Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF DIAGNOSIS CODES THAT HEALTH NET OF CALIFORNIA, INC. (CONTRACT H0562) SUBMITTED TO CMS

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Report in Brief
Date: September 2023
Report No. A-09-18-03007

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

Medicare Advantage Compliance Audit of Diagnosis Codes That Health Net of California, Inc. (Contract H0562) Submitted to CMS

Why OIG Did This Audit

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

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

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

How OIG Did This Audit

We selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. Health Net provided medical records as support for 1,325 HCCs associated with 195 of the 200 enrollees. We used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

What OIG Found

Health Net did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, although most of the diagnosis codes that Health Net submitted were supported in the medical records and therefore validated 1,103 of the 1,333 sampled enrollees' HCCs, the remaining 230 HCCs were not validated and resulted in overpayments. These 230 unvalidated HCCs included 46 HCCs for which we identified 46 other, replacement HCCs for more and less severe manifestations of the diseases. Second, there were an additional 123 HCCs for which the medical records supported diagnosis codes that Health Net should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,333 HCCs. Rather, the risk scores should have been based on 1,272 HCCs (1,103 validated HCCs plus 46 other HCCs plus 123 additional HCCs). As a result, Health Net received $69,182 of net overpayments for 2015 for the sampled enrollees. As demonstrated by the errors found in our sample, Health Net's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

What OIG Recommends and Health Net Comments

We recommend that Health Net: (1) refund to the Federal Government the $69,182 of net overpayments and (2) continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

In written comments on our draft report, Health Net stated that it will take appropriate steps for the HCCs that it agrees are unsupported by medical records but requested that we reconsider our recommendations and work with Health Net to address issues identified in its comments before finalizing our report. Health Net stated that medical records supported certain diagnoses and that we identified certain HCCs as unsupported for which it had submitted revisions before the start of our audit. After considering Health Net's comments and reviewing the additional information that Health Net provided, we revised our findings and reduced the associated recommended refund amount (from $90,488 to $69,182) for the final report, but we made no change to our second recommendation.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/91803007.asp.

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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.[1]

Incorrect diagnosis codes can lead to improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either an overpayment or an underpayment). An estimated 6.78 percent of payments to MA organizations for calendar year 2018 were improper, mainly due to MA organizations submitting unsupported diagnosis codes to CMS.[2] Our previous audits have shown that MA organizations submitted diagnosis codes that did not comply with Federal requirements.

This audit is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS. We reviewed one MA organization, Health Net of California, Inc. (Health Net), with respect to the diagnosis codes that Health Net submitted to CMS for contract number H0562.[3] (See Appendix B for a list of related Office of Inspector General (OIG) reports on MA organizations.)

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

[2] The Department of Health and Human Services' *Fiscal Year 2020 Agency Financial Report* estimated that 6.78 percent of the payments for the MA program were improper. This figure includes errors for both overpayments and underpayments. The error rate is determined in accordance with the Payment Integrity Information Act of 2019, P.L. No. 116-117 (Mar. 2, 2020), which repealed and replaced the Improper Payments Information Act of 2002, P.L. No. 107-300 (Nov. 26, 2002); the Improper Payments Elimination and Recovery Act of 2010, P.L. No. 111-204 (July 22, 2010); the Improper Payments Elimination and Recovery Improvement Act of 2012, P.L. No. 112-248 (Jan. 10, 2013); and the Fraud Reduction and Data Analytics Act of 2015, P.L. No. 114-186 (June 30, 2016). Similar to the Improper Payments Elimination and Recovery Improvement Act of 2012, the Payment Integrity Information Act of 2019 requires Federal agencies to: (1) review their programs and activities to identify programs that may be susceptible to significant improper payments, (2) test for improper payments in high-risk programs, and (3) develop and implement corrective action plans for high-risk programs.

[3] All subsequent references to "Health Net" in this report refer solely to contract number H0562.

OBJECTIVE

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

BACKGROUND

Medicare Advantage Program

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

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

For 2022, CMS paid MA organizations $403.3 billion, which represented 45 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.[5]

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

[4] 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.

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

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

amount for each geographic area to determine the base rate that the MA organization is paid for each of its enrollees.[7]

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

To determine an enrollee's health status for purposes of calculating the risk score, CMS uses diagnoses that the enrollee receives from acceptable data sources, including certain physicians and hospitals.[8] 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, to Hierarchical Condition Categories (HCCs). Each HCC has a factor (which is a numerical value) assigned to it for use in each enrollee's risk score.

CMS transitioned from one HCC payment model to another during our audit period. As part of this transition, for 2015, CMS calculated risk scores based on both payment models. CMS refers to these models as the "Version 12 model" and the "Version 22 model," each of which has unique HCCs. Accordingly, a diagnosis code can map to either a Version 12 model HCC or a Version 22 model HCC, or to both models. For example, the diagnosis code for "Acute kidney failure, unspecified" maps to the Version 12 model HCC for Renal Failure and the Version 22 model HCC for Acute Renal Failure.

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

As a part of the risk adjustment program, CMS consolidates certain HCCs into related-disease groups. Within each of these groups, CMS assigns an HCC for only the most severe manifestation of a disease in a related-disease group. Thus, if MA organizations submit diagnosis codes for an

[7] 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.

[8] CMS required face-to-face encounters during our audit period. However, in April 2020, CMS issued a memorandum to MA organizations stating that diagnoses resulting from telehealth services can meet the face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication. This memorandum is available online at https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf (accessed on Aug. 31, 2023).

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.[9]

The risk adjustment program is prospective; CMS uses the diagnosis codes that the enrollee received for 1 year (known as the service year) to determine HCCs and calculate risk scores for the following year (known as the payment year). Thus, an enrollee's risk score does not change for the year in which a diagnosis is made. Instead, the risk score changes for the entirety of the year after the diagnosis has been made. Further, the risk score calculation is an additive process: As HCC factors accumulate, an enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment program compensates MA organizations for the additional risk of providing coverage to enrollees who are expected to require more health care resources.

CMS multiplies the risk scores by the base rates to calculate the total monthly Medicare payment that an MA organization receives for each enrollee before applying the budget sequestration reduction.[10] Thus, if the factors used to determine an enrollee's risk score are incorrect, CMS will make an improper payment to an MA organization. Specifically, if medical records do not support the diagnosis codes that an MA organization submitted to CMS, the HCCs are unvalidated, which causes overstated enrollee risk scores and overpayments from CMS.[11] Conversely, if medical records support the diagnosis codes that an MA organization did not submit to CMS, validated HCCs may not have been included in enrollees' risk scores, which may cause those risk scores to be understated and may result in underpayments.

CMS designed its contract-level Risk Adjustment Data Validation (RADV) audits to be its primary corrective action on improper payments, which were estimated at 6.78 percent of payments to MA organizations for 2018. These CMS RADV audits verify that diagnoses submitted by MA organizations for risk-adjusted payment are supported by medical record documentation.

Health Net of California, Inc.

Health Net, an MA organization with headquarters in Woodland Hills, California, has several geographically based Medicare Part C contracts with CMS. As of December 31, 2015, Health Net

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

[10] 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.

[11] Federal regulations (42 CFR § 422.310(e)) require MA organizations (when undergoing an audit conducted by the Secretary) to submit "medical records for the validation of risk adjustment data." For purposes of this report, we use the terms "supported" or "unsupported" to denote whether the reviewed diagnoses were evidenced in the medical records. If our audit determined that the diagnoses were supported or unsupported, we accordingly use the terms "validated" or "unvalidated" with respect to the associated HCC.

provided coverage under contract number H0562 to approximately 187,000 enrollees in California. For our audit period (the 2015 payment year), CMS paid Health Net approximately $1.9 billion to provide this coverage.[12] In 2016, Health Net was acquired by Centene Corporation, a multinational health care company headquartered in St. Louis, Missouri.

HOW WE CONDUCTED THIS AUDIT

Our audit focused on enrollees on whose behalf Health Net submitted to CMS, for the 2014 service year, at least one diagnosis code that mapped to an HCC used in the enrollees' risk scores for the 2015 payment year. We identified a sampling frame of 85,223 enrollees from which we selected a stratified random sample of 200 enrollees on whose behalf CMS made payments totaling $2,892,959 to Health Net. Health Net provided medical records as support for 1,325 HCCs associated with 195 of the 200 sampled enrollees, but it did not provide any medical records for 8 HCCs associated with 5 sampled enrollees. Health Net stated that it received some medical records associated with these five enrollees, but Health Net did not submit the records to us because it believed that the records did not validate any HCCs.

We used an independent medical review contractor to review the medical records to determine whether the diagnosis codes validated the 1,325 HCCs associated with the 195 sampled enrollees. The contractor also reviewed these same records to determine whether any additional HCCs were validated by diagnosis codes that Health Net did not submit but should have submitted.

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

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains the Federal regulations regarding compliance programs that MA organizations must follow.

FINDINGS

Health Net did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements for 114 of the 200 sampled enrollees.

[12] All of the payment amounts that CMS made to Health Net as well as the adjustment amounts that we identified in this report reflect the budget sequestration reduction. The Medicare sequestration reduction is 2 percent.

First, 1,103 of the 1,333 sampled enrollees' HCCs were validated; however, the medical records did not validate the remaining 230 HCCs, which resulted in overpayments.[13] These 230 unvalidated HCCs included 46 HCCs for which we identified 46 other HCCs for more and less severe manifestations of the diseases. These 46 other HCCs should have been included in the enrollees' risk scores (instead of the 46 unvalidated HCCs), which would have reduced the overpayments associated with the 230 unvalidated HCCs in our sample.[14]

Second, in reviewing the medical record documentation for the diagnosis codes associated with the 1,333 sampled enrollee HCCs, we identified support for diagnosis codes that Health Net should have submitted to CMS but did not. If Health Net had submitted these diagnosis codes, an additional 123 HCCs would have been included in the enrollees' risk scores. These risk scores would have increased, and CMS's payments to Health Net would have been higher.

In summary, the risk scores for the 200 sampled enrollees should not have been based on the 1,333 HCCs. Rather, the risk scores should have been based on 1,272 HCCs (1,103 validated HCCs plus 46 other HCCs associated with more and less severe manifestations of diseases plus 123 additional validated HCCs that Health Net did not submit to CMS). As a result, Health Net received $69,182 of net overpayments for 2015 for the enrollees in our sample.

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

FEDERAL REQUIREMENTS

Payments to MA organizations are adjusted for risk factors, including the health status of each enrollee (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)).

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

[13] For 8 of the 230 HCCs, medical records were not provided.

[14] The less severe manifestations of the diseases associated with 26 of the 46 other HCCs led to overpayments, while 6 of the 46 led to no payment effect. The more severe manifestations associated with 13 of the 46 other HCCs led to underpayments, while 1 of the 46 led to no payment effect.

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(b)(1) and (c)(2)–(3)). Further, the MA organizations must implement procedures to ensure that diagnoses come only from acceptable data sources, which include hospital inpatient facilities, hospital outpatient facilities, and physicians (the Manual, chap. 7, § 40).

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

HEALTH NET DID NOT SUBMIT SOME DIAGNOSIS CODES IN ACCORDANCE WITH FEDERAL REQUIREMENTS

Health Net did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. Specifically, Health Net either submitted some diagnosis codes that were not supported in the medical records or did not submit all of the correct diagnosis codes; both types of errors caused CMS to calculate incorrect risk scores for 114 of the 200 sampled enrollees.[15]

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

The diagnosis codes that Health Net submitted to CMS were not supported in the medical records for 230 of the 1,333 sampled enrollees' HCCs. The 230 HCCs were not validated and should not have been used in the enrollees' risk scores. These errors, which also included more and less severe manifestations of the diseases, caused net overpayments from CMS to Health Net for 114 sampled enrollees.

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

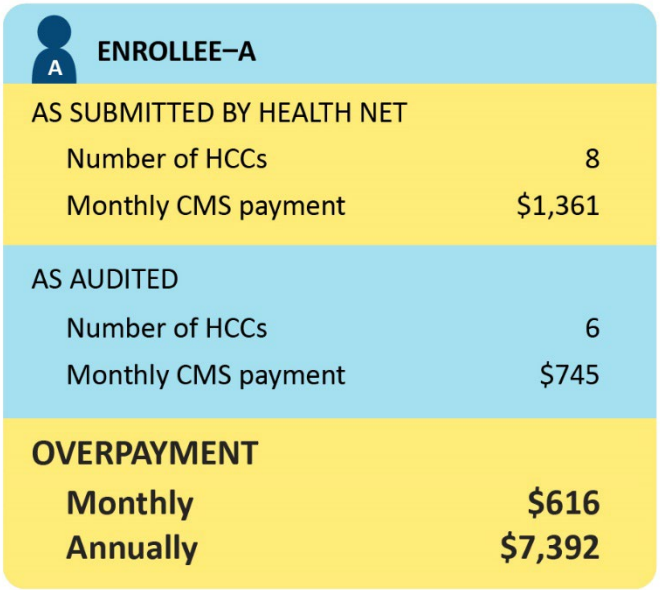
Medical Records Did Not Support Submitted Diagnosis Codes or Any Other Diagnosis Codes

For 176 of the 230 HCCs (66 sampled enrollees), the medical records did not support either the diagnosis code that Health Net submitted or any other diagnosis code that would have validated the HCC. These errors caused overpayments.

For example, for Enrollee A, Health Net submitted a diagnosis code for "Paraplegia," which maps to both the Version 12 and Version 22 model HCCs for Paraplegia. However, that diagnosis was not supported in the submitted medical records. Our independent medical review contractor stated that "there is no documentation of any condition that will result in the assignment of [the HCC for Paraplegia]. There is documentation of functional paraplegia . . . that does not result in an HCC."

As shown in Figure 1, the diagnosis codes that Health Net submitted to CMS on behalf of Enrollee A mapped to eight HCCs, which CMS used to calculate a $1,361 monthly payment that it made to Health Net. Because the HCCs for Paraplegia were not validated, the CMS payment should have been based on six HCCs, which would have resulted in a monthly payment of $745. This error caused a $7,392 overpayment for the year.

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



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

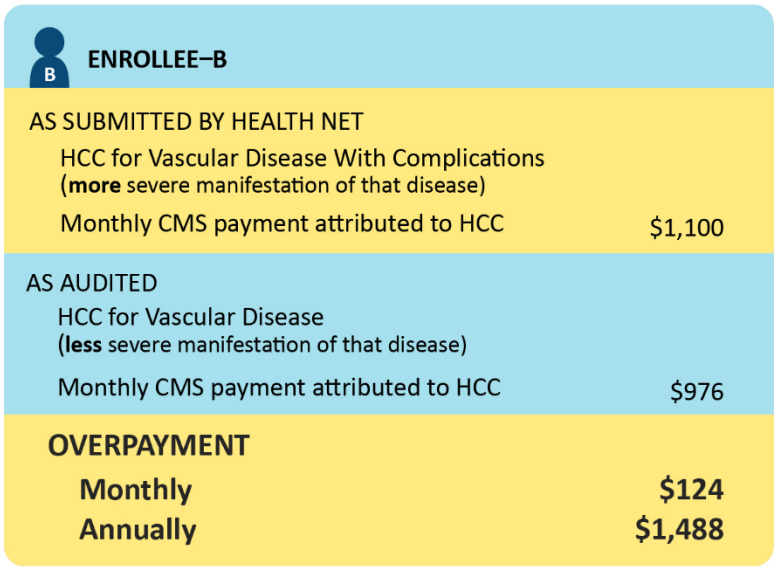
For 46 of the 230 HCCs (24 sampled enrollees), the medical records did not support the diagnosis codes that Health Net submitted. However, we identified 46 other HCCs (that were supported by other diagnosis codes) for more and less severe manifestations of the diseases. These 46 other HCCs should have been included in the enrollees' risk scores (instead of the 46 unvalidated HCCs).

For 32 of the 46 unvalidated HCCs (16 sampled enrollees), the diagnosis codes that Health Net submitted mapped to a more severe manifestation of the HCCs in the related-disease group but were not supported in the medical records. However, there were other diagnosis codes, which mapped to 32 other HCCs for less severe manifestations, that should have been used in the enrollees' risk scores. These errors led to overpayments for 26 of the 32 other HCCs and no payment effect for the remaining 6 HCCs.

For example, for Enrollee B, Health Net submitted a diagnosis for "Arterial embolism and thrombosis of lower extremity." This diagnosis maps to both the Version 12 and Version 22 model HCCs for Vascular Disease with Complications, both of which are more severe manifestations of the HCCs in those related-disease groups. That diagnosis was not supported in the submitted medical records. However, there was support for the diagnosis "Peripheral angiopathy in diseases classified elsewhere," which maps to HCCs that were both less severe manifestations of the HCCs in those related-disease groups (Vascular Disease for both the Version 12 and Version 22 model HCCs). Accordingly, Enrollee B's risk score should have been based on the HCCs with the less severe manifestation instead of the HCCs with the more severe manifestation.

As shown in Figure 2 on the following page, this error caused a $1,488 overpayment for the year.

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

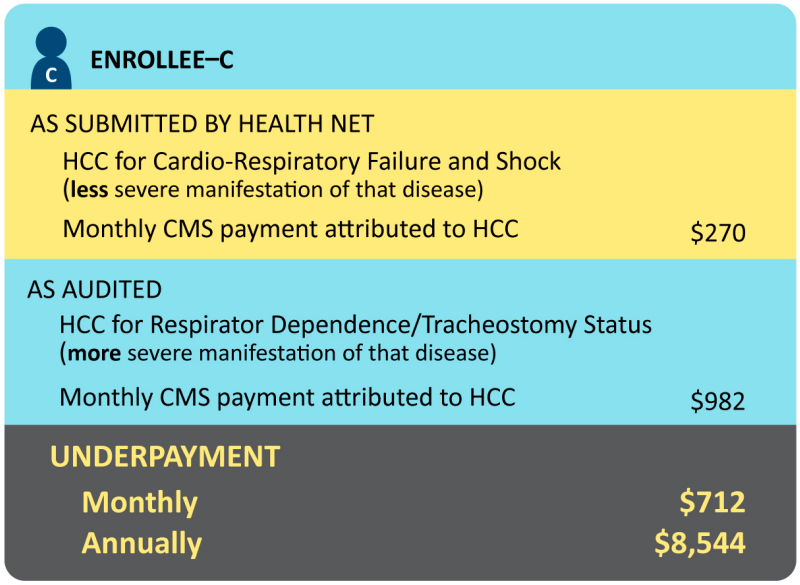


For 14 of the 46 unvalidated HCCs (8 sampled enrollees), Health Net did not submit diagnosis codes that mapped to a more severe manifestation of the HCCs in the related-disease groups. Instead, Health Net submitted only the diagnosis codes that mapped to the less severe manifestations. If Health Net had submitted the correct diagnosis codes, the more severe HCCs would have been used instead of the less severe HCCs in the risk scores. These errors led to underpayments for 13 of the 14 other HCCs and no payment effect for the remaining 1 HCC.

For example, for Enrollee C, Health Net submitted a diagnosis of "Acute respiratory failure," which maps to both the Version 12 and Version 22 model HCCs for Cardio-Respiratory Failure and Shock (and is a less severe manifestation of the HCCs in that related-disease group). However, our independent medical review contractor found support for the diagnosis "Dependence on respirator status," which maps to both the Version 12 and Version 22 model HCCs for Respirator Dependence/Tracheostomy Status (and is a more severe manifestation of the HCCs in that related-disease group). Accordingly, Enrollee C's risk score should have been based on the HCCs with the more severe manifestation instead of the HCCs with the less severe manifestation.

As shown in Figure 3 on the following page, this error caused an $8,544 underpayment for the year.

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



Health Net Did Not Provide Certain Medical Records

For 8 of the 230 HCCs (5 sampled enrollees), the HCCs were not validated because Health Net did not provide any medical records that supported these HCCs. These errors caused overpayments.

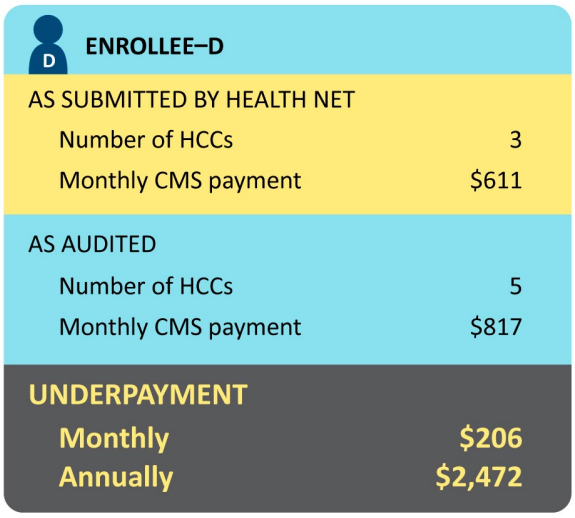
There Were Some Diagnosis Codes That Health Net Should Have Submitted but Did Not Submit to CMS

Health Net did not submit all of the correct diagnosis codes. Specifically, there were an additional 123 HCCs (54 sampled enrollees) for which the medical records supported diagnosis codes that Health Net should have submitted but did not submit to CMS and that should have been used in the enrollees' risk scores. These errors caused underpayments from CMS to Health Net.

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

As shown in Figure 4 on the following page, this error caused a $2,472 underpayment.

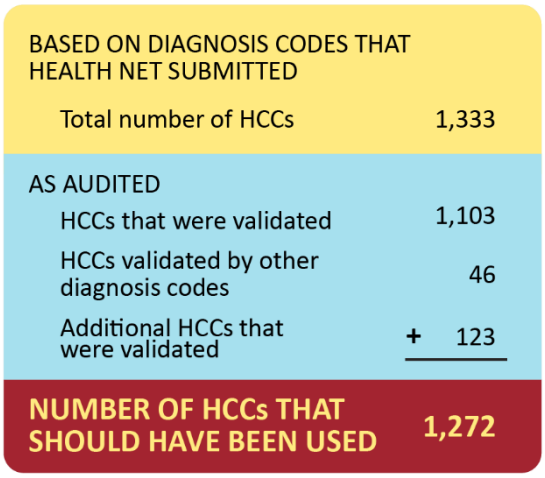
Figure 4: Underpayment Calculation for Enrollee D, Who Had HCCs That Were Validated From a Diagnosis Code That Health Net Should Have Submitted but Did Not Submit to CMS



Summary of Diagnosis Codes Not Submitted in Accordance With Federal Requirements

Because Health Net did not submit some diagnosis codes in accordance with Federal requirements for the 200 sampled enrollees, their risk scores should not have been based on the 1,333 HCCs. Rather, their risk scores should have been based on the 1,272 validated HCCs. Figure 5 summarizes these differences.

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



THE POLICIES AND PROCEDURES THAT HEALTH NET USED TO PREVENT, DETECT, AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS COULD BE IMPROVED

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

Health Net had a compliance program to ensure that it submitted accurate diagnosis codes for use in CMS's risk adjustment program. To prevent the submission of incorrect diagnosis codes to CMS, Health Net educated its providers on the correct usage of diagnosis codes. Health Net also had policies and procedures designed to detect inaccurate diagnosis codes that had already been submitted to CMS and to resubmit corrected diagnosis codes within the required timeframe. These policies and procedures included performing data validation reviews, such as "mock" RADV reviews and HCC-focused reviews. For the "mock" reviews, Health Net mimics the contract-level RADV reviews performed by CMS, looking at a smaller sample of members from selected provider groups. For the HCC-focused reviews, Health Net looked at HCCs associated with diagnosis codes for conditions that were usually diagnosed in an institutional setting for which there was no institutional claim for the enrollee, provider groups with a high prevalence of certain HCCs, and HCCs that were new and unique. In addition, for risk adjustment purposes, Health Net required its providers to verify that prior-year conditions for its enrollees were still active during the current year. However, because we identified 353 HCC errors (230 unvalidated HCCs plus 123 additional HCCs that were validated), the risk scores for the 200 sampled enrollees should have been based on 1,272 HCCs instead of 1,333 HCCs. For this reason, Health Net's policies and procedures associated with its compliance program could be improved, and this improvement could help reduce the occurrence of similar errors in subsequent periods.

HEALTH NET RECEIVED NET OVERPAYMENTS

Health Net received $69,182 of net overpayments (consisting of $258,686 of overpayments and $189,504 of underpayments) for the 200 sampled enrollees.

RECOMMENDATIONS

We recommend that Health Net of California, Inc.:

- refund to the Federal Government the $69,182 of net overpayments and

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

HEALTH NET COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Health Net requested that we reconsider our recommendations and work with Health Net to address issues identified in its comments before finalizing our report. Regarding our first recommendation, Health Net stated that it will take appropriate steps with respect to the HCCs that it agrees are unsupported by medical records. In this respect, Health Net did not agree with the refund amount and stated that the medical record documentation, which it provided to us again with additional information, supported certain diagnoses. Health Net also stated that we identified unsupported HCCs for which it had proactively submitted deletions to CMS before the start of our audit. In addition, Health Net stated that we applied both a flawed audit methodology and an improper standard on Health Net for submitting data to CMS. Regarding our second recommendation, Health Net stated that it "is engaged in a continual process of evaluating and enhancing its compliance procedures and will consider this recommendation."

After considering Health Net's comments and reviewing the additional information that Health Net provided, we revised our findings accordingly (including the example depicted in Figure 1) and reduced the associated recommended refund amount (from $90,488 to $69,182) for this final report. We made no change to our second recommendation.

A summary of Health Net's comments and our responses follows. Health Net's comments appear in their entirety as Appendix E.

HEALTH NET REQUESTED THAT WE RECONSIDER OUR FINDING THAT MEDICAL RECORDS DID NOT SUBSTANTIATE CERTAIN AUDITED HIERARCHICAL CONDITION CATEGORIES

Health Net Comments

In the additional information that it provided to us, Health Net identified 13 HCCs (for 8 sampled enrollees) for which it believed we should reconsider the medical review determinations.[16] The additional information included previously submitted medical records that Health Net marked and to which it added comments, to highlight details that it believed validated the 13 HCCs. In addition, Health Net stated that our audit identified 15 unsupported HCCs that Health Net proactively submitted to CMS for deletion before the start of our audit, and Health Net provided us with documentation to support these deletions. Although Health Net stated that our audit identified 15 unsupported HCCs that it submitted for deletion, Health Net provided us with documentation identifying 28 unsupported HCCs that it had submitted for deletion related to 15 sampled enrollees.

[16] In its comments, Health Net asked us to reconsider our findings for 8 HCCs; however, Health Net submitted additional information for 13 HCCs related to 8 sampled enrollees.

Office of Inspector General Response

Our independent medical review contractor reviewed all of the additional information that Health Net provided for the 13 HCCs and validated 11 HCCs but did not find support in the medical records to validate the remaining 2 HCCs.

With regard to the 28 unsupported HCCs that Health Net proactively submitted to CMS for deletion, Health Net provided documentation supporting that it had submitted revisions to CMS before the start of our audit.

- For eight of the HCCs, Health Net had provided similar documentation during our fieldwork, and we had not included those HCCs in our audit.

- For four of the HCCs, Health Net did not provide the supporting documentation until it commented on our draft report. Based on that documentation, we removed the four HCCs from our audit. Specifically:

    - We removed two of the HCCs from our audit and revised the relevant sections of our report.

    - For two of the HCCs, we agree with Health Net that these HCCs should not have been included and removed them from our audit. However, we found support for another HCC that was a less severe manifestation of the disease for one of the two HCCs removed. Accordingly, we have reclassified this HCC from an error in the category "medical records did not support submitted diagnosis codes but we identified other HCCs, for more and less severe manifestations of the diseases, that were supported by other diagnosis codes" (as shown in the draft report) to validated (in this final report).

- For the remaining 16 HCCs for which Health Net had submitted revisions, Health Net also submitted other diagnosis codes to CMS for the sampled enrollees that mapped to the same HCCs. Because the deletions that Health Net submitted to CMS did not change the sampled enrollees' risk scores, we did not remove these HCCs from our audit.

Consequently, the number of unvalidated HCCs decreased from 245 in our draft report to 230 for this final report. Accordingly, we revised our findings for the 15 HCCs (11 validated HCCs plus 4 HCCs removed from our audit) and reduced the refund amount in our first recommendation from $90,488 to $69,182.[17] In addition, our independent medical review contractor confirmed

[17] For one sampled enrollee, in our draft report we classified one HCC as an error in the category "medical records did not support the submitted diagnosis codes but we identified other HCCs, for more and less severe manifestations of the diseases, that were supported by other diagnosis codes." After further analysis, we determined that this HCC was used in the enrollee's original risk score, and it was validated. Accordingly, we have reclassified this HCC from an error to a validated HCC and have revised the relevant sections of our report.

that Health Net's written comments and additional information had no impact on the decisions that the contractor made for other sampled enrollee-years and stated that there were "no systemic issues identified" in its reviews.

HEALTH NET STATED THAT OUR AUDIT PROCESSES DO NOT ALLOW FOR APPEALS THAT ARE STANDARD FOR OTHER CMS REVIEWS

Health Net Comments

Health Net stated that it "believes it is unfair that, beyond this opportunity to comment on OIG's Draft Report, OIG does not provide a process for appealing the medical record review findings." Health Net also stated that appeal processes that allow MA organizations to challenge findings are "customary in the industry" and that "it is unfair not to include such a formal appeal opportunity here and urges OIG to reconsider its findings."

Office of Inspector General Response

Health Net has, erroneously, conflated our review process with the Secretary's RADV appeals process. We provided Health Net with the opportunity to provide up to five sets of medical records per HCC reviewed. 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's policies and procedures. In accordance with 42 CFR section 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 RADV appeals process.

HEALTH NET STATED THAT WE APPLIED REVIEW STANDARDS THAT WERE NOT PROMULGATED PURSUANT TO LEGAL REQUIREMENTS

Health Net Comments

Health Net stated that our "audit's methodology applied substantive standards that were not promulgated pursuant to the notice-and-comment requirements set forth in *Azar v. Allina Health Services*."[18] According to Health Net: "The [Department of Health and Human Services] Office of General Counsel has advised CMS that it may not bring enforcement actions for overpayment collections based on substantive standards in audits that have not been properly promulgated." Health Net stated that in this respect our audits "must similarly apply only properly promulgated and binding legal standards."

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

Office of Inspector General Response

We disagree with Health Net's comment that we applied review standards that were not promulgated pursuant to the notice-and-comment requirements set forth in *Azar v. Allina Health Services.* Our audit methodology applied standards from the Code of Federal Regulations and the Manual. Specifically, Federal regulations 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.[19] In addition, 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.[20] Health Net 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.

HEALTH NET STATED THAT MEDICARE ADVANTAGE ORGANIZATIONS ARE NOT EXPECTED TO ASSURE 100-PERCENT ACCURACY OF PROVIDER-SUBMITTED DIAGNOSIS CODES

Health Net Comments

Health Net stated that our assessment of its policies and procedures and our related recommendation that Health Net continue to improve its policies and procedures implies that its "compliance efforts must assure 100% accuracy with respect to the vast quantities of diagnosis codes" that it submits to CMS and that we believe that Health Net is "required to have policies and procedures in place that eliminate *all* unsupported codes." To this point, Health Net said that our report stands in contrast with a recent court's ruling and Federal regulations and that "[v]erifying 100% of submitted risk adjusted data would be prohibitive . . . ." Health Net added that while it "strives to identify and eliminate unsupported codes, no compliance program is reasonably expected to eliminate all types of errors. Even where an audit reveals some errors, that does not mean policies and procedures were not effective." Further, Health Net stated that it "is engaged in a continual process of evaluating and enhancing its compliance procedures and will consider this recommendation."

Office of Inspector General Response

We do not agree with Health Net's statement that our recommendation imposes a 100-percent perfection standard on Health Net. Our description of Health Net's policies and procedures as ones that "could be improved" to ensure compliance with CMS's program requirements serves to point directly to our second recommendation that Health Net *continue* to enhance these policies and procedures. In this regard, Health Net's consideration of this recommendation as it continues to improve and enhance its compliance procedures will assist Health Net in attaining

[19] 42 CFR §§ 422.504(l) and 422.310(d)(1).

[20] 42 CFR § 422.504(a).

better assurance with regard to the accuracy and completeness of the risk adjustment data that it submits in the future.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid Health Net approximately $1.9 billion to provide coverage to approximately 187,000 enrollees who resided in California for the 2015 payment year.[21] We identified a sampling frame of 85,223 enrollees who had at least 1 HCC in their risk scores; Health Net received $1,080,614,010 in payments from CMS for these enrollees for 2015. We selected for audit a stratified random sample of 200 enrollees on whose behalf CMS made payments totaling $2,892,959 to Health Net.

Our audit objective did not require an understanding or assessment of Health Net'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 July 2018 to December 2022.

METHODOLOGY

To accomplish our objective, we performed the following steps:

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

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

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

- We reviewed Health Net's policies and procedures to understand how Health Net submitted diagnosis codes to CMS.

- We developed our sampling frame using data from CMS systems. Our sampling frame consisted of enrollees who had at least one HCC in their risk scores. To create this frame, and as explained further in Appendix C, we used data from the CMS:

    - Risk Adjustment Processing System, which MA organizations use to submit diagnosis codes to CMS;

[21] Payment year 2015 data were the most current data available when we started our audit.

- Risk Adjustment System, which identifies the HCCs that CMS factors into each enrollee's risk score calculation; and

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

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

- We obtained 1,271 medical records from Health Net as support for the 1,325 HCCs associated with 195 of the 200 sampled enrollees. Health Net did not provide any medical records for eight HCCs associated with five sampled enrollees.

- We used an independent medical review contractor to determine whether the diagnosis codes in the medical records validated the 1,325 HCCs.

- The independent medical review contractor's coding review of the 1,271 medical records followed a specific process to determine whether there was support for a diagnosis code and an associated HCC. Under the process:

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

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

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

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

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

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

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

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

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

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

- We provided the results of our audit to Health Net officials on November 29, 2022 and provided updated results on September 15, 2023.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

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

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 85,223 Health Net enrollees who: (1) were continuously enrolled under contract number H0562 throughout all of the 2014 service year and January 2015 and (2) had at least one HCC in their 2015 payment year risk scores. Because CMS adjusts its risk-adjusted payments in the calendar year subsequent to when a beneficiary is diagnosed, we restricted our population to individuals who were enrolled—and thus diagnosed—at Health Net during the 2014 service year.

Our sampling frame included enrollees who were:

- not classified as having hospice or end-stage renal disease (ESRD) status at any time during the 2014 service year through January 2015 and

- continuously enrolled in Medicare Part B coverage during the 2014 service year.

SAMPLE UNIT

The sample unit was one enrollee.

SAMPLE DESIGN AND SAMPLE SIZE

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

[health-related portion of the enrollee's risk score]
×
[number of monthly 2015 capitation payments affected by the enrollee's risk score][22]

We classified the enrollees according to the magnitude of the risk-adjusted payments made on their behalf. A higher monthly-weighted-health risk score signified a higher amount of risk-adjusted payments on behalf of that enrollee for the year. We then ranked the 85,223 enrollees according to their monthly-weighted-health risk score from lowest to highest and separated them into 3 strata. The specific strata are shown in the table on the following page.

[22] We excluded from this calculation the months in 2015 for which enrollees were classified as having hospice or ESRD status.

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

Stratum	Sample Size	Number of Enrollees	Monthly-Weighted-Health Risk Score Range	Sampling Frame Dollar Total
1	50	28,407	0.081–5.46	$182,844,440
2	50	28,414	5.464–12.684	298,860,096
3	100	28,402	12.695–142.632	598,909,474
Total	**200**	**85,223**		**$1,080,614,010**

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

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

ESTIMATION METHODOLOGY

We have chosen not to report any estimates of net Medicare overpayments in the sampling frame because the lower limit of the two-sided 90-percent confidence interval was less than the known net overpayment amount in the sample. Therefore, we are recommending recovery of only the net overpayment amount for the items in our sample.

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

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

> Any entity seeking to contract as an MA organization must . . .
>
> (4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following . . . .
>
> (vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum, include the following core requirements:
>
> (A) Written policies, procedures, and standards of conduct that—
>
> (1) Articulate the organization's commitment to comply with all applicable Federal and State standards;
>
> (2) Describe compliance expectations as embodied in the standards of conduct;
>
> (3) Implement the operation of the compliance program;
>
> (4) Provide guidance to employees and others on dealing with potential compliance issues;
>
> (5) Identify how to communicate compliance issues to appropriate compliance personnel;
>
> (6) Describe how potential compliance issues are investigated and resolved by the organization; and
>
> (7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials . . . .
>
> (F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The

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

(G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

(1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.

(2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section.

(3) The MA organization should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee.

APPENDIX E: HEALTH NET COMMENTS

January 30, 2023

Via Email and Overnight Delivery

Ms. Lori Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Re: Health Net of California, Inc. Response to Draft Audit Report No. A-09-18-03007

Dear Ms. Ahlstrand:

Health Net of California, Inc. ("Health Net") appreciates the opportunity to respond to the United States Department of Health and Human Services ("HHS") Office of Inspector General's ("OIG") Draft Report No. A-09-18-03007, entitled *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Health Net of California, Inc., (Contract H0562) Submitted to CMS* (the "Draft Report" or "OIG Draft Report"), which was provided to Health Net on December 15, 2022.

For the reasons set forth below, Health Net respectfully submits that OIG should not finalize the Draft Report or its recommendations:

- **The Audit Methodology is Flawed:** OIG should permit appeals of audit findings prior to finalizing its recommendations, as is standard for CMS reviews, and should only apply standards promulgated pursuant to legal requirements;

- **Medical Record Documentation Supported Certain Diagnoses:** OIG incorrectly concluded that medical record documentation did not support certain diagnoses when, in fact, it did; and

- **OIG Applied an Improper Standard:** OIG's findings and recommendations improperly imply that plans are expected to assure 100% accuracy of provider-submitted codes, whereas the proper standard should be whether the plans made good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted.

Health Net has made significant investments in its Medicare risk adjustment compliance program, and we remain committed to improving the quality of data submitted. We have established robust policies and procedures related to risk adjustment and we continue to refine our practices to keep pace with evolving industry standards. We therefore request that OIG reconsider its recommendations, and work closely with Health Net to address the issues identified in our response letter before finalizing its Draft Report.

Health Net welcomes the opportunity to discuss OIG's methodology, findings, and recommendations.

I. Error Determinations for Hierarchical Condition Categories

A. *Legal Concerns with OIG's Methodology.*

i. OIG's Processes Do Not Allow for Appeals that Are Standard for Other CMS Reviews.

As a threshold matter, Health Net believes it is unfair that, beyond this opportunity to comment on OIG's Draft Report, OIG does not provide a process for appealing the medical record review findings.

Appeal processes, which afford an opportunity for challenging the agency's findings and conclusions, are standard in other CMS reviews. For example, 42 C.F.R. § 422.311 establishes that MAOs that do not agree with their RADV audit results may appeal, including for disputes related to medical record review determinations and payment error calculations.[1] MAOs may even request a RADV hearing to be conducted by a Hearing Officer with formal proceedings.[2]

Beyond CMS's RADV process, under 42 C.F.R. § 422.330, when CMS identifies overpayments associated with payment data submitted by MAOs, it sends a data correction notice to the MAO and conduct a payment offset.[3] If the MAO does not agree with the payment offset, it may appeal under a three-level appeal process.[4]

Recognizing the complexities involved in medical record documentation and MA payments, appeal processes that allow MAOs to challenge findings are a standard of CMS reviews, and customary in the industry. Health Net submits it is unfair not to include such a formal appeal opportunity here and urges OIG to reconsider its findings as to Health Net in that vein.

ii. The Audit Applied Review Standards that Were Not Promulgated Pursuant to Legal Requirements.

We note as well, as other MAOs have,[5] that the audit's methodology applied substantive standards that were not promulgated pursuant to the notice-and-comment requirements set forth in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019), and the subsequent implementation memorandum from the HHS Office of the General Counsel.[6] In *Allina*, the Supreme Court held that substantive standards governing payments under Medicare must be promulgated pursuant to notice-and-comment rulemaking under 42 U.S.C. § 1395hh(b), regardless of whether such standards are

[1] 42 C.F.R. § 422.311(c).
[2] *Id.*
[3] 42 C.F.R. § 422.330.
[4] *Id.*
[5] *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc (Contract H2663) Submitted to CMS*, A-07-17-01173 (Oct. 2021) ("Coventry Audit"), Appendix D, available at https://oig.hhs.gov/oas/reports/region7/71701173.pdf; *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., (Contract H3359) Submitted to CMS*, A-02-18-01029 (Jan. 2022) ("Healthfirst Audit"), Appendix G, available at https://oig.hhs.gov/oas/reports/region2/21801029.pdf.
[6] Impact of *Allina* on Medicare Payment Rules at 1-3. Accessible at https://www.law360.com/articles/1222453/attachments/0.

framed as rules, policies, or otherwise. The HHS Office of the General Counsel has advised CMS that it may not bring enforcement actions for overpayment collections based on substantive standards in audits that have not been properly promulgated.[7] OIG's audits, of course, must similarly apply only properly promulgated and binding legal standards.

In providing these comments and otherwise participating in these proceedings, Health Net reserves all rights with respect to substantive standards set forth in the Medicare Managed Care Manual, the Risk Adjustment Training Manual, and other documents that were not promulgated in accordance with 42 U.S.C. § 1395hh(b) and notice-and-comment requirements.[8]

B. *Health Net Respectfully Requests That OIG Reconsider the Draft Report's Finding That Medical Records Do Not Substantiate Certain Audited HCCs.*

OIG highlights examples of individual medical records where it believes the HCCs under review are not validated. However, even within the limitations of the audit procedures and review standards that OIG applied, as discussed above, the medical record documentation provided clearly supports the HCCs highlighted in at least eight instances. These HCCs are discussed in Appendix A. We respectfully request that OIG at least reconsider its findings for these eight HCCs.

II. Standards and Expectations

A. *Plans Are Not Expected to Assure 100% Accuracy of Provider-Submitted Codes, as the Draft Report's Findings and Recommendations Imply.*

Various aspects of the Draft Report imply that MAOs' compliance efforts must assure 100% accuracy with respect to the vast quantities of diagnosis codes they receive from providers and are required to submit to CMS. For example, the Draft Report's finding that the purported errors identified "occurred because the policies and procedures that Health Net had to prevent, detect, and correct compliance with CMS's program requirements, as mandated by Federal regulations, could be improved, and this improvement could help reduce the occurrence of similar errors in subsequent periods"[9] might be read to suggest that OIG believes Health Net is required to have policies and procedures in place that eliminate *all* unsupported codes. Health Net requests that OIG eliminate this finding. While Health Net strives to identify and eliminate unsupported codes, no compliance program is reasonably expected to eliminate all types of errors. Even where an audit reveals some errors, that does not mean policies and procedures were not effective.

MAOs receive millions of claims from the providers rendering care to their members. Typically, these claims reflect multiple diagnoses assigned by the providers, and result in an enormous volume of data that MAOs must receive and submit to CMS.[10] Verifying 100% of submitted risk adjustment data would be prohibitive for MAOs (and place extraordinary additional burdens on providers).

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[7] *Id.*

[8] OIG has responded in other audit reports that MAOs' contracts with CMS call for adherence to CMS instructions and guidance. However, CMS remains subject to the statutory requirements, which may not be avoided through language in a form agreement which may itself conflict with statutory requirements.

[9] Draft Report at 13.

[10] 42 CFR § 422.310(b) and 42 CFR § 422.310(d)(3).

The MA regulatory framework, accordingly, does not include an expectation or requirement that MAOs ensure 100% medical record support for codes. As this absence acknowledges, such a mandate would be impractical, financially unsustainable for MAOs, and inconsistent with the goal of administrative simplicity that underlies the HCC model.

In recognition of these facts, CMS has acknowledged that MAOs "cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that [CMS], the OIG, and DOJ believe is reasonable to enforce."[11] Federal regulations require that MAOs submit all risk adjustment data from healthcare providers and requires an attestation in respect of risk adjustment data. However, that attestation does not impose a requirement for an MAO to ensure that all submitted codes are supported by medical records. Rather, MAOs will only "be held responsible for making good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted." OIG itself has acknowledged that MAOs are not able to provide an "absolute guarantee of accuracy."[12]

Moreover, an expectation to ensure 100% accuracy would disregard the known presence of unsubstantiated codes in the traditional Medicare data and would render the risk adjustment system actuarially inequivalent. In its appeal of the district court's ruling in *UnitedHealthcare Ins. Co v. Azar*, the United States recognized that broad monitoring obligations would implicate actuarial equivalence. The United States defended an asserted obligation to delete unsupported codes on grounds that the obligation was limited: "the [2014] Overpayment Rule requires only that insurers delete erroneous diagnoses when those errors are identified, *not that insurers conduct comprehensive audits*."[13] The government conceded that MAOs do not have an obligation to identify and delete "all erroneous diagnosis, or even a large fraction of them."[14] The court of appeals cited the government's representation in its ruling, stating that the "[Overpayment] Rule only requires insurers to refund amounts they *know* were overpayments, i.e., payments they *are aware* lack support in a beneficiary's medical record. That limited scope does not impose a self-auditing mandate."[15]

Health Net respectfully requests that the final report acknowledge the more limited scope of MAOs' obligations. In particular, Health Net requests that the final report expressly include and acknowledge statements made by the United States in the *UnitedHealthcare* litigation that MAOs do not have an obligation to identify and delete every erroneous diagnosis, or even a large fraction of them. Health Net respectfully requests corresponding revisions to the Draft Report's recommendations, which we believe could be read in a manner that misstates the nature and extent of MAOs' obligations.

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[11] 65 Fed. Reg. 40170, 40268 (June 29, 2000).

[12] *Id* at 40268; *see also id.* at 40250-40252 ("Attestation of encounter data is essential for guaranteeing the accuracy and completeness of data submitted for payment purposes, and to allow us to pursue penalties . . . where it can be proven that a plan knowingly submitted false data. However, in response to concerns from M+C organizations, we have restricted the attestation requirement to confirmation of the completeness of the data and the accuracy of coding . . . the attestation requirement is thus in no way a legal trap").

[13] *UnitedHealthcare*, No. 18-5326, Brief for Appellants, at 2-3 (D.C. Cir. Apr. 23, 2020) (emphasis added).

[14] *See id.* at 39-40.

[15] *UnitedHealthcare Ins. Co. v. Becerra*, 9 F.4th 868, 884, No. 18-5326 (D.C. Cir. Aug. 13, 2021) (emphasis in original). The Draft Report also says that "Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS." However, we note that no regulation is cited for this statement, particularly to the extent it implies an obligation to assure 100% accuracy.

III. Response to Recommendations

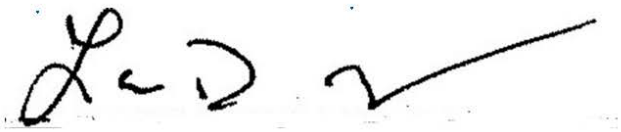
Health Net will take appropriate steps with respect to those HCCs we agree are unsupported by the medical record and consult with CMS about mechanisms for addressing OIG's findings on a net basis. Health Net does not agree with OIG's findings regarding the overpayment amount, as we believe some of the specific HCCs identified as unsupported by the OIG's audit are actually supported by the medical record as discussed above.[16] Additionally, the OIG identified 15 unsupported HCCs that were proactively submitted by Health Net to CMS for deletion prior to receiving notification of this audit in 2018.

Regarding the recommendation to improve policies and procedures, Health Net is engaged in a continual process of evaluating and enhancing its compliance procedures and will consider this recommendation. We also look forward working with CMS and the OIG to better understand the specific improvements Health Net should make, and their views regarding required compliance efforts and obligations within the actuarial and legal context discussed above.

IV. Conclusion

Health Net appreciates the opportunity to comment on the Draft Report. We look forward to receiving the final report after OIG has had an opportunity to consider the issues we have raised. If you have any questions concerning this response letter, please do not hesitate to contact me.

Sincerely,



Lori-Don Gregory
Vice President, Medicare Compliance Officer

[16] Health Net notes continuing legal questions as to the impact of the statutory requirement of actuarial equivalence on determinations of overpayment stemming from audits such as this one.

Appendix A

As discussed in Section I.B. of its response letter, Health Net believes that, even aside from the issues with the audit procedures and review standards discussed in the response letter, the medical record documentation Health Net provided clearly supports the HCCs highlighted in at least the following eight instances:

i. Chronic Obstructive Pulmonary Disease (HCC 108/111, V12/22)

The audit results listed one enrollee (Sample 3-150) as not supported stating "*there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of HCC 108 [HCC 111]. COPD is noted in PMH with no medications to support an active treatment.*"

Health Net respectfully disagrees with this decision. Chronic obstructive pulmonary disease (COPD) is a lifelong condition that affects management of care in a patient with comorbidities. In this instance the member's COPD is also affected by the member's history of congestive heart failure (CHF), cerebral vascular accident (CVA), and seizures. The CMS 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide states, "Certain combinations of coexisting diagnoses for an individual can increase their medical costs. Examples of the disease interactions include … a three-way combination of chronic obstructive pulmonary disease (COPD), cerebrovascular disease (CVD), and coronary artery disease (CAD)".[17] While not in the preferred format, the provider still acknowledges the diseases exist which overall affects ongoing management of the member's conditions and ultimately leads to ICD-9-CM code 496, which results in the HCC 108/111 (V12/V22).

ii. Diabetes with Renal or Peripheral Circulatory Manifestation (HCC 15, V12)

The audit results listed one enrollee (Sample 3-193) as not supported stating "*there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of HCC 15.*" It went on to further cite that a lower HCC 16 was more appropriate.

Health Net respectfully disagrees with both decisions. Chronic kidney disease (CKD) stage 3 was stated in the subjective section of the office note in the provider's active voice. The assessment section further states a plan for labs including a "Comprehensive metabolic panel w GFR" and "Microalbumin/create ratio urine, random." Not only can CKD stage 3 be confirmed as supported with continued evaluation, but it can also be linked to diabetes mellitus. This automatic linking rule was later confirmed by both ICD-10-CM guidelines and the American Hospital Association's (AHA) Coding Clinic as acceptable.[18] The Coding Clinic is widely

[17] *See* CMS, *2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guides* at 29, available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2012183293-yv-participant-guide-publish_052909.pdf

[18] *See* American Hospital Association Coding Clinic (First Quarter 2016, Volume 3) at 11.

acknowledged by government agencies as a reputable resource and often utilizes answers provided by this organization dating back, in some cases, thirty years. Thus, the appropriate code for a patient that has both diabetes mellitus type II in addition to chronic kidney disease, stage 3 is ICD-9-CM 250.40 resulting in HCC 15 (V12).

iii. Endocrine and Metabolic Disorders (HCC23, V22)

The audit results listed one enrollee (Sample 3-107) as not supported stating *"there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of HCC 23."*

Health Net respectfully disagrees with this decision. The patient is being treated for Urinary Tract Infection where Homocystenemia is documented in the Assessment and Plan (A/P) section of the note. Homocystenemia indexes to ICD-9-CM 270.4, HCC 23 (V22). Additionally, Homocystenemia has various spelling alternatives such as Homoscysteinemia or Homocystinemia, which are synonymous with the index spelling of Homocystinemia. Further, the provider ran lab work where results relayed a high range of homocysteine and interpreted the lab results documenting a definitive diagnosis.

iv. Major Depressive, Bipolar, and Paranoid Disorders (HCC 55/58, V12/22)

The audit results listed one enrollee (Sample 3-126) as not supported stating, *"there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of HCC 55 [HCC 58].*

Health Net respectfully disagrees with this decision. In this instance, it appears the independent medical record reviewer did not consider the provider's entire note. Bipolar disorder was addressed in the History of Present Illness (HPI) which indexes to ICD-9-CM 296.80, HCC 55/58, V12/V22. Bipolar disease is a lifelong condition which was supported in the provider's active voice as having "significant underlying depression." Further, the patient was under current psychiatric care with multiple medications (Paxil, Amitriptyline, Trazodone) and stated that the patient tried "a new psychotropic agent Sertigan [for a] month."

v. Rheumatoid Arthritis and Inflammatory Connective Tissue Disease (HCC 38/40, V12/22)

The audit results listed two enrollees (Sample 3-121 and 3-162) as not supported. The first sample states *"there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of HCC 38 [HCC 40]. The beneficiary has a listed history of lupus, however, there is no active monitoring or treatment of this condition found during review. History of other musculoskeletal disorder (V13.59) should be assigned but does not result an in HCC"* and for the second sample, the citation stated *"there is no documentation of any condition that will result in assignment of an ICD-9-CM code that*

translates to the assignment of HCC 38. There is past medical history of rheumatoid arthritis (V13.4) which does not result in HCC."

Health Net respectfully disagrees with both findings. For enrollee (Sample 3-121), Lupus, mapping to 710.0 HCC 38/40 (V12/22), was noted in the Past Medical History (PMH) of multiple encounters during the inpatient stay. Lupus is a lifelong autoimmune condition which would affect management of care in a patient with pneumonia, demand ischemia, and coronary artery disease, as this patient presented. There is currently no cure for lupus, nor does lupus resolve; therefore, ongoing management of this disease is necessary to prevent exacerbation of the illness. Further, the patient was hospitalized with shortness of breath and chest pain which are common symptoms of lupus. The AHA Coding Clinic, Third Quarter 2007, relays guidance on capturing diseases found in the inpatient setting citing:

> *If there is documentation in the medical record to indicate the patient has COPD, it should be coded. Even if this condition is listed only in the history section with no contradictory information, the condition should be coded. Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. This advice applies to inpatient coding.*

For the second enrollee (Sample 3-162), Rheumatoid arthritis (RA), mapping to ICD-9-CM 714.0 HCC 38/40 (V12/22), is a chronic autoimmune disorder that affects management of care in a patient with additional comorbidities such as unstable angina, history of myocardial infarction (MI) and hypertension (HTN). RA patients are also twice as likely to have manifestations of heart disease, which this patient exhibited in addition to taking Tramadol for pain control. As the patient was seen in the Emergency Department, all these factors are taken into consideration and affect medical decision making. The CMS 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide states "rheumatoid arthritis (ICD-9-CM 714.0, HCC 38)" as an ongoing condition that coexists with other conditions and "is likely that patients having these conditions would have their general health status evaluated … and these diagnoses would be documented and reportable at that time."[19]

[19] *See* CMS, *2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guides* at 148, available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2012183293-yv-participant-guide-publish_052909.pdf

vi. Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock (HCC 2, V12/22)

The audit results listed enrollee (Sample 3-141) as not supported stating, *"there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of HCC 2; however, there is documentation of urosepsis (ICD-9-CM 599.0) with Escherichia coli (ICD-9-CM 041.49) identified as the organism. These codes do not result in HCC 2 or any other HCC."*

Health Net respectfully disagrees with this decision. Sepsis is separately identified from the E. coli Urinary Tract Infection (UTI) in the discharge diagnoses of the inpatient stay. The patient was admitted with "symptoms felt to be urosepsis" in the History of Present Illness (HPI), but in the hospital course the provider clearly documents how the patient progressed from a UTI/urosepsis to systemic sepsis outside of the urinary tract (103 temp, Tachycardia, Leukocytosis). The provider specifies during the hospital course that the patient has UTI with sepsis (i.e., sepsis due to UTI). Per AHA Coding Clinic, sepsis due to UTI is coded with the specific infection code and the sepsis code (ICD-9-CM 995.91, HCC 2).[20]

vii. Vascular Disease (HCC 105, V12)

Finally, the audit results listed enrollee (Sample 3-116) as not supported stating, "*there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of HCC 105. There is mention of venous insufficiency (459.81) which does not result in HCC."*

Health Net respectfully disagrees with this decision. ICD-9-CM 453.40 HCC 105 (V12) is supported in the documentation as "Chronic DVT on Coumadin", which was noted in the Chief Complaint under the major problem (MP) section. Additional support showed Coumadin as current citing specifically that the "medication reconciliation was done", and where "venous insufficiency" was noted in Physical Exam (Objective) for extremities. Chronic DVTs occur after the acute phase in which the clot becomes hard and scars the vein for an extended period and sometimes permanently resulting in continued insufficient blood flow.

[20] *See* American Hospital Association Coding Clinic (Third Quarter 2012, Volume 29) at 11.