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# **Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Priority Health (Contract H2320) Submitted to CMS**



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### Why OIG Did This Audit

- Under the Medicare Advantage (MA) program, CMS makes monthly payments to MA organizations based in part on the health status of the enrollees being covered.
- To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.
- This audit of Priority Health (Priority) is part of a series of audits in which we are reviewing high-risk diagnosis codes that MA organizations submitted to CMS for use in its risk adjustment program.

### What OIG Found

Most of the selected diagnosis codes that Priority submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements.

- For 252 of the 300 sampled enrollee-years, medical records did not support the diagnosis codes and resulted in \$828,010 in net overpayments.
- On the basis of our sample results, we estimated that Priority received at least \$4.4 million in net overpayments for 2018 and 2019.

As demonstrated by the errors found in our sample, Priority'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

We recommend that Priority:

1. refund to the Federal Government the \$4.4 million of estimated net overpayments;
2. identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred after our audit period and refund any resulting overpayments to the Federal Government; and
3. continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnoses that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

Priority disagreed with some of our findings and all of our recommendations.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

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

This audit is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS.<sup>2</sup> Using data mining techniques and considering discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. (For example, we consolidated 54 breast cancer diagnoses into 1 group.) This audit covered Priority Health (Priority) for contract number H2320, and focused on 10 groups of high-risk diagnosis codes for payment years 2018 and 2019.<sup>3, 4</sup>

### OBJECTIVE

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

### BACKGROUND

#### Medicare Advantage Program

The MA program offers people eligible for Medicare managed care options by allowing them to enroll in private health care plans rather than having their care covered through Medicare's

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

<sup>2</sup> MA compliance audit reports issued by the Office of Inspector General (OIG) are published on the [OIG website](#).

<sup>3</sup> All subsequent references to "Priority" in this report refer solely to contract number H2320.

<sup>4</sup> The 2018 and 2019 payment year data were the most recent data available at the start of the audit.

traditional fee-for-service program.<sup>5</sup> Individuals who enroll in these plans are known as enrollees. To provide benefits to enrollees, CMS contracts with MA organizations, which in turn contract with providers (including hospitals) and physicians.

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

For 2024, CMS paid MA organizations \$494 billion, which represented 44 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>6</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>7</sup> CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that an MA organization is paid for each of its enrollees.<sup>8</sup>
- *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

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<sup>5</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>6</sup> The Social Security Act (the Act) §§ 1853(a)(1)(C) and (a)(3); 42 CFR § 422.308(c).

<sup>7</sup> The Act § 1854(a)(6); 42 CFR § 422.254 *et seq.*

<sup>8</sup> CMS's bid-benchmark comparison also determines whether the MA organization must offer supplemental benefits or must charge a basic enrollee premium for the benefits.

process results in an individualized risk score for each enrollee, which CMS calculates annually.

To determine an enrollee's health status for purposes of calculating the risk score, CMS uses diagnoses that the enrollee receives from acceptable data sources, including certain physicians and hospitals. MA organizations collect the diagnosis codes from providers based on information documented in the medical records and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs).<sup>9</sup> Each HCC has a factor (which is a numerical value) assigned to it for use in each enrollee's risk score.

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

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

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

CMS multiplies the risk scores by the base rates to calculate the total monthly Medicare payment that an MA organization receives for each enrollee before applying the budget sequestration reduction.<sup>10</sup> Thus, if the factors used to determine an enrollee's risk score are

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<sup>9</sup> During our audit period, CMS calculated risk scores based on the Version 22 CMS-HCC model for payment year 2018 and the Version 23 CMS-HCC model for payment year 2019.

<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.

incorrect, CMS will make an improper payment to an MA organization. Specifically, if medical records do not support the diagnosis codes that an MA organization submitted to CMS, the HCCs are not validated, which causes overstated enrollee risk scores and overpayments from CMS.<sup>11</sup> Conversely, if medical records support the diagnosis codes that an MA organization did not submit to CMS, validated HCCs may not have been included in enrollees' risk scores, which may cause those risk scores to be understated and may result in underpayments.

### High-Risk Groups of Diagnoses

Using data mining techniques and discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. For this audit, we focused on 10 high-risk groups:

- *Acute stroke*: An enrollee received one acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have an acute stroke diagnosis on a corresponding inpatient or outpatient hospital claim. In these instances, a diagnosis of history of stroke (which does not map to an HCC) typically should have been used.
- *Acute myocardial infarction*: An enrollee received one diagnosis (that mapped to the HCC for Acute Myocardial Infarction) on only one physician or outpatient claim during the service year but did not have an acute myocardial infarction diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician or outpatient claim). In these instances, a diagnosis indicating a history of a myocardial infarction (which does not map to an HCC) typically should have been used.
- *Embolism*: An enrollee received one diagnosis that mapped to either the HCC for Vascular Disease or to the HCC for Vascular Disease With Complications (Embolism HCCs) on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf. An anticoagulant medication is typically used to treat an embolism. In these instances, a diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used.
- *Lung cancer*: An enrollee received one lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period either before or after the diagnosis. In these

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<sup>11</sup> 42 CFR § 422.310(e) requires MA organizations (when undergoing an audit conducted by the Secretary) to submit "medical records for the validation of risk adjustment data." For purposes of this report, we use the terms "supported" or "not supported" to denote whether the reviewed diagnoses were evidenced in the medical records. If our audit determines that the diagnoses are supported or not supported, we accordingly use the terms "validated" or "not validated" with respect to the associated HCC.

instances, a diagnosis of history of lung cancer (which does not map to an HCC) typically should have been used.

- *Breast cancer*: An enrollee received one breast cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of breast cancer (which does not map to an HCC) typically should have been used.
- *Colon cancer*: An enrollee received one colon cancer diagnosis (that mapped to the HCC for Colorectal, Bladder, and Other Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of colon cancer (which does not map to an HCC) typically should have been used.
- *Prostate cancer*: An enrollee 74 years old or younger received one prostate cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of prostate cancer (which does not map to an HCC) typically should have been used.
- *Ovarian cancer*: An enrollee received one ovarian cancer diagnosis that mapped to either the HCC for Lymphoma and Other Cancers or to the HCC for Metastatic Cancer and Acute Leukemia (Ovarian Cancer HCCs) on only one claim during the service year but did not have surgical therapy or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis. In these instances, a diagnosis of history of ovarian cancer (which does not map to an HCC) typically should have been used.
- *Sepsis*: An enrollee received one sepsis diagnosis (that mapped to the HCC for Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock) on only one physician or outpatient claim during the service year but did not have a sepsis diagnosis on a corresponding inpatient hospital claim. A sepsis diagnosis generally results in an inpatient hospital admission.
- *Pressure Ulcer*: An enrollee received one pressure ulcer diagnosis<sup>12</sup> that mapped to either the HCC for Pressure Ulcer of Skin With Full Thickness Skin Loss or the HCC for Pressure Ulcer of Skin With Necrosis Through to Muscle, Tendon, or Bone (Pressure

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<sup>12</sup> Pressure ulcer diagnoses are categorized into five groups according to severity: stages 1, 2, 3, 4, and unstageable. For this audit, we audited only the most severe types of pressure ulcers: stages 3, 4, and unstageable.

Ulcer HCCs) on only one claim during the service year but did not have a pressure ulcer diagnosis on another inpatient, outpatient, or physician claim for either the calendar year before or the calendar year after the service year. Individuals diagnosed with the most severe types of pressure ulcers generally receive treatment on multiple occasions.

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

## **Priority Health**

Priority is an MA organization based in Grand Rapids, Michigan. As of December 2019, Priority provided coverage under contract number H2320 to 118,143 enrollees. For the 2018 and 2019 payment years (audit period), CMS paid Priority approximately \$2.1 billion to provide coverage to its enrollees.<sup>13</sup>

## **HOW WE CONDUCTED THIS AUDIT**

Our audit included enrollees on whose behalf providers documented diagnosis codes that mapped to 1 of the 10 high-risk groups during the 2017 and 2018 service years, for which Priority received increased risk-adjusted payments for payment years 2018 and 2019, respectively. Because enrollees could be classified into more than one high-risk group or could have high-risk diagnosis codes documented in more than 1 year, we classified these individuals according to the condition and the payment year, which we refer to as “enrollee-years.”

We identified 2,515 unique enrollee-years and limited our review to the portions of the payments that were associated with these high-risk diagnosis codes (\$5,876,059). We selected for audit a stratified random sample of 300 enrollee-years as shown in Table 1 on the following page.

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<sup>13</sup> All of the payment amounts that CMS made to Priority and the net overpayment amounts that we identified in this report reflect the budget sequestration reduction.

**Table 1: Sampled Enrollee-Years**

High-Risk Group	Number of Sampled Enrollee-Years
(1) Acute stroke	30
(2) Acute myocardial infarction	30
(3) Embolism	30
(4) Lung cancer	30
(5) Breast cancer	30
(6) Colon cancer	30
(7) Prostate cancer	30
(8) Ovarian cancer	30
(9) Sepsis	30
(10) Pressure ulcer	30
<b>Total for All High-Risk Groups</b>	<b>300</b>

Priority provided medical records as support for the selected diagnosis codes associated with all 300 of the sampled enrollee-years. We used an independent medical review contractor to review the medical records to determine whether the HCCs associated with the sampled enrollee-years were validated. For the HCCs that were not validated, if the contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, or if we identified another diagnosis code (on CMS's systems) that mapped to an HCC in the related-disease group, we included the financial impact of the resulting HCC (if any) in our calculation of net overpayments.

We conducted this performance audit in accordance with generally accepted government auditing standards (GAGAS). 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, Appendix C contains our sample results and estimates, and Appendix D contains the Federal regulations regarding MA organizations' compliance programs.

## FINDINGS

With respect to the 10 high-risk groups covered by our audit, most of the selected diagnosis codes that Priority submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 48 of the 300 sampled enrollee-years, the medical records validated the reviewed HCCs. For the remaining 252 enrollee-years, however, the medical records that Priority provided did not support the diagnosis codes; therefore, the associated HCCs were not validated and resulted in \$828,010 in net overpayments.

As demonstrated by the errors found in our sample, Priority’s policies and procedures to prevent, detect, and correct noncompliance with CMS’s program requirements, as mandated by Federal regulations, could be improved. On the basis of our sample results, we estimated that Priority received \$4,479,698 in net overpayments for 2018 and 2019.<sup>14</sup>

## FEDERAL REQUIREMENTS

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

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

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

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

Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS. Federal regulations also state that MA organizations must “adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS’ program requirements . . . .” Further, MA

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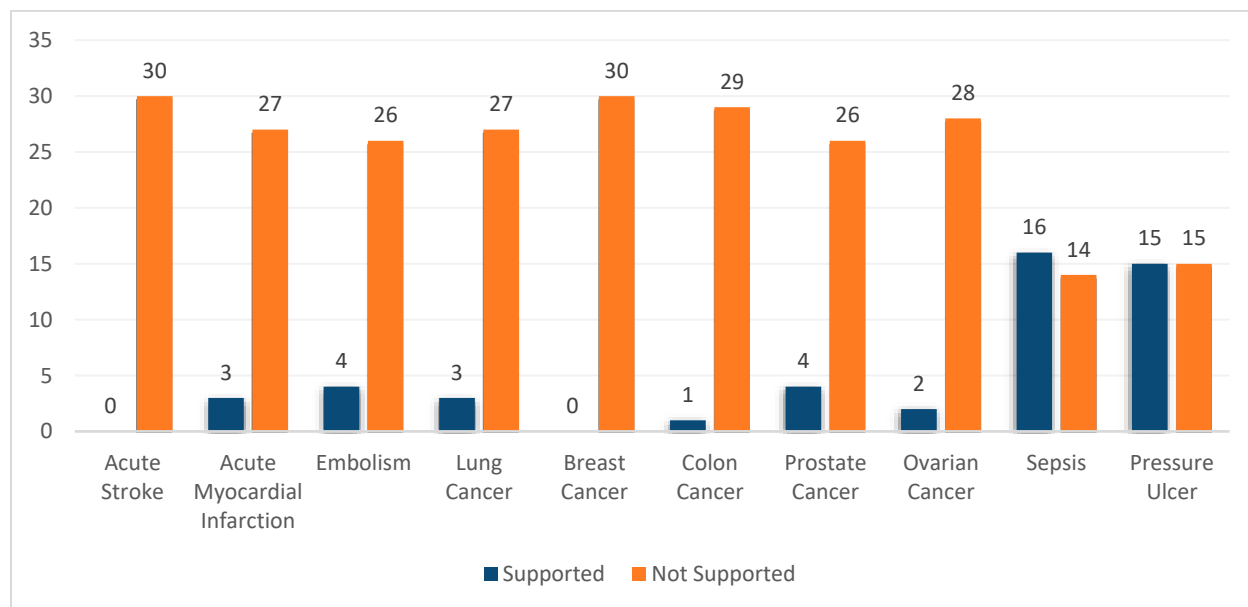
<sup>14</sup> To be conservative, we estimate net overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

organizations must establish and implement an effective system for routine monitoring and identification of compliance risks (42 CFR § 422.503(b)(4)(vi)).

### **MOST OF THE SELECTED HIGH-RISK DIAGNOSIS CODES THAT PRIORITY HEALTH SUBMITTED TO CMS DID NOT COMPLY WITH FEDERAL REQUIREMENTS**

Most of the selected high-risk diagnosis codes that Priority submitted to CMS for use in CMS’s risk adjustment program did not comply with Federal requirements. Specifically, as shown in the figure below, for 252 of the 300 sampled enrollee-years the medical records that Priority provided did not support the diagnosis codes. In these instances, Priority should not have submitted the diagnosis codes to CMS and received the resulting net overpayments.

**Figure: Analysis of High-Risk Groups**



#### **Incorrectly Submitted Diagnosis Codes for Acute Stroke**

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

- For 18 enrollee-years, the medical records in each case did not support an acute stroke diagnosis.<sup>15</sup>

<sup>15</sup> For risk adjustment purposes, CMS uses only diagnoses that enrollees receive from acceptable data sources (a face-to-face encounter with a provider, physician, or other practitioner) (42 CFR § 422.310(d)(3)); the Manual, chap. 7, §§ 40 and 120.1). For 1 of these enrollee-years, the documentation that Priority submitted was a radiology report signed and credentialed by a radiologist. Because this documentation did not meet CMS’s requirements for acceptable data sources (it did not reflect a face-to-face encounter), we could not make a coding determination, and therefore the reviewed HCC could not be validated.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of an acute cerebrovascular accident (CVA) that results in the assignment of the HCC under review. There is documentation of a transient ischemic attack (TIA) [diagnosis] which does not result in an HCC.”<sup>16, 17</sup>

- For 10 enrollee-years, the medical records indicated in each case that the individual had previously had a stroke, but the records did not justify an acute stroke diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of [a] (CVA) that results in the assignment of the HCC under review. There is documentation of a past medical history of . . . [a] (CVA) [diagnosis] which does not result in an HCC.”

- For each of the remaining 2 enrollee-years, Priority submitted an acute stroke diagnosis code (which was not supported in the medical records) instead of a diagnosis code for hemiplegia or hemiparesis (which was supported by the medical records).<sup>18</sup> For these 2 enrollee-years, the independent medical review contractor stated that the patient either had a “left hemiplegia [diagnosis] from a past medical history of CVA” or a “hemiplegia and hemiparesis [diagnosis] following cerebral infarction affecting left non-dominant side.”

The contractor stated that, for both instances, the correct diagnoses should have been hemiplegia or hemiparesis, both of which map to the HCC for Hemiplegia/Hemiparesis. Accordingly, Priority should not have received a payment for the acute stroke diagnosis but instead should have received a payment for the hemiplegia or hemiparesis diagnosis. One of these errors caused an underpayment.

As a result of these errors, the HCC for Ischemic or Unspecified Stroke was not validated, and Priority received \$53,530 in net overpayments for these 30 sampled enrollee-years.

### **Incorrectly Submitted Diagnosis Codes for Acute Myocardial Infarction**

Priority incorrectly submitted diagnosis codes for acute myocardial infarction for 27 of 30 sampled enrollee-years. Specifically:

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<sup>16</sup> CVA is the medical term for a stroke. A stroke occurs when blood flow to a part of the brain is stopped by either a blockage or the rupture of a blood vessel.

<sup>17</sup> A TIA is a temporary period of symptoms similar to those of a stroke.

<sup>18</sup> Hemiparesis is weakness or inability to move on one side of the body. Moreover, hemiplegia is defined as complete paralysis or loss of function of one-half of the body, including one leg and arm, because of injury or disease in the motor centers of the brain.

- For 12 enrollee-years, the medical records in each case did not support an acute myocardial infarction diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. The final diagnosis was [a] bifascicular block which does not result in an HCC.”<sup>19</sup>

- For 9 enrollee-years, the medical records indicated in each case that the individual had previously had an acute myocardial infarction, but the records did not justify an acute myocardial infarction diagnosis at the time of the physician’s service.

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

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

As a result of these errors, the HCC for Acute Myocardial Infarction was not validated, and Priority received \$43,240 in overpayments for these 27 sampled enrollee-years.

### **Incorrectly Submitted Diagnosis Codes for Embolism**

Priority incorrectly submitted diagnosis codes for embolism for 26 of 30 sampled enrollee-years. Specifically:

- For 15 enrollee-years, the medical records in each case did not support a diagnosis that mapped to an Embolism HCC.<sup>20</sup>

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<sup>19</sup> A bifascicular block delays or stops signals between the left and right bundle branches (fascicles) of the heart. This condition affects the heart’s lower pumping chambers (ventricles), causing the heart to pump too slowly or out of rhythm (arrhythmia).

<sup>20</sup> For 3 of these enrollee-years, the documentation that Priority submitted (radiology reports) did not reflect a face-to-face visit. Because these records did not meet CMS’s requirements for acceptable data sources, the reviewed HCCs could not be validated (footnote 15).

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review.”

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

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of deep vein thrombosis [diagnosis] which does not result in an HCC.”<sup>21</sup>

As a result of these errors, the Embolism HCCs were not validated, and Priority received \$72,028 in overpayments for these 26 sampled enrollee-years.

### **Incorrectly Submitted Diagnosis Codes for Lung Cancer**

Priority incorrectly submitted diagnosis codes for lung cancer for 27 of 30 sampled enrollee-years. Specifically:

- For 18 enrollee-years, the medical records indicated in each case that the individual had previously had lung cancer, but the records did not justify a lung cancer diagnosis at the time of the physician’s service.

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

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

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<sup>21</sup> Deep vein thrombosis occurs when a blood clot forms in one or more of the deep veins of the body, usually in the legs.

- For the remaining 2 enrollee-years, the medical records in each case did not support a lung cancer diagnosis.<sup>22</sup>

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. The medical documentation states a concern for malignancy of lung cancer which is not a definitive diagnosis. Therefore, the diagnosis of lung cancer should not be assigned per outpatient coding guidelines.”

As a result of these errors, the HCC for Lung and Other Severe Cancers was not validated, and Priority received \$193,783 in overpayments for these 27 sampled enrollee-years.

### **Incorrectly Submitted Diagnosis Codes for Breast Cancer**

Priority incorrectly submitted diagnosis codes for breast cancer for all 30 sampled enrollee-years. Specifically:

- For 28 enrollee-years, the medical records indicated in each case that the individual had previously had breast cancer, but the records did not justify a breast cancer diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of breast cancer [diagnosis] which does not result in an HCC.”

- For the remaining 2 enrollee-years, the medical records in each case did not support a breast cancer diagnosis.<sup>23</sup>

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review.”

As a result of these errors, the HCC for Breast, Prostate, and Other Cancers and Tumors was not validated, and Priority received \$36,729 in overpayments for these 30 sampled enrollee-years.

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<sup>22</sup> For 1 of these enrollee-years, the documentation that Priority submitted was a radiology report signed and credentialed by a radiologist. Because this record did not meet CMS’s requirements for acceptable data sources, the reviewed HCC could not be validated (footnote 15).

<sup>23</sup> For 1 of these enrollee-years, the documentation that Priority submitted was a radiology report signed and credentialed by a radiologist. Because this record did not meet CMS’s requirements for acceptable data sources, the reviewed HCC could not be validated (footnote 15).

## **Incorrectly Submitted Diagnosis Codes for Colon Cancer**

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

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

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of colon cancer [diagnosis] which does not result in an HCC.”

- For 4 enrollee-years, the medical records in each case did not support the submitted colon cancer diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis on CMS’s systems that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Priority should not have received an increased payment for the submitted colon cancer diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.
- For the remaining 1 enrollee-year, the medical record did not support a colon cancer diagnosis. Specifically, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review.”

As a result of these errors, the HCC for Colorectal, Bladder, and Other Cancers was not validated, and Priority received \$79,000 in overpayments for these 29 sampled enrollee-years.

## **Incorrectly Submitted Diagnosis Codes for Prostate Cancer**

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

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

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

- For the remaining 2 enrollee-years, the medical records in each case did not support a prostate cancer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. The medical documentation states the patient has prostate cancer with no indication of an active treatment plan to code as a current condition.”

As a result of these errors, the HCC for Breast, Prostate, and Other Cancers and Tumors was not validated, and Priority received \$33,304 in overpayments for these 26 sampled enrollee-years.

### **Incorrectly Submitted Diagnosis Codes for Ovarian Cancer**

Priority incorrectly submitted diagnosis codes for ovarian cancer for 28 of 30 sampled enrollee-years. Specifically:

- For 15 enrollee-years, the medical records indicated in each case that the individual had previously had ovarian cancer, but the records did not justify an ovarian cancer diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of ovarian cancer [diagnosis] which does not result in an HCC.”

- For 7 enrollee-years, the medical records in each case did not support the submitted ovarian cancer diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis on CMS’s systems that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Priority should not have received an increased payment for the submitted ovarian cancer diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.
- For the remaining 6 enrollee-years, the medical records in each case did not support an ovarian cancer diagnosis.<sup>24</sup>

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. There is mention of a family history of ovarian carcinoma only.”

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<sup>24</sup> For 1 of these enrollee-years, the documentation that Priority submitted was a radiology report signed and credentialed by a radiologist. Because this record did not meet CMS’s requirements for acceptable data sources, the reviewed HCC could not be validated (footnote 15).

As a result of these errors, the Ovarian Cancer HCCs were not validated, and Priority received \$153,899 in overpayments for these 28 sampled enrollee-years.

### **Incorrectly Submitted Diagnosis Codes for Sepsis**

Priority incorrectly submitted diagnosis codes for sepsis for 14 of 30 sampled enrollee-years. Specifically:

- For 13 enrollee-years, the medical records in each case did not support a sepsis diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review.”

- For the remaining 1 enrollee-year, the medical record indicated that the individual had previously had sepsis, but the record did not justify a sepsis diagnosis at the time of the physician’s service.

For the medical record associated with this enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of [a] sepsis [diagnosis] which does not result in an HCC.”

As a result of these errors, the HCC for Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock was not validated, and Priority received \$50,060 in overpayments for these 14 sampled enrollee-years.

### **Incorrectly Submitted Diagnosis Codes for Pressure Ulcer**

Priority incorrectly submitted diagnosis codes for pressure ulcer for 15 of 30 sampled enrollee-years. Specifically:

- For 8 enrollee-years, the medical records in each case did not support a pressure ulcer diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a pressure ulcer of unspecified buttock, stage 2 [diagnosis] that does not result in an HCC.”

- For the remaining 7 enrollee-years, the medical records in each case did not support the submitted pressure ulcer diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis on CMS’s systems that mapped to an HCC for a

less severe manifestation of the related-disease group. Accordingly, Priority should not have received an increased payment for the submitted pressure ulcer diagnosis, but it should have received a lesser increased payment for the other diagnosis identified.

As a result of these errors, the Pressure Ulcer HCCs were not validated, and Priority received \$112,437 in overpayments for these 15 sampled enrollee-years.

### **Summary of Incorrectly Submitted Diagnosis Codes**

In summary and with respect to the 10 high-risk groups covered by our audit, Priority received \$828,010 in net overpayments for 252 of the 300 sampled enrollee-years.

### **THE POLICIES AND PROCEDURES THAT PRIORITY HEALTH HAD TO PREVENT, DETECT, AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS COULD BE IMPROVED**

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

During our audit period, Priority had compliance procedures in place that were designed to prevent the submission of incorrect diagnosis codes. These procedures included a variety of provider-specific outreach efforts to train and educate its providers on medical record documentation, including how to: (1) accurately document diagnosis codes that are at high risk for being miscoded (including some that we also identified for this audit) and (2) distinguish between active and historical medical conditions. In addition, Priority used an online provider portal to communicate updated coding guidelines as well as other coding topics to its providers.

Priority's compliance procedures also included detection and correction measures designed to determine whether the diagnosis codes that it submitted to CMS were correct. For example, Priority performed data validation audits of providers for which it selected previously submitted claims to verify that the diagnosis codes were supported by medical record documentation. In addition, Priority performed coding reviews of its coding vendors to determine whether the vendors' coders met a 95-percent accuracy rate.

Furthermore, during our audit period, Priority performed an annual risk assessment to verify that its compliance department used effective monitoring and auditing practices. This assessment was designed to identify any aspects of Priority's participation in CMS's risk adjustment program that were at high risk of noncompliance or that could be prone to fraud, waste, and abuse. For any high-risk areas identified, Priority's compliance committee developed a plan to monitor and audit these areas.

We acknowledge that Priority had compliance procedures in place during the audit period that included measures designed to ensure that diagnosis codes, including some of the diagnoses that we classified as high risk for being miscoded, comply with Federal requirements. However,

because we found that 252 of the 300 sampled enrollee-years were not supported by medical records, we believe that these procedures, as they relate to diagnoses that are at high risk for being miscoded, could be improved.

### **PRIORITY HEALTH RECEIVED NET OVERPAYMENTS**

As a result of the errors we identified, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Priority received \$4,479,698 in net overpayments for our audit period.

### **RECOMMENDATIONS**

We recommend that Priority Health:

- refund to the Federal Government the \$4,479,698 of estimated net overpayments;<sup>25</sup>
- identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred after our audit period and refund any resulting overpayments to the Federal Government; and
- continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS’s risk adjustment program) and take the necessary steps to enhance those procedures.

### **PRIORITY HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, Priority disagreed with some of our findings and all of our recommendations, and requested that we withdraw the recommendations. Priority did not agree with our findings for 20 of the 257 enrollee-years that we had identified as errors in our draft report and separately provided additional information for our consideration. Priority stated that it planned to further evaluate our findings for the remaining 237 enrollee-years that our draft report had identified.

Priority also stated that our audit “violate[d] actuarial equivalence requirements,” and was “an unreliable measure of payment accuracy.” Additionally, Priority stated that the Office of Inspector General (OIG) has “no authority to use extrapolation,” and that we “failed to follow the procedures prescribed by statute. . . .” Furthermore, Priority said that it is not “required by statute or regulation” to identify similar instances of noncompliance that occurred after our

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<sup>25</sup> OIG audit recommendations do not represent final determinations. Action officials at CMS will determine whether an overpayment exists and will recoup any overpayments consistent with CMS’s policies and procedures. In accordance with 42 CFR § 422.311, which addresses audits conducted by the Secretary (including those conducted by OIG), if a disallowance is taken, MA organizations have the right to appeal the determination that an overpayment occurred through the Secretary’s Risk Adjustment Data Validation (RADV) appeals process.

audit period and that it “has an effective compliance program in place that is designed to comply with applicable legal and regulatory requirements.”

After reviewing Priority’s comments and the additional information Priority provided, we reduced the number of enrollee-years in error from 257 (in our draft report) to 252 and adjusted our calculation of net overpayments for this final report. Accordingly, we reduced the amount in our first recommendation from \$4,575,972 to \$4,479,698. We maintain that our second and third recommendations remain valid.

A summary of Priority’s comments and our responses follows. Priority’s comments appear as Appendix E. We are separately providing Priority’s comments along with the additional information it gave us to CMS.

## **PRIORITY HEALTH DISAGREED WITH THE OIG’S RECOMMENDATION THAT IT REFUND OVERPAYMENTS**

### **Priority Health Did Not Agree With the OIG’s Findings for 20 Sampled Enrollee-Years**

#### *Priority Health Comments*

Priority disagreed with our findings for 20 sampled enrollee-years (as shown in Table 2) and separately provided additional information supporting its belief that the HCCs in question were validated.

**Table 2: Summary of Enrollee-Years for Which Priority Health Disagreed With Our Findings**

High-Risk Group	Number of Sampled Enrollee-Years
Acute stroke	1
Embolism	3
Colon cancer	5
Prostate cancer	2
Sepsis	6
Pressure ulcer	3
<b>Total</b>	<b>20</b>

#### *OIG Response*

The independent medical review contractor reviewed the additional information that Priority provided for the 20 sampled enrollee-years.

- For 15 of the 20 enrollee-years, the independent medical review contractor reaffirmed that the reviewed HCCs were not validated.

For example, for 1 enrollee-year from the colon cancer high-risk group, the contractor upheld its original decision upon reconsideration and stated that “[t]here is no documentation of recurrence, monitoring, or current treatment. A past history of [a] colon cancer [diagnosis] should be assigned which does not result in any HCC.”

- For the remaining 5 enrollee-years, the contractor found support for the reviewed HCCs and therefore validated the HCCs.<sup>26</sup>

Accordingly, we reduced the number of enrollee-years in error from 257 (in our draft report) to 252 for this final report. We also reduced the associated statistical estimates and monetary recommendation. The independent medical review contractor confirmed that the additional information that Priority gave to us had no impact on the decisions that the contractor had made for other sampled enrollee-years that our draft report had identified.

### **Priority Health Stated That the OIG’s Audit Violated Actuarial Equivalence Requirements**

#### *Priority Health Comments*

Priority stated that our audit violated a payment principle known as “actuarial equivalence,” which is imposed by statute, because we did not “include an adjustment to account for the error rate found in [traditional] Medicare.” Specifically, Priority said that “[a]ny extrapolation methodology to determine a contract-level payment error must be adjusted to account for the fact that the [FFS] data from the [traditional] Medicare program. . . was unaudited and therefore includes a certain number of unsupported codes.” According to Priority, “[t]he failure to make such an adjustment results in the application of a more exacting standard to the MA program relative to traditional Medicare” and “may also result in the underpayment of [MA organizations], undermining the purpose of the risk adjustment system.”

Furthermore, Priority stated that our “focus on a subset of ‘high-risk’ diagnosis codes further exacerbates the problem.” To expand, Priority said that “providers generate the vast majority of diagnosis codes that Priority Health submits to CMS for risk adjustment purposes. And providers are just as likely to be making diagnosis coding errors in traditional Medicare” as they are in the MA program. Moreover, Priority added that these potentially erroneous diagnosis codes “predominantly stem from unintentional errors in provider submissions that will likely persist despite appropriate oversight by [MA organizations] and diligent efforts to educate providers.” To illustrate its point, Priority cited an OIG report on acute stroke diagnoses that were submitted by traditional Medicare providers and that resulted in increased payments to MA organizations.<sup>27</sup>

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<sup>26</sup> The five enrollee-years were in the following high-risk groups: embolism (3) and pressure ulcer (2).

<sup>27</sup> The previous report to which Priority referred was *Incorrect Acute Stroke Diagnosis Codes Submitted by Traditional Medicare Providers Resulted in Millions of Dollars in Increased Payments to Medicare Advantage Organizations* ([A-07-17-01176](#); Sept. 16, 2020).

According to Priority, because we did not adjust our audit findings to account for either “an overall payment error rate” or a payment error rate for the specific high-risk diagnosis codes included in this audit, “[a]ny CMS recoupment” of the estimated net overpayment would put Priority “at risk of systemic *underpayment*” (emphasis in original). Priority stated that therefore, “it is arbitrary and capricious for OIG to make such a recommendation . . . .”

Priority also referred to CMS’s 2012 public notice to MA organizations that CMS would (in Priority’s words), “apply a[n] FFS Adjuster when determining the final payment recovery amount in order to maintain actuarial equivalence.” Priority also referred to CMS’s publication in 2018 of “a proposed rule in which [CMS] signaled that it would not use the FFS Adjuster”—a rule that CMS finalized in February 2023.<sup>28</sup> Priority stated that it “strongly disagrees” with the final rule’s decision to not adopt an FFS Adjuster, stating that the decision was “not only contrary to law, but also arbitrary and capricious.”

### *OIG Response*

Regarding Priority’s statement that our audit violated actuarial equivalence because we did not include an adjustment, we note that after Priority commented on our draft report, a U.S. District Court vacated and remanded the final rule.<sup>29</sup> However, this ruling does not impact our findings or cause us to change our recommendations. Notwithstanding this ruling, CMS has not issued any requirements that compel us to reduce our overpayment calculations. Our audit methodology correctly applied CMS requirements to properly identify the net overpayment amount associated with the HCCs that were not validated for each sample item. We followed CMS’s risk adjustment program requirements to determine the payment that CMS should have made for each enrollee-year and to estimate net overpayments.

We also disagree with Priority’s statement that our focus on high-risk diagnosis codes further “exacerbates” the payment principle of actuarial equivalence. Our audit revealed a substantial error rate (252 of 300 enrollee-years) in the high-risk groups of diagnosis codes on which this audit focused. Accordingly, we note that Federal regulations require MA organizations to implement procedures for “promptly responding to compliance issues as they are raised” and to “[correct] such problems promptly and thoroughly to reduce the potential for recurrence” (42 CFR § 422.503(b)(4)(vi)(G)). These Federal regulations apply to diagnosis codes originating on provider submissions—including the high-risk groups on which we focused—and submitted by MA organizations to CMS for risk adjustment purposes.

Moreover, we continue to recognize that CMS—not OIG—is responsible for making operational and program payment determinations for the MA program, including the application of any FFS Adjuster requirements. If CMS deems it appropriate to apply an FFS Adjuster, it will, during the

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<sup>28</sup> All subsequent references to “final rule” in this report refer solely to the CMS final rule issued on Feb. 1, 2023. 88 Fed. Reg. at 6643.

<sup>29</sup> U.S. District Court of the Northern District of Texas ruling can be found at: [gov.uscourts.txnd.380836.76.0.2.pdf](https://gov.uscourts.txnd.380836.76.0.2.pdf) (accessed on Dec. 9, 2025).

audit resolution process, adjust our net overpayment finding by whatever amount it determines necessary. For these reasons, we believe that our recommended refund of net overpayments based on our revised findings is appropriate.

### **Priority Health Stated That the OIG’s Audit Was an Unreliable Measure of Payment Accuracy Because of Its Focus on Potential Overpayments**

#### *Priority Health Comments*

Priority stated that our audit “focuse[d] on ‘high-risk groups of diagnoses,’ targeting potential overpayments rather than both overpayments and underpayments.” Additionally, Priority stated that we “further construct[ed] a sample based on specific situations in which these specific diagnoses are most likely to be unsupported by medical records.” To illustrate its point, Priority referred to the methodology we used to identify the enrollee-years for the acute stroke high-risk group, under which we audited only enrollee-years for which the diagnosis appeared on only one physician claim during the service year and did not appear on a corresponding inpatient or outpatient claim. According to Priority, our methodology to identify diagnoses that were at higher risk of being miscoded “was systematically skewed towards identifying overpayments, rather than underpayments,” and therefore our audit results were “an unreliable measure of payment accuracy.”

Priority also said that although we stated in the draft report that we accounted for both overpayments and underpayments, we “provide[d] no details about the amount of underpayments that [we] calculated.” Priority requested that we “disclose the amount of underpayments, if any, that [we] identified” and added that any underpayment amount we identified “likely substantially understate[d] the prevalence of underpayments . . . .”

Furthermore, Priority stated that our audit only “solicited medical records to substantiate diagnosis codes actually submitted to CMS” and did not solicit medical records to support diagnosis codes that were not submitted to CMS. Therefore, Priority added, we “could not have detected this important source of underpayments.” Priority also referred to CMS’s risk adjustment submission guidance that allows MA organizations to delete diagnosis codes at any time but only allows the MA organizations to submit newly found diagnosis codes for a period of time before the payment year is closed.

#### *OIG Response*

We disagree with Priority’s assertion that our audit focused only on finding potential overpayments. Our objective was to determine whether selected high-risk diagnosis codes that Priority submitted to CMS for use in CMS’s risk adjustment program complied with Federal requirements. We identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into 10 specific high-risk groups. This process involved a carefully designed audit methodology (Appendix A). Our objective did not extend to diagnosis codes not previously submitted by Priority or to HCCs that were beyond the scope of our audit.

Furthermore, we did consider underpayments as they related to our objective, as we explain in Appendix A of our report. For the HCCs that were not validated, if the independent medical review contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, or if we identified another diagnosis code (on CMS's systems) that mapped to an HCC in the related-disease group, we included the financial impact of the resulting HCC (if any) in our calculation of net overpayments. During our exit conference, we gave Priority officials the net overpayment calculation for each sampled enrollee-year, which included an underpayment that we identified in the acute stroke high-risk group.

A valid estimate of overpayments, given the objective of our audit, does not need to take into consideration all potential HCCs or underpayments within the audit period. We based our estimate of net overpayments on the results of the independent medical review contractor's review; this estimate addressed only the accuracy of the portion of payments related to the reviewed HCCs and did not extend to HCCs that were beyond the scope of this audit.

### **Priority Health Stated That the OIG Has No Authority To Use Extrapolation To Estimate a Contract-Level Net Overpayment Amount**

#### *Priority Health Comments*

Priority stated that it does not believe that “there is a clear statutory basis for either CMS or OIG to use extrapolation to calculate overpayments in the MA program.” Specifically, Priority cited a provision in the Medicare statute that permits Medicare contractors to extrapolate only when there has been a determination by the Secretary of Health and Human Services (HHS) of a sustained or high level of payment error or when documented educational intervention has failed to correct errors.<sup>30</sup> Priority stated that our draft report “provides no indication that the requisite determination was made by the Secretary.”

Priority also referred to a citation in our draft report to Federal regulations that states that CMS may apply extrapolation to audits for payment year 2018 and subsequent payment years. According to Priority, “even supposing that this [Federal] regulation is lawful . . . it in no way provides OIG with authority to use extrapolation to calculate a contract-level overpayment amount” (emphasis in original). Additionally, Priority stated that although the preamble to CMS's final rule states that CMS can collect extrapolated amounts that OIG calculates, “there is nothing in the regulatory text of the [final] rule that authorizes CMS to collect extrapolated overpayments calculated by OIG.” Priority added that “‘the regulatory ‘preamble’ . . . ‘itself lacks the force and effect of law.’”<sup>31</sup>

Moreover, Priority stated that “[t]o the extent that OIG relied upon the Inspector General Act (IGA) to conduct this audit, the IGA does not authorize OIG” to use extrapolation. Priority

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<sup>30</sup> Priority cited 42 U.S.C. § 1395ddd(f)(3).

<sup>31</sup> Priority cited a passage from a Federal court ruling in *AT&T Corp. v. FCC*, 970 F.3d 344, 350-1 (D.C. Cir. 2020).

stated that “Congress delegated authority to the Inspector General, not the [HHS] Secretary or CMS, in the IGA” and that no Federal or CMS regulations give OIG the authority to use extrapolation. Priority also stated that in other OIG reports, we “failed to account for the gap between any audit authority under the IGA and [our] recommendations on extrapolated overpayments . . . .” Specifically, Priority stated that “if neither CMS nor OIG can calculate or collect extrapolated overpayments, then public recommendations . . . serve only to confuse the public and cause reputational harm to [MA organizations].”

### *OIG Response*

We disagree with Priority’s assertion that we do not have authority under the IGA to calculate extrapolated overpayments. Neither Federal statute nor any other authority limits our ability to use sampling techniques with extrapolation to calculate overpayments or recommend a recovery based on extrapolation. Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.<sup>32</sup> We note that the requirement that a determination of a sustained or high level of payment error or documented failed educational intervention must be made before extrapolation applies only to Medicare contractors.<sup>33</sup>

Furthermore, and as stated above, we acknowledge that a U.S. District Court has vacated and remanded the final rule (footnote 29). However, notwithstanding this ruling, CMS has not issued any requirements stating that we cannot recommend a recovery based on extrapolation. We reiterate that it is CMS—not OIG—that is responsible for making operational and program payment determinations for the MA program.

### **Priority Health Stated That the OIG Failed To Follow Procedures Prescribed by Statute**

#### *Priority Health Comments*

Priority cited Federal requirements that, according to Priority, require CMS to use notice-and-comment rulemaking when it adopts “any ‘rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . .’”<sup>34</sup> Priority also cited a U.S. Supreme Court ruling that HHS must follow notice-

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<sup>32</sup> See *Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at \*26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at \*17 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

<sup>33</sup> The Act § 1893(f)(3); CMS *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 8, § 8.4.1.4.

<sup>34</sup> Priority cited 42 U.S.C. § 1395hh(a)(2).

and-comment rulemaking when issuing Medicare policies that establish or change substantive legal standards.<sup>35</sup>

In this context, Priority stated that our audit process imposed a “standard of perfection in coding, which is a substantively different legal standard from the past and is not required by the federal requirements cited by OIG in the Draft Report” and thus, “these standards must be subject to notice-and-comment rulemaking.”<sup>36</sup>

Furthermore, Priority stated that we “did not promulgate through notice-and-comment rulemaking” the standards or process that our independent medical review contractor used when reviewing medical records. Specifically, Priority stated that our draft report “did not identify the coding guidelines . . . or any supplemental coding resources” that our independent medical review contractor used when making coding review determinations. Priority stated that we “should confirm the standards that were applied,” and noted that the ICD coding guidelines, the Manual, and the other coding resources we cited in our draft report have not been promulgated by Federal regulations adopted through notice-and-comment rulemaking.

#### *OIG Response*

We do not agree with Priority’s comments regarding the need for notice-and-comment rulemaking to establish the methodology we used in this audit. We did not apply any new regulatory requirements that would be subject to notice-and-comment rulemaking, and in that sense our audit does not make major changes to a CMS-administered program.

Furthermore, we disagree with Priority’s statement that our audit imposed “a standard of perfection” for coding diagnoses. That was not our intention or our focus for this audit. We limited our audit and recommendations to certain diagnosis codes that we had determined to be at high risk for being miscoded. We found that most of the diagnosis codes we reviewed were indeed miscoded and resulted in net overpayments made by the Federal Government.

We also disagree with Priority’s comments regarding the need to promulgate through notice-and-comment rulemaking the medical record review standards used by our independent medical review contractor. Federal regulations at 42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(c)(2)-(3) require that diagnoses be coded according to ICD Coding Guidelines. Moreover, the Manual is legally binding on an MA organization, based not only on regulation but also on its contract with CMS. An MA organization that contracts with CMS must agree to follow CMS’s instructions, including the provisions of the Manual.<sup>37</sup> Priority has agreed to operate in compliance with the Manual under the terms of its contract with CMS and is bound by the requirements of that contract, including any applicable provisions of the Manual.

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<sup>35</sup> Priority cited *Azar v. Allina Health Services*, 139 S. Ct. 1804, 1816 (2019).

<sup>36</sup> Priority cited 65 Fed. Reg. 40170, 40268 (June 29, 2000).

<sup>37</sup> 42 CFR § 422.504(a).

Our independent medical review contractor performed its review to determine whether the diagnoses in the medical records associated with the sampled enrollee-years were coded according to: (1) ICD-10-CM *Official Guidelines for Coding and Reporting*, (2) the AHA Coding Clinic for ICD-10-CM and ICD-10-PCS, and (3) the CMS-published *Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance*. We provided Priority with the results of our audit and information on the procedures that the contractor followed to make its determinations.

### **Priority Health Stated That the OIG’s Audit Methodology Amounted to Unlawful Retroactive Application of a New Policy**

#### *Priority Health Comments*

Priority stated that our audit methodology departed from “CMS’s longstanding practice” and thus, according to Medicare statute, should not be applied because our “imposition of a new audit methodology to a prior year amounted to retroactive application of a new policy.” Furthermore, Priority stated that we did not provide any details on the validity of the statistical software that we used, or on whether any independent statistician or expert had confirmed its accuracy. Priority added that “[t]he lack of information provided on the statistical software used injects uncertainty into the auditing process and OIG’s findings.”

#### *OIG Response*

We disagree with Priority’s statement that we imposed a “retroactive application of a new policy.” We are not recommending the application of any new statutory or regulatory requirements and therefore, Priority’s reference to the Medicare statute’s prohibition of retroactive application of rules is not applicable to this audit. In accordance with the Inspector General Act of 1978, 5 U.S.C. App., our audits are intended to provide an independent assessment of HHS programs and operations. Although our approach was generally consistent with the methodology CMS uses in its audits, it did not mirror CMS’s approach in all aspects, nor did it have to.

Furthermore, regarding Priority’s statement regarding the validity and accuracy of our statistical software (i.e., RAT-STATS), we note that the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.<sup>38</sup> We properly executed a statistically valid sampling methodology in that we defined our sampling frame (enrollees with a high-risk diagnosis) and sample unit, randomly selected our sample, applied relevant criteria to evaluate the sample, and used RAT-STATS to

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<sup>38</sup> See *John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at \*34-35 (W.D. Pa. 2012), *aff’d* 555 F. App’x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff’d*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at \*17 (S.D. Fla. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at \*13 (S.D. Tex. 2012).

apply the correct formulas to estimate the net overpayments in the sampling frame made to Priority.

The HHS Departmental Appeals Board (DAB) has ruled that in terms of its use for statistical sampling, the RAT-STATS random number generator is sufficiently random.<sup>39</sup> Additionally, RAT-STATS performs a limited set of statistical computations, and the formulas are well-known, well-established, and easy to replicate. Because Priority has not given us information on any specific discrepancies it identified for our sampling methodology or computations, we maintain that our methodology and estimates provide a reasonable and statistically valid basis for our extrapolated monetary recommendations.

### **Priority Health Stated That the OIG Did Not Disclose Additional Information About the Independent Medical Review Contractor’s Initial Decisions or Its Identity and That the Tie Breaker Process Is Arbitrary and Capricious**

#### *Priority Health Comments*

Priority expressed concerns regarding our independent medical record coding process. Regarding those concerns, Priority made several related points:

- Priority stated that it received only the final coding determinations from our independent medical review contractor and that therefore, Priority “has no way of evaluating the contractor’s decision-making process as a whole . . . .”
- Priority stated that we did not reveal the identity of the independent medical review contractor. Therefore, according to Priority, it had no way of “evaluating whether the contractor was qualified, applied consistent standards across its work for OIG and other clients, or was free from conflicts of interest.” Priority requested that we disclose this information “pursuant to the Data Quality Act and [GAGAS].”
- Priority also stated that it disagreed that the Registered Health Information Technician (RHIT) credential (held by some coders employed by our independent medical review contractor) is an “appropriate qualification for this type of risk adjustment coding audit.”
- Priority also stated that our use (as described in Appendix A) of a physician reviewer as a “tie breaker” was “arbitrary and capricious . . . .” Specifically, Priority said that we “did not give weight to the diagnoses coded by treating physicians when OIG’s coders split on the question of whether the diagnoses were supported.” Priority added that “[t]he lack of weight given to the diagnosis by the treating physician is arbitrary and capricious because the treating physician has more education, training, and skills than the coders, and was closer to the patient than the coders.” Therefore, according to Priority, “[i]f

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<sup>39</sup> New York State Department of Social Services, DAB No. 1531 (1995).

one of OIG’s coders agrees with the treating physician’s diagnosis, then the diagnosis is plainly valid and there should be no ‘tie’ to break.”

### *OIG Response*

We disagree with Priority’s comments about the qualifications of our medical review process and our independent medical review contractor. Specifically:

- As explained in our audit methodology (Appendix A), the coding review followed a specific process to determine whether there was support for a diagnosis code and the associated HCC. At the conclusion of this process, we used only the final coding review determination for each sampled enrollee-year to calculate overpayments or underpayments. During our audit, we gave Priority details on the final coding review determinations for each sampled enrollee-year, which included our contractor’s determinations and the reasons for those determinations, including any coding and documentation standards that applied.
- It is not our practice to name our independent medical review contractor. Identifying our contractor by name would not provide information about our contractor’s qualifications beyond what we state in this audit report. Additionally, we take proactive measures as a routine aspect of our audit process to ensure that there are no conflicts of interest among the parties involved in the performance of the audit.
- With respect to Priority’s statement that an RHIT credential is an inappropriate qualification for this type of audit, we informed Priority that our medical reviews were performed by professional coders credentialed by the American Health Information Management Associations (AHIMA), the American Academy of Professional Coders (AAPC), or both. (See footnote 46 in Appendix A.) These coders were duly experienced in coding ICD-10-CM diagnosis codes for hospital inpatient, outpatient, and physician medical records. The independent medical review contractor’s coding reviewers were fully qualified, on the basis of certifications as well as experience, to accurately and objectively perform the work for which they were employed.
- We disagree that our use of a physician reviewer as “tie breaker” was “arbitrary and capricious.” The independent medical review contractor used both skilled coders and physician reviewers (when necessary) to review medical record documentation. The coders and physician reviewers did not make clinical judgments; rather, they applied coding rules to accurately assign applicable ICD codes that translated to HCCs. We believe that the use of a physician to serve as the final decision maker (i.e., tie breaker) was a reasonable method for determining whether the medical records adequately supported the reported diagnosis codes.

## Priority Health Stated That the OIG’s Audit Approach Created Significant Challenges for Medicare Advantage Organizations When Developing Their Annual Bid Amounts

### *Priority Health Comments*

Priority stated that every year, MA organizations “spend *significant* time and effort in developing accurate rates to ensure they can adequately cover services used” (emphasis in original). Priority said our audit “undermines these efforts” because our audits “often occur long after payment years are settled or the audits span multiple payment years.” Priority also said that recommending a refund amount for a settled payment year “signals” that the settled payment year is inaccurate and that therefore, the annual bid rate calculations may not represent the actual costs of delivering care. According to Priority, the “uncertainty” of when the audit will be conducted, the impact and the scope of the audit, and the time between when the audit is settled and when the bids are submitted “makes it exceedingly difficult to develop accurate risk score projections.”

Furthermore, Priority referred to our audits as “one-sided” because, Priority stated, they “only seek to *recoup* revenue from [MA organizations] . . .” (emphasis in original). Therefore, according to Priority, “any action by [MA organizations] to account for such recoupments in the bid estimates ultimately serve to *reduce* benefits to members during the bid development and submission process” (emphasis in original). Additionally, Priority stated the “unpredictability of OIG’s audits makes it impossible for plans to trust that a settled payment year is actually settled. When [MA organizations] lack this certainty, it creates risk that [enrollees] may be exposed to premium instability and/or reduced benefits.”

### *OIG Response*

Priority’s statement—that our audits “undermine” an MA organization’s efforts to set bid amounts to ensure that the organizations can “adequately cover services used”—points to possible outcomes that range far outside the scope of our audit. Under the provisions of Federal regulations at 42 CFR § 422.254(b)(1), “[t]he monthly aggregate bid amount submitted by an MA organization for each plan is the organization’s estimate of the revenue required . . . for providing coverage to an MA eligible [individual] with a national average risk profile.” CMS uses the amounts from the bid proposals to create contracts with MA organizations (like Priority). As a provision of its contract with CMS, Priority agreed that the OIG has the right to inspect, evaluate, and audit any pertinent information for any particular contract period. However, neither Federal regulations nor the contract with CMS permit changes to bid proposal amounts in anticipation of OIG audits.

As previously stated, for this audit, our objective was to determine whether Priority submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. OIG audit findings and recommendations do not represent final determinations by CMS. During the audit resolution process, CMS will determine whether an overpayment

exists and will work with Priority to recoup any overpayments consistent with its policies and procedures (footnote 25).

## **PRIORITY HEALTH DISAGREED WITH THE OIG’S RECOMMENDATION TO IDENTIFY SIMILAR INSTANCES OF NONCOMPLIANCE THAT OCCURRED AFTER OUR AUDIT PERIOD**

### **Priority Health Comments**

Priority disagreed with our second recommendation—to identify similar instances of noncompliance that occurred after our audit period—and requested that we withdraw this recommendation from our final report. Priority stated that applicable regulations do not require it to “perform the audits OIG recommends.”

Furthermore, Priority stated that “[t]here is no statutory authority—and CMS has not issued any regulations (or even non-binding guidance)—requiring [MA organizations] to conduct audits of specific ‘high-risk diagnoses’ and make associated repayments.” To elaborate on this point, Priority stated that “OIG is in effect unilaterally imposing a new substantive requirement” on Priority. In addition, Priority said that to the extent that our recommendation “conflicts with CMS’s regulations or attempts to impose its own interpretation of those regulations on [MA organizations], it arbitrarily and capriciously subjects Priority Health to two contradictory regulatory regimes.” Furthermore, Priority reiterated that “to the extent OIG intends to impose new legal standards on [MA organizations], it must do so through notice-and-comment rulemaking.”

### **OIG Response**

We do not agree with Priority’s interpretation of the Federal requirements. Contrary to Priority’s assertions, we maintain that our recommendation that Priority review whether similar instances of high-risk diagnoses occurred after our audit period remains valid and conforms to the requirements specified in Federal regulations (42 CFR § 422.503(b)(4)(vi) (Appendix D)).

These Federal regulations state that MA organizations must “implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS’ program requirements . . . .” These regulations also require MA organizations to implement procedures and a system for investigating “potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence” (42 CFR § 422.503(b)(4)(vi)(G)). Thus, CMS has, through the issuance of these Federal regulations, assigned the responsibility for dealing with potential compliance issues to the MA organizations.

In this regard, CMS has provided additional guidance in chapter 7, § 40, of the Manual, which states:

If upon conducting an internal review of submitted diagnosis codes, the [MA organization] determines that any diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible . . . . Once CMS calculates the final risk scores for a payment year, [MA organizations] may request a recalculation of payment upon discovering the submission of inaccurate diagnosis codes that CMS used to calculate a final risk score for a previous payment year and that had an impact on the final payment. [MA organizations] must inform CMS immediately upon such a finding.

Furthermore, as stated above, we do not agree with Priority’s comments regarding the need for notice-and-comment rulemaking as it applies to our second recommendation. We did not apply any new regulatory requirements or impose any new legal standards that would be subject to notice-and-comment rulemaking. Accordingly, we maintain the validity of our second recommendation that Priority identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred after our audit period.

#### **PRIORITY HEALTH DISAGREED WITH THE OIG’S RECOMMENDATION TO CONTINUE TO EXAMINE ITS EXISTING COMPLIANCE PROCEDURES AND TAKE NECESSARY STEPS TO ENHANCE THEM**

##### **Priority Health Comments**

Priority disagreed with our third recommendation that it continue to examine its existing compliance procedures for diagnoses that are at high risk for being miscoded and enhance those procedures as necessary. Specifically, Priority stated that it “has a robust compliance program that is designed to comply with all legal and regulatory requirements.” Priority also stated that MA organizations “have broad discretion to design and implement their compliance programs, including their auditing and monitoring functions.” Furthermore, Priority added that our “review of claims data from payment years 2018 and 2019 is not representative of Priority Health’s current compliance practices, which were not reviewed by OIG.”

Priority also noted that we acknowledged in our draft report that Priority had measures in place during the audit period to ensure that diagnosis codes comply with Federal requirements. Priority stated that it “works to continuously improve and refine [its] compliance program to evolving risks on an ongoing basis” and “remains committed to continuous compliance improvement.” Therefore, Priority requested that we withdraw this recommendation from our final report.

##### **OIG Response**

Priority is correct in that our audit examined its compliance procedures that were in place during our audit period and not its current compliance program. Our audit revealed a substantial error rate (252 of 300 enrollee-years) in the high-risk groups of diagnosis codes

(Appendix C). We acknowledge that Priority had compliance procedures in place to promote the accuracy of diagnosis codes submitted to CMS to calculate risk-adjusted payments, including procedures related to the high-risk diagnosis codes that are the subject of this audit. Federal regulations at 42 CFR § 422.503(b) require MA organizations like Priority to establish and implement an effective system for routine monitoring and the identification of compliance risks. This regulation further explains that a compliance system should consider both internal monitoring and external audits.

We continue to believe that Priority's compliance program could be improved. The continued improvement of procedures will assist Priority in attaining better assurance with regard to the accuracy, completeness, and truthfulness of the risk adjustment data that it submits to CMS in the future. Accordingly, we maintain that our third recommendation, that Priority examine its existing compliance procedures, is valid.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

CMS paid Priority approximately \$2.1 billion to provide coverage to its enrollees for 2018 and 2019. We identified a sampling frame of 2,515 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes during the 2017 and 2018 service years. Priority received \$42,857,187 in payments from CMS for these enrollee-years for 2018 and 2019. We selected for audit 300 enrollee-years with payments totaling \$5,210,746.

The 300 enrollee-years included 30 acute stroke diagnoses, 30 acute myocardial infarction diagnoses, 30 embolism diagnoses, 30 lung cancer diagnoses, 30 breast cancer diagnoses, 30 colon cancer diagnoses, 30 prostate cancer diagnoses, 30 ovarian cancer diagnoses, 30 sepsis diagnoses, and 30 pressure ulcer diagnoses. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$1,112,195 for our sample.

Our audit objective did not require an understanding or assessment of Priority'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 March 2022 through September 2025.

### METHODOLOGY

To accomplish our objective, we performed the following steps:

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

- 10 diagnosis codes for colon cancer,
  - 1 diagnosis code for prostate cancer,
  - 9 diagnosis codes for ovarian cancer,
  - 30 diagnosis codes for sepsis, and
  - 50 diagnosis codes for pressure ulcer.
- We used CMS’s systems to identify the enrollee-years on whose behalf providers documented the high-risk diagnosis codes. Specifically, we used extracts from CMS’s:
    - Risk Adjustment Processing System (RAPS)<sup>40</sup> and Encounter Data System (EDS)<sup>41</sup> to identify enrollees who received high-risk diagnosis codes from a physician during the service years,
    - Risk Adjustment System (RAS)<sup>42</sup> to identify enrollees who received an HCC for the high-risk diagnosis codes,
    - Medicare Advantage Prescription Drug System (MARx)<sup>43</sup> to identify enrollees for whom CMS made monthly Medicare payments to Priority before applying the budget sequestration reduction, for the relevant portions of the service and payment years (Appendix C),
    - EDS<sup>44</sup> to identify enrollees who received specific procedures, and
    - Prescription Drug Event (PDE) file<sup>45</sup> to identify enrollees who had Medicare claims with certain medications dispensed on their behalf.
  - We communicated with Priority officials to gain an understanding of: (1) the policies and procedures that Priority followed to submit diagnosis codes to CMS for use in the risk adjustment program and (2) Priority’s monitoring of those diagnosis codes to detect and correct noncompliance with Federal requirements.
  - We identified a sampling frame of 2,515 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes for the 2017 and 2018 service years.

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<sup>40</sup> MA organizations use the RAPS to submit diagnosis codes to CMS.

<sup>41</sup> CMS uses the EDS to collect encounter data, including diagnosis codes, from MA organizations.

<sup>42</sup> The RAS identifies the HCCs that CMS factors into each enrollee’s risk score calculation.

<sup>43</sup> The MARx identifies the payments made to MA organizations.

<sup>44</sup> The EDS contains information on each item (including procedures) and service provided to enrollees.

<sup>45</sup> The PDE file contains claims with prescription drugs that have been dispensed to enrollees through the Medicare Part D (prescription drug coverage) program.

- We selected for audit a stratified random sample of 300 enrollee-years (Appendix C).
- We used an independent medical review contractor to perform a coding review for the 300 enrollee-years to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements.<sup>46</sup>
- The independent medical review contractor’s coding review followed a specific process to determine whether there was support for a diagnosis code and the associated HCC:
  - If the first senior coder found support for the diagnosis code on the medical record(s), the HCC was considered validated.
  - If the first senior coder did not find support on the medical record(s), a second senior coder performed a separate review of the same medical record(s):
    - 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 the coding supervisor independently reviewed the medical record(s) to make the final determination.
  - If either the first or second senior coder asked the coding supervisor for assistance, the coding supervisor’s decision became the final determination. Additionally, at any point in the review process, a senior coder or coding supervisor may have consulted a physician reviewer for additional clarification.
- We used the results of the independent medical review contractor, and CMS’s systems, to calculate overpayments or underpayments (if any) for each enrollee-year. Specifically, we calculated:
  - a revised risk score in accordance with CMS’s risk adjustment program and
  - the payment that CMS should have made for each enrollee-year.
- We estimated the total net overpayment made to Priority for the high-risk groups included in the sampling frame for the audit period in accordance with CMS’s

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<sup>46</sup> Our independent medical review contractor used senior coders, all of whom possessed one or more of the following qualifications and certifications: RHIT, Certified Coding Specialist (CCS), Certified Coding Specialist – Physician-Based (CCS-P), Certified Professional Coder (CPC), and Certified Risk Adjustment Coder (CRC). RHITs have completed a 2-year degree program and have passed an AHIMA certification exam. The AHIMA also credentials individuals with CCS and CCS-P certifications and the AAPC credentials both CPCs and CRCs.

regulations for the use of extrapolation in Risk Adjustment Data Validation audits for recovery purposes.

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

We conducted this performance audit in accordance with GAGAS. 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**

We identified Priority enrollees who: (1) were continuously enrolled in Priority throughout all of the 2017 or 2018 service year and January of the following year, (2) were not classified as being enrolled in hospice or as having end-stage renal disease status at any time during 2017 or 2018 or in January of the following year, and (3) received a high-risk diagnosis during 2017 or 2018 that caused an increased payment to Priority for 2018 or 2019, respectively.

We presented the data for these enrollees to Priority for verification and performed an analysis of the data included on CMS's systems to ensure that the high-risk diagnosis codes increased CMS's payments to Priority. After we performed these steps, our finalized sampling frame consisted of 2,515 enrollee-years.

### **SAMPLE UNIT**

The sample unit was an enrollee-year, which covered either payment year 2018 or 2019.

### **SAMPLE DESIGN AND SAMPLE SIZE**

The design for our statistical sample comprised 10 strata of enrollee-years. For the enrollee-years in each respective stratum, each individual received:

- an acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have an acute stroke diagnosis on a corresponding inpatient or outpatient hospital claim (473 enrollee-years);
- an acute myocardial infarction diagnosis (that mapped to the HCC for Acute Myocardial Infarction) on only one physician or outpatient claim during the service year but did not have an acute myocardial infarction diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician or outpatient claim (627 enrollee-years);
- an embolism diagnosis (that mapped to an Embolism HCC) on only one claim during the service year but did not have an anticoagulant medication dispensed on his or her behalf (203 enrollee-years);
- a lung cancer diagnosis (that mapped to the HCC for Lung and Other Severe Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments related to the lung cancer diagnosis administered within a 6-month period before or after the diagnosis (95 enrollee-years);

- a breast cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments related to the breast cancer diagnosis administered within a 6-month period before or after the diagnosis (324 enrollee-years);
- a colon cancer diagnosis (that mapped to the HCC for Colorectal, Bladder, and Other Cancers) on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (159 enrollee-years);
- a prostate cancer diagnosis (that mapped to the HCC for Breast, Prostate, and Other Cancers and Tumors), for an individual 74 years old or younger, on only one claim during the service year but did not have surgical therapy, radiation treatments, or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (342 enrollee-years);
- an ovarian cancer diagnosis (that mapped to an Ovarian Cancer HCC) on only one claim during the service year but did not have surgical therapy or chemotherapy drug treatments administered within a 6-month period before or after the diagnosis (38 enrollee-years);
- a sepsis diagnosis (that mapped to the HCC for Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock) on only one physician or outpatient claim during the service year but did not have a sepsis diagnosis on a corresponding inpatient hospital claim (211 enrollee-years); or
- a pressure ulcer diagnosis (that mapped to a Pressure Ulcer HCC) on only one claim during the service year but did not have a pressure ulcer diagnosis on another inpatient, outpatient, or physician claim for either the calendar year before or the calendar year after the service year (43 enrollee-years).

The specific strata are shown in Table 3 on the following page.

**Table 3: Sample Design for Audited High-Risk Groups**

<b>Stratum (High-Risk Groups)</b>	<b>Frame Count of Enrollee-Years</b>	<b>CMS Payment for HCCs in Audited High-Risk Groups</b>	<b>Sample Size</b>
1 – Acute stroke	473	\$913,241	30
2 – Acute myocardial infarction	627	1,101,848	30
3 – Embolism	203	539,451	30
4 – Lung cancer	95	721,229	30
5 – Breast cancer	324	418,114	30
6 – Colon cancer	159	423,497	30
7 – Prostate cancer	342	420,509	30
8 – Ovarian cancer	38	218,028	30
9 – Sepsis	211	730,229	30
10 – Pressure ulcer	43	389,913	30
<b>Total</b>	<b>2,515</b>	<b>\$5,876,059</b>	<b>300</b>

**SOURCE OF RANDOM NUMBERS**

We generated the random numbers with the OIG, OAS, statistical software.

**METHOD FOR SELECTING SAMPLE ITEMS**

We sorted the items in each stratum by the enrollee-year (a combination of the enrollee identifier and the payment year being reviewed), then consecutively numbered the items in each stratum in the stratified sampling frame. After generating random numbers according to our sample design, we selected the corresponding frame items for review.

**ESTIMATION METHODOLOGY**

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

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 4: Sample Details and Results**

<b>Audited High-Risk Groups</b>	<b>Frame Size</b>	<b>CMS Payments for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)</b>	<b>Sample Size</b>	<b>CMS Payments for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)</b>	<b>Number of Sampled Enrollee-Years With HCCs That Were Not Validated</b>	<b>Net Overpayments for HCCs That Were Not Validated (for Sampled Enrollee-Years)</b>
1 – Acute stroke	473	\$913,241	30	\$57,485	30	\$53,530
2 – Acute myocardial infarction	627	1,101,848	30	53,414	27	43,240
3 – Embolism	203	539,451	30	82,592	26	72,028
4 – Lung cancer	95	721,229	30	227,909	27	193,783
5 – Breast cancer	324	418,114	30	36,729	30	36,729
6 – Colon cancer	159	423,497	30	85,510	29	79,000
7 – Prostate cancer	342	420,509	30	37,941	26	33,304
8 – Ovarian cancer	38	218,028	30	173,752	28	153,899
9 – Sepsis	211	730,229	30	100,590	14	50,060
10 – Pressure ulcer	43	389,913	30	256,273	15	112,437
<b>Total</b>	<b>2,515</b>	<b>\$5,876,059</b>	<b>300</b>	<b>\$1,112,195</b>	<b>252</b>	<b>\$828,010</b>

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

Point estimate	\$4,751,979
Lower limit	\$4,479,698
Upper limit	\$5,024,261

**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.



James I. Korn  
Regional Inspector General for Audit Services  
Office of Audit Services, Region VII  
1201 Walnut Street, Suite 1309  
Kansas City, MO 64106

June 30, 2025

**Re: Priority Health’s Response to the Office of Inspector General’s (OIG) Draft Report No. A-07-22-01208**

Dear Mr. Korn,

Priority Health writes to respond to OIG’s Draft Report No. A-07-22-01208 concerning the audit of Contract H2320, entitled *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Priority Health (Contract H2320) Submitted to CMS* (Draft Report). We thank OIG for its collaboration throughout the audit process and appreciate the opportunity to respond to the Draft Report.

Priority Health is a nationally recognized, Michigan-based nonprofit health plan dedicated to improving the health and lives of the 1.3 million members we serve across Michigan, Indiana, and Ohio. As the second-largest health plan in Michigan and the fourth-largest provider-sponsored health plan in the country, we are transforming how care is delivered—emphasizing affordability and empowering individuals to take charge of their health. Our comprehensive portfolio includes health benefit options for employer groups and individuals, as well as Medicare and Medicaid plans. Priority Health offers Medicare Advantage (MA) plans to eligible beneficiaries under Contract H2320.

We disagree with OIG’s recommendations in the Draft Report and respectfully request that OIG withdraw its recommendations based on the following:

- **Priority Health disagrees with OIG’s first recommendation that Priority Health refund the Federal Government \$4,575,972 of alleged estimated overpayments.** We disagree with this recommendation for several reasons, including that OIG’s audit violates actuarial equivalence requirements, the audit is an unreliable measure of payment accuracy, OIG has no authority to use extrapolation to estimate contract-level net overpayment amounts for “high-risk” codes or otherwise, and OIG failed to follow the procedures prescribed by statute, among other reasons outlined in this response.
- **Priority Health disagrees with OIG’s second recommendation that Priority Health identify, for the high-risk diagnoses included in the Draft Report, similar instances of noncompliance that occurred after the audit period and refund any resulting overpayments.** Priority Health is not required by statute or regulation to conduct audits at the level or standard that OIG suggests.

- **Priority Health disagrees with OIG’s third recommendation to continue examination of Priority Health’s existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.** Priority Health has an effective compliance program in place that is designed to comply with applicable legal and regulatory requirements. We have invested significant time and resources into developing a compliance program that aligns with CMS’s goal of ensuring the integrity of the MA program. We regularly refine our compliance practices as new risk areas emerge and the industry evolves. We take seriously our role of being good stewards of the MA program and our existing compliance program reflects this value.

We ask that OIG reconsider these recommendations and work collaboratively with us to finalize a report that does not include the issues identified in this response. We welcome the opportunity to discuss any revised findings.

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**I. Priority Health disagrees with OIG’s first recommendation that Priority Health refund the Federal Government \$4,575,972 of alleged estimated overpayments**

**A. OIG’s audit violates actuarial equivalence requirements**

Under the MA program, MA organizations (MAOs) contract with CMS to provide their enrollees with at least the same benefits available under Medicare Parts A and B, although they often also offer beneficiaries supplemental benefits. MAOs are not compensated based on the volume of medical services provided to enrollees. Rather, they are paid on a prospective, per-enrollee basis, receiving a monthly lump sum for each enrollee, regardless of the services that are actually provided to enrollees. MAOs therefore bear the financial risk of providing services to their enrollees that cost more than the per-enrollee payments they receive.

The Social Security Act directs CMS to adjust such per-enrollee payments to “ensure actuarial equivalence”<sup>1</sup> with traditional Medicare, so as to “pay the same amount to [MA] insurers for their beneficiaries’ care as CMS would spend on those same beneficiaries if they were instead enrolled in traditional Medicare.”<sup>2</sup> To reflect the potential variation in costs of care among different enrollees, Congress directed CMS to use risk factors predictive of differing costs of care, such as health status of enrollees, to adjust such payments.<sup>3</sup> Risk adjustment estimates the costs of a particular population of enrollees, based on underlying traditional Medicare data for a similarly situated population with the same conditions.

<sup>1</sup> 42 U.S.C. § 1395w-23(a)(1)(C)(i) (“[T]he Secretary shall adjust the payment amount ...for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status ... so as to ensure actuarial equivalence.”).

<sup>2</sup> *UnitedHealthcare Insurance Co. v. Becerra*, 16 F.4th 867, 883 (D.C. Cir. 2021).

<sup>3</sup> 42 U.S.C. § 1395w-23(a)(1)(C)(i).

Priority Health reports to CMS diagnosis information regarding the health status of its enrolled MA population to enable CMS to apply the risk factors. This information is primarily generated by medical providers and is based on the providers' clinical judgment, which is typical of most MAOs.

OIG's audit methodology violates the actuarial equivalence requirement imposed by statute. Indeed, the actuarial equivalence standard went entirely unacknowledged in the Draft Report. Like many other MAOs, Priority Health takes the position that, to adhere to the actuarial equivalence requirement, any calculation of a contract-level payment error in an audit of an MA contract must include an adjustment to account for the error rate found in original Medicare. Any extrapolation methodology to determine a contract-level payment error must be adjusted to account for the fact that the fee-for-service (FFS) data from the original Medicare program that CMS used to develop the MA risk adjustment model was unaudited and therefore includes a certain number of unsupported codes. The failure to make such an adjustment results in the application of a more exacting standard to the MA program relative to traditional Medicare. This violates the actuarial equivalence requirement and may also result in the underpayment of MAOs, undermining the purpose of the risk adjustment system.<sup>4</sup> Principles of risk adjustment systems are violated when payments to an MAO are determined by applying coefficients calculated using diagnosis codes from original Medicare claims—that are partially unsubstantiated by medical records—to MA diagnosis codes that are fully substantiated by medical records.<sup>5</sup> Subjecting MA diagnosis codes to different documentation standards than those that apply in original Medicare violates risk adjustment principles and upsets actuarial equivalence in violation of the Social Security Act.

OIG's focus on a subset of "high-risk" diagnosis codes further exacerbates the problem. To see why, consider that providers generate the vast majority of diagnosis codes that Priority Health submits to CMS for risk adjustment purposes. And providers are just as likely to be making diagnosis coding errors in traditional Medicare with respect to such "high-risk" codes and patterns as they are in the MA program. Indeed, OIG itself recently published a report on acute stroke diagnoses from claims in traditional Medicare demonstrating this result.<sup>6</sup> In its report, OIG identified "specific acute stroke diagnosis codes that, when reported on a single physician's claim without being reported on a corresponding inpatient hospital claim" as potentially high risk of

<sup>4</sup> See American Academy of Actuaries, *Comment Letter on RADV Sampling and Error Calculation Methodology* (Jan. 21, 2011), available at <https://perma.cc/3YJA-NN2B> ("This type of data inconsistency . . . may also create systematic underpayment, undermining the purpose of the risk-adjustment system and potentially resulting in payment inequities.").

<sup>5</sup> See American Academy of Actuaries, *Comment Letter on RADV Sampling and Error Calculation Methodology* (Jan. 21, 2011), available at <https://perma.cc/QR76-LGR5>. See also Wakely Consulting Group, LLC, *Actuarial Report on CMS' November 1, 2018 Proposed Rule* (Aug. 27, 2019), available at <https://perma.cc/HVS9-38WZ>; Avalere Health, *Eliminating the FFS Adjuster from the RADV Methodology May Affect Plan Payment* (Mar. 2019), available at <https://perma.cc/96R7-YQ9L>; Milliman, *Medicare Advantage RADV FFS Adjuster: White Paper* (Aug. 23, 2019), available at <https://perma.cc/8GQX-ZS6G>.

<sup>6</sup> See OIG, *Audit Report No. A-07-17-01176, Incorrect Acute Stroke Diagnosis Codes Submitted by Traditional Medicare Providers Resulted in Millions of Dollars in Increased Payments to Medicare Advantage Organizations* (Sept. 2020), available at <https://oig.hhs.gov/reports/all/2020/incorrect-acute-stroke-diagnosis-codes-submitted-by-traditional-medicare-providers-resulted-in-millions-of-dollars-in-increased-payments-to-medicare-advantage-organizations/>.

being miscoded.<sup>7</sup> This is very similar to the “high-risk” acute stroke group OIG audited here.<sup>8</sup> In that study of traditional Medicare claims, OIG found that *almost all acute diagnosis codes* were not supported by medical record documentation when such codes originated from “physicians submitting . . . claims billed under traditional Medicare.”<sup>9</sup>

The similar incidence across traditional Medicare and MA of unsupported diagnosis codes also underlines that such codes predominantly stem from unintentional errors in provider submissions that will likely persist despite appropriate oversight by MAOs and diligent efforts to educate providers. Such errors cannot be eradicated unless MAOs conduct 100% audits of providers—which they are under no obligation to perform and which would be infeasible.<sup>10</sup>

Based on Priority’s Health understanding of this audit, OIG did not adjust its audit findings to account for an overall payment error rate in original Medicare. Nor did OIG adjust its audit findings for a payment error rate in original Medicare for the specific diagnosis codes chosen by OIG. Any CMS recoupment of OIG’s extrapolated overpayment recommendation would therefore violate the statute and put Priority Health at risk of systemic *underpayment*. Since OIG’s recommendation, if followed by CMS, would cause CMS to violate the statutory requirement to maintain actuarial equivalence between payments under original Medicare and MA,<sup>11</sup> it is arbitrary and capricious for OIG to make such a recommendation to CMS.

Notably, CMS itself has previously acknowledged that, to maintain actuarial equivalence, any extrapolated overpayment amount would have to account for the presence of a certain proportion of unsupported codes in original Medicare. In 2012, CMS gave public notice that, in RADV audits, it would apply a FFS Adjuster when determining the final payment recovery amount in order to maintain actuarial equivalence. CMS reasoned that “[t]he FFS Adjuster accounts for the fact that the documentation standard used in RADV audits to determine a contract’s payment error rate (medical records) is different from the documentation standard used to develop the Part C risk adjustment model (FFS claims).” The actual amount of the adjuster, CMS explained, would be calculated based on a RADV-like review of records submitted to support FFS claims data.”<sup>12</sup>

<sup>7</sup> See *id.* at 4.

<sup>8</sup> OIG indicated that one of their focused high-risk groups in this audit was “Acute stroke: An enrollee received one acute stroke diagnosis (that mapped to the HCC for Ischemic or Unspecified Stroke) on only one physician claim during the service year but did not have an acute stroke diagnosis on a corresponding inpatient or outpatient hospital claim...” Draft Report, at 4.

<sup>9</sup> OIG, *Audit Report No. A-07-17-01176*, at 6 (emphasis added); see also *id.* (“Almost all of the selected acute stroke diagnosis codes that physicians submitted to CMS under traditional Medicare—codes that CMS later used to make payments to [Medicare Advantage] organizations on behalf of the 582 reviewed transferred enrollees—did not comply with Federal requirements. For 2 of the 582 transferred enrollees, the medical record documentation supported the submitted acute stroke diagnosis codes. For the remaining 580 transferred enrollees, the medical records did not support the acute stroke diagnosis codes that the physicians submitted to CMS . . . These errors originated from physicians submitting incorrect acute stroke diagnosis codes on claims billed under traditional Medicare.”).

<sup>10</sup> See generally *UnitedHealthcare*, 16 F.4th at 884 (“Nothing in the Overpayment Rule obligates insurers to audit their reported data”).

<sup>11</sup> See 42 U.S.C. §§ 1395w-23(b)(4)(C)-(D), 1395w-24(a)(5)(A), (a)(6)(A)(i)-(iii).

<sup>12</sup> CMS, *Notice of Final Payment Error Calculation Methodology For Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* 4-5 (Feb. 24, 2012), available at <https://www.cms.gov/Research-Statistics->

Six years later, however, CMS published a proposed rule in which it signaled that it would not use the FFS Adjuster because it had conducted a FFS Adjuster Study that suggested that “errors in FFS claims data do not have any systematic effect on the risk score calculated by the CMS-HCC risk adjustment model, and therefore do not have any systematic effect on the payments made to MA organizations.”<sup>13</sup>

Although CMS received many comments indicating flaws with CMS’s FFS Adjuster Study, the Secretary finalized the RADV rule without a FFS Adjuster on February 1, 2023.<sup>14</sup> Perhaps recognizing the serious flaws in the FFS Adjuster Study, the Secretary relied upon additional arguments in finalizing the RADV rule without a FFS Adjuster. First, the Secretary argued that the statutory actuarial equivalence requirement does not “apply to the obligation to return improper payments for [MAO] diagnosis codes that are unsupported by medical records.”<sup>15</sup> Second, the Secretary asserted that “it would be unreasonable to interpret the [Social Security] Act as requiring a minimum reduction in payments in one provision (the coding pattern provision), while at the same time prohibiting CMS in an adjacent provision (the actuarial equivalence provision) from enforcing those longstanding documentation requirements (by requiring an offset to the recovery amount calculated for CMS audits).”<sup>16</sup> CMS conflates two distinct issues. The coding intensity adjustment factor adjusts for differences in coding *patterns* in MA compared to FFS, and is specifically *not* intended to adjust for coding *inaccuracies*, as CMS clearly stated in its annual announcement.<sup>17</sup> The FFS Adjuster was intended to adjust for errors in FFS data. The presence of a coding intensity adjustment to account for difference in coding patterns does nothing to address data errors in FFS, nor does it suggest that a FFS Adjuster is not necessary. Moreover, CMS could readily apply a FFS Adjuster while continuing to enforce its documentation standards. Priority Health strongly disagrees with the RADV rule’s failure to adopt a FFS Adjuster: this was not only contrary to law, but also arbitrary and capricious.

## **B. OIG’s audit is an unreliable measure of payment accuracy because of its focus on potential overpayments through targeted audit samples**

OIG’s targeted audit focuses on “high-risk groups of diagnoses,” targeting potential overpayments rather than both overpayments and underpayments. Thus, setting aside the fact that

[Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf](#).

<sup>13</sup> *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, 83 Fed. Reg. 54,982, 55,040 (Nov. 1, 2018).

<sup>14</sup> *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, 88 Fed. Reg. 6,643, 6,644 (Feb. 1, 2023).

<sup>15</sup> *Id.* at 6,656.

<sup>16</sup> *Id.*

<sup>17</sup> *Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, at 18-19 (Apr. 5, 2010) (“the MA coding adjustment factor is not intended to adjust for inaccurate coding, but for the impact on risk scores of coding patterns that differ from FFS coding....”).

OIG's audits do not account for actuarial equivalence, the results produced by OIG audits do not, and cannot, reflect overall payment accuracy.

As described in the Draft Report, OIG targeted a narrow set of diagnoses similar to many other audits OIG has conducted of MAOs.<sup>18</sup> As OIG describes its methodology, “[u]sing data mining techniques and discussions with medical professionals, [it] identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups”; specifically for this audit, it “focused on 10 high-risk groups.”<sup>19</sup> However, OIG does not just limit its audit to specific diagnoses codes, but further constructs a sample based on specific situations in which these specific diagnoses are most likely to be unsupported by medical records. For instance, one of the “high-risk groups” of diagnoses targeted in this audit relates to acute stroke. Not only did OIG target in its sample enrollee years where a diagnosis mapped to the hierarchical conditional category (HCC) for Ischemic or Unspecified Stroke, OIG only audited those enrollee-years where an acute stroke diagnosis was found on only one physician claim during the service year, and did not have an acute stroke diagnosis on a corresponding inpatient or outpatient claim. Based on Priority Health’s understanding of this audit process, as described by OIG, OIG’s methodology was systematically skewed towards identifying overpayments, rather than underpayments.<sup>20</sup> Such results are an unreliable measure of payment accuracy.

Moreover, while OIG represents in the Draft Report that it accounted for both overpayments and underpayments,<sup>21</sup> it provides no details about the amount of underpayments that it calculated. Priority Health requests that OIG disclose the amount of underpayments, if any, that it identified. Whatever that amount is, it likely substantially understates the prevalence of underpayments because OIG’s methodology had a one-sided focus on overpayments, rather than underpayments.

Further, OIG’s audit only solicited medical records to substantiate diagnosis codes actually submitted to CMS. But, as the Draft Report itself acknowledges, when medical records support diagnosis codes that an MAO did not submit to CMS, this will result in underpayments.<sup>22</sup> OIG’s audit therefore could not have detected this important source of underpayments. This problem is exacerbated by the fact that, once the year is closed, MAOs cannot submit these newly found codes for corrected payment: CMS has a one-way system which is to only accept deletes after a closed year.

<sup>18</sup> For example, see Appendix B to the Draft Report representing only some of the audits of this nature that OIG has performed.

<sup>19</sup> Draft Report, at 4.

<sup>20</sup> The government has taken a similar position in False Claims Act (FCA) litigation, arguing that two-way reviews of diagnoses codes are proper and one-way reviews are not. *See United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1175 (9th Cir. 2016).

<sup>21</sup> Draft Report, at 21.

<sup>22</sup> Draft Report, at 4.

### C. **OIG has no authority to use extrapolation to estimate a contract-level net overpayment amount for “high-risk” codes or otherwise**

We do not believe there is a clear statutory basis for either CMS or OIG to use extrapolation to calculate overpayments in the MA program. The Social Security Act only authorizes Medicare contractors to use extrapolation to determine overpayment amounts, and only in narrowly circumscribed circumstances. Specifically, there must either be a determination by the Secretary that there is a sustained or high level of payment error, or a documented educational intervention that has failed to correct the payment error.<sup>23</sup> The Draft Report provides no indication that the requisite determination was made by the Secretary.

OIG cites 42 C.F.R. § 422.311(a)(2) as the basis for its authority to use extrapolation.<sup>24</sup> That regulation provides that “CMS may apply extrapolation to [RADV] audits” for payment year 2018 and after.<sup>25</sup> But even supposing that this regulation is lawful despite the statutory restrictions on the use of extrapolation, it in no way provides *OIG* with authority to use extrapolation to calculate a contract-level overpayment amount.

To the extent that OIG relied upon the Inspector General Act (IGA) to conduct this audit, the IGA does not authorize OIG to calculate or collect extrapolated overpayments from MAOs through audits.<sup>26</sup> Congress delegated authority to the Inspector General, not the Secretary or CMS, in the IGA.<sup>27</sup> And nothing in the Social Security Act or in the CMS regulations promulgated thereunder gives OIG—as opposed to CMS—the authority to extrapolate a contract-level overpayment amount. Notably, the statutory authority for 42 C.F.R. § 422.311(a)(2) is the Social Security Act, not the IGA.<sup>28</sup>

To be sure, in the preamble to the final RADV rule published on February 1, 2023, CMS declared that “HHS-OIG . . . undertakes audits of MAOs, similar to RADV audits, as part of its oversight functions,” and that “CMS can collect the improper payments identified during those HHS-OIG audits, including the extrapolated amounts calculated by OIG.”<sup>29</sup> But there is nothing in the regulatory text of the RADV rule that authorizes CMS to collect extrapolated overpayments calculated by OIG. And “the regulatory ‘preamble’ . . . ‘itself lacks the force and effect of law.’”<sup>30</sup>

OIG has previously failed to account for the gap between any audit authority under the IGA and its recommendations on extrapolated overpayments in its MAO audit reports, arguing

<sup>23</sup> See 42 U.S.C. § 1395ddd(f)(3).

<sup>24</sup> Draft Report, at 21-22 n.33.

<sup>25</sup> 42 C.F.R. § 422.311(a)(2).

<sup>26</sup> See 5 U.S.C. §§ 402, 406(a)(2).

<sup>27</sup> *Id.* §§ 402, 404, 406.

<sup>28</sup> See 42 C.F.R. § 422.300 (“This subpart is based on sections 1106, 1128J(d), 1853, 1854, and 1858 of the [Social Security] Act.”).

<sup>29</sup> 88 Fed. Reg. at 6,645 n.6.

<sup>30</sup> *AT&T Corp. v. FCC*, 970 F.3d 344, 350 (D.C. Cir. 2020); see also *Wilgar Land Co. v. Director, Off. of Workers’ Comp. Programs*, 85 F.4th 828, 837 (6th Cir. 2023).

that there is no statutory constraint on OIG’s ability to make such recommendations to CMS.<sup>31</sup> But if neither CMS nor OIG can calculate or collect extrapolated overpayments, then public recommendations on the calculation or collection of extrapolated overpayments serve only to confuse the public and cause reputational harm to MAOs.

#### **D. OIG failed to follow procedures prescribed by statute**

For CMS to adopt any “rule, requirement, or other statement of policy ... that establishes or changes a substantive legal standard governing ... the payment for services,” the Medicare Act requires it to engage in notice-and-comment rulemaking.<sup>32</sup> The Supreme Court has confirmed that such process “gives affected parties fair warning of potential changes in the law and an opportunity to be heard on those changes—and it affords the agency a chance to avoid errors and make a more informed decision.”<sup>33</sup>

OIG’s audit process, and resulting recommendations, effectively impose a standard of perfection in coding, which is a substantively different legal standard from the past and is not required by the federal requirements cited by OIG in the Draft Report.<sup>34</sup> As such, these standards must be subject to notice-and-comment rulemaking.

Further, OIG did not promulgate through notice-and-comment rulemaking the medical record review standards that OIG used in this audit. Although the Draft Report indicated that providers “code diagnoses using the International Classification of Diseases (ICD), Clinical Modification (CM), *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines),” OIG did not identify the coding guidelines used, or any supplemental coding resources, including those published by the American Health Information Management Association, the American Medical Association, the American Hospital Association, and the American Academy of Professional Coders, which may have been utilized by coders at the independent medical review contractor (Review Contractor), in the Draft Report. While Priority Health believes that the Review Contractor likely used ICD-10, and supplemental resources, OIG should confirm the standards that were applied during the independent review conducted by the Review Contractor. In any event, neither the ICD-10 coding guidelines, nor the Medicare Managed Care Manual cited by OIG in the Draft Report nor any other supplemental resources listed, have been promulgated by regulation under 42 U.S.C. § 1395hh(a)(1).

<sup>31</sup> See, e.g., OIG, *Report No. A-07-19-01195, Medicare Advantage Compliance Audit Of Specific Diagnosis Codes That BlueCross BlueShield Of Tennessee (Contract H7917) Submitted to CMS* at 23 (Sept. 2022), available at <https://oig.hhs.gov/reports/all/2022/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-bluecross-blueshield-of-tennessee-inc-contract-h7917-submitted-to-cms/> (“With respect to BCBST’s comments that the Inspector General Act of 1978, 5 U.S.C. App does not authorize us to extrapolate, we note that neither the statute nor any other authority limits our ability to recommend a recovery to CMS based on extrapolation.”).

<sup>32</sup> 42 U.S.C. § 1395hh(a)(2).

<sup>33</sup> *Azar v. Allina Health Servs.*, 587 U.S. 566, 582 (2019).

<sup>34</sup> *Medicare Program: Medicare+Choice Program*, 65 Fed. Reg. 40,170, 40,268 (June 29, 2000) ([MAOs] “cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that [CMS], [ ] OIG, and [DOJ] believe is reasonable to enforce.”).

#### **E. OIG’s audit methodology amounts to unlawful retroactive application of a new policy**

OIG uses an audit methodology that departs from CMS’s longstanding practice. Under the Medicare statute, any “substantive change in . . . statements of policy, or guidelines of general applicability,” “shall not be applied . . . retroactively,” unless the Secretary determines that “such retroactive application is necessary to comply with statutory requirements,” or “failure to apply the change retroactively would be contrary to the public interest.”<sup>35</sup> Neither condition was satisfied here. Accordingly, OIG’s imposition of a new audit methodology to a prior year amounted to retroactive application of a new policy.

Further, in the Draft Report, OIG indicates that it used OIG’s Office of Audit Services statistical software to generate random numbers as part of its sampling process, and to estimate the total amount of alleged net overpayments in the sampling frame.<sup>36</sup> No additional detail was provided on the validity of the statistical software used, or whether any independent statistician or other expert has confirmed its accuracy. It is not clear whether OIG has recently validated its software or engaged external parties to verify the precision of its software. Given the serious implications of an OIG recommendation to refund alleged overpayment amounts, OIG and MAOs alike should have greater confidence that the systems used to sample and estimate overpayment amounts are reliable, regularly updated, and validated by independent experts in the field. The lack of information provided on the statistical software used injects uncertainty into the auditing process and OIG’s findings.

#### **F. OIG did not disclose additional information about the Review Contractor’s initial decisions or its identity**

Priority Health received only the final determination by the Review Contractor on each enrollee-year sample. Priority Health therefore has no way of evaluating the contractor’s decision-making process as a whole, including the assessments made by the contractor at various levels of review. In addition, OIG did not identify the name of its independent Review Contractor. Thus, Priority Health has no way of evaluating whether the contractor was qualified, applied consistent standards across its work for OIG and other clients, or was free from conflicts of interest. Priority Health requests that OIG disclose all such information pursuant to the Data Quality Act and generally accepted government auditing standards.<sup>37</sup>

In addition, OIG notes that the senior coders performing reviews on behalf of the Review Contractor included coders with a Registered Health Information Technician (RHIT) qualification. Priority Health disagrees that RHIT is an appropriate qualification for this type of risk adjustment coding audit.

<sup>35</sup> 42 U.S.C. §1395hh(e)(l)(A).

<sup>36</sup> Draft Report, at 26.

<sup>37</sup> Treasury and General Government Appropriations Act for Fiscal Year 2001, Pub. L. 106-554, § 515 (2001) (referred to as the Data Quality Act or the Information Quality Act); Gov’t Accountability Off., *Government Auditing Standards 2018 Revision: Technical Update* (Apr. 2021), available at <https://www.gao.gov/assets/gao-21-368g.pdf>.

### **G. The tie-breaker process is arbitrary and capricious**

OIG did not give weight to the diagnoses coded by treating physicians when OIG’s coders split on the question of whether the diagnoses were supported. OIG treated splits between coders as ties, and looked to the Review Contractor’s coding supervisor to break the ties instead of the treating physician. The lack of weight given to the diagnosis by the treating physician is arbitrary and capricious because the treating physician has more education, training, and skills than the coders, and was closer to the patient than the coders. If one of OIG’s coders agrees with the treating physician’s diagnosis, then the diagnosis is plainly valid and there should be no “tie” to break.

### **H. The repayment amount requested is not accurate because some sampled conditions are supported in medical records**

Based on Priority Health’s review of OIG’s findings, Priority Health disagrees with findings made by OIG that certain sampled enrollee years are not validated, and therefore OIG’s recommended repayment amount is incorrect and overstated. Priority Health has identified at least 20 sampled enrollee years where medical record documentation substantiates the condition, contrary to OIG’s Review Contractor’s determination. While not described here, Priority Health has submitted documentation with respect to those 20 sampled enrollee years consistent with OIG’s direction in connection with this response. Priority Health requests that OIG correct its findings with respect to the corresponding HCCs and modify any related estimated repayment amounts.

### **I. OIG’s audit approach creates significant challenges for MAOs when developing their annual bids**

Every year, MAOs submit bids to CMS that reflect the estimated costs of treating an enrollee of average risk. MAOs carefully analyze and compile bids based on historic costs, and this information influences the benefit packages that an MAO can offer members. Therefore, MAOs spend *significant* time and effort in developing accurate rates to ensure they can adequately cover services used.

OIG’s audit approach undermines these efforts. OIG’s audits often occur long after payment years are settled or the audits span multiple payment years. When OIG recommends refunds for a settled payment year, it signals that the settled year information is inaccurate and, thus, the bid rate calculations, which are based on the settled year may be similarly not accurate representations of the costs of delivering care. The uncertainty of when OIG will audit, the impact and scope of the audits, and the time lag between when an audit is settled and when bids are submitted makes it exceedingly difficult to develop accurate risk score projections. Further, given that OIG’s audits are one-sided and only seek to *recoup* revenue from MAOs, any action by MAOs to account for such recoupments in the bid estimates ultimately serve to *reduce* benefits to members during the bid development and submission process. The unpredictability of OIG’s audits makes it impossible for plans to trust that a settled payment year is actually settled. When MAOs lack this certainty, it creates risk that members may be exposed to premium instability and/or reduced benefits.

For these reasons, Priority Health disagrees with OIG’s recommendation to refund the Federal Government \$4,575,972 of estimated net overpayments. We strongly believe these are valid reasons for OIG to reconsider its audit approach, as well as the underlying assumptions made in the Draft Report, and, as noted above, dispute OIG’s Review Contractor’s determination with respect to several enrollee years. We do not agree that we are obligated to pay extrapolated amounts; however, Priority Health plans to further evaluate repayment of those sampled enrollee years that Priority Health is not disputing here.

## **II. Priority Health disagrees with OIG’s second recommendation because it is not required to conduct audits to the standard that OIG suggests**

OIG recommends that Priority Health “identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred after [the] audit period and refund any resulting overpayments to the Federal Government.”<sup>38</sup> Priority Health does not agree with this recommendation and respectfully requests that OIG withdraw it. MA regulations do not require Priority Health to perform the audits OIG recommends.

CMS has stated that under federal regulations, MAOs must “implement an effective compliance program, which must include measures that prevent, detect, and correct . . . noncompliance” with CMS’ program requirements and that MAOs’ compliance plans “must, at a minimum, include [certain] core requirements,” which include “an effective system for routine monitoring and identification of compliance risks” including “internal monitoring and audits and, as appropriate, external audits to evaluate . . . compliance with CMS requirements and the overall effectiveness of the compliance program.”<sup>39</sup> However, OIG’s recommendation cannot be squared with the broad discretion that MAOs have to design and implement their compliance programs, including with respect to auditing and monitoring functions.<sup>40</sup> There is no statutory authority—and CMS has not issued any regulations (or even non-binding guidance)—requiring MAOs to conduct audits of specific “high-risk diagnoses” and make associated repayments.

By recommending that Priority Health perform additional audits of “high-risk diagnoses,” OIG is in effect unilaterally imposing a new substantive requirement on Priority Health. To the extent OIG’s recommendation conflicts with CMS’s regulations or attempts to impose its own interpretation of those regulations on MAOs, it arbitrarily and capriciously subjects Priority Health to two contradictory regulatory regimes. Moreover, as explained above, to the extent OIG intends to impose new legal standards on MAOs, it must do so through notice-and-comment rulemaking. Accordingly, Priority Health respectfully requests that OIG reconsider and withdraw this recommendation.

<sup>38</sup> Draft Report, at 18.

<sup>39</sup> See e.g., Medicare Managed Care Manual, Chapter 21, §§ 30 and 50.6.

<sup>40</sup> *Publication of the OIG’s Compliance Program Guidance for Medicare+Choice Organizations Offering Coordinated Care Plans*, 64 Fed. Reg. 61,893, 61,900 (Nov. 15, 1999) (“The exact methods used by the [MA] organization to accomplish this can be determined by the organization, however, it should ordinarily conduct sample audits and spot checks of this system to verify whether it is yielding accurate information.”).

### **III. Priority Health disagrees with OIG’s third recommendation because Priority Health has an effective compliance program in place that is designed to comply with all legal and regulatory requirements**

OIG recommends that Priority Health “continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS’s risk adjustment program) and take the necessary steps to enhance those procedures.”<sup>41</sup>

Priority Health has a robust compliance program that is designed to comply with all legal and regulatory requirements. OIG recognized that Priority Health “had compliance procedures in place during the audit period that included measures designed to ensure that diagnosis codes, including some of the diagnoses that [OIG] classified as high risk for being miscoded, comply with Federal requirements,” including provider education and communication, data validation audits, annual risk assessment, and coding reviews.<sup>42</sup> Notwithstanding Priority Health’s efforts, the Draft Report states that the “policies and procedures Priority Health had to prevent, detect and correct noncompliance with federal requirements could be improved” and recommends that Priority Health “continue its examination of its existing compliance procedures to identify areas where improvements can be made.”<sup>43</sup>

As discussed above, MAOs have broad discretion to design and implement their compliance programs, including their auditing and monitoring functions.<sup>44</sup> Moreover, Priority Health’s compliance program in place at the time of OIG’s review of claims data from payment years 2018 and 2019 is not representative of Priority Health’s current compliance practices, which were not reviewed by OIG. While Priority Health disagrees with OIG’s finding and recommendation, Priority Health works to continuously improve and refine our compliance program to evolving risks on an ongoing basis.

Priority Health’s compliance program is already robust and compliant with applicable legal and regulatory requirements, and Priority Health remains committed to continuous compliance improvement. Accordingly, Priority Health respectfully requests that OIG withdraw its recommendation that Priority Health enhance its compliance program.

<sup>41</sup> Draft Report, at 18.

<sup>42</sup> Draft Report, at 17.

<sup>43</sup> Draft Report, at 17-18.

<sup>44</sup> 64 Fed. Reg. at 61,900 (“The exact methods used by the [MA] organization to accomplish this can be determined by the organization, however, it should ordinarily conduct sample audits and spot checks of this system to verify whether it is yielding accurate information.”).

#### IV. Conclusion

We appreciate the opportunity to comment on the Draft Report. For the foregoing reasons, Priority Health disagrees with OIG’s findings and recommendations.<sup>45</sup> We ask that OIG withdraw its recommendations and finalize a report that considers the issues we have raised.

We share OIG’s goal of ensuring the integrity of the MA program and, above all, providing effective, comprehensive care to MA enrollees.

If you have any questions concerning this response letter, please do not hesitate to contact us.

Sincerely,



Cindy Rollenhagen  
Vice President, Compliance and Privacy Officer



Heather DeHaan  
Director, Medicare Compliance Officer

<sup>45</sup> Although the Draft Report asserts that “OIG audit recommendations do not represent final determinations,” and therefore that Priority Health may only pursue the RADV audit appeal process under 42 C.F.R. § 422.311(c) if and when CMS issues an overpayment determination, Priority Health does not concede this point.

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