

The following table presents the averages in the population and sample for each respective variable.

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<sup>19</sup> StataCorp. 2019. Stata Statistical Software: Release 16. College Station, TX: StataCorp LLC.

<sup>20</sup> FTI used the 5% significance level to determine whether a metric of interest in the sample was representative of the population. This means that if the sample was, in fact, representative of the population with respect to the metric of interest then one would expect to see a failed test result associated with the audited sample fewer than 1 in 20 times.

Stratum 3 – Average Values in the Population vs. Sample

MARXPMT	\$22,836	\$24,786
BlendedRASRiskScore	2.9	3.2
HealthRelatedRiskScore	2.4	2.7
RS_NumPMT	27.3	30.4

The non-representative and biased sample for stratum 3 is important because stratum 3 accounts for over half (55%) of the total payments of the population.<sup>21</sup> Furthermore, the point estimate of the extrapolated overpayment in stratum 3 is \$67,542,411, which accounts for 72.4% of the overall extrapolated overpayment of \$93,261,503.<sup>22</sup> The following table provides a breakdown of the point estimate of the extrapolated overpayment by stratum:

Stratum	Extrapolated Overpayment	%
1	\$527,140	0.6%
2	\$25,191,952	27.0%
3	\$67,542,411	72.4%
<b>Overall</b>	<b>\$93,261,503</b>	<b>100%</b>

*b. OIG’s Sample Design is Fatally Flawed and Unreliable*

FTI determined that that the stratified sample design used for the audit of the Contract was fatally flawed and unreliable. The OIG stratified the Contract’s enrolled population by the members’ monthly-weighted risk score. According to the Draft Report, “[OIG] ranked the 93,437 enrollees according to their monthly-weighted-health risk score from lowest to highest and separated them into 3 strata.”<sup>23</sup> Importantly, the OIG created the three strata with approximately equal size (i.e., each stratum has approximately the same number of enrollees):

<sup>21</sup> Draft Report at p. 17.

<sup>22</sup> Draft Report at p. 18.

<sup>23</sup> Draft Report at pp. 16-17.

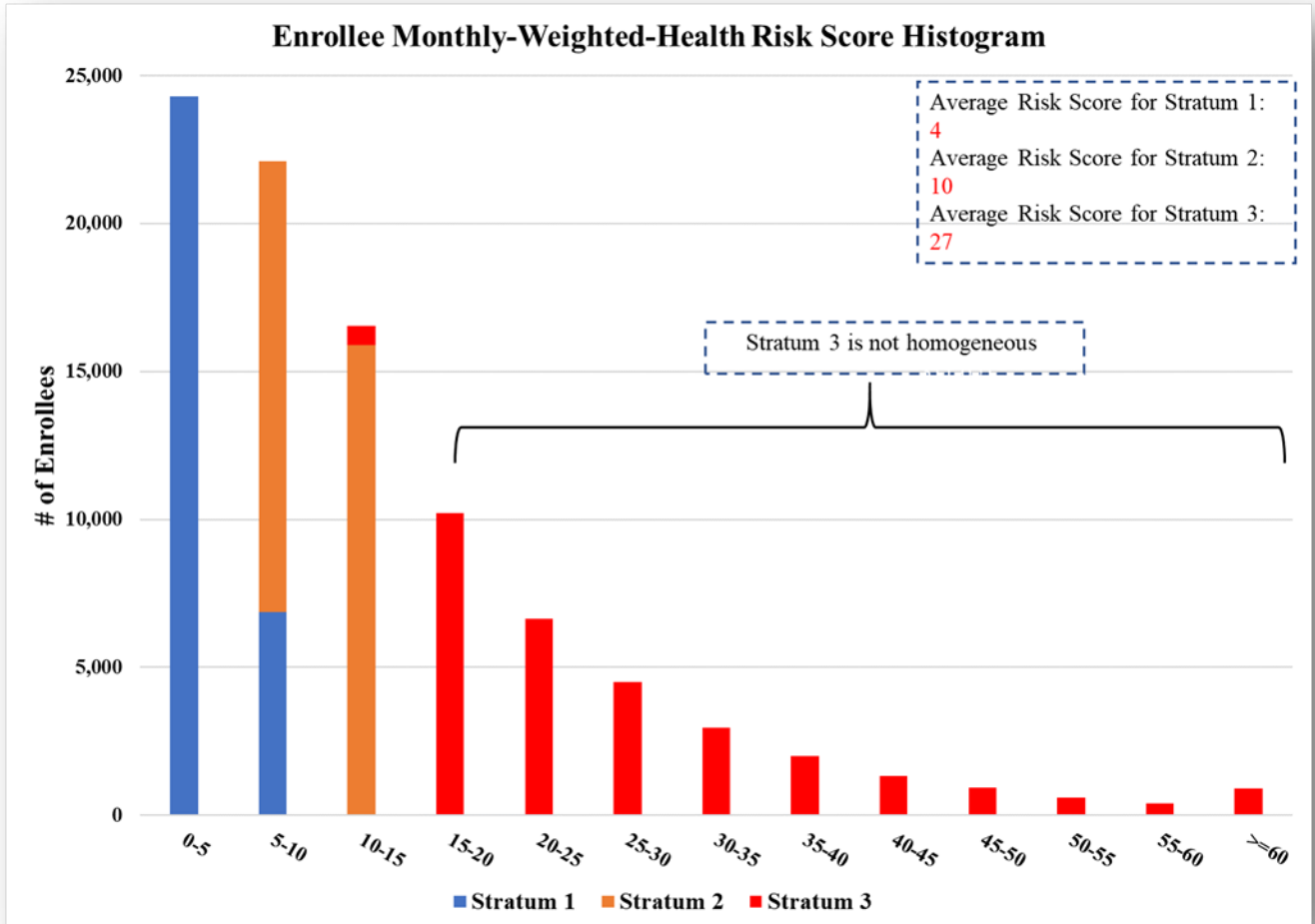
OIG Stratification Summary Table – pg. 17 of Draft Report

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

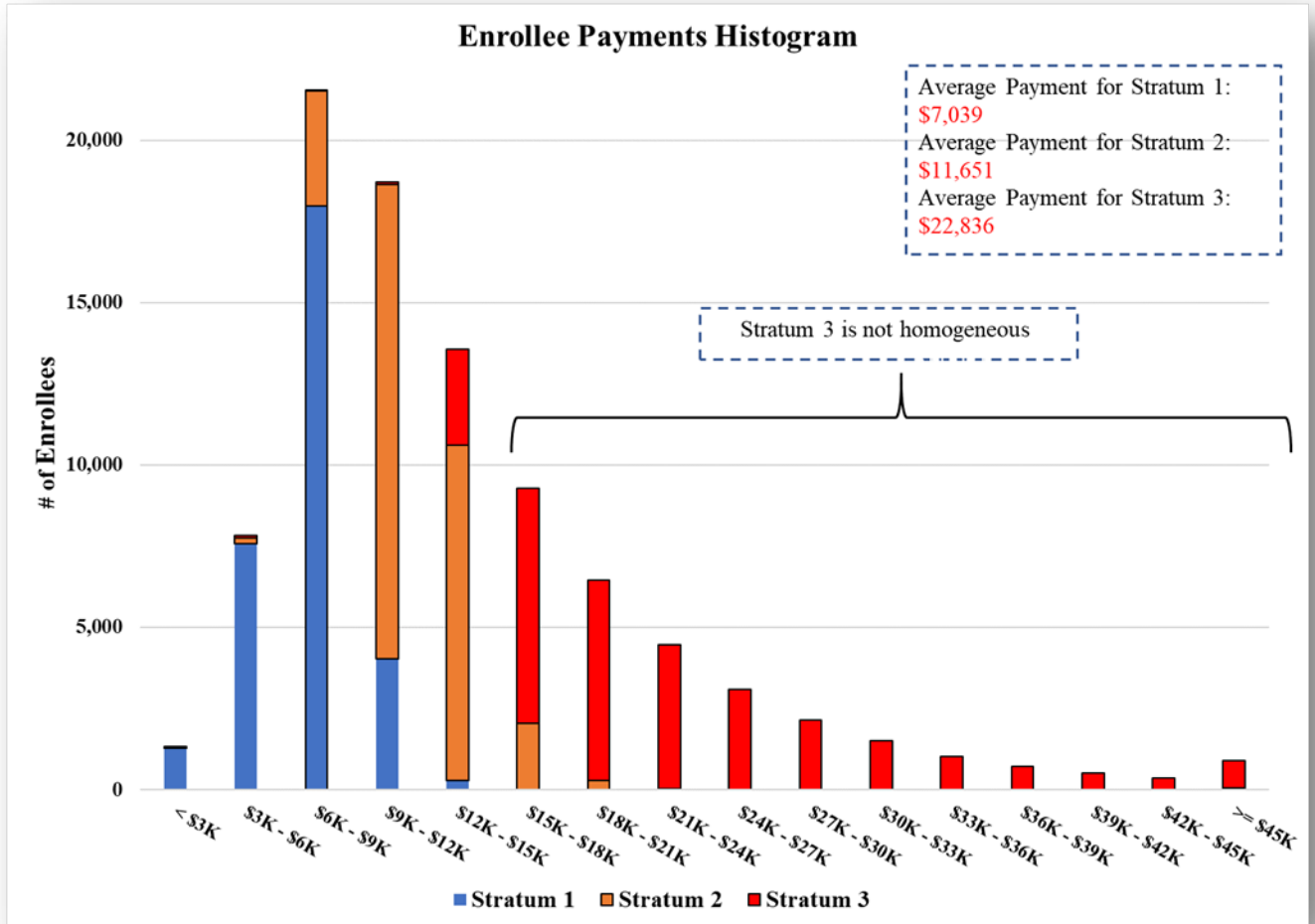
<b>Stratum</b>	<b>Sample Size</b>	<b>Number of Enrollees</b>	<b>Monthly-Weighted-Health Risk Score Range</b>	<b>Sampling Frame Dollar Total</b>
1	50	31,181	0.081–6.589	\$219,475,872
2	50	31,111	6.590–14.775	362,462,075
3	100	31,145	14.784 –177.180	711,226,146
<b>Total</b>	<b>200</b>	<b>93,437</b>		<b>\$1,293,164,093</b>

Because the OIG did not place a limit on the largest risk score in stratum 3, the range of risk scores for enrollees in this stratum was much larger than the range of enrollee risk scores in strata 1 and 2. The chart below presents a histogram of the number of enrollees, by stratum, in monthly-weighted-health risk score intervals of 5 (e.g., 0-5, 5-10, etc.). The chart shows that enrollees in stratum 1 (identified by the blue bars) were present only in the 0-5 and 5-10 risk score intervals, and enrollees in stratum 2 (identified by the orange bars) were present only in the 5-10 and 10-15 risk score intervals. By contrast, the risk scores for enrollees in stratum 3 (identified by the red bars) were widely dispersed and present in a wide range of risk score intervals.





The chart below presents a similar histogram for different ranges of CMS payments for the enrollees. Similar to the chart above, this chart presents the number of enrollees with CMS payments < \$3,000, CMS payments between \$3,000 and \$6,000, and so on. Also similar to the chart above, the range of CMS payments for enrollees in strata 1 and 2 were concentrated in the first few payment ranges, whereas the enrollees in stratum 3 had a wide range of CMS payments and were dispersed throughout many payment ranges.



FTI determined that this sample design was inherently flawed as it created, by design, a stratum of enrollees with a very large variance of risk scores and associated payments. The highly regarded textbook *Sampling Techniques* by William G. Cochran notes that the purpose of stratification is to divide the population into “homogeneous” subpopulations to create a “precise estimate for the whole population”:

Stratification may produce a gain in precision in the estimates of characteristics of the whole population. It may possible (*sic*) to divide a heterogenous population into subpopulations, each of which is internally homogeneous. This is suggested by the name *strata*, with its implication of a division into layers. If each stratum is homogeneous, in that the measurements vary little from one unit to another, a precise estimate of any stratum mean can be obtained from a small sample in that

stratum. These estimates can then be combined into a precise estimate for the whole population.<sup>24</sup>

Here, the OIG's stratified audited sample did not create a stratum of homogeneous enrollees in the stratum associated with the largest risk scores. This problem was magnified by the fact that the enrollees with the highest risk scores, by definition, also had the highest CMS payments. Simply put, the stratum that accounted for the majority of the payments, by design, did not contain enrollees with "homogeneous" risk scores or payments. This oversight rendered the sample design susceptible to not being representative of the population in stratum 3. In fact, FTI's analysis showed that stratum 3 was not statistically representative of the Contract's enrolled population with respect to enrollee payments and risk scores, causing the resulting overpayment extrapolations to be fatally flawed and unreliable.

### **III. SCAN's Compliance Program is Effective in Preventing, Detecting, and Correcting Noncompliance with Federal Requirements**

#### **A. The Draft Report Evidences the Effectiveness of SCAN's Compliance Program Policies and Procedures**

SCAN disagrees with statements in the Draft Report that the errors identified in the report "occurred because SCAN's policies and procedures to prevent, detect, and correct noncompliance with CMS's requirements, as mandated by Federal Regulations, were not always effective."<sup>25</sup> SCAN notes that this is a standard statement in audit reports issued by the OIG, and, in SCAN's case, is inconsistent with the Draft Report's finding that most of the audited HCCs were, in fact, supported and validated. That is, the Draft Report evidences the general effectiveness of SCAN's compliance program policies and procedures.

If it is the OIG's position that any errors, regardless of how many, evidence a failure in the effectiveness of compliance program policies and procedures, that position is impractical. For example, as discussed in Section II.B.1 above, CMS itself does not target a zero-error benchmark in guidelines that direct reviews performed by certified coders. Moreover, as evidenced by the errors made by the OIG's independent medical review contractor in invalidating HCCs that were supported by the medical documentation submitted by SCAN, zero errors is not a realistic benchmark.

By recommending that SCAN improve the effectiveness of its compliance program policies and procedures, the OIG presumably identified specific deficiencies. However, the Draft Report provides no specific guidance or suggestions on what improvements to SCAN's compliance program policies and procedures might be needed. This again, suggests that the OIG believes that *any* errors evidence the lack of effective compliance program policies and procedures.

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<sup>24</sup> Cochran, W.G. (1977) *Sampling Techniques*. 3rd Edition, John Wiley & Sons, New York, pp 89-90.

<sup>25</sup> Draft Report at p. 5.

SCAN does agree that an effective compliance program should be subject to periodic reviews for appropriate enhancements. As such, it is SCAN's regular practice to evaluate its compliance program policies and procedures to identify appropriate improvement opportunities consistent with CMS requirements and expectations. This includes obtaining independent assessments of the effectiveness of the plan's compliance program. The most recent review of the effectiveness of SCAN's compliance program was performed by The Burchfield Group, which found:

- A visible culture of compliance
- A dedicated team that strives to do the right thing and continually improve
- A mature compliance program that has worked diligently to build partnerships with operational areas
- A detailed FDR oversight process, particularly of delegated provider groups

Set forth below is a description of the core components of SCAN's compliance program for ensuring the accuracy of its risk adjustment submissions to CMS. Described first are process improvements SCAN implemented during and subsequent to the audit review period.

B. Chronology of Key Process Improvements to SCAN's Compliance Program and Coding Accuracy Controls: 2014 – 2019

Consistent with SCAN's commitment to maintain a compliance program that is not static and is regularly assessed to identify and incorporate improvements, set forth below are some of the key process improvements SCAN has implemented to its policies and procedures in recent years.

2014

- Implemented enhanced targeting methodology and adjusted audit format to utilize data validation against encounter data submissions.

2015

- Revised Corrective Action Plan ("CAP") templates for delegated providers to include root cause analysis, and implemented standardized CAP templates across all audit areas.
- Revised oversight audits to ensure standardization and alignment of processes with CMS audit protocols.

2016

- Increased the number of targeted group level data validation audits of provider groups to increase oversight of SCAN's delegated provider network.

2017

- Launched regular provider engagement meetings for reviewing the completeness and accuracy of encounter data submissions from provider groups, and ensuring they meet CMS encounter data quality standards.

2018

- Enhanced SCAN's first tier, downstream and related entity ("FDR") auditing approach by introducing a webinar component that mirrors CMS' audit protocols and approach.

2019

- Implemented an annual risk assessment of those delegated provider groups that use a management services organization ("MSO") to manage their delegated functions. The purpose of this risk assessment is to determine the need for additional oversight activities and to tailor SCAN's monitoring and auditing to fit the risk profile of each delegated provider group and its MSO (as applicable).

C. SCAN's Regulatory Oversight and Performance Monitoring of FDRs Is Robust And Effective

The foundation of SCAN's compliance program is the federal regulations at 42 C.F.R. § 422.503(b)(4)(vi) and 42 C.F.R. § 423.504(b)(4)(vi); Chapter 21–Compliance Program Guidelines in the Medicare Managed Care Manual; and Chapter 9 – Compliance Program Guidelines in the Prescription Drug Benefit Manual. Key features of SCAN's compliance program include but are not limited to:

1. Requiring Standards of Conduct – SCAN requires its contracted providers and vendors to maintain standards of conduct for their employees and to abide by FWA laws, regulations, and CMS sub-regulatory guidance.

2. Establishing and Communicating Regulatory Requirements – SCAN regularly communicates with its contracted providers and vendors on topics that include federal and state regulatory requirements, and ensures contracted providers and vendors understand SCAN's compliance expectations. These communications include notices of CMS Fraud Alerts; reminders about the importance of reporting suspected fraud, waste and abuse and potential compliance issues; and providing Medicare Advantage program updates via provider communications and SCAN's Provider Operations Manual ("POM").

In addition to the compliance requirements set forth in SCAN's provider contracts, SCAN's POM establishes specific standards and requirements for delegated providers. These requirements, with which all contracted providers must comply, include:

- *Chapter 10: Delegation Oversight* requires that delegated providers comply with all applicable law, including Medicare and Medi-Cal laws, regulations, and CMS standards.
- *Chapter 14: Encounter Data* includes the following provisions:
  - SCAN and its providers must "Submit full and complete data that conform to CMS' requirements for MAPD data equivalent to Medicare fee-for-service data, as well as other relevant national standards."

- Providers must “Submit medical records for the validation of encounter data, as required by CMS. There may be penalties for submission of false data.”
- Providers must “Certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of all data submitted.”
- “Cooperation with all federal, state, and SCAN audits is mandatory (e.g. Risk Adjustment Data Validation (RADV) audits, Recovery Audit Contractor (RAC) audits, data validation audits, etc.) to ensure accuracy, timeliness, and completeness of submitted results.”
- Delegated providers are requested to perform monthly (but not less than quarterly) reconciliations using the production reports available on the SCAN Portal and to process monthly correction files for all errors in SCAN’s data rejection reports.

3. Performing Routine Monitoring and Auditing of Providers – SCAN conducts routine monitoring and auditing of FDR performance to assess compliance with delegated Part C and Part D requirements. As part of these oversight activities, SCAN requires corrective actions to remediate identified performance deficiencies. The auditing of Medicare Part C functions delegated to contracted providers is conducted by SCAN’s Delegation Oversight Unit (“DOU”) and Risk Adjustment Unit, as applicable.

SCAN’s DOU is responsible for auditing the functions delegated to provider First Tier Entities. The DOU auditors perform oversight of delegated functions including utilization management, special needs plan model of care, claims adjudication, compliance with financial solvency requirements, and credentialing. The DOU auditors also audit First Tier Entities’ compliance with SCAN’s compliance program, FWA requirements, and standards of conduct requirements. The DOU auditors regularly perform audits of these delegated areas as set forth in SCAN’s FDR Oversight Program Description.

D. SCAN’s Coding Accuracy Governance Structure Provides Appropriate Guidance and Oversight

SCAN’s Enterprise Compliance Committee (“ECC”) provides guidance and oversight for the plan’s compliance program policies and procedures. A core component of SCAN’s compliance program is the plan’s coding accuracy governance structure. SCAN’s Coding Quality Oversight Committee (“CQOC”) and Health Care Informatics (“HCI”) Coding Quality Governance Committee oversee the plan’s coding accuracy training and education; monitoring and auditing of providers and vendors; and the remediating of cited deficiencies.

1. SCAN’s CQOC is responsible for providing oversight and guidance on the development and implementation of data accuracy, completeness, and quality programs; and ensuring the effectiveness of SCAN’s oversight of coding accuracy and completeness by delegated providers. Coding irregularities are reported for discussion to and oversight by the CQOC.

2. SCAN’s HCI Coding Quality Governance Committee meets on a regular basis to review encounter submission reports. This committee is responsible for reviewing

identified irregularities in encounter data submissions and deciding whether to perform an ad hoc audit of a delegated provider. Questionable or suspicious data are reviewed by SCAN's HCI team. SCAN promptly notifies providers of identified coding irregularities or errors to ensure appropriate actions are taken to correct errors and submit accurate coding data. HCI maintains an enterprise-wide policy that governs the handling of encounter data rejections and errors according to CMS requirements in order to support the submission of accurate encounter data records for risk adjustment and encounter data processing.

E. SCAN Has Comprehensive Coding Accuracy Training Programs for Providers and Plan Staff

1. Provider Training

SCAN facilitates regular communications and educational forums with delegated providers to train and educate, and to share performance feedback. This includes SCAN's Encounters and HCC User Group ("EHUG"), which typically meets quarterly with providers, and covers topics such as CMS coding changes, plan operational changes, and emerging coding and auditing topics to be addressed by SCAN and its providers.

Additional training and education topics covered by SCAN with its delegated providers include:

- Specific training and education tailored to providers' unique challenges determined through SCAN's audits of those particular providers;
- SCAN's web platform that provides industry updates and guidelines for proper coding; and
- Education and training on specific topics from SCAN's HCI staff, as requested by providers.

2. Staff Training

SCAN only allows certified coders to perform medical record reviews and requires these plan staff to have the following credentials:

- Current licensure as Certified Coding Specialist (CCS) or Certified Professional Coder (CPC);
- 1-2 years of coding experience;
- Knowledge of medical terminology, abbreviations, anatomy and physiology, major disease processes, pharmacology, coding guidelines, and Coding Clinic guidance and requirements;
- Knowledge of medical codes involving selections of most accurate and descriptive codes using the ICD-10-CM; and
- Knowledge of paper-based medical records and electronic medical records for inpatient and outpatient records.

As part of SCAN's onboarding process for its coding staff, education and training are provided on the following topics:

- General coding guidelines as outlined in the ICD-9/10-CM book;
- Coding updates from the Coding Clinic; and
- Case scenarios of frequently misdiagnosed conditions, including correct coding practices.

SCAN's coding staff regularly attend and participate in industry forums and best practice trainings including:

- Webinars on ICD-10-CM code assignments; and
- Quarterly Coding Clinic updates.

### 3. Staff Performance Monitoring

SCAN supervisors provide 100% oversight of all coding work for the first two weeks of all new coding staff, and then 50% of all coding work for the following two weeks to ensure coding team members demonstrate compliant, competent work product. Thereafter, the ongoing performance of SCAN's coding staff is regularly monitored, and feedback is provided as part of ongoing staff training, education, and performance reviews. Coding staff are audited on a weekly basis and appropriate feedback is provided by their supervisors.

#### F. SCAN Performs Regular Coding Accuracy Monitoring and Auditing of Contracted Providers

SCAN performs a series of ongoing monitoring activities to assess and measure the level of coding accuracy of its contracted providers, which includes:

- Regular Provider Engagement Meetings – SCAN meets regularly with contracted providers to ensure that data submissions do not include errors that will cause rejections by CMS. SCAN's provider outreach team periodically meets with all contracted provider groups to review encounter and risk adjustment reports. This process consists of reviewing analytical reports that show a provider group's encounter trends and risk adjustment factor ("RAF") build. Inconsistent or sudden increases in RAF scores are highlighted and discussed to confirm accuracy and, if warranted, suspicious files are routed to SCAN's Coding Quality Audit Team in HCI for review and follow-up.
- Encounter Data Edit Reports – SCAN regularly reviews and provides feedback to provider groups on the accuracy and completeness of submitted encounter data records. The main purposes of this encounter data validation process are to confirm eligibility; find provider name/NPI mismatches; identify invalid diagnosis codes; identify potential medically unlikely conditions; and identify alternate submission chart reviews to link to a parent 837 encounter record. Key components of SCAN's Encounter Data Edit Reports include:



- Clearinghouse Edits –SCAN uses to gather contracted provider encounters, and implement EDI edits to ensure the 837 files are properly formatted.
- Import Workflow Edits – SCAN uses as a validation workflow for pre-validating encounter data received from clearinghouses and the encounters received from providers in order to identify potentially corrupt files.
- Export Workflow Edit Reports – SCAN provides regular feedback to provider groups based upon CMS 2777 and MAO-002 level edits as part of efforts to proactively reduce encounter data rejection rates by CMS. This process provides important feedback to provider groups for correcting rejected encounter data records and resubmitting them to SCAN.

SCAN performs the following auditing activities of its contracted providers to assess coding accuracy compliance and identify required corrective actions:

- Data Validation Audits (“DVAs”) – Performed to ensure data accuracy and completeness through retrospective medical chart review. On an annual basis, SCAN’s Coding Quality Audit Team in HCI performs retrospective chart reviews to validate the accuracy of the encounters that SCAN receives from its providers.
- Biennial Group Level Audits (“GLAs”) – Clinical documentation and coding quality reviews performed by HCI staff on a random sample of SCAN’s members from selected provider groups. The selection criteria, timeline, and goals are similar to the requirements for CMS RADV audits. The purposes of GLAs are to analyze SCAN’s operational readiness and ability to implement and complete a coding accuracy audit, and assess the coding accuracy of delegated provider groups.

GLAs allow SCAN to evaluate the accuracy and compliance of its delegated provider groups and to identify areas on which SCAN’s Risk Adjustment teams should focus. Once the GLA is performed, HCI staff transition roles to train and educate providers about identified areas of non-compliance as part of ensuring appropriate and effective corrective action measures are designed and implemented.

- Inconsistent Data Validation (“ICDV”) Audits – Performed annually as part of SCAN’s efforts to validate the clinical accuracy of diagnostic data submitted to CMS. The ICDV audits are performed when claims and encounters with inconsistent conditions are flagged by SCAN for further review. For example, an ICDV audit is commonly performed when encounters are identified with conditions that are generally diagnosed in a place of service that is inconsistent with the encounter type.
- Ad Hoc Targeted Audits – Unscheduled audits that are performed when SCAN staff identify potential data anomalies from a particular provider group. A targeted audit could be performed, for example, in connection with a provider that recently submitted questionable encounter data or scored low on a recent coding accuracy audit. Based upon the audit results, SCAN may pursue various courses of action that

include, but are not limited to expanding the audit sampling to further assess the provider group’s diagnostic data, requiring corrective actions to remediate identified deficiencies, or scheduling training and education for provider group staff on specific process improvement opportunities identified through the audit.

**G. SCAN Performs Regular Monitoring and Auditing of Vendors’ Coding Accuracy**

HCI’s Coding & Audit team reviews files submitted by contracted vendors that perform medical coding for SCAN before these encounter records are submitted to CMS. Vendors must achieve on average at least 95% accuracy for the entire year in order to continue in good-standing with SCAN. Any vendor that fails to meet this compliance level of performance will be subjected to disciplinary actions that include, but are not limited to, being placed on a corrective action plan or terminated from SCAN’s network.

SCAN performs a 100% audit of the initial file submitted by each newly contracted vendor that performs risk adjustment coding for SCAN’s members. The frequency of subsequent coding accuracy auditing of these vendors, and the audit sample sizes, are determined based upon the results of SCAN’s initial audits and other potential risk factors stemming from the vendor’s performance:

Initial Audit Score	Subsequent Auditing Approach
95% or higher accuracy:	Use audit sample size of 10%
Between 94%-85% accuracy:	Use audit sample size of 15%-20%. If vendor does not achieve at least 95% accuracy in subsequent audits, it will be placed on a corrective action plan and monitored by HCI management.
Below 85% accuracy:	Perform a 100% file review. If performance does not improve based upon subsequent audits, HCI staff will escalate this issue to management for intervention, including termination of the vendor.

**IV. Conclusion**

For the reasons set forth above, SCAN disagrees with the Draft Report’s finding that 192 HCCs were unsupported and therefore invalidated, and with the recommendation that SCAN should refund to the Federal Government \$66,997,864 in alleged overpayments. Rather, the net total potential overpayments under the Contract that may be due CMS in connection with the audited sample are at most \$188,169. SCAN also does not concur with the Draft Report’s claim that SCAN’s compliance program policies and procedures were not always effective.

It is SCAN’s expectation that, in accordance with government auditing standards, the OIG will thoroughly review this response so that any final report that is issued reflects due consideration of SCAN’s response.

Patrick J. Cogley  
December 23, 2020  
Page 23

Please do not hesitate to contact Andrew Whitelock, Chief Risk Executive, if you have any questions or require additional information.

Sincerely,

*Sachin H. Jain*

Sachin H. Jain  
President and Chief Executive Officer

Enclosures

cc: Michael Plumb, Chief Financial Officer, SCAN  
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