

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE ADVANTAGE  
COMPLIANCE AUDIT OF SPECIFIC  
DIAGNOSIS CODES THAT PEOPLES  
HEALTH NETWORK (CONTRACT  
H1961) SUBMITTED TO CMS**

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## Report in Brief

Date: May 2022

Report No. A-06-18-05002

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



### Why OIG Did This Audit

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

To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS.

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

### How OIG Did This Audit

We sampled 242 unique enrollee-years with the high-risk diagnosis codes for which Peoples Health received higher payments for 2015 through 2016. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$712,200.

## Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Peoples Health Network (Contract H1961) Submitted to CMS

### What OIG Found

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that Peoples Health submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 144 of the 242 enrollee-years, the diagnosis codes that Peoples Health submitted to CMS were not supported in the medical records and resulted in \$412,938 in overpayments.

These errors occurred because the policies and procedures that Peoples Health had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of our sample results, we estimated that Peoples Health received at least \$3.3 million in overpayments for these high-risk diagnosis codes in 2015 and 2016.

### What OIG Recommends and Peoples Health Comments

We recommend that Peoples Health (1) refund to the Federal Government the \$3.3 million in overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and (3) enhance 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.

Peoples Health did not concur with any of our recommendations. However, it also did not specifically disagree with any of the errors we identified associated with the 144 enrollee-years. Instead, Peoples Health stated that we used flawed audit and extrapolation methodologies, did not evaluate the overall enrollee-year payments or risk scores, and failed to follow CMS's risk adjustment audit rules. After considering Peoples Health's comments, we maintain that our findings and recommendations are valid.

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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, sex, and health status of that individual. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources relative to healthier enrollees, who would be expected to require fewer health care resources. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS.<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 27 major depressive disorder diagnoses into 1 group.) This audit covered Peoples Health Network (Peoples Health), for contract number H1961 and focused on seven groups of high-risk diagnosis codes.<sup>3</sup>

### OBJECTIVE

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

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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. Effective October 1, 2015, CMS transitioned from the ninth revision of the ICD coding guidelines (ICD-9-CM) to the tenth revision (ICD-10-CM). Each revision includes different diagnosis code sets.

<sup>2</sup> See Appendix B for related Office of Inspector General reports.

<sup>3</sup> All subsequent references to "Peoples Health" in this report refer solely to contract number H1961.

## BACKGROUND

### Medicare Advantage Program

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

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

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

### Risk Adjustment Program

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

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

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

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

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

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

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



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

To determine an enrollee's health status for purposes of calculating the risk score, CMS uses diagnoses that the enrollee receives from acceptable data sources, including certain physicians and hospitals. MA organizations collect the diagnosis codes from providers based on information documented in the medical records and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs).<sup>8</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 (in either the Version 12 model or the Version 22 model), CMS assigns a separate factor that further increases the risk score. CMS refers to these combinations as disease interactions. For example, if MA organizations submit diagnosis codes (in the Version 12 model) for an enrollee that map to the HCCs for acute stroke, acute myocardial infarction, and chronic obstructive pulmonary disease (COPD), CMS assigns a separate factor for this disease interaction. By doing so, CMS increases the enrollee's risk score for each of the three HCC factors and by an additional factor for the disease interaction.

The risk adjustment program is prospective; 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 for providing coverage to enrollees expected to require more health care resources.

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<sup>8</sup> CMS transitioned from one HCC model to another during our audit period. As part of this transition, for 2015, CMS calculated risk scores based on both models. CMS refers to these models as the Version 12 model and the Version 22 model, each of which has unique HCCs. CMS blended the two separate risk scores into a single risk score that it used to calculate a risk-adjusted payment. Accordingly, for 2015, an enrollee's blended risk score is based on the HCCs from both models. For 2016, CMS calculated risk scores on the Version 22 model.

CMS multiplies the risk scores by the base rates to calculate the total Medicare monthly payment that an MA organization receives for each enrollee before applying the budget sequestration reduction.<sup>9</sup> Miscoded diagnoses submitted to CMS may result in HCCs that are not validated and incorrect enrollee risk scores, which may lead to improper payments (overpayments) from CMS to MA organizations. Conversely, correctly coded diagnoses that MA organizations do not submit to CMS may lead to improper payments (underpayments).

## High-Risk Groups of Diagnoses

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

- *Acute Stroke*: An enrollee received one acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim. A diagnosis of history of stroke (which does not map to an HCC) typically should have been used.
- *Acute Heart Attack*: An enrollee received one diagnosis that mapped to either the HCC for Acute Myocardial Infarction or to the HCC for Unstable Angina and Other Acute Ischemic Heart Disease (Acute Heart Attack HCCs) on only one physician claim but did not have that diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician's claim). A diagnosis for a less severe manifestation of a disease in the related-disease group typically should have been used.
- *Acute Stroke and Acute Heart Attack combination*: An enrollee met the conditions of both the acute stroke and acute heart attack high-risk groups in the same year.<sup>11</sup>
- *Major Depressive Disorder*: An enrollee received a major depressive disorder diagnosis (which maps to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) during the service year but did not have an antidepressant medication dispensed on his or her

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

<sup>10</sup> Unless otherwise specified, the HCCs described in this report have the same name under both the Version 12 and Version 22 models.

<sup>11</sup> We combined these enrollees into one group because an individual's risk scores could have been further increased if that enrollee also had a COPD diagnosis (which was not part of our audit). If our audit identified an error that invalidated either the acute stroke or acute heart attack HCC, then the disease interaction factor would also be identified as an error. By combining these enrollees in one group, we eliminated the possibility of including the disease interaction factor twice in overpayment calculations (if any).

behalf. In these instances, the major depressive disorder diagnoses may not be supported in the medical records.

- *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) but did not have an anticoagulant medication dispensed on his or her behalf. An anti-coagulant medication is typically used to treat an embolism. A diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used.
- *Vascular Claudication*: An enrollee received one diagnosis related to vascular claudication (which maps to the HCC for Vascular Disease) but had medication dispensed on his or her behalf that is frequently dispensed for a diagnosis of neurogenic claudication.<sup>12</sup> In these instances, the vascular claudication diagnoses may not be supported in the medical records.
- *Potentially Mis-keyed Diagnosis Codes*: An enrollee received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition (which mapped to a possibly unvalidated HCC). For example, ICD-9 diagnosis code 250.00 (which maps to the HCC for Diabetes Without Complication) could be transposed as diagnosis code 205.00 (which maps to the HCC for Metastatic Cancer and Acute Leukemia and in this example would be unvalidated). Using an analytical tool that we developed, we identified 832 scenarios in which diagnosis codes could have been mis-keyed because of data transposition or other data entry errors, which could have resulted in the assignment of an unvalidated HCC.

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

## Peoples Health Network

Peoples Health is an MA organization based in Metairie, Louisiana. As of December 31, 2016, Peoples Health provided coverage under contract number H1961 to approximately 54,800 enrollees. For the 2015 and 2016 payment years (audit period), CMS paid Peoples Health approximately \$1.3 billion to provide coverage to its enrollees.<sup>13</sup>

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<sup>12</sup> Vascular claudication and neurogenic claudication are different diagnoses. Vascular claudication is a condition that can result in leg pain while walking and is caused by insufficient blood flow. Neurogenic claudication is a condition that can also result in leg pain but is caused by damage to the neurological system, namely the spinal cord and nerves.

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

## HOW WE CONDUCTED THIS AUDIT

Our audit included enrollees on whose behalf providers documented diagnosis codes that mapped to one of the seven high-risk groups during the 2014 and 2015 service years, for which Peoples Health received increased risk-adjusted payments for payment years 2015 and 2016, respectively. Because enrollees could be classified in more than one high-risk group or have high-risk diagnosis codes documented in more than 1 year, we classified these individuals according to the condition and the payment year, which we refer to as “enrollee-years.” We identified 3,362 unique enrollee-years and limited our review to the portions of the payments that were associated with these high-risk diagnosis codes (\$7,741,921). We selected for audit a sample of 242 enrollee-years, which comprised (1) a stratified random sample of 220 (out of 3,340) enrollee-years for the first 6 high-risk groups and (2) 22 enrollee-years for the remaining high-risk group.

Table 1 breaks out the numbers of sampled enrollee-years (of the 242) associated with each of the 7 high-risk groups.

**Table 1: Sampled Enrollee-Years**

High-Risk Group	Number of Sampled Enrollee-Years
1. Acute stroke	54
2. Acute heart attack	30
3. Acute stroke/Acute heart attack combination	18
4. Major depressive disorder	30
5. Embolism	30
6. Vascular claudication	58
<b>Total for Stratified Random Sample</b>	<b>220</b>
7. Potentially mis-keyed diagnosis codes	22
<b>Total for All High-Risk Groups</b>	<b>242</b>

Peoples Health provided medical records as support for the selected diagnosis codes associated with 240 of the 242 enrollee-years.<sup>14</sup> 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. If the contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, we included the financial impact of the resulting HCC (if any) in our calculation of overpayments.

<sup>14</sup> Peoples Health could not locate any medical records for 2 enrollee-years.

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

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

## **FINDINGS**

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that Peoples Health submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 98 of the 242 sampled enrollee-years, the medical records validated the HCCs under review, or we identified another diagnosis code (on CMS's systems) that mapped to the HCC under review. For the remaining 144 enrollee-years, however, the diagnosis codes were not supported in the medical records or could not be supported because Peoples Health could not locate the medical records.

These errors occurred because the policies and procedures that Peoples Health had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. As a result, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Peoples Health received at least \$3.3 million in overpayments for 2015 and 2016.<sup>15</sup>

## **FEDERAL REQUIREMENTS**

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

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)).

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<sup>15</sup> Specifically, we estimated that Peoples Health received at least \$3,312,219 (\$3,206,071 for the statistically sampled groups plus \$106,148 for the group of potentially mis-keyed diagnosis codes) in overpayments. To be conservative, we recommend recovery at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

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

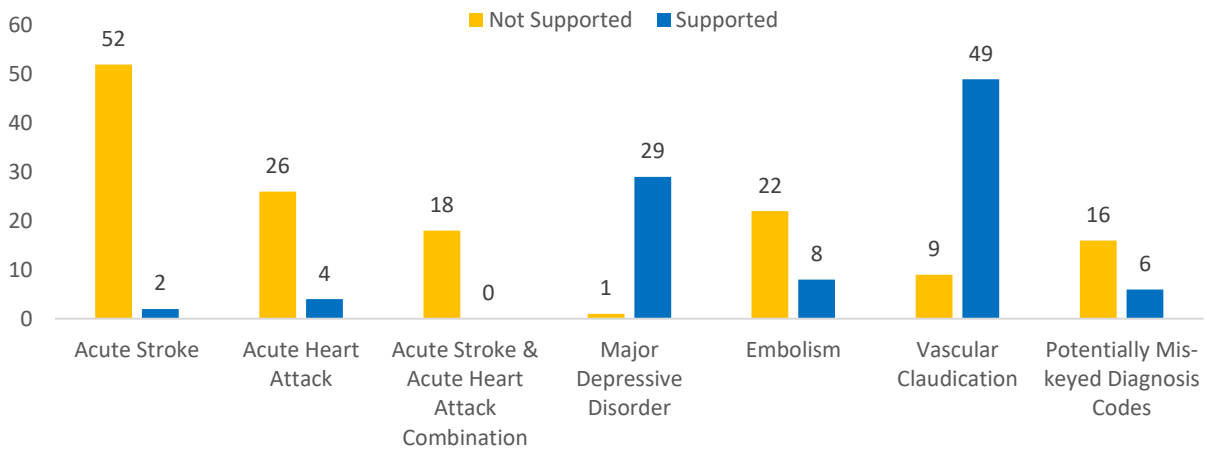
CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (the Manual, chapter 7 (last rev. Sept. 19, 2014)). Specifically, CMS requires all submitted diagnosis codes to be documented on the medical record and to be documented as a result of a face-to-face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

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

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

Most of the selected high-risk diagnosis codes that Peoples Health submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. As shown in the figure on the following page, the medical records for 144 of the 242 sampled enrollee-years did not support the diagnosis codes. In these instances, Peoples Health should not have submitted the diagnosis codes to CMS and received the resulting overpayments.

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



### Incorrectly Submitted Diagnosis Codes for Acute Stroke

Peoples Health incorrectly submitted diagnosis codes for acute stroke for 52 of 54 sampled enrollee-years. Specifically:

- For 51 enrollee-years, the medical records did not support an acute stroke diagnosis:
  - For 40 enrollee-years, the medical records indicated in each case that the individual had previously had a stroke, but the records did not justify an acute stroke diagnosis at the time of the physician’s service.

For example, for 1 enrollee-year, the medical record (for a service that occurred in 2015) indicated that the individual had an acute stroke in 2001. The independent medical review contractor noted that “there is no evidence of an acute stroke or any related condition that result[s] in an assignment of the submitted HCC [for Ischemic or Unspecified Stroke] or a related HCC. . . . There is mention of a history of a stroke but no description of residuals or sequelae<sup>16</sup> that should be coded.” The history of stroke diagnosis code does not map to an HCC.

- For 11 enrollee-years, the medical records did not support the acute stroke diagnosis.

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

<sup>16</sup> Residuals and sequelae are the remaining medical or pathological conditions resulting from a prior disease, injury, or attack.

assignment of [a diagnosis] code that translates to the assignment of the HCC [for Ischemic or Unspecified Stroke]. Patient is being seen in a follow up visit after being hospitalized previously for difficulty in swallowing and facial drooping. Symptoms [were] resolved and CVA [cerebrovascular accident] work up was negative.”

- For the 1 remaining enrollee-year, Peoples Health could not locate any medical records to support the acute stroke diagnosis; therefore, the HCC for Ischemic or Unspecified Stroke was not validated.

As a result of these errors, the HCCs for Ischemic or Unspecified Stroke were not validated, and Peoples Health received \$123,547 in overpayments for these 52 sampled enrollee-years.

### **Incorrectly Submitted Diagnosis Codes for Acute Heart Attack**

Peoples Health incorrectly submitted diagnosis codes for acute heart attack for 26 of 30 sampled enrollee-years. Specifically:

- For 15 enrollee-years, the medical records did not support an acute myocardial infarction diagnosis. However, we identified support for another diagnosis of a less severe manifestation of the related-disease group.
  - For 13 enrollee-years, we identified support for an old myocardial infarction diagnosis.
    - For 8 enrollee-years, which occurred in 2015, the old myocardial infarction diagnosis mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Peoples Health should not have received an increased payment for the acute myocardial infarction diagnosis but should have received a lesser increased payment for the old myocardial infarction diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in assignment of [the Unstable Angina and Other Acute Ischemic Heart Disease] HCC. There is mention of an old myocardial infarction [which] results in [the] HCC [for Angina Pectoris/Old Myocardial Infarction].”



- For 5 enrollee-years, which occurred in 2016, the old myocardial infarction diagnosis did not map to an HCC.<sup>17</sup> Peoples Health should not have received an increased payment for acute myocardial infarction.
    - For 1 enrollee-year, which occurred in 2015, we identified support for an acute ischemic heart disease diagnosis,<sup>18</sup> which mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Peoples Health should not have received an increased payment for the acute myocardial infarction diagnosis but should have received a lesser increased payment for the acute ischemic heart disease diagnosis.
    - For 1 enrollee-year, which occurred in 2016, we identified support for an unspecified angina pectoris diagnosis,<sup>19</sup> which mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Peoples Health should not have received an increased payment for the acute myocardial infarction diagnosis but should have received a lesser increased payment for the unspecified angina pectoris diagnosis.
  - For 11 enrollee-years, the medical records did not support either an acute myocardial infarction diagnosis or an old myocardial infarction diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor stated that “there is no documentation of any condition that will result in assignment of [the Unstable Angina and Other Acute Ischemic Heart Disease] HCC. There is documentation of chest pain, which does not result in an HCC.”

As a result of these errors, the Acute Heart Attack HCCs were not validated, and Peoples Health received \$37,036 in overpayments for these 26 sampled enrollee-years.

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

For 18 sampled enrollee-years, Peoples Health had submitted diagnosis codes in which physicians had documented conditions for both the acute stroke and acute heart attack high-risk groups in the same year (footnote 11). However, we found errors for all 18 of the enrollee-

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<sup>17</sup> In 2015, CMS used the Version 12 model; for 2016, CMS used only the Version 22 model, which did not include an HCC for Old Myocardial Infarction, to calculate risk scores (footnote 8).

<sup>18</sup> Acute ischemic heart disease is defined as any condition brought on by a sudden reduction or blockage of blood flow to the heart, which is most commonly caused by plaque rupture or clot formation in the heart’s arteries.

<sup>19</sup> Angina pectoris is defined as a disease marked by brief, sudden attacks of chest pain or discomfort caused by deficient oxygenation of the heart muscles, usually due to impaired blood flow to the heart.

years because the medical records did not support either the acute stroke diagnosis, the acute myocardial infarction diagnosis, or both.

Table 2 breaks out the findings for the 18 enrollee-years for which the medical records did not support the submitted diagnosis codes.

**Table 2: Acute Stroke and Acute Heart Attack Combination Findings**

Count of Enrollee-Years	Acute Stroke HCC		Acute Heart Attack HCC	
	Medical Record Validated HCC	Support for Different HCC Found	Medical Record Validated HCC	Support for Different HCC Found
9*	No	No	No	No
6	No	No	No	Yes – Old Myocardial Infarction <sup>20</sup>
1	No	No	No	Yes – Old Myocardial Infarction & Angina Pectoris <sup>21</sup>
1	Yes	No	No	Yes – Old Myocardial Infarction <sup>22</sup>
1	No	No	No	Yes – Angina Pectoris <sup>23</sup>

\* For example, for 1 of the 9 enrollee-years, the independent medical review contractor noted that “there is no documentation of any condition that will result in the assignment of a [diagnosis] code that translates to the assignment of [the Ischemic or Unspecified Stroke or Acute Myocardial Infarction] HCCs. The patient was seen in an office visit for follow up on hypertension, anxiety, and hand pain [which does] not result in [an] HCC.”

As a result of these errors, either the HCCs for Ischemic or Unspecified Stroke or Acute Heart Attack were not validated, and Peoples Health received \$69,279 in overpayments for these 18 sampled enrollee-years.

<sup>20</sup> For these 6 enrollee-years, which occurred in payment year 2015, the old Myocardial Infarction diagnosis mapped to an HCC for a less severe manifestation of the related-disease group under the version 12 model.

<sup>21</sup> For this 1 enrollee-year, which occurred in payment year 2015, the old Myocardial Infarction diagnosis (under the version 12 model) and Angina Pectoris diagnosis (under the version 22 model) both mapped to HCCs for a less severe manifestation of the related-disease group.

<sup>22</sup> For this 1 enrollee-year, which occurred in payment year 2015, the old Myocardial Infarction diagnosis mapped to an HCC for a less severe manifestation of the related-disease group under the version 12 model.

<sup>23</sup> For this 1 enrollee-year, which occurred in payment year 2016, the Angina Pectoris diagnosis mapped to an HCC for a less severe manifestation of the related-disease group under the version 22 model.

## **Incorrectly Submitted Diagnosis Code for Major Depressive Disorder**

Peoples Health incorrectly submitted a diagnosis code for major depressive disorder for 1 of 30 sampled enrollee-years. The medical records did not support a major depressive disorder diagnosis. The independent medical review contractor noted that “[t]here is no documentation of any condition that will result in a [diagnosis] code that translates to the assignment of [the Major Depressive, Bipolar, and Paranoid Disorder] HCC. Provider has documented [depressive disorder, not otherwise specified] which does not result in an HCC.”

As a result of the error, the HCC for Major Depressive, Bipolar, and Paranoid Disorder was not validated, and Peoples Health received a \$2,433 overpayment for the sampled enrollee-year.

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

Peoples Health incorrectly submitted diagnosis codes for embolism for 22 of 30 sampled enrollee-years. Specifically:

- For 15 enrollee-years, the medical records did not support the embolism diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in assignment of [a diagnosis] code that translates to the assignment of [an Embolism HCC]. [The] patient presented with obstructive sleep apnea which does not result in [an] HCC.”

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

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in [the] assignment of [a diagnosis] code that translates to the assignment of [an Embolism] HCC. . . despite the patient’s continued use of anti-coagulation, documentation does not support pulmonary embolism<sup>24</sup> as an active diagnosis. The patient has a history of pulmonary embolism which does not result in [an Embolism] HCC.”

As a result of these errors, the Embolism HCCs were not validated, and Peoples Health received \$55,671 in overpayments for these 22 sampled enrollee-years.

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<sup>24</sup> Pulmonary embolism is defined as a condition in which one or more arteries in the lungs become blocked by a blood clot.

## Incorrectly Submitted Diagnosis Codes for Vascular Claudication

Peoples Health incorrectly submitted diagnosis codes for vascular claudication for 9 of 58 sampled enrollee-years. Specifically:

- For 7 enrollee-years, the medical records did not support a vascular claudication diagnosis:
  - For 5 enrollee-years, the medical records did not support the vascular claudication diagnosis.

For example, for 1 enrollee-year, the independent medical review contractor noted that “there is no documentation of any condition that will result in assignment of [a diagnosis] code that translates to the assignment of [the Vascular Disease] HCC. Patient was diagnosed with sinusitis<sup>25</sup> . . . [which does not result] in [an] HCC.”
  - For 2 enrollee-years, the medical records did not support a vascular claudication diagnosis, but the record did indicate that the individual previously incurred a peripheral vascular disease. A past medical history of peripheral vascular disease does not result in an HCC.
- For 1 enrollee-year, the medical record provided was illegible. Specifically, the independent medical review contractor noted that “there is no documentation of a diagnosis that would result in [the Vascular Disease] HCC. . . [h]andwritten note is mostly illegible.”
- For the 1 remaining enrollee-year, Peoples Health could not locate any medical records to support the vascular claudication diagnosis; therefore, the Vascular Disease HCC was not validated.

As a result of these errors, the HCCs for Vascular Disease were not validated, and Peoples Health received \$18,824 in overpayments for these 9 sampled enrollee-years.

## Potentially Mis-keyed Diagnosis Codes

Peoples Health submitted potentially mis-keyed diagnosis codes for 16 of 22 enrollee-years. In each of these cases, the enrollee-years received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition. Appendix F contains the potentially mis-keyed diagnosis codes that we identified for the 16 enrollee-years.

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<sup>25</sup> Sinusitis is defined as a condition in which the cavities around the nasal passages become inflamed.

For all 16 enrollee-years, the medical records did not support the diagnosis for the unrelated condition. Because of these errors, Peoples Health submitted to CMS unsupported diagnosis codes that mapped to unvalidated HCCs.

For example, for 1 enrollee-year, Peoples Health submitted eight diagnosis codes for left heart failure (428.1) and only one diagnosis code for pseudomonal pneumonia (482.1) to CMS. The independent medical review contractor limited its review to the pneumonia diagnosis, for which it did not find support.

As a result of these errors, the HCCs associated with the potentially mis-keyed diagnosis codes were not validated, and Peoples Health received \$106,148 in overpayments for these 16 enrollee-years.

### **THE POLICIES AND PROCEDURES THAT PEOPLES HEALTH USED TO DETECT AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS WERE NOT ALWAYS EFFECTIVE**

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

The compliance procedures that Peoples Health had in place during our audit period included preventative measures by which it performed outreach to its providers to educate them on several topics, including the importance of using correct diagnosis codes to improve medical record documentation. Peoples Health also had procedures in place to detect whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct. For one of these procedures, Peoples Health required coding specialists to review medical record documentation and identify any diagnosis codes that may have been incorrectly or erroneously reported. Additionally, Coding Audit Managers performed monthly *Quality Audit Reviews* of a selection of each coding specialist's workload to determine whether the coder followed departmental requirements and to identify and correct any deficiencies or trends discovered in the coder's reporting. However, Peoples Health's policies and procedures did not focus on the identification of diagnosis codes that were at high risk for being miscoded. For this reason and because the diagnosis codes for 144 of the 242 sampled enrollee-years were not supported by the medical records, we believe that Peoples Health's compliance procedures to prevent and detect incorrect high-risk diagnoses during our audit period were not always effective.

### **PEOPLES HEALTH RECEIVED 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 Peoples Health received at least \$3.3 million in overpayments (\$3.2 million for the statistically sampled groups plus \$106,148 for the group of potentially mis-keyed diagnosis codes) in 2015 and 2016 (Appendix D).

## RECOMMENDATIONS

We recommend that Peoples Health Network:

- refund to the Federal Government the \$3,312,219 in estimated overpayments;
- identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and
- enhance 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.

### PEOPLES HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Peoples Health did not concur with any of our recommendations. However, it also did not specifically disagree with any of the errors we identified associated with the 144 enrollee-years. Instead, Peoples Health stated that we used flawed audit and extrapolation methodologies, did not evaluate the overall enrollee-year payments or risk scores, and failed to follow CMS's risk adjustment audit rules. Peoples Health requested that we withdraw our recommendations. Peoples Health's comments are summarized below and appear in their entirety as Appendix G.

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

### PEOPLES HEALTH DID NOT AGREE WITH THE AUDIT AND EXTRAPOLATION METHODOLOGIES THAT THE OFFICE OF INSPECTOR GENERAL USED TO IDENTIFY OVERPAYMENTS

#### Peoples Health Comments

According to Peoples Health, the goal of our audit was to determine whether hand-selected high-risk diagnosis codes submitted to the Government were supported in the patients' medical records; the goal was not to evaluate the overall member payments or risk scores. Peoples Health stated that "[b]ecause [we] did not audit all of the underlying diagnoses that comprised or should have comprised the member's risk score, the audit did not evaluate CMS payments and therefore the audit cannot identify potential CMS overpayments." To illustrate its point, Peoples Health noted that while we may have determined that it was inappropriately paid for a high-risk diagnosis code, we did not determine whether it should have been paid for a different (even higher paying) diagnosis code for the same member.

In addition, Peoples Health said that we limited the population of enrollees audited to those with a submitted diagnosis, a decision that, according to Peoples Health, increased the bias for identifying overpayments because “members without a submitted diagnosis would likely contain numerous offsetting ‘underpayments,’ which would lower the alleged overpayment or eliminate it entirely.”

Furthermore, Peoples Health also stated that “[t]o the extent [we] will rely on CMS to determine an overpayment amount for this audit, [we] did not follow established CMS audit and extrapolation rules.” Peoples Health noted that “[i]nstead, [we] developed [our] own audit and extrapolation procedures.” To summarize this point, Peoples Health stated that “[d]etermining an overpayment amount under the [risk-adjusted data validation (RADV)] rules based on [our] procedures is inconsistent with CMS’s existing RADV audit program and the regulations governing RADV audit dispute and appeal processes.”

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

We disagree with Peoples Health’s statements regarding our audit and extrapolation methodologies. Specifically, it was beyond the scope of our audit to identify all possible diagnosis codes that Peoples Health could have submitted on behalf of the sampled enrollee-years.

We agree with Peoples Health that our audit and extrapolation methodologies were different from the CMS RADV review methodology. Although our approach for reviewing the medical records was generally consistent with the methodology used by CMS in its RADV audits, it did not mirror CMS’s approach in all aspects, nor did it have to. Our audits are intended to provide an independent assessment of Department of Health and Human Services (HHS) programs and operations in accordance with the Inspector General Act of 1978, 5 U.S.C. App.

For this audit, our objective was to determine whether selected high-risk diagnosis codes that Peoples Health submitted to CMS for use in CMS’s risk adjustment program complied with Federal requirements. For each of the sampled enrollee-years, Peoples Health had previously submitted to CMS only one claim with a high-risk diagnosis code that mapped to the reviewed HCC. We asked Peoples Health to provide a copy of the related medical record for review. We also informed Peoples Health that it could submit up to four more medical records of its choosing that could support the reviewed HCC. These additional medical records, when originally coded, did not contain a diagnosis code that mapped to the reviewed HCC. We asked our independent medical review contractor to review all the medical records that Peoples Health submitted to determine whether the documentation supported any diagnosis codes that mapped to the reviewed HCCs. In this regard, we considered instances in which the medical review contractor found support for a diagnosis that should have been used rather than the diagnosis that was submitted to CMS.

As stated in the Background of this report, we identified each of the diagnoses included in this audit as at high risk for being miscoded. Because CMS makes an increased payment to MA

organizations for certain diagnosis codes, restricting our audit to these codes we identified as high-risk increases the potential for identifying overpayments. However, that restriction does not bias the findings nor the recommendations in this report.

Accordingly, we believe that our audit and extrapolation methodologies allowed us to correctly calculate the overpayment amounts relevant to our objective. A valid estimate of overpayments does not need to take into consideration all potential HCCs or underpayments within the audit period. Our estimate of overpayments addresses only the portion of the payments related to the reviewed HCCs and does not extend to the HCCs that were beyond the scope of our audit. In accordance with our objective, and as detailed in Appendices C and D, we properly executed a statistically valid sampling methodology in that we defined our sampling frame (Peoples Health enrollee-years with a high-risk diagnosis) and sample unit, randomly selected our sample, applied relevant criteria to evaluate the sample, and used statistical sampling software to apply the correct formulas to estimate the overpayments made to Peoples Health.

## **PEOPLES HEALTH DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S APPLICATION OF CMS REQUIREMENTS FOR CALCULATING OVERPAYMENTS**

### **Peoples Health Comments**

Peoples Health stated that our “audit merely confirms the existence of known, systemic errors” and that because we failed to follow CMS’s risk adjustment audit rules, “there is no reason to think that the errors identified in [our] audit represent an actual overpayment.”

According to Peoples Health, “[p]roviders submit erroneous [diagnosis] codes in both the FFS Medicare program and the MA program” and that the Government “is aware of this and has acknowledged that MA plans risk adjustment data will contain errors.” In this regard, Peoples Health referenced a provision of the Social Security Act that, according to Peoples Health, “requires CMS to develop a risk adjustment model that would ensure ‘actuarial equivalence’ between MA payments and the cost that FFS Medicare would have incurred if it provided the benefits directly.”

In addition, Peoples Health stated that “CMS has recognized that errors exist in all provider data and has acknowledged that it is unfair to use FFS data with known errors to set MA rates and to expect no errors in plan risk adjustment data in an MA audit.” To this point, Peoples Health cited a portion of an announcement that CMS made in 2012 that stated, “the documentation standard used in [risk adjustment data validation] audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part



C risk adjustment model (FFS claims).”<sup>26</sup> To address this concern, Peoples Health (with reference to the same announcement) stated that “CMS applies an FFS Adjuster to the extrapolated recovery amount.”

To summarize its point, Peoples Health stated that because our audit “examined targeted, suspected high-error diagnoses that exist in all provider data and that [we have] not calculated or applied an appropriate FFS Adjuster, there is no reason to think that the errors identified in [our] audit represent an actual overpayment.” Peoples Health also stated that we have “no reasonable basis for [our] conclusions under generally accepted government auditing standards.” Accordingly, Peoples Health disagreed that it should refund to the Federal Government the estimated overpayments of \$3,312,219.

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

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

We used the results of our independent medical review contractor’s coding review to determine which of the high-risk HCCs were not substantiated and, in some instances, to identify HCCs that should have been used but were not used in the sampled enrollees’ risk score calculations. We followed the requirement of CMS’s risk adjustment program to determine the payment that CMS should have made for each enrollee. We used the overpayments identified for each enrollee to determine our estimated overpayment amount.

Peoples Health stated that we did not consider actuarial equivalence (that is, calculate or apply an FFS Adjuster) in our overpayment calculations. To this point, and with consideration of Peoples Health’s comments, we recognize that CMS is responsible for making operational and program payment determinations for the MA program, including the application of any FFS Adjuster requirements. CMS has not issued any requirements that compel us to reduce our overpayment calculations.<sup>27</sup> If CMS deems it appropriate to apply an FFS Adjuster, it will adjust our overpayment finding by whatever amount it determines necessary. Thus, we believe that the steps we followed in this audit provide a reasonable basis for our findings and conclusions,

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<sup>26</sup> The different documentation standard to which Peoples Health referred relates to the fact that, although diagnosis codes affect payment methodologies in MA, the diagnosis codes generally do not affect payments made in the Medicare FFS program.

<sup>27</sup> We note that in 2018, CMS proposed “not to include an FFS Adjuster in any final RADV payment error methodology” (Proposed Rule at 83 Fed. Reg. 54982, 55041 (Nov.1, 2018)).

including our calculation of estimated overpayments.<sup>28</sup>

## **PEOPLES HEALTH DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S RECOMMENDATION TO IDENTIFY SIMILAR INSTANCES OF NONCOMPLIANCE THAT OCCURRED BEFORE OR AFTER THE AUDIT PERIOD**

### **Peoples Health Comments**

Peoples Health disagreed with our recommendation to perform additional reviews to determine whether similar instances of high-risk diagnoses occurred before or after the audit period and to refund any overpayments because, according to Peoples Health, (1) our audit has not shown that it was overpaid, and (2) the regulations do not require it to perform these additional reviews. Furthermore, Peoples Health noted that if it conducted additional reviews, it would be underpaid.

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

We do not agree with Peoples Health's interpretation of the Federal requirements. We recognize that MA organizations have the latitude to design their own federally mandated compliance programs. We also recognize that CMS applies a "good faith attestation" standard when MA organizations certify the high volume of data that they submit to CMS for use in the risk adjustment program. However, contrary to Peoples Health's assertions, we believe that our recommendation for Peoples Health to review whether similar instances of high-risk diagnoses occurred before or after our audit period conforms to the requirements specified in Federal regulations (42 CFR § 422.503(b)(4)(vi)). (See Appendix E.)

Specifically, those Federal regulations state that MA organizations must "implement an effective compliance program, which must include measures that prevent, detect, and correct noncompliance with CMS' program requirements." Further, those regulations specify that Peoples Health's compliance plan "must, at a minimum, include [certain] core requirements," which include "an effective system for routine monitoring and identification of compliance risks . . . [including] internal monitoring and audits and, as appropriate, external audits to evaluate . . . compliance with CMS requirements and the overall effectiveness of the compliance program." These regulations also require MA organizations to implement procedures and a system for investigating "potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence." Thus, CMS has, through the issuance of these Federal regulations, assigned the responsibility for dealing with potential compliance issues to the MA organizations.

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<sup>28</sup> OIG audit findings and recommendations do not represent final determinations by CMS. Action officials at CMS will determine whether an overpayment exists and will recoup any overpayments consistent with CMS policies and procedures. In accordance with 42 CFR § 422.311, which addresses audits conducted by the Secretary of HHS (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 RADV appeals process.

We believe that our audit has identified overpayments and that the error rate identified in this report demonstrates that Peoples Health has compliance issues that need to be addressed. These issues may extend to periods of time beyond our scope. Accordingly, we maintain that our recommendation is valid.

## **PEOPLES HEALTH DID NOT AGREE WITH THE OFFICE OF INSPECTOR GENERAL'S RECOMMENDATION TO ENHANCE ITS EXISTING COMPLIANCE PROGRAM**

### **Peoples Health Comments**

Peoples Health disagreed with our recommendation to enhance its existing compliance procedures for diagnoses that are at high risk for being miscoded because, according to Peoples Health, "its compliance program is strong and complies with the MA regulatory requirements." Peoples Health also stated that "an MA plan's compliance oversight cannot be expected to identify and correct all coding errors submitted by providers to a plan." Additionally, Peoples Health stated that "[we] acknowledged that Peoples [Health] had preventative measures by which it performed outreach to its providers to educate them on the importance of using correct diagnosis codes to improve medical documentation [and] that Peoples [Health] had procedures to detect whether diagnosis codes submitted to CMS to calculate risk-adjusted payment[s] were correct." Peoples Health noted that its compliance practices were effective and met regulatory requirements. Thus, Peoples Health stated that our recommendation "exceeds the auditing and monitoring required under existing regulations" and should be withdrawn.

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

We do not agree with Peoples Health that our recommendation exceeds the monitoring and audits required under Federal regulations. Federal regulations (42 CFR § 422.503(b)) require MA organizations like Peoples Health 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. However, as stated earlier in this report, while we acknowledged that Peoples Health performed provider outreach and had procedures in place to review diagnosis codes submitted to CMS to calculate risk-adjusted payments, we concluded that Peoples Health's compliance system was not always effective because it did not focus on the identification of diagnosis codes that were at high risk of being miscoded and because the diagnosis codes for 144 of the 242 sampled enrollee-years, or approximately 60 percent, were not supported by the medical records.<sup>29</sup> Accordingly, we maintain that our recommendation is valid.

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<sup>29</sup> See the section "The Policies and Procedures That Peoples Health Used to Detect and Correct Noncompliance With Federal Requirements Were Not Always Effective."

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

CMS paid Peoples Health \$1,304,040,375 to provide coverage to its enrollees for 2015 and 2016. We identified a sampling frame of 3,362 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes during the 2014 and 2015 service years; Peoples Health received \$58,998,493 in payments from CMS for these enrollee-years for 2015 and 2016. We selected for audit 242 enrollee-years with payments totaling \$4,529,247.

The 242 enrollee-years included 54 acute stroke diagnoses, 30 acute heart attack diagnoses, 18 acute stroke diagnosis and acute heart attack diagnosis combinations, 30 major depressive disorder diagnoses, 30 embolism diagnoses, 58 vascular claudication diagnoses, and 22 potentially mis-keyed diagnoses. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$712,200.

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

We performed audit work from August 2018 through November 2021.

### METHODOLOGY

To accomplish our objective, we performed the following steps:

- We reviewed applicable Federal laws, regulations, and guidance.
- We discussed with CMS program officials the Federal requirements that MA organizations should follow when submitting diagnosis codes to CMS.
- We identified, through data mining and discussions with medical professionals at a Medicare administrative contractor, diagnosis codes and HCCs that were at high risk for noncompliance. We also identified the diagnosis codes that potentially should have been used for cases in which the high-risk diagnoses were miscoded.
- We consolidated the high-risk diagnosis codes into specific groups, which included:
  - 6 diagnosis codes for acute stroke,
  - 35 diagnosis codes for acute heart attack,
  - 27 diagnosis codes for major depressive disorder,
  - 57 diagnosis codes for embolism, and
  - 4 diagnosis codes for vascular claudication.

- We developed an analytical tool that identified 832 scenarios in which either ICD-9 or ICD-10 diagnosis codes, when mis-keyed into an electronic claim because of a data transposition or other data entry error, could result in the assignment of an incorrect HCC to an enrollee’s risk score. For each of the 832 occurrences, the tool identified a potentially mis-keyed diagnosis code and the likely correct diagnosis code. Accordingly, we considered the mis-keyed diagnosis codes to be high risk.
- We used CMS’s systems to identify the enrollee-years on whose behalf providers documented the high-risk diagnosis codes. Specifically, we used extracts from CMS’s:
  - Risk Adjustment Processing System (RAPS)<sup>30</sup> to identify enrollees who received high-risk diagnosis codes from a physician during the service years;
  - Risk Adjustment System (RAS)<sup>31</sup> to identify enrollees who received an HCC for the high-risk diagnosis codes;
  - Medicare Advantage Prescription Drug (MARx)<sup>32</sup> to identify the total Medicare payments that CMS calculated, before applying the budget sequestration reduction, for Peoples Health for the payment years;
  - Encounter Data System (EDS)<sup>33</sup> to identify enrollees who received specific procedures; and
  - Prescription Drug Event (PDE) file<sup>34</sup> to identify enrollees who had Medicare claims with certain medications dispensed on their behalf.
- We interviewed Peoples Health officials to gain an understanding of (1) the policies and procedures that Peoples Health followed to submit diagnosis codes to CMS for use in the risk-adjustment program and (2) Peoples Health’s monitoring of those diagnosis codes to identify and detect noncompliance with Federal requirements.
- We selected for audit a sample of 242 enrollee-years that included (1) a stratified random sample of 220 enrollee-years and (2) 22 enrollee-years as identified by our analytical tool.

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<sup>30</sup> MA organizations use the RAPS to submit diagnosis codes to CMS.

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

<sup>32</sup> The MARx identifies the payments made to MA organizations.

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

<sup>34</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 used an independent medical review contractor to perform a coding review for 240 of the 242 enrollee-years to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements.<sup>35, 36</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, the HCC was considered validated.
  - If the first senior coder did not find support on the medical record, a second senior coder performed a separate review of the same medical record:
    - If the second senior coder also did not find support, the HCC was considered not validated.
    - If the second senior coder found support, then a physician independently reviewed the medical record to make the final determination.
  - If either the first or second senior coder asked a physician for assistance, the physician’s decision became the final determination.
- We used the results of the independent medical review contractor to calculate overpayments or underpayments (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 overpayment made to Peoples Health during the audit period.
- We discussed the results of our audit with Peoples Health officials on May 7, 2021.

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

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

<sup>36</sup> Peoples Health could not locate any medical records for two enrollee-years.

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

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

Report Title	Report Number	Date Issued
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Tufts Health Plan, Inc. (Contract H2256) Submitted to CMS</i>	<a href="#"><u>A-01-19-00500</u></a>	2/14/2022
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UPMC Health Plan, Inc. (Contract H3907) Submitted to CMS</i>	<a href="#"><u>A-07-19-01188</u></a>	11/05/2021
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc. (Contract H2663) Submitted to CMS</i>	<a href="#"><u>A-07-17-01173</u></a>	10/28/2021
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Anthem Community Insurance Company, Inc. (Contract H3655) Submitted to CMS</i>	<a href="#"><u>A-07-19-01187</u></a>	5/21/2021
<i>Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc., (Contract H1036) Submitted to CMS</i>	<a href="#"><u>A-07-16-01165</u></a>	4/19/2021
<i>Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross Blue Shield of Michigan (Contract H9572) Submitted to CMS</i>	<a href="#"><u>A-02-18-01028</u></a>	2/24/2021
<i>Some Diagnosis Codes That Essence Healthcare, Inc., Submitted to CMS Did Not Comply With Federal Requirements</i>	<a href="#"><u>A-07-17-01170</u></a>	4/30/2019



## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

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

We presented the data for these enrollees to Peoples Health for verification and performed an analysis of the data included in CMS's systems to ensure that the high-risk diagnosis codes increased CMS's payments to Peoples Health. After we performed these steps, our finalized sampling frame consisted of 3,362 enrollee-years.

### SAMPLE UNIT

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

### SAMPLE DESIGN

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

- an acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (926 enrollee-years);
- a diagnosis that mapped to an Acute Heart Attack HCC on only one physician claim but did not have that diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician claim (431 enrollee-years);
- an acute stroke diagnosis and a diagnosis that mapped to an Acute Heart Attack HCC in the same year and that met the criteria mentioned in the previous two bullets (18 enrollee-years);
- a major depressive disorder diagnosis (which maps to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) on one claim during the service year but for which antidepressant medication was not dispensed (723 enrollee-years);
- a diagnosis that mapped to an Embolism HCC but for which an anticoagulant medication was not dispensed (194 enrollee-years); or

- a vascular claudication diagnosis (which maps to the HCC for Vascular Disease) but for which medication was dispensed for neurogenic claudication (1,048 enrollee-years).

The specific strata are shown in Table 3.

**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	926	\$2,157,839	54
2 – Acute heart attack	431	826,763	30
3 – Acute stroke / acute heart attack combination	18	83,433	18
4 – Major depressive disorder	723	1,722,485	30
5 – Embolism	194	485,966	30
6 – Vascular claudication	1,048	2,303,833	58
<b>Total – First Six Strata</b>	<b>3,340</b>	<b>\$7,580,319</b>	<b>220</b>

\*Rounded to the nearest whole dollar amount.

After we selected the 220 enrollee-years, we identified an additional group of 22 enrollee-years that represented individuals who received 1 of the 832 potentially mis-keyed diagnosis codes (which mapped to a potentially unvalidated HCC) and multiple instances of diagnosis codes that were likely keyed correctly. Thus, we selected for audit a total of 242 enrollee-years

### **SOURCE OF RANDOM NUMBERS**

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

### **METHOD FOR SELECTING SAMPLE ITEMS**

We sorted the items in each stratum by enrollee identifier and payment year and then consecutively numbered the items in each stratum in the stratified sampling frame. We generated the random numbers for our sample according to our sample design, and we then selected the corresponding frame items for review. We also selected all 22 items from the potentially mis-keyed group.

## **ESTIMATION METHODOLOGY**

We used the OIG, OAS, statistical software to estimate the total amount of overpayments to Peoples Health at the lower limit of the two-sided 90-percent confidence interval (Appendix D). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time. We also identified the overpayments from the 22 potentially mis-keyed diagnosis codes and added that amount to the estimate for the statistical sample to obtain the total overpayments.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**Table 4: Sample Results**

<b>Audited High-Risk Groups</b>	<b>Frame Size</b>	<b>CMS Payment for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)</b>	<b>Sample Size</b>	<b>CMS Payment for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)</b>	<b>Number of Sampled Enrollee-Years With Unvalidated HCCs</b>	<b>Over-payment for Unvalidated HCCs (for Sampled Enrollee-Years)</b>
1 – Acute stroke	926	\$2,157,839	54	\$130,677	52	\$123,547
2 – Acute heart attack	431	826,763	30	61,797	26	37,036
3 – Acute stroke / acute heart attack combination	18	83,433	18	83,433	18	69,279
4 – Major depressive disorder	723	1,722,485	30	74,426	1	2,433
5 – Embolism	194	485,966	30	71,622	22	55,671
6 – Vascular claudication	1,048	2,303,833	58	128,643	9	18,824
<b>Total – First Six Strata</b>	<b>3,340</b>	<b>\$7,580,319</b>	<b>220</b>	<b>\$550,598</b>	<b>128</b>	<b>\$306,790</b>
7 – Potentially mis-keyed diagnoses	22	\$161,602	22	\$161,602	16	\$106,148
<b>Total – All</b>	<b>3,362</b>	<b>\$7,741,921</b>	<b>242</b>	<b>\$712,200</b>	<b>144</b>	<b>\$412,938</b>

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

	<b>Estimated Overpayment for Statistical Sample</b>	<b>Overpayment for Potentially Mis-keyed Diagnosis Group</b>	<b>Total Estimated Overpayments</b>
<b>Point Estimate</b>	\$3,478,750	\$106,148	\$3,584,898
<b>Lower Limit</b>	3,206,071	106,148	3,312,219
<b>Upper Limit</b>	3,751,429	106,148	3,857,577

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

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

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

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

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

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

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

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

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

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

**APPENDIX F: BREAKOUT OF POTENTIALLY MIS-KEYED DIAGNOSIS CODES**

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

Number of Sampled Enrollee-years	One Diagnosis for a Condition (Determined To Be Incorrect)			Multiple Diagnoses for a Condition (Not Reviewed)		Overpayment
	Diagnosis Code	Diagnosis Code Description	Hierarchical Condition Category That Was Not Validated	Diagnosis Code	Diagnosis Code Description	
5	482.0	Pneumonia Due to Klebsiella Pneumoniae	Aspiration and Specified Bacterial Pneumonias	428.0	Congestive Heart Failure, Unspecified	\$23,660
4	205.00	Acute Myeloblastic Leukemia, Not Having Achieved Remission	Metastatic Cancer and Acute Leukemia	250.00	Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled	62,152
2	482.1	Pseudomonal Pneumonia	Aspiration and Specified Bacterial Pneumonias	428.1	Left Heart Failure	10,595
2	433.01	Occlusion and Stenosis of Basilar Artery With Cerebral Infarction	Ischemic or Unspecified Stroke	433.10	Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction	4,358
1	518.81	Acute Respiratory Failure	Cardio-Respiratory Failure and Shock	581.81	Nephrotic Syndrome in Diseases Classified Elsewhere	3,381
1	714.9	Unspecified Inflammatory Polyarthropathy	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	174.9	Malignant Neoplasm of Breast (Female), Unspecified	1,631
1	227.4	Benign Neoplasm of Pineal Gland	Breast, Prostate, Colorectal and Other Cancers and Tumors	272.4	Other and Unspecified Hyperlipidemia	371
<b>16</b>						<b>\$106,148</b>



## APPENDIX G: PEOPLES HEALTH COMMENTS



March 4, 2022

Patricia Wheeler  
Regional Inspector General for Audit Services  
Office of Audit Services, Region VI  
1100 Commerce Street  
Dallas, TX 75242

**RE: Peoples Response to OIG's Draft Report for Audit A-06-18-05002**

Dear Ms. Wheeler:

Peoples Health ("Peoples") writes to respond to the United States Department of Health and Human Services ("HHS") Office of the Inspector General's ("OIG's") Draft Report for Audit No. A-06-18-05002, entitled *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Peoples Health Network (Contract H1961) Submitted to CMS* ("Draft Report"). Peoples respectfully requests that the OIG withdraw its recommendations that Peoples refund an extrapolated amount of \$3.2 million, conduct internal audits of additional time periods, and make improvements to its compliance program. The OIG's recommendations should be withdrawn because the audit and extrapolation methodologies were flawed. The audit did not evaluate overall member payments or risk scores and therefore the outcome cannot be used to determine whether overpayments were made. In addition, the OIG failed to follow CMS's risk adjustment audit rules. CMS already has a set of risk adjustment audits designed to determine if actual overpayments exist.

- I. Peoples does not concur with the OIG's recommendations because its audit and extrapolation methodologies were flawed.
  - A. The audit did not evaluate total member payments and therefore it cannot be used to calculate overpayments.

The OIG's goal for this audit was to determine whether hand-selected high-risk diagnosis codes submitted to the government were supported in the patients' medical records. This was not an audit of overall member payments or risk scores. A member's risk score determines how much CMS pays a Medicare Advantage ("MA") plan for a member. Because the OIG did not audit all of the underlying diagnoses that comprised or should have comprised the member's risk score, the audit did not evaluate CMS payments and therefore the audit cannot identify potential CMS overpayments. For example, OIG may have determined that the plan was inappropriately paid for one diagnosis that they had specifically targeted for review but did not look beyond its predetermined sample to determine whether a plan should have been paid for different (even higher-paying) diagnosis codes for the same member. As such, OIG could not make any conclusion regarding whether the plan was actually overpaid.

In addition, the OIG limited the population of enrollees audited to those with a submitted diagnosis, a decision that increased the bias for identifying overpayment. The members without a submitted diagnosis would likely contain numerous offsetting "underpayments," which would lower the alleged overpayment or eliminate it entirely.

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To the extent the OIG claims it will rely on CMS to determine an overpayment amount for this audit, the OIG did not follow established CMS audit and extrapolation rules. Instead, the OIG developed its own audit and extrapolation procedures that were not subject to notice and comment rule making. Determining an overpayment amount under the RADV rules based on the OIG's procedures is inconsistent with CMS's existing RADV audit program and the regulations governing RADV audit dispute and appeal processes.<sup>1</sup>

In addition, the OIG did not identify the coding and documentation standards used in the audit. CMS regulations require codes to be submitted pursuant to the ICD-10-CM Official Coding Guidelines. To the extent that the OIG is using additional non-regulatory standards, OIG should identify those standards.

If the OIG seeks to test risk adjustment payments, it should focus on a comprehensive RADV process that evaluates MAO risk scores for both under and over payments and incorporates a fee-for-service (FFS) adjuster based on empirical data. This is the process CMS has adopted for RADV audits with input from plans through the notice and comment rulemaking process.

- B. The audit merely confirms the existence of known, systemic errors in provider claims submissions.

The OIG stated in its draft report that it reviewed "high-risk" diagnosis codes that are subject to a high rate of error. The audited codes were not generated by Peoples; they were submitted by Medicare-certified providers to Peoples. Providers submit erroneous codes in both the FFS Medicare program and the MA program. The government is aware of this and has acknowledged that MA plan risk adjustment data will contain errors and that plans "cannot reasonably be expected to know whether every piece of data is correct, nor is that the standard that [CMS], the OIG, and DoJ believe is reasonable to enforce."<sup>2</sup>

One of the key concepts in the Medicare risk adjusted payment model is that of "actuarial equivalence." The Social Security Act (SSA) requires CMS to develop a risk adjustment model that would ensure "actuarial equivalence" between MA payments and the cost that FFS Medicare would have incurred if it provided the benefits directly.<sup>3</sup> This principle is so important to the Medicare Advantage payment model that the SSA requires CMS to report to Congress the actuarial soundness of the agency's risk adjustment methodology.

In Risk Adjustment Data Validation (RADV) Audits, CMS has recognized that errors exist in all provider data and has acknowledged that it is unfair to use FFS data with known errors to set MA rates and to expect no errors in plan risk adjustment data in an MA audit. In order to account for the error rates in FFS data in the RADV audits, CMS applies an FFS Adjuster to the extrapolated recovery amount.<sup>4</sup> If the

<sup>1</sup> 42 C.F.R. §422.311; 2021 Program Audit Process Overview Medicare Parts C and D Oversight and Enforcement Group Division of Audit Operations Updated October 2020, <https://www.cms.gov/files/document/2021-program-audit-processoverview.pdf>.

<sup>2</sup> 65 Fed. Reg. 40,169, 40,268 (June 29, 2000).

<sup>3</sup> See 42 U.S.C. 1395W-23(a)(1)(C).

<sup>4</sup> CMS Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Feb. 24, 2012) (stating that "the FFS adjuster accounts for the fact that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk adjustment model (FFS claims)").



FFS Adjuster amount is greater than the preliminary recovery amount, the final recovery amount is equal to zero.<sup>5</sup>

Because this audit examined targeted, suspected high-error diagnoses that exist in all provider data and the OIG has not calculated or applied an appropriate FFS adjuster, there is no reason to think that the errors identified in this audit represent an actual overpayment. To determine if a plan was overpaid, an audit would have to show that a plan had more net errors than the FFS data used to determine risk adjustment payments. In order to make that determination, the OIG would need to apply an FFS adjuster specific to the audit's targeted population of codes utilizing the same selection criteria. Because the OIG has failed to account for errors in the underlying FFS data, it has no reasonable basis for its conclusions under the generally accepted government auditing standards. Further, without an appropriate FFS adjuster, this OIG audit is inappropriate and unfair, singling out only some plans for audit and recommending refunding payment to the government for known common provider coding errors. For the reasons explained above, Peoples disagrees with the OIG's recommendations that Peoples refund to the Federal Government \$3,312,219.

- II. Peoples disagrees with the recommendation to conduct a self-audit of periods that occurred before or after the audit period.

The OIG recommends that Peoples identify similar instances of "noncompliance" for high-risk diagnoses that occurred before or after the audit period and "refund any resulting overpayments."<sup>6</sup> As explained above in Section I, Peoples disagrees that this audit has shown Peoples has been overpaid because it has not shown that Peoples data have more errors than equivalent FFS data. As such, there is no need to conduct additional reviews. In fact, if Peoples conducted additional reviews, it would be underpaid. Further, the regulations do not require Peoples to perform such audits.

- III. Peoples Disagrees with the Recommendation for Enhanced Compliance Procedures.

The OIG recommends that Peoples enhance its compliance procedures "to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements."<sup>7</sup> Peoples disagrees with this recommendation because its compliance program is strong and complies with the MA regulatory requirements.<sup>8</sup> As previously noted, an MA plan's compliance oversight cannot be expected to identify and correct all coding errors submitted by providers to a plan.

Peoples compliance practices that were examined by the OIG follow MA regulations. The OIG acknowledged that Peoples had preventive measures by which it performed outreach to its providers to educate them on the importance of using correct diagnosis codes to improve medical record documentation. The OIG also acknowledged that Peoples had procedures to detect whether diagnosis

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<sup>5</sup> CMS is currently considering whether the "actuarial equivalence" requirement in the Social Security Statute, 42 U.S.C. 1395w-23(a)(1)(C), requires the use of the FFS Adjuster in RADV audits, but it has not retracted the February 2012 Notice.

<sup>6</sup> OIG Draft Report at 16.

<sup>7</sup> OIG Draft Report at 15.

<sup>8</sup> 42 C.F.R. § 422.503(b)(4)(vi) (requiring MA plans to "[a]dopt and implement an effective compliance program, which must include measures to prevent, detect and correct fraud, waste and abuse").

codes submitted to CMS to calculate risk-adjusted payment were correct. Peoples robust compliance practices are effective and meet the regulatory requirements. The OIG's recommendation exceeds the auditing and monitoring required under existing regulations.

IV. Conclusion

Peoples does not concur with the OIG's three proposed recommendations and respectfully requests that they be withdrawn.

Sincerely,

A handwritten signature in black ink, appearing to read "Warren Murrell".

Warren Murrell  
President and CEO  
Peoples Health