Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF DIAGNOSIS CODES THAT EMBLEMHEALTH (CONTRACT H3330) SUBMITTED TO CMS

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September 2024
A-06-18-02001

Office of Inspector General

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Report in Brief

Date: September 2024
Report No. A-06-18-02001

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

Why OIG Did This Audit

Under the Medicare Advantage (MA) program, 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 into Hierarchical Condition Categories (HCCs), based on similar clinical characteristics and severity and cost implications. CMS makes higher payments for enrollees who receive diagnoses that map to HCCs.

For this audit, we reviewed one of the contracts that EmblemHealth has with CMS with respect to the diagnosis codes that EmblemHealth submitted. Our objective was to determine whether EmblemHealth 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. EmblemHealth provided medical records as support for 1,220 HCCs associated with 199 of the 200 enrollees. We used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

Medicare Advantage Compliance Audit of Diagnosis Codes EmblemHealth (Contract H3330) Submitted to CMS

What OIG Found

EmblemHealth 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 EmblemHealth submitted were supported in the medical records and therefore validated 860 of the 1,222 sampled enrollees' HCCs, the remaining 362 HCCs were not validated and resulted in overpayments. These 362 unvalidated HCCs included 54 HCCs for which we identified 54 other HCCs for more and less severe manifestations of the diseases. Second, there were an additional 65 HCCs for which the medical records supported diagnosis codes that EmblemHealth should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,222 HCCs. Rather, the risk scores should have been based on 979 HCCs (860 validated HCCs plus 54 other HCCs plus 65 additional HCCs) and resulted in $551,917 in net overpayments. On the basis of our sample results, we estimated that EmblemHealth received at least $130 million in net overpayments for 2015. Because of Federal regulations that limit the use of extrapolation in RADV audits for recovery purposes to payment year 2018 and forward, we are reporting the overall estimated net overpayment amount but are recommending a refund of $551,917 in net overpayments. As demonstrated by the errors found in our sample, EmblemHealths'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 EmblemHealth Comments

We recommend that EmblemHealth refund to the Federal Government $551,917 of net overpayments and continue to ensure that its policies and procedures have been adequately designed and implemented to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments. EmblemHealth disagreed with our findings and did not concur with our recommendations and provided additional information to validate specific HCCs. EmblemHealth also questioned our audit methodology and said our inclusion of estimated overpayments is inappropriate.

After reviewing EmblemHealth's comments and the additional information provided, we revised our findings and the associated net overpayment amount in our first recommendation. We also revised the wording for our second recommendation.

The full report can be found on the OIG website.

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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.[3] We reviewed one MA organization, EmblemHealth, with respect to the diagnosis codes that EmblemHealth submitted to CMS for contract number H3330.[4]

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

[2] The Department of Health and Human Services Agency Financial Report, Fiscal Year 2020, 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] See Appendix B for a list of related Office of Inspector General reports.

[4] All subsequent references to "EmblemHealth" in this report refer solely to contract number H3330.

OBJECTIVE

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

BACKGROUND

Medicare Advantage Program

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

Under the MA program, CMS makes advance payments each month to MA organizations for the expected costs of providing health care coverage to enrollees. These payments are not adjusted to reflect the actual costs that the organizations incurred for providing benefits and services. Thus, MA organizations will 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.[6]

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

- Base rate: Before the start of each year, each MA organization submits bids to CMS that reflect the MA organization's estimate of the monthly revenue required to cover an

[5] The Balanced Budget Act of 1997, P.L. No. 105-33, as modified by section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act, P.L. No. 108-173, established the MA program.

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

enrollee with an average risk profile.[7] CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that the MA organization is paid for each of its enrollees.[8]

- 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.[9] MA organizations collect the diagnosis codes from providers based on information documented in the medical records and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs). Each HCC has a factor (which is a numerical value) assigned to it for use in each enrollee's risk score.

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

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

As a part of the risk adjustment program, CMS consolidates certain HCCs into related-disease groups. Within each of these groups, CMS assigns an HCC for only the most severe

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

[8] 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.

[9] 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 Nov. 2, 2023.

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.[10]

The risk adjustment program is prospective. Specifically, 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 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 accumulate, an enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment program compensates MA organizations for the additional risk for providing coverage to enrollees who are expected to require more health care resources.

CMS multiplies the risk scores by the base rates to calculate the total monthly Medicare payment that an MA organization receives for each enrollee before applying the budget sequestration reduction.[11] 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.[12] 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.

[10] 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.

[11] 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.

[12] 42 CFR § 422.310(e) requires MA organizations (when undergoing an audit conducted by the Secretary) to submit "medical records for the validation of risk adjustment data." For purposes of this report, we use the terms "supported" or "unsupported" to denote whether the reviewed diagnoses were evidenced in the medical records. If our audit determines that the diagnoses are supported or unsupported, we accordingly use the terms "validated" or "unvalidated" with respect to the associated HCC.

EmblemHealth

EmblemHealth is an MA organization with headquarters in New York, New York, that provides coverage in several counties statewide. As of December 31, 2015, EmblemHealth provided coverage under contract number H3330 to approximately 125,000 enrollees in New York. For our audit period (the 2015 payment year), CMS paid EmblemHealth approximately $1.43 billion to provide this coverage.[13]

HOW WE CONDUCTED THIS AUDIT

Our audit focused on enrollees on whose behalf EmblemHealth 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 75,345 enrollees from which we selected a stratified random sample of 200 enrollees on whose behalf CMS made payments totaling $3,273,863 to EmblemHealth. EmblemHealth provided medical records as support for 1,220 HCCs (total of both HCC payment models) associated with 199 of the 200 sampled enrollees, but it did not provide any medical records for 2 HCCs associated with 1 sampled enrollee.

We used an independent medical review contractor to review the medical records to determine whether the diagnosis codes validated the 1,220 HCCs. The contractor also reviewed these same records to determine whether any additional HCCs were validated by diagnosis codes that EmblemHealth 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 our sample results and estimates.

FINDINGS

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

[13] All of the payment amounts that CMS made to EmblemHealth and the adjustment amounts that we identified in this report reflect the budget sequestration reduction.

First, 860 of the 1,222 sampled enrollees' HCCs were validated; however, the medical records did not validate the remaining 362 HCCs and resulted in overpayments.[14] These 362 unvalidated HCCs included 54 HCCs for which we identified 54 other HCCs for more and less severe manifestations of the diseases. These 54 other HCCs should have been included in the enrollees' risk scores (instead of the 54 unvalidated HCCs), which would have reduced the overpayments associated with the 362 unvalidated HCCs in our sample.[15]

Second, in reviewing the medical record documentation for the diagnosis codes associated with the 1,222 sampled enrollees' HCCs, we identified support for diagnosis codes that EmblemHealth should have submitted to CMS but did not. If EmblemHealth had submitted these diagnosis codes, an additional 65 HCCs would have been included in the enrollees' risk scores. These risk scores would have increased, and CMS's payments to EmblemHealth would have been higher.

In summary, the risk scores for the 200 sampled enrollees should not have been based on the 1,222 HCCs. Rather, the risk scores should have been based on 979 HCCs (860 validated HCCs plus 54 other HCCs associated with more and less severe manifestations of diseases plus 65 additional validated HCCs that EmblemHealth did not submit to CMS). As a result, EmblemHealth received $551,917 in net overpayments. On the basis of our sample results, we estimated that EmblemHealth received at least $130,668,231 in net overpayments for 2015.[16] See Appendix D for sample results and estimates. Because of Federal regulations that limit the use of extrapolation in RADV audits for recovery purposes to payment year 2018 and forward, we are reporting the overall estimated net overpayment amount but are recommending a refund of $551,917 in net overpayments.[17]

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

[14] For 2 of the 362 HCCs, medical records were not provided.

[15] The less severe manifestations of the diseases for 47 HCCs led to net overpayments for 41 HCCs and net underpayments for 6 HCCs. The more severe manifestations for seven HCCs led to a net overpayment for three HCCs and a net underpayment for four HCCs.

[16] To be conservative, we estimated net overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[17] After we had reviewed the sampled enrollees, CMS updated Federal regulations that limit the use of extrapolation in RADV audits to payment years 2018 and forward (88 Fed. Reg. 6643 (Feb. 1, 2023)).

FEDERAL REQUIREMENTS

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

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

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

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

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

See Appendix E for Federal regulations regarding compliance programs that MA organizations must follow.

EMBLEMHEALTH DID NOT SUBMIT SOME DIAGNOSIS CODES IN ACCORDANCE WITH FEDERAL REQUIREMENTS

EmblemHealth did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. Specifically, EmblemHealth 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 134 of the 200 sampled enrollees.[18]

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

The diagnosis codes that EmblemHealth submitted to CMS were not supported in the medical records for 362 of the 1,222 sampled enrollees' HCCs. The 362 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 EmblemHealth for 128 sampled enrollees.

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

For 300 of the 362 unvalidated HCCs (110 sampled enrollees), the medical records did not support either the diagnosis code that EmblemHealth submitted or any other diagnosis code that would have validated the HCC.[19] These errors caused overpayments.

For example, for Enrollee A, EmblemHealth submitted a diagnosis code for Idiopathic Peripheral Autonomic Neuropathy, Unspecified, which maps to the Version 12 model HCC named Polyneuropathy.[20] However, that diagnosis was not supported in the submitted medical records. Our independent medical review contractor stated that "there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment [of the HCC for Polyneuropathy]."

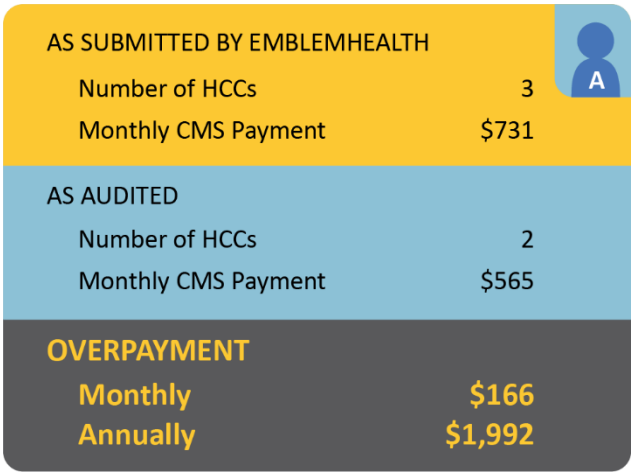
As shown in Figure 1 on the following page, the diagnosis codes that EmblemHealth submitted to CMS on behalf of Enrollee A mapped to three HCCs, which CMS used to calculate a $731 monthly payment that it made to EmblemHealth. Because the Polyneuropathy HCC was not validated, the CMS payment should have been based on two HCCs, which would have resulted in a monthly payment of $565. This error caused a $1,992 overpayment for the year.

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

[19] For one sampled enrollee, EmblemHealth did not provide any medical records to support two HCCs; therefore, the HCCs were not validated.

[20] Idiopathic Peripheral Autonomic Neuropathy, Unspecified, refers to damage of the peripheral nerves for which a cause cannot be determined. When the peripheral nerves are damaged, there are often symptoms that affect the feet.

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

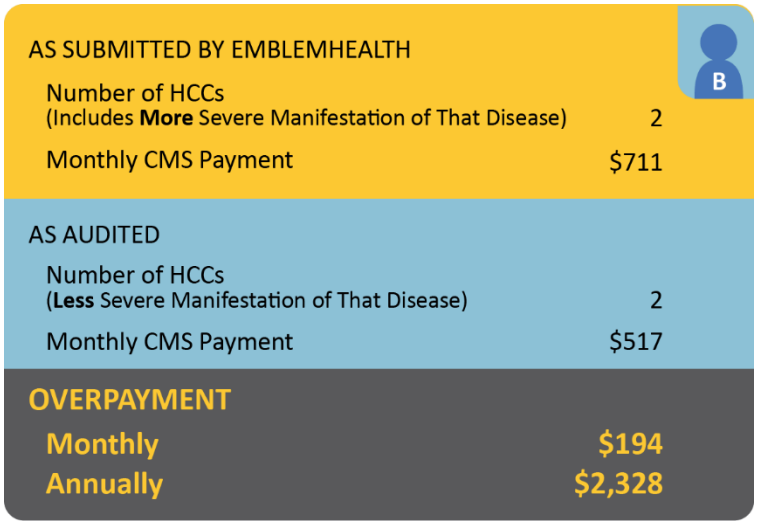
For 54 of the 362 unvalidated HCCs (32 sampled enrollees), the medical records did not support the diagnosis codes that EmblemHealth submitted. However, we identified 54 other HCCs (that were supported by other diagnosis codes) for more and less severe manifestations of the diseases. These 54 other HCCs should have been included in the enrollees' risk scores (instead of the 54 unvalidated HCCs).

For 47 of the 54 unvalidated HCCs (27 sampled enrollees), the diagnosis codes that EmblemHealth 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 47 other HCCs for less severe manifestations, that should have been used in the enrollees' risk scores. These errors led to net overpayments for 41 HCCs and net underpayments for 6 HCCs.

For example, for Enrollee B, the medical records did not support the diagnosis Diabetes With Ophthalmic Manifestations, Type II or Unspecified Type, Not Stated as Uncontrolled. This diagnosis maps to HCCs that are both more severe manifestations of the HCCs in those related-disease groups (Diabetes With Ophthalmologic or Unspecified Manifestation for the Version 12 model and Diabetes With Chronic Complications for the Version 22 model). However, our independent medical review contractor found support for the diagnosis Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled, which maps to HCCs that were both less severe manifestations of the HCCs in those related-disease groups (Diabetes Without Complication for both the Version 12 and 22 models). Accordingly, Enrollee B's risk score should have been based on the HCCs with the less severe manifestation instead of the HCCs with the more severe manifestation.

As shown in Figure 2, this error caused a $2,328 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



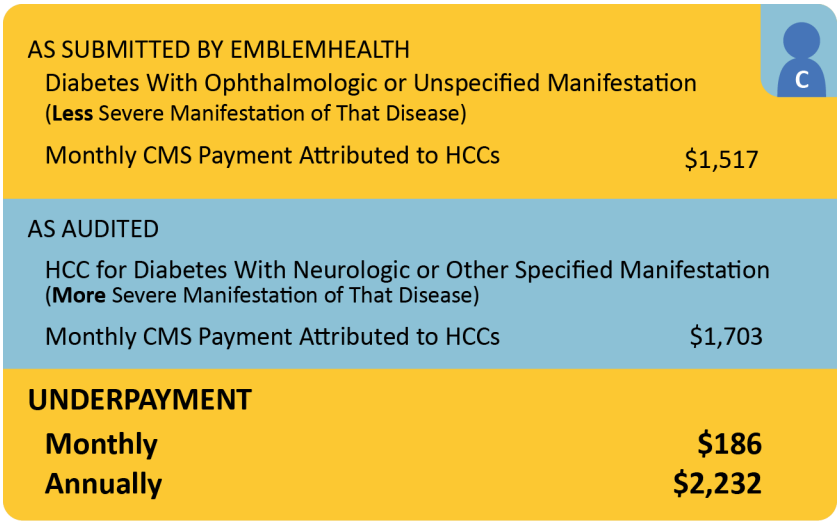
For 7 of the 54 unvalidated HCCs (5 sampled enrollees), EmblemHealth did not submit diagnosis codes to CMS that mapped to the most severe manifestation of the HCCs in the related-disease groups. Instead, EmblemHealth submitted only the diagnosis codes that mapped to the less severe manifestations. If EmblemHealth 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 net overpayments for three HCCs and net underpayments for four HCCs.

For example, for Enrollee C, EmblemHealth submitted a diagnosis code of Diabetes With Unspecified Complication, Type II or Unspecified Type, Not Stated As Uncontrolled, which maps to the Version 12 model HCC for Diabetes with Ophthalmologic or Unspecified Manifestation (and is a less severe manifestation of the HCCs in that related-disease group).[21] However, our independent medical review contractor found support for the diagnosis Diabetes With Neurological Manifestations, Type II or Unspecified Type, Not Stated As Uncontrolled, which maps to the Version 12 HCC for Diabetes With Neurologic or Other Specified Manifestation (and is a more severe manifestation of the HCCs in that related-disease group). Accordingly, Enrollee C's risk score should have been based on the HCC with the more severe manifestation instead of the HCC with the less severe manifestation.

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

As shown in Figure 3, this error caused a $2,232 underpayment for the year.

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



Medical Records With Other Issues That Caused Unsupported Diagnosis Codes

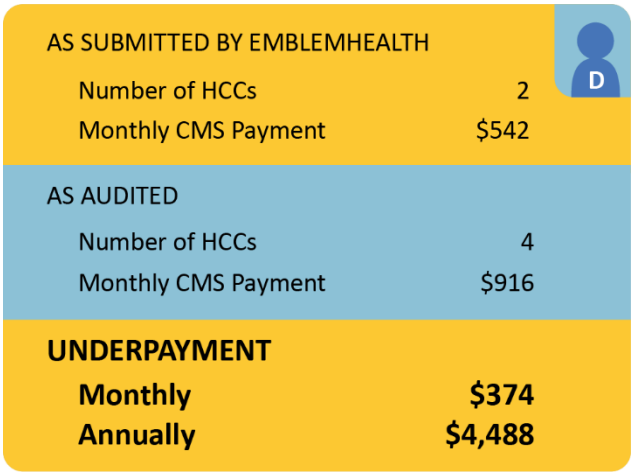
Six of the 362 HCCs (3 sampled enrollees) were not validated because the medical record diagnosis did not result from a face-to-face encounter with a provider, supplier, physician, or other practitioner. Furthermore, 2 of the 362 HCCs (1 sampled enrollee) were not validated because EmblemHealth could not locate the records. These errors caused overpayments.

Diagnosis Codes That EmblemHealth Should Have Submitted but Did Not Submit to CMS

EmblemHealth did not submit all of the correct diagnosis codes. Specifically, there were an additional 65 HCCs (38 sampled enrollees) for which the medical records supported diagnosis codes that EmblemHealth 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 EmblemHealth. For example, for Enrollee D, EmblemHealth did not submit a diagnosis code for Asymptomatic Human Immunodeficiency Virus (HIV) Infection Status. 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 EmblemHealth should have submitted but did not submit to CMS—maps to and validates both the Version 12 model HCC for HIV/AIDS and the Version 22 model HCC also named HIV/AIDS.

As shown in Figure 4, this error caused a $4,488 underpayment.

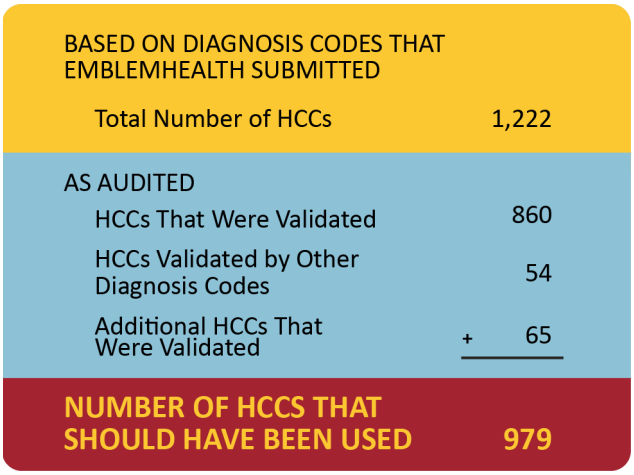
Figure 4: Underpayment Calculation for Enrollee D, Who Had HCCs That Were Validated From a Diagnosis Code That EmblemHealth Should Have Submitted but Did Not Submit to CMS



Summary of Diagnosis Codes Not Submitted in Accordance With Federal Requirements

Because EmblemHealth 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 1,222 HCCs. Rather, their risk scores should have been based on the 979 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



Moreover, EmblemHealth received $551,917 in net overpayments (consisting of $604,409 of overpayments and $52,492 of underpayments) for the 200 sampled enrollees (Appendix D).

THE POLICIES AND PROCEDURES THAT EMBLEMHEALTH HAD TO PREVENT, DETECT, AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS COULD BE IMPROVED

As demonstrated by the errors found in our sample (the risk scores for the 200 sampled enrollees should have been based on 979 HCCs instead of 1,222 HCCs), we believe that the policies and procedures that EmblemHealth had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations at 42 CFR § 422.503(b)(4)(vi), could be improved.

On the basis of the information that EmblemHealth provided to us, we believe that it had limited policies and procedures for ensuring the accuracy of diagnosis codes. In this respect, EmblemHealth generally relied on the accuracy of the diagnosis codes listed on the claims that its providers submitted. EmblemHealth, in some instances, performed reviews by which it compared the diagnosis codes from the claims with the associated medical records.

According to EmblemHealth, these policies and procedures changed after our audit period. EmblemHealth officials told us that they have implemented preventative measures to educate its providers based upon chart reviews and updated its detection and correction techniques to compare diagnosis codes on claims with medical records. Further, EmblemHealth officials stated that as part of its oversight plan, it performs "mock" risk adjustment data validation audits and, if necessary, deletes any unsupported enrollee diagnosis codes.

EMBLEMHEALTH RECEIVED NET OVERPAYMENTS

On the basis of our sample results, we estimated that EmblemHealth received at least $130,668,231 of net overpayments for 2015.

Because of Federal regulations that limit the use of extrapolation in RADV audits for recovery purposes, we are reporting the estimated net overpayment amount but are recommending a refund of $551,917 in net overpayments that EmblemHealth received for the 200 sampled enrollees (footnote 17).

RECOMMENDATIONS

We recommend that EmblemHealth:

- refund to the Federal Government the $551,917 of net overpayments[22] and

- continue to ensure that its policies and procedures have been adequately designed and implemented to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

EMBLEMHEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, EmblemHealth did not agree with our findings and did not concur with our recommendations. Specifically, EmblemHealth disagreed with our findings for 6 of the 365 HCCs identified in our draft report and provided explanations as to why it believed these HCCs were validated. EmblemHealth did not directly agree or disagree with our findings for the remaining 359 HCCs. EmblemHealth also provided explanations as to why it believed 10 additional HCCs should be included in the sampled enrollees' risk scores.[23]

Regarding our first recommendation, EmblemHealth stated that our audit methodology had several flaws. EmblemHealth implied that our audit process was not timely and noted that a timelier process would likely have allowed it to validate more of the diagnoses. EmblemHealth stated that our inclusion of estimated overpayments is inappropriate based on CMS's decision not to extrapolate audit findings before payment year 2018. EmblemHealth also stated that our second recommendation to implement programs to improve compliance processes should be revised to consider improvements made during the past decade.

We reviewed EmblemHealth's comments and the additional explanations that it provided and, accordingly, we reduced the recommended refund in our first recommendation from $572,032 to $551,917 for this final report. We also revised the wording for our second recommendation.

A summary of EmblemHealth's comments and our responses follow. EmblemHealth's comments appear as Appendix F. We excluded the attachment to EmblemHealth's comments

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

[23] In its comments, EmblemHealth stated that it disagreed with our independent medical review contractor's determinations for 19 HCCs; however, it provided explanations for only 16 HCCs in an attachment to its comments. Specifically, EmblemHealth disputed six HCC determinations from our draft report. In addition, EmblemHealth submitted 10 additional HCCs that were not originally included in the sampled enrollees' risk scores but that it believed should have been.

because it contained personally identifiable information. We are separately providing EmblemHealth's comments and the attachment in their entirety to CMS.

EMBLEMHEALTH DID NOT CONCUR WITH OIG'S FIRST RECOMMENDATION TO REFUND NET OVERPAYMENTS

EmblemHealth Did Not Agree With Our Findings for Specific Hierarchical Condition Categories

EmblemHealth Comments

EmblemHealth disagreed with our findings for six HCCs identified as errors in our draft report and provided explanations on why it believed the medical records supported the diagnoses and corresponding HCCs. EmblemHealth also provided explanations on why it believed 10 additional HCCs should be included in the sampled enrollees' risk scores.

Office of Inspector General Response

Our independent medical review contractor reviewed all the explanations that EmblemHealth provided for the 16 HCCs. Our contractor:

(1) found support and validated 3 HCCs and reversed its original decisions,

(2) reaffirmed that 3 HCCs were not validated and upheld its original decisions, and

(3) found support for the 10 additional HCCs.

Accordingly, we updated the number of HCCs that should have been used in the sampled enrollees' risk scores from 966 (as reported in our draft report) to 979. We also revised our findings and reduced the associated monetary recommendation. Further, our independent medical review contractor performed a quality review on the determinations for which it either reversed its original decisions or identified an additional HCC and did not identify any systemic issues.

EmblemHealth Stated That OIG's Audit Methodology Had Several Flaws

EmblemHealth Comments

EmblemHealth stated that we had "several methodological flaws with the audit . . . that raise questions about the accuracy of the findings and recommendations" to which EmblemHealth made these related points:

- EmblemHealth did not agree with our decision to limit our audit "to individuals for whom the plan reported at least one diagnosis resulting in at least one hierarchical condition code" and thereby exclude enrollees for whom EmblemHealth did not report

any risk adjustment diagnosis codes. In so doing, EmblemHealth stated that we did "not fully represent those individuals for whom EmblemHealth may have been underpaid for diagnoses that [it] did not report." Thus, according to EmblemHealth, we "overstate[d] the amounts owed under the audit." EmblemHealth also stated that it disagreed with our responses to other MA organizations that including the individuals without any risk adjustment data was beyond the scope of our audits. As such, EmblemHealth suggested that we "repeat the audit with a more representative sample or, in the alternative, exclude these findings from the Final Report."

- EmblemHealth stated it understood that our "coders" may have included individuals "experienced in medical necessity reviews, rather than risk adjustment coding reviews." EmblemHealth stated that the difference is "relevant" because "[i]ndividuals who are experienced in performing medical necessity reviews may not be as accustomed to the standards needed to perform risk adjustment coding reviews." To this point, EmblemHealth stated that if our coders are not certified risk adjustment coders (CRCs), "then the audit should be repeated using experienced CRCs before the Final Report is published."

- EmblemHealth noted that the 8 to 10-year lag between when the encounters occurred for this audit (2014) and when we performed the audit (2018-2024) rendered "a true determination of accuracy practically impossible." To this point, EmblemHealth noted barriers to collecting medical records (including providers changing practices, providers dying, or electronic health record systems that may have been upgraded, changed, or failed, rendering some medical records inaccessible) and that some providers refused to cooperate with requests for medical records.

Office of Inspector General Response

We disagree with EmblemHealth's assertion that our audit methodology was "flawed," and we disagree that our findings and recommendations were inaccurate. Specifically:

- Our decision to limit our audit to individuals with at least one diagnosis that mapped to an HCC did not overstate our net overpayment calculation. EmblemHealth's comments imply that our estimation of total net overpayments extends to its entire contract. This is not accurate nor is it the intention of this report. Our objective was to determine whether EmblemHealth submitted diagnosis codes in accordance with Federal requirements; thus, we limited our audit to those enrollees for whom EmblemHealth had submitted diagnosis codes that mapped to HCCs. We identified both overpayments and underpayments associated with these sampled enrollees and incorporated both types of payments in our estimation. In this respect, we note that a valid estimate of net overpayments, given the objective of our audit, does not need to take into consideration all potential HCCs or underpayments within the audit period; this estimate addressed only the accuracy of the portion of payments related to the reviewed HCCs and did not extend to enrollees for whom EmblemHealth did not submit

any diagnosis codes that mapped to an HCC.

- Our medical reviews were performed by professional coders credentialed by the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC). Additionally, our independent medical review contractor used experienced 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 CRC. RHITs have completed a 2-year degree program and have passed an AHIMA certification exam. AHIMA also credentials individuals with CCS and CCS-P certifications and the AAPC credentials both CPCs and CRCs. These senior coders were experienced in coding ICD-9-CM diagnosis codes for hospital inpatient, outpatient, and physician medical records.

- Regarding EmblemHealth's comment that our "8 to 10-year lag between the encounters and the audit renders a true determination of accuracy practically impossible," payment year 2015 data was the most recent data available when we started our audit in 2018. In this respect, we provided a reasonable period – 8 months – for EmblemHealth to submit medical records for the audited HCCs. EmblemHealth provided the bulk of its medical records in 2019 and did not request any hardship exceptions for medical records that it could not obtain from providers. We provided the results from our independent medical review contractor to EmblemHealth in 2022.

We maintain that our audit methodology remains valid and, accordingly, we did not make any adjustments to this report based on EmblemHealth's comments regarding our audit methodology.

EMBLEMHEALTH STATED THAT OIG'S SECOND RECOMMENDATION TO IMPLEMENT PROGRAMS TO IMPROVE COMPLIANCE PROCESSES SHOULD BE REVISED TO CONSIDER IMPROVEMENTS MADE DURING THE PAST DECADE

EmblemHealth Comments

EmblemHealth stated that our findings relate to "dates of service and payments made nearly a decade ago." To this point, EmblemHealth noted seven specific improvements to its compliance procedures, including steps for its vendors to "follow consistent and compliant coding practices" and the formation of an "HCC Data Confirmation Team" to oversee its coding validation activities. As such, EmblemHealth requested that we "reevaluate [our second] recommendation based on these changes."

Office of Inspector General Response

We acknowledge that EmblemHealth has taken steps to enhance its compliance program after our audit period.

Federal regulations (42 CFR § 422.503(b)) require MA organizations like EmblemHealth to establish and implement an effective system for routine monitoring and identification of compliance risks. This regulation further explains that a compliance system should consider both internal monitoring and external audits. For this audit, the number of sampled enrollees with at least 1 incorrect HCC included in their risk score (134 of 200 (Appendix C)) demonstrated that EmblemHealth's compliance program could be improved. Thus, EmblemHealth should consider the results of this audit to reduce the occurrence of similar errors in subsequent periods and to identify appropriate improvement opportunities consistent with CMS's requirements and expectations.

Although we have not reviewed the effectiveness of the improvements that EmblemHealth said it has made to its policies and procedures, we note EmblemHealth's statement that it made these changes to "demonstrate the seriousness with which [it takes its] compliance responsibilities."

Thus, and with respect to EmblemHealth's statements about its policies and procedures and our audit findings, we revised our second recommendation to include that EmblemHealth should "continue to improve" its policies and procedures.

EMBLEMHEALTH STATED OIG'S ESTIMATED EXTRAPOLATION AMOUNT IS UNJUSTIFIED

EmblemHealth Comments

EmblemHealth stated that our inclusion of estimated overpayments in our report was inappropriate and urged us to omit references to extrapolation in the final report. Specifically, EmblemHealth stated that we had provided "estimates for overpayment amounts as if the audit results were to have been extrapolated from the 200-beneficiary sample to all of the enrollees in the audited contract" and made three related points:

- EmblemHealth stated that CMS's RADV final rule does not allow extrapolation "on audit findings for years prior to the 2018 payment year." To this point, EmblemHealth stated that our reference to extrapolated results "describes a hypothetical that will not occur, is inconsistent with what CMS believes to be in the best interest of the MA program."

- EmblemHealth also stated that pending Federal court litigation (*Humana Inc. et al v. Becerra et al.,* 4:23-cv-00909 (N.D. Tex. Sept. 1, 2023) "raises significant questions about the legality of the RADV Final Rule" and that "extrapolation and extrapolation methodologies . . . remain unsettled." Specifically, EmblemHealth noted "concerns that extrapolating without an appropriate adjuster would violate the Social Security Act requirement that the risk adjustment system be developed using 'actuarial equivalence' principles." EmblemHealth further stated that "it is inappropriate for OIG to include estimated liabilities premised on extrapolation until these issues are heard, particularly given both the potential prejudice to [MA organizations] and the legally uncollectible

status of the extrapolated amounts."

- In addition, EmblemHealth stated that we inappropriately used a "less targeted sampling methodology" that is inconsistent with CMS's final rule for RADV audits that, according to EmblemHealth, includes "a more targeted, risk-based approach that incorporates risk factors, such as HCCs that were more likely to be in error."

Office of Inspector General Response

We disagree that the inclusion of "extrapolated" net overpayments in this final report is inappropriate. We clearly point out (in Appendix A) that we designed a sampling frame with specific requirements and limited our estimations to that frame. Regarding the other concerns that EmblemHealth mentioned:

- Federal requirements limit the use of extrapolation in RADV audits for recovery purposes prior to payment year 2018; therefore, we are not recommending a refund of the estimated net overpayments. Moreover, the inclusion of the estimated net overpayment amount ($130,668,231) is a valid representation of the effect of medical records not always supporting the diagnoses reported to CMS, and the inclusion of this amount in our report is not inconsistent with Federal requirements.

- We do not agree with EmblemHealth that we need to wait until pending litigation is resolved to include estimated net overpayments in this final report. In this regard and with respect to EmblemHealth's comment about applying a fee-for-service adjustment, we recognize that CMS—not OIG—is responsible for making operational and program payment determinations for the MA program and that any OIG audit findings and recommendations do not represent final determinations by CMS. CMS will evaluate our recommendations and will adjust our net overpayment finding by whatever amount it determines necessary (footnote 22). Furthermore, CMS in its Final Rule stated that it "will not apply an adjustment factor (known as a Fee-For-Service (FFS) Adjuster) in RADV audits."[24]

- We disagree with EmblemHealth that our audit needs to follow CMS's RADV audit approach. OIG is an independent oversight agency, and we do not need to follow CMS RADV processes. All our audits are intended to provide an independent assessment of Department of Health and Human Services programs and operations in accordance with the Inspector General Act of 1978, 5 U.S.C. chapter 4. We believe that our audit methodology provides a reasonable basis for our findings and recommendations.

Accordingly, we did not make any updates to our report based upon EmblemHealth's comments regarding our inclusion of estimated overpayments in our report.

[24] 88 Fed. Reg. 6643 (Feb. 1, 2023).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid EmblemHealth approximately $1.4 billion to provide coverage to approximately 125,000 enrollees in New York for the 2015 payment year.[25] We identified a sampling frame of 75,345 enrollees who had at least 1 HCC in their risk scores; EmblemHealth received $1.1 billion in payments from CMS for these enrollees for 2015. We selected for audit a stratified random sample of 200 enrollees on whose behalf CMS made payments totaling $3,273,863 to EmblemHealth.

Our audit objective did not require an understanding or assessment of EmblemHealth'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 February 2024.

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

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

- We developed our sampling frame using data from CMS systems. Our sampling frame consisted of enrollees who had at least 1 HCC in their risk scores. To create this frame, and as explained further in Appendix C, we used data from the following CMS systems:

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

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

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

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

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

- We obtained 1,072 medical records from EmblemHealth as support for the 1,220 HCCs associated with 199 of the 200 sampled enrollees. EmblemHealth did not provide any medical records for two HCCs associated with one sampled enrollee.

- We used an independent medical review contractor to determine whether the diagnosis codes in the medical records validated the 1,220 HCCs.

- The independent medical review contractor's coding review of the 1,072 medical records followed a specific process to determine whether there was support for a diagnosis code and associated HCC. Under the process:

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

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

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

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

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

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

- 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 the following:

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

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

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

- We limited the total net overpayment that we recommended for recovery to the sampled enrollees.[26]

- We provided the results of our audit to EmblemHealth officials on April 5, 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.

[26] Federal regulations at 42 CFR § 422.311(a) state: ". . . the Secretary annually conducts RADV audits to ensure risk adjusted payment integrity and accuracy." Recovery of improper payments from MA organizations will be conducted in accordance with the Secretary's payment error extrapolation and recovery methodologies. CMS may apply extrapolation to audits for payment year 2018 and subsequent payment years (88 Fed. Reg. 6643, 6655 (Feb. 1, 2023)).

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Advantage Compliance Audit of Diagnosis Codes That CarePlus Health Plans, Inc. (Contract H1019) Submitted to CMS	A-04-19-07082	10/26/2023
Medicare Advantage Compliance Audit of Diagnosis Codes That Health Net of California, Inc. (Contract H0562) Submitted to CMS	A-09-18-03007	9/22/2023
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 75,345 EmblemHealth enrollees who (1) were continuously enrolled under contract number H3330 throughout all of the 2014 service year and January 2015 and (2) had at least 1 HCC in their 2015 payment year risk scores. Because CMS adjusts its risk-adjusted payments in the calendar year after an individual is diagnosed, we restricted our population to individuals who were enrolled—and thus diagnosed—at EmblemHealth 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

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

SAMPLE UNIT

The sample unit was one enrollee.

SAMPLE DESIGN

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

[health-related portion of the enrollee's risk score]
x
[number of monthly 2015 capitation payments affected by the enrollee's risk score][27]

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 75,345 enrollees according to their monthly-weighted-health risk score from lowest to highest and separated them into 3 strata. The specific strata are shown in Table 1 on the following page.

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

Table 1: 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	25,110	0.081 to 4.92	$167,837,821
2	50	25,122	4.932 to 11.88	285,774,376
3	100	25,113	11.891 to 146.928	608,696,443
Total	**200**	**75,345**		**$1,062,308,640**

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OAS), 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 used the OAS statistical software to estimate the total amount of net overpayments to EmblemHealth at the lower limit of the two-sided 90-percent confidence interval (Appendix D). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Sampling Frame Dollar Total	Sample Size	Dollar Value of Sample	Number of Sampled Enrollees With Incorrect Diagnosis Codes	Dollar Value of Net Overpayments for Sampled Enrollees
1	25,110	$167,837,821	50	$332,164	22	$13,173
2	25,122	285,774,376	50	592,608	31	72,268
3	25,113	608,696,443	100	2,349,091	81	466,476
Total	**75,345**	**$1,062,308,640**	**200**	**$3,273,863**	**134**	**$551,917**

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

Point estimate	$160,072,103
Lower limit	130,668,231
Upper limit	189,475,976

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: EMBLEMHEALTH COMMENTS

55 Water Street, New York, New York 10041-8190

March 21, 2024

Ms. Patricia Wheeler
Regional Inspector General for Audit Services Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: EmblemHealth Response to Draft Audit Report No. Report Number: A-06-18-02001

Dear Ms. Wheeler:

EmblemHealth appreciates this opportunity to respond to the U.S. Department of Health and Human Services, Office of Inspector General's ("OIG"") Draft Audit Report No. A-06-18-02001, entitled *Medicare Advantage Compliance Audit of Diagnosis Codes That EmblemHealth (Contract H3330) Submitted to CMS* (the "Draft Report"). EmblemHealth is a nonprofit, mission-based health plan. EmblemHealth proudly serves Medicare beneficiaries in the greater New York City area through Medicare Advantage ("MA") Contract H3330.

EmblemHealth values its partnership with the Centers for Medicare & Medicaid Services ("CMS") and OIG in support of the MA program. We are keenly aware of our responsibilities to our enrollees and taxpayers as a Medicare Advantage organization ("MAO"). Although EmblemHealth recognizes OIG's critical oversight role in ensuring we and other MAOs meet these responsibilities, we respectfully disagree with the Draft Report's findings and recommendations.

- The report presents OIG's audit findings for the 2015 payment year reflecting diagnoses submitted for 2014 dates of service, almost ten years ago. EmblemHealth has since made significant changes to our compliance processes that are not fully explained in the Draft Report.

- Moreover, the significant amount of time between the data collection (2014) and audit years (2018-2024) complicated our collection of medical records to validate diagnoses. A more timely audit process would have likely allowed us to validate more of the diagnoses in medical records.

- EmblemHealth also believes that significant questions about the audit methodology remain that OIG has not adequately answered and that likely inflate the audit findings.

- Finally, the Draft Report's inclusion of an estimate based on extrapolation is inappropriate for several reasons. This estimate does not reflect the CMS decision not to extrapolate audit findings before the 2018 payment year nor does it consider the improvements in our coding processes since the audit year. These findings, if published

in the Final Report, have the potential to damage our enterprise's well-earned reputation for prioritizing the interests of enrollees and taxpayers as a nonprofit, mission-based health plan.

We elaborate on these issues in our comments below. Notwithstanding these concerns, EmblemHealth remains committed to working collaboratively with CMS, OIG, and others to ensure that Medicare beneficiaries continue to receive timely and clinically appropriate care.

I. EmblemHealth Does Not Concur with OIG's Recommendations.

A. EmblemHealth disputes OIG's recommendation to refund to the Federal Government the $572,032 of net overpayments identified in the audit report for the reasons described below.

As noted above, EmblemHealth understands OIG's responsibility and authority to perform oversight of the MA program. The 2021 decision by the D.C. Circuit Court of Appeals in *United Healthcare Ins. Co. v. Becerra*[1] confirms that MA plans are responsible for correcting payment errors under HHS's authority granted by the False Claims Act. ***The Draft Report reflects several methodological flaws with the audit, however, that raise questions about the accuracy of the findings and recommendations.***

1. OIG did not use a random sample of EmblemHealth's enrollees.

OIG limited its audit to individuals for whom the plan reported at least one diagnosis resulting in at least one hierarchical condition code ("HCC") assignment for the payment year. In so doing, its evaluation overstates the amounts owed under the audit.

EmblemHealth understands that OIG has previously written in response to previous plan concerns about its methodology that including individuals for whom an MAO did not report any risk adjustment diagnosis codes in the sample is "beyond the scope of our audit."[2] We disagree. OIG acknowledges that, "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***)."[3] OIG's description of the objective of the audit, however, is more constrained—"to determine whether EmblemHealth submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements."[4]

If OIG had reported only the number of HCCs which it found to be unsupported based on a sample of individuals with a reported diagnosis, that may have been more appropriate to the stated objective. Instead, the Draft Report also assigns a dollar value to these HCCs, which it calls "overpayment amounts." By failing to include unscored members in the sample, the report omitted a critical factor from its calculation of the "overpayment amounts." Appendix A indicates that approximately 40% of the members in the audited contract did not have an

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[1] *UnitedHealthcare Insurance Co. v. Becerra*, 16 F.4th 867 (D.C. Cir. August 13, 2021, reissued November 1, 2021
[2] For the most recent example of this comment, please see "Medicare Advantage Compliance Audit of Specific Diagnosis Codes that MediGold (Contract H3668) submitted to CMS" (February 2024 -- A-07-20-01198) at 21.
[3] Draft Report at 1 (emphasis added).
[4] *Id.* at 2.

associated HCC during 2015. As other MAOs have noted, failing to include these individuals in the sample does not fully represent those individuals for whom EmblemHealth may have been ***underpaid*** for diagnoses that we did not report.[5] That means the assessed "overpayment amounts" would likely have been less than reported if OIG had applied a truly random sample that included individuals with and without an associated HCC.

These issues are particularly relevant as readers consider both the impacts of our coding accuracy during the time of the audit and the potential impact of extrapolating the errors to the contract level. We therefore suggest that OIG repeat the audit with a more representative sample or, in the alternative, exclude these findings from the Final Report.

2. OIG has not clearly established that its medical record reviewers have the necessary experience to perform these audits.

OIG previously described the qualifications of its coders but has not yet addressed whether the coders are Certified Risk Adjustment Coders ("CRC") or Certified Professional Coders ("CPC"). The distinction is relevant. Our understanding is that OIG's independent contractor may include coders experienced in medical necessity reviews, rather than risk adjustment coding reviews. CRC is a specialized certification focused on risk adjustment coding, auditing, and making a final determination whether the documentation supports a risk adjustment diagnosis code. Individuals who are experienced in performing medical necessity reviews may not be as accustomed to the standards needed to perform risk adjustment coding reviews. OIG should clearly state whether its coders are experienced CRCs, and for how long they have been certified. If the coders are not CRCs, then the audit should be repeated using experienced CRCs before the Final Report is published.

3. The findings include HCCs that we continue to believe are valid based on the medical records we submitted.

We continue to disagree with the reviewers' determination invalidating 19 HCCs that were considered during the audit. Attached please find a chart documenting these HCCs and the reasons we believe they should be validated based on the records we supplied.[6] We respectfully request OIG reconsider these items and adjust the overpayment amount accordingly.

4. The audit was performed several years after the data reporting year, which affected our ability to validate diagnoses.

As noted above, there was a significant amount of time between the data collection (2014) and audit years (2018-2024) that complicated our collection of medical records to validate diagnoses. Indeed, the 8-10 year lag between the encounters and the audit renders a true determination of accuracy practically impossible. Several of the medical professionals responsible for the diagnoses have changed practices or passed away, which created a significant barrier to collecting medical records that could have validated our submission. Likewise, paper

[5] *See supra*, fn. 2 *citing* "Medicare Advantage Compliance Audit of Specific Diagnosis Codes that MediGold (Contract H3668) submitted to CMS" (February 2024 – A-07-20-01198) at 42-43 (noting that OIG's audit methodology "was so targeted that it could not equally identify overpayments and underpayments.")
[6] Attached hereto as Attachment 1.

records may have become unavailable or lost, and electronic health record systems may have been upgraded, changed, or failed, rendering some medical records inaccessible. Most importantly, some providers and facilities refused to cooperate with requests for medical records, with no realistic threat of sanction for their intransigence.

We recommend the report advise CMS to take additional steps to inform providers of their obligations to respond to health plan requests for information necessary for responses to HHS audits. We also suggest the Final Report recognize these complications and appropriately caveat the findings. Such a flawed data set cannot be a sufficiently sound basis for the audit results as reported.

B. EmblemHealth recommends OIG revise its recommendation that we implement programs to improve our compliance processes to consider the significant investments we have made since the audit year to support these efforts.

The report reflects OIG's audit findings related to dates of service and payments made nearly a decade ago. Since payment year 2015, EmblemHealth has made significant improvements to our technology environment that has converted 20th Century infrastructure into a state-of-the-art platform allowing us to use every tool necessary to support our compliance with coding guidelines. We have also made targeted process improvements to improve coding accuracy.

1. EmblemHealth Coding Guidelines

EmblemHealth developed and implemented guidelines with our vendors to ensure they all follow consistent and compliant coding practices. These guidelines are focused on ensuring we do not submit codes from past medical history or "problem lists," which we know has been a focus of concern for both CMS and OIG.

2. Vendor Coding Accuracy Reviews

We use these guidelines to conduct quarterly reviews of our vendors to ensure they meet our high standards of coding accuracy and delete unsupported codes.

3. Two-Way Claim Validation

We carefully analyze chart reviews conducted by our vendors and delete codes from corresponding claims when they are not supported by the record.

4. HCC Data Confirmation Team

We formed an HCC Data Confirmation team consisting of a former clinician, highly trained risk adjustment coders, and a data analyst to oversee all of EmblemHealth's coding validation activities. We also insourced all coding accuracy reviews to this team.

5. High-Risk Claim Reviews

Our HCC Data Confirmation team uses analytics to identify submitted diagnoses that have a low probability of being supported by the underlying medical record and then deletes those HCCs that are in fact not found to be supported by the medical record. High-risk diagnosis codes include those identified in OIG and CMS audits, single-source submissions, and inappropriate place of service codes. We recently updated this list based on the list of high-risk diagnosis codes in the OIG Tool Kit.

6. Automation

We are using automation to identify common coding errors. For example, the HCC Data Confirmation team is currently using advanced tools to identify claims for deletion when Stroke and/or Sepsis diagnoses are submitted with a doctor's office as the place of service because it seems unlikely these conditions would be treated in outpatient settings. We are also evaluating whether automation can help us develop a solution that triggers messages to providers requesting the submission of a supporting medical record before these and other high-risk diagnoses are submitted to CMS.

7. Provider Coding Accuracy Webinars

EmblemHealth is developing provider coding accuracy webinars to educate providers on proper coding and documentation. There will be an emphasis on educating providers about high-risk diagnosis codes and how to avoid submitting them if they are not supported by the medical record.

* * * * *

As noted above, EmblemHealth is a nonprofit, mission-based health plan. We are responsible to our communities, not shareholders, and understand our reputation for compliance is a critical part of the value we provide to consumers. The investments described above demonstrate the seriousness with which we take our compliance responsibilities. EmblemHealth remains focused on improving its risk adjustment compliance apparatus and will continue to consider other changes to ensure we are following CMS's coding rules. ***The OIG recommendation seems based on its observations of processes in place in 2015—nearly ten years ago—without accounting for EmblemHealth's refined processes and the investments described above. OIG should reevaluate its recommendation based on these changes and note that its findings predicated on the 2015 observations do not reflect EmblemHealth's current procedures and controls.***

II. The Report's Estimated Extrapolation Amount is Unjustified.

The Draft Report provides estimates for overpayment amounts as if the audit results were to have been extrapolated from the 200-beneficiary sample to all of the enrollees in the audited contract. ***We believe these references are inappropriate for the reasons discussed below and request they be eliminated in the final report.***

A. Extrapolation is Neither Legally Permissible nor Appropriate.

1. The RADV Final Rule Does Not Allow Extrapolation for This Audit.

As OIG notes, CMS announced in its 2023 RADV Final Rule[7] that it will not apply extrapolation on audit findings for years prior to the 2018 payment year. The Final Rule represents a conscious decision by CMS *not* to apply extrapolation to prior years because, "CMS determined it is in the overall best interests of the RADV program and ultimately the Part C program itself to limit all RADV improper payment recoveries for PYs 2011 through 2017 to enrollee-level adjustments for those enrollees sampled in the payment validation audits."[8] The reference in the OIG report to extrapolated results, therefore, describes a hypothetical that will not occur, is inconsistent with what CMS believes to be in the best interest of the MA program, and is based on audit findings that continue to reflect the methodological flaws previously described

2. Pending Litigation Challenges the Validity of Extrapolation.

Pending federal court litigation, *Humana Inc. et al v. Becerra et al*., 4:23-cv-00909 (N.D. Tex. Sept. 1, 2023), raises significant questions about the legality of the RADV Final Rule. The issues raised in that case are very different from those previously addressed by the United States Court of Appeals for the D.C. Circuit in *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867 (D.C. Cir. 2021), especially extrapolation and extrapolation methodologies, which remain unsettled. Therefore, it is inappropriate for OIG to include estimated liabilities premised on extrapolation until these issues are heard, particularly given both the potential prejudice to MAOs and the legally uncollectible status of the extrapolated amounts.

The *Humana* Brief[9] includes several arguments that must be resolved before extrapolation and its results should be publicized. For example, we agree with the plaintiffs' brief that the RADV Final Rule inappropriately applies the *UnitedHealthcare* court's findings to extrapolation. CMS's justification for doing so in the RADV Final Rule is questionable. It states:

> First, as described by the D.C. Circuit, these provisions do not apply to the obligation to return improper payments for MAO diagnosis codes that are unsupported by medical records. Although the D.C. Circuit did not address the RADV audit context in its decision in UnitedHealthcare, this position is consistent with the D.C. Circuit's reasoning in that case. (See UnitedHealthcare, 16 F.4th at 869, 891-92.) Second, it would be unreasonable to interpret the Act as requiring a minimum reduction in payments in one provision (the coding pattern provision), while at the same time prohibiting CMS in an adjacent provision (the actuarial

[7] *See* Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 (88 Fed. Reg. 6643 (Feb. 1, 2023) ("RADV Final Rule").
[8] RADV Final Rule at 6654.
[9] "*Humana* Brief" found at Humana_2024.02.13_RESPONSE-to-MOTION-to-Transfer-Venue-or-Dismiss.pdf (georgetown.edu) attached hereto as Attachment 2.

equivalence provision) from enforcing those longstanding documentation requirements (by requiring an offset to the recovery amount calculated for CMS audits).[10]

This argument is internally inconsistent. First, CMS correctly asserts, based on the *UnitedHealthcare* decision, that actuarial equivalence does not apply to its authority under the False Claims Act to collect penalties from sample-level audits. CMS then suggests, however, that the decision's authority to extrapolate sample errors to the contract level either outweighs or has a neutral impact on the law's requirement that the MA risk adjustment system be developed using actuarially equivalent principles.[11]

That position fails to reconcile with the industry's legitimate concerns that extrapolating without an appropriate adjuster would violate the Social Security Act requirement that the risk adjustment system be developed using "actuarial equivalence" principles. ***Putting it simply, applying sample level audit results to contract level audits undermines the actuarial equivalence of the MA risk adjustment model.*** The *Humana* Brief describes several reasons why this is so. There are underlying differences in the fee-for-service data used to calculate risk adjusted payments to MA plans and the plan data that are evaluated during RADV audits. For example, "CMS uses claims forms, not medical records, to calculate the payment model's cost estimates. This is a critical distinction because fee-for-service Medicare beneficiaries' medical records often do not contain documentation of the diagnosis codes listed in their providers' claims for payment."[12] These factors were acknowledged by the American Academy of Actuaries and *even by CMS itself* in its 2012 Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audit[13].

The *UnitedHealthcare* decision does not substantiate that CMS's extrapolation methodology is supported by the law. As the RADV Final Rule correctly states, "RADV audits *only* address issues relating to diagnoses that are not supported by valid medical record *documentation*."[14] (emphasis added). By choosing to extrapolate these documentation errors beyond those found in its legitimate oversight role authorized by the False Claims Act, however, CMS has decided to apply the sample results to individuals whose records have not been audited. As the *Humana* Brief notes, extrapolation is not authorized by the False Claims Act, which, citing the *UnitedHealthcare* decision, "requires only that an insurer report and return to CMS

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[10] RADV Final Rule at 6656

[11] Section 1853(a)(1)(C)(i) requires CMS to establish a Medicare Advantage risk adjustment system "for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure ***actuarial equivalence***" (emphasis added).

[12] Attachment 2, *Humana* Brief, at 20.

[13] Please see CMS, Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits, found at February XX, 2012 (cms.gov) page 4, Risk Adjustment Data Validation Contract-Level Audit, where it states it would be applying a fee-for-service (FFS) adjuster to account "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 to develop the Part C risk-adjustment model (FFS claims)."

[14] RADV Final Rule at 6657.

known errors in its beneficiaries' diagnoses."[15] The brief argues that the agency's application of extrapolation in this instance is unjustified, concluding "[t]here is no conceivable reason why Congress would have allowed the agency to unravel the actuarial soundness of the Medicare Advantage program—and evade the Medicare statute's actuarial-equivalence requirement—through actuarially baseless contract-wide audit recoveries."[16]

CMS's flawed 2018 analysis of the FFS adjuster also does not substantiate the agency's proposed extrapolation approach and should be discounted. MA plans have argued that the Social Security Act's actuarial equivalence requirements mean CMS must apply a FFS adjuster to the calculation of extrapolated audit findings. As we and others have noted[17], the agency's study did not apply the conditions MA plans are likely to face under a RADV audit or acknowledge the underlying differences in the data as cited in the *Humana* Brief.

The issues discussed above were not adjudicated in *UnitedHealthcare* and should be resolved before the estimated impact of extrapolation is included in the OIG's report. In the interim, it is inappropriate for OIG to include extrapolation-based estimates without at least applying a FFS adjuster in the final report.

3. Applying Extrapolation to an Untargeted and Random Sample is Inconsistent with CMS RADV Processes.

The RADV Final Rule announces a "shift" in the agency's RADV approach "from a largely untargeted, random sampling from a universe of most of an audited MAO's enrollees to a more targeted, risk-based approach that incorporates risk factors, such as HCCs that were more likely to be in error."[18] OIG's EmblemHealth audit is an example of the less targeted sampling methodology. Its application of extrapolation to our audit findings is inconsistent with the shift in CMS's audit approach and is therefore inappropriate to include in the final report.

* * * * *

Most importantly, as we note above, EmblemHealth has been taking numerous actions to improve our compliance with diagnosis submission requirements. We expect these improvements to significantly improve our audit findings. ***Publishing the extrapolation estimate for an audit period almost ten years ago when extrapolation did not apply, and based on internal processes that we have significantly improved since then will only lead to inaccurate and prejudicial conclusions that have the potential to inappropriately damage our reputation. We therefore urge OIG to omit references to extrapolation in the final report.***

[15] *See* Attachment 2, *Humana* Brief, at 35.
[16] *Ibid.*
[17] *Ibid*, at 29-31.
[18] RADV Final Rule at 6658.

III. Conclusion

EmblemHealth greatly appreciates the opportunity to comment on the Draft Report. Please continue to contact Joe Greene, EmblemHealth's Director, External Regulatory Audit at jgreene@emblemhealth.com or 518-446-8045 with any questions you may have.

Sincerely,

Debra M. Lightner

Debra M. Lightner
Chief Compliance Officer