

Audit Heat: What Recent Enforcement Actions Reveal About MA Risk Adjustment

A Norwood Solutions Webinar

September 2026

Jason Jobes · SVP, Solutions

Today's Journey

This webinar will:

1. Walk through two recent DOJ settlements and three OIG audits
2. Detail exactly how each case unfolded — mechanism, timeline, and resolution
3. Flag which conditions are likely next, and how to get ahead of them

Webinar Goal

By the end of this session, you'll know what regulators are finding, why it reaches providers — not just MA plans, and tactical items your compliance, risk adjustment, or CDI program should do next.

Risk Adjustment Headlines Adding to the Summer Heat

Over \$750M in recommended recoupments or settlements were announced across a 45-day span. The theme is the same—risk adjustable diagnoses were submitted without sufficient documentation.

PRESS RELEASE

The Villages Health System LLC Agrees to \$541.5M Settlement to Resolve False Claims Act Allegations

PRESS RELEASE

Medicare Advantage Provider Complete Health to Pay \$14,100,000 to Settle False Claims Act Suit



Home > Reports and Publications > All Reports and Publications > 2026 > Medicare Advantage Compliance Audit of Specific Diagn...

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UnitedHealthcare of Wisconsin, Inc. (Contract H5253) Submitted to CMS

Issued on 09/10/2026 | Posted on 09/15/2026 | Report number: A-07-24-01214

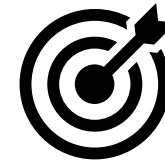


DOJ Case 1: The Villages Health System

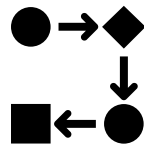
In August, the Department of Justice disclosed a \$541.5M False Claims Act settlement with The Villages Health. The settlement stems from multiple years of unchecked performance that led to significantly inflated risk scores.



**Self-Disclosed Performance
After Discovery**



**Significant Percent of
Unsupported HCCs**



**Retrospective Amendments
and Code Sprints**



**Bankruptcy Due to
Excessive Liabilities**

What TVH Actually Did

The settlement agreement lays out in detail where things went wrong for TVH. It was a series of cascading events that appeared to go unchecked.

2016 & 2019

- Outside coding consultants — one paid in part by a major MAO — advise TVH it is “under-coding”

Compensation

- TVH factors that advice into components of staff compensation

Retrospective
Amendments

- Apr 2020–Aug 2024: staff insert added diagnosis codes into records
- Sent to rendering (or non-rendering) provider to accept or reject

Sprints

- Mar 2021–Aug 2024: staff target providers who’d previously shown willingness to add a given HCC
- Same accept/reject process, but proactively targeted by HCC

Aug 2024 Probe
Audit

- TVH hires outside counsel and a consultant to sample coding accuracy
- Both practices terminated the moment the issue is identified

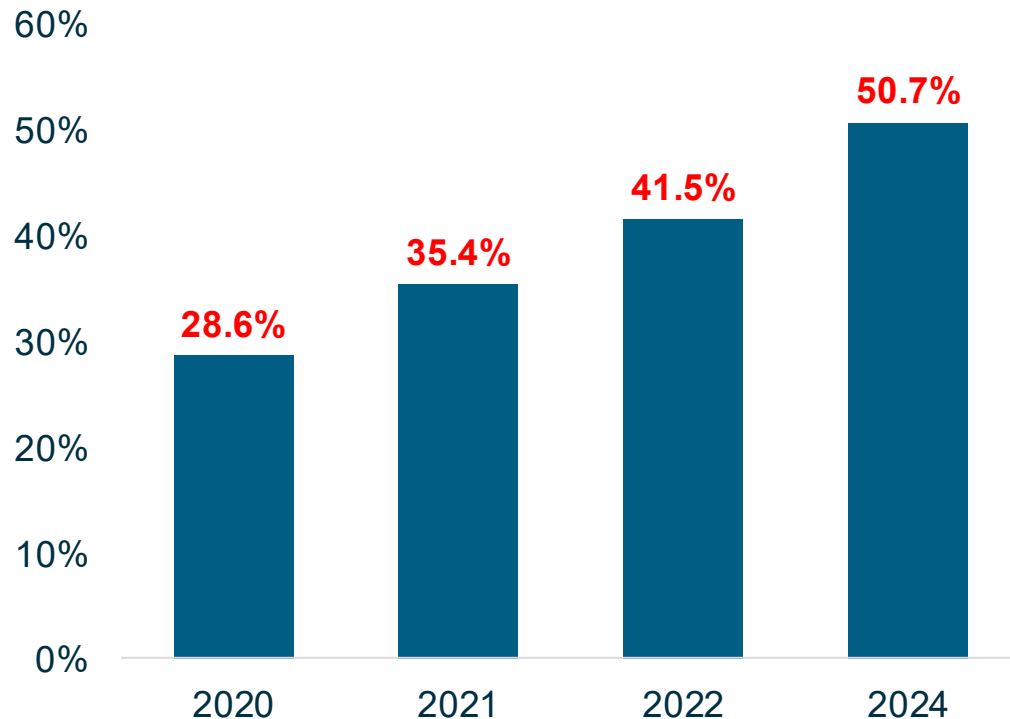
Self-Disclosure
and Bankruptcy

- Dec 27, 2024: submitted to OIG
- July 3, 2025: TVH files for Chapter 11 bankruptcy protection.

Audit Findings- Green Flags Turn Red

Unsupported-HCC rate by year and three real examples of what "unsupported" meant in practice.

Unsupported HCCs After Audit by Service Year



2023 excluded — reviewed separately two ways (54% by TVH's internal coders, 23% by its outside consultant); see prior slide.

What “Unsupported” Looked Like — Straight From the Settlement

E66.01

Morbid (severe) obesity due to excess calories

Flagged when documented BMI was under 35, or 35–39 with no weight-related comorbidity also noted.

D69.1

Qualitative platelet defect

Patient was on a bleeding-risk medication (Eliquis, Xarelto, Coumadin, aspirin, Plavix, Meloxicam) but the record had no underlying bleeding disorder or symptoms documented.

D84.81

Immunodeficiency due to conditions classified elsewhere

Record only noted that diabetes increases infection risk generally — no patient-specific immunodeficiency findings.

Why This Resolved as a Settlement — Not Worse

Self-disclosure was the difference between a negotiated settlement and something far worse.

Self-Disclosure

What happened: TVH voluntarily reported through OIG's Self-Disclosure Protocol rather than waiting for an audit or whistleblower to surface it.

DOJ credited: voluntary self-disclosure, remedial action taken, and full cooperation with the investigation.

Still costly: Self-disclosure doesn't erase exposure — TVH still paid \$541.5M in the settlement.

The Takeaway

What it bought: It moved the outcome from potential treble damages and exclusion to a negotiated civil settlement — and no Corporate Integrity Agreement.

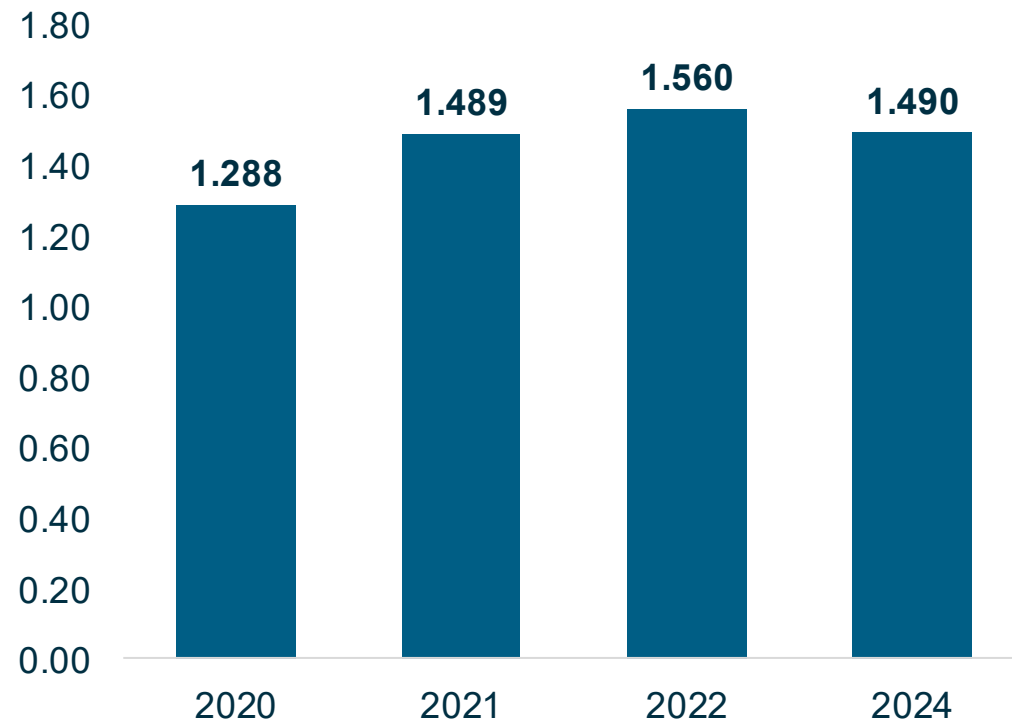
What it won't do: Waiting for an external audit to find the problem first removes that mitigating factor entirely.

The lesson: For every MA-adjacent organization: find it yourself, and disclose it, before someone else does.

Warning Sign- Risk Score Changes

Benchmarking internally and externally can provide a practical check and balance. While risk score is only one component of the value-based care equation, it can be a good barometer of performance.

Stated Risk Score by Date of Service Year



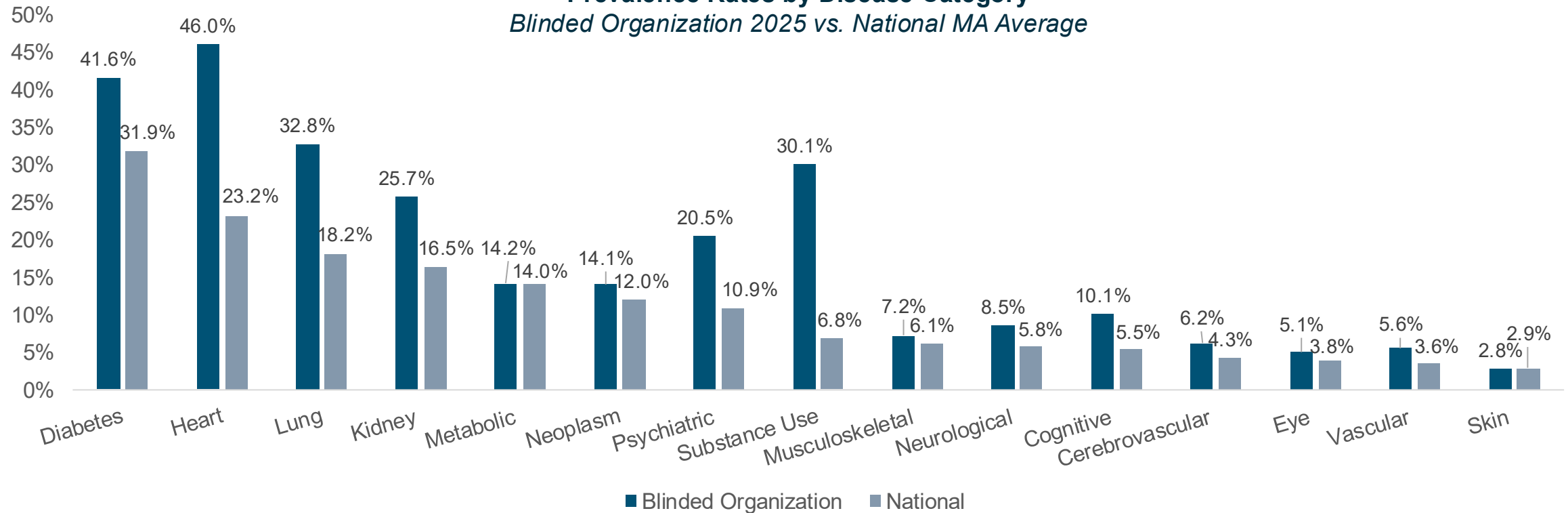
Observations and Recommendations

- TVH's risk score increased by 0.201 points or 15.6% in one year. The magnitude of this shift should raise flags
- Benchmark performance at the overall risk score, the clinical disease group, and the individual HCC. Look for areas where performance varies appreciably from the norm.
- Audit performance areas where risk may occur. Intentionally target specific HCCs, providers, and clinical areas.

Sample- Prevalence Rates Comparison

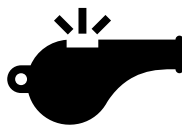
The example below is an example of a real comparison Norwood did for a partner. This analysis started at the clinical category level. The organization in question had a substance abuse rate more than 4 times the national average. Compounding performance we noted that 58% of those conditions were addressed only once in a calendar year. The organization was immediately able to identify the risks, evaluate documentation accuracy, and revise provider education.

Prevalence Rates by Disease Category
Blinded Organization 2025 vs. National MA Average



DOJ Case 2: Complete Health

While the magnitude of the impact from Complete Health is significantly less than TVH, the \$14.1M False Claims Act settlement provides additional cautions.



**External Whistleblower
Identified the Concern**



**Incorrect Documentation and
Coding Guidance**



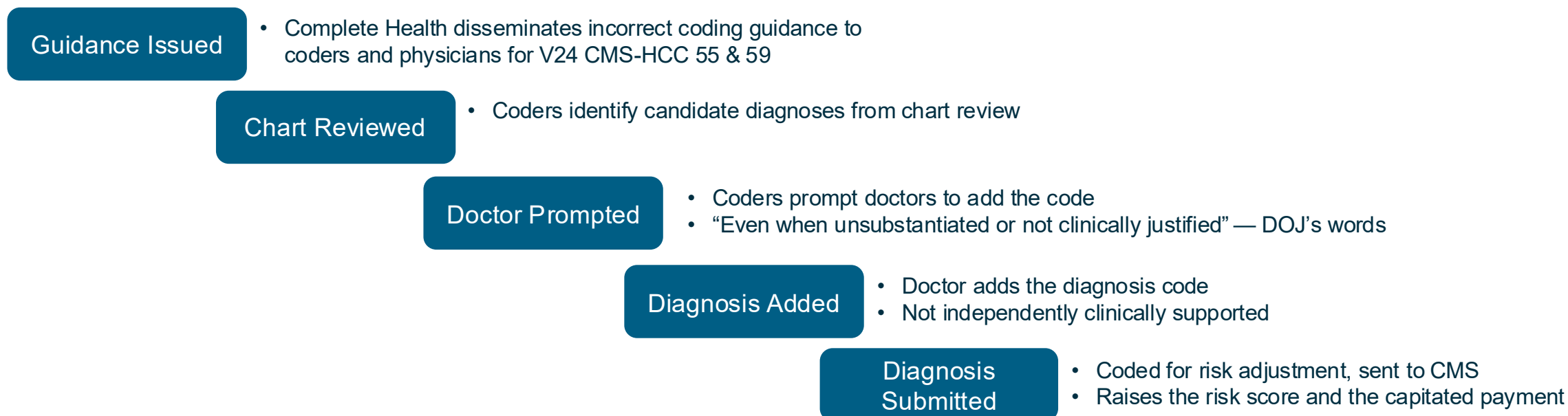
**Pre-Visit Prompts and Post-
Visit Leading Queries**



**\$14.1M Penalty- Over \$2M
to the Whistleblower**

The Summary of the Problem

Complete Health's exposure centered on how diagnoses reached the claim — a workflow issue as much as a coding one.



The Fine Print

The DOJ lays out the process that it questioned in the submission of diagnoses that resulted in overpayment. What it didn't clarify in the settlement is what constitutes a leading query.

Specifically, coders added specific risk-adjusting diagnosis codes as “suggestions” in the beneficiary’s electronic medical record before a beneficiary visit, creating pressure for providers to add these diagnoses during the beneficiary’s visit. If providers did not add the diagnosis codes during the beneficiary’s visit, *coders then sent leading queries* to treating providers through Complete Health’s electronic medical record software requesting that providers review and add specific risk-adjusting diagnosis codes within HCC 55 and HCC 59 that were not clinically valid and not considered in the care, management or treatment of the beneficiary to the beneficiary’s medical record. As a result, the doctors added those diagnosis codes, which were not accurate. Medical coders also added diagnosis codes for submission to MAOs after a beneficiary’s visit and without provider involvement when they were not supported by the medical record documentation.

**Direct quote from the DOJ’s
settlement with Complete Health**

Things to Consider for Your Program

- 1) How do you present conditions for your providers to review?
- 2) How do you handle conditions that are not addressed in a visit?
- 3) How do you review conditions and codes post visit or retrospectively?
- 4) What is the process to add or remove codes to an encounter?

No Self-Disclosure, No Cooperation Credit

TVH: Self-Disclosed

Who found it: TVH found it itself, through its own Aug 2024 probe audit.

What it bought: Cooperation credit under Justice Manual §4-4.112, and no Corporate Integrity Agreement.

Still: \$541.5M paid — self-disclosure reduced the damage, it didn't erase it.

Complete Health: Whistleblower-Driven

Who found it: A former Associate Director of Risk Adjustment at VIVA Health — Complete Health's own MAO partner — not a Complete Health employee.

What it cost: No self-disclosure means no cooperation credit — the settlement resolved a qui tam suit filed in 2022, litigated for years.

The relator: Karen Bowers received approximately \$2,467,500 — about 17% of the \$14.1M recovery — under the FCA's qui tam provisions.

Recent Targeted OIG Reports- September 2026

In a two week span the OIG released three reports, all focused on the same high risk HCCs. The findings are eerily similar and continue to serve as a warning sign for plans. However, the real impact is unclear.

Metric	UHC Contract H5253	Humana Contract H5216	UHC Contract H0609
Date Released	September 15 th	September 15 th	September 23 rd
Dates of Service Reviewed	2020 and 2021	2020 and 2021	2020 and 2021
Lives in the Contract (Dec. 2021)	682,374	1,750,122	342,694
HCCs Reviewed	250	220	230
HCCs Supported	67	42	58
<u>Error Rate</u>	<u>73.2%</u>	<u>80.9%</u>	<u>74.8%</u>
Direct Overpayments	\$722,280	\$669,237	\$622,927
Extrapolated Overpayment	\$46.9 Million	\$130.9 Million	\$24.4 Million

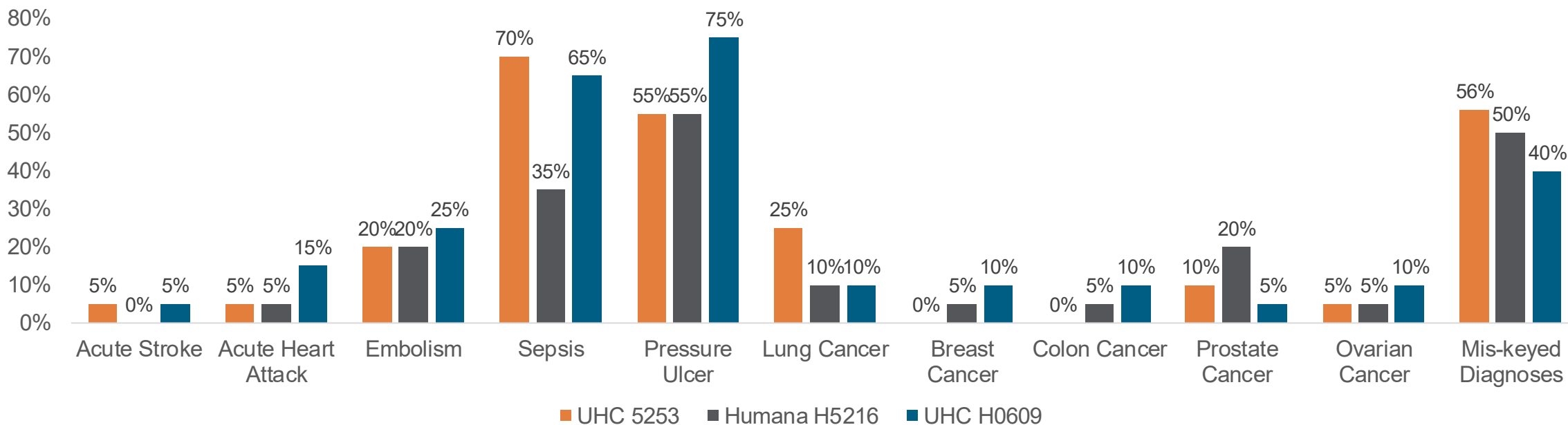
\$202M

The total amount recommended for repayment by the three plans.

Performance by Targeted HCC

Outside of mis-keyed diagnoses, the OIG has continued to focus on the same HCCs for several years. Based on current performance, continued focus on these can be expected.

HCC Documentation Sufficiency by Category and Plan



24%

The accuracy rate for the HCCs reviewed in the OIG targeted audits.

Mis-keyed Diagnoses- A Blast From the Past

The OIG details all 50 of the mis-keyed diagnoses from the reports. We aggregated them and found that 3 conditions accounted for 58% of the conditions but 85% of the overpayment. Zeroing in on these is imperative.

Top Financial Impact Mis-Keyed Diagnoses Identified in the 3 OIG Reports

Diagnosis Captured Once (Determined Incorrect)	Diagnosis Captured Multiple Times (Not Reviewed)	Found In	Enrollee- Years	Overpayment
C78.00 / C78.2 — Secondary Malignant Neoplasm of Lung or Pleura	E78.00 / E78.2 — Hypercholesterolemia /Hyperlipidemia	All 3 Reports	20	\$343,341
G10 — Huntington's Disease	I10 — Essential (Primary) Hypertension	UHC WI + Humana	6	\$26,897
I62.9 — Nontraumatic Intracranial Hemorrhage	G62.9 — Polyneuropathy, Unspecified	UHC WI + UHC TX	3	\$9,499

84.8% of Impact in 3 Diagnoses

\$379,737 across 29 enrollee-years — 84.8% of all identified mis-keyed overpayment. This represents a significant, systemic risk that you should review for in retrospective reviews.

Ramifications for Providers

The DOJ and OIG actions widen the exposure well beyond the organizations named — any plan still using performance-based coding incentives inherits similar risk. While a critical evolution towards value-based care, it must still be done right.

Financial Exposure

- False claims act treble damages, per-claim penalties
- Refunds reach back multiple contract years
- Legal, audit, and remediation costs on top
- Payer contracts to pass liability back to providers

Compensation Structure Risk

- Compensation tied to RAF or chart volume can create a liability
- Retrospective reviews of the record must be timely and done appropriately
- It is imperative that conditions be reviewed for both additions and deletions

Documentation & Coding Standards

- MEAT becomes the default defensibility bar
- Leading queries read as creation, not clarification
- Amendments without a clinical basis or beyond a certain timeframe will draw scrutiny

Compliance Program Exposure

- You must have a robust compliance and documentation program
- You must know your data and your risks
- Boards face personal accountability questions
- OIG selection isn't random — patterns attract it

What's Next: What We Are Watching

These five reports targeted specific conditions. The underlying mechanism — chart mining under audit pressure — doesn't stop with them. Here's where it likely shows up next.



Substance Use Disorder

- Already confirmed in both TVH and Complete Health
- High-value HCC, easy to overstate from history
- Requires active treatment, not a stale diagnosis



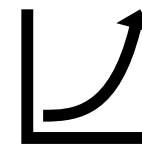
Dementia

- Expanded under V24/V28 — heavy capture interest
- Published research: ~34% false-positive rate on review
- Prone to being inferred, not documented



Audits Tailored to Orgs

- RADV audits have already expanded to every MA plan
- Data mining has been a focal point meaning abnormalities will be identified and reviewed
- Conditions captured only once in a calendar year



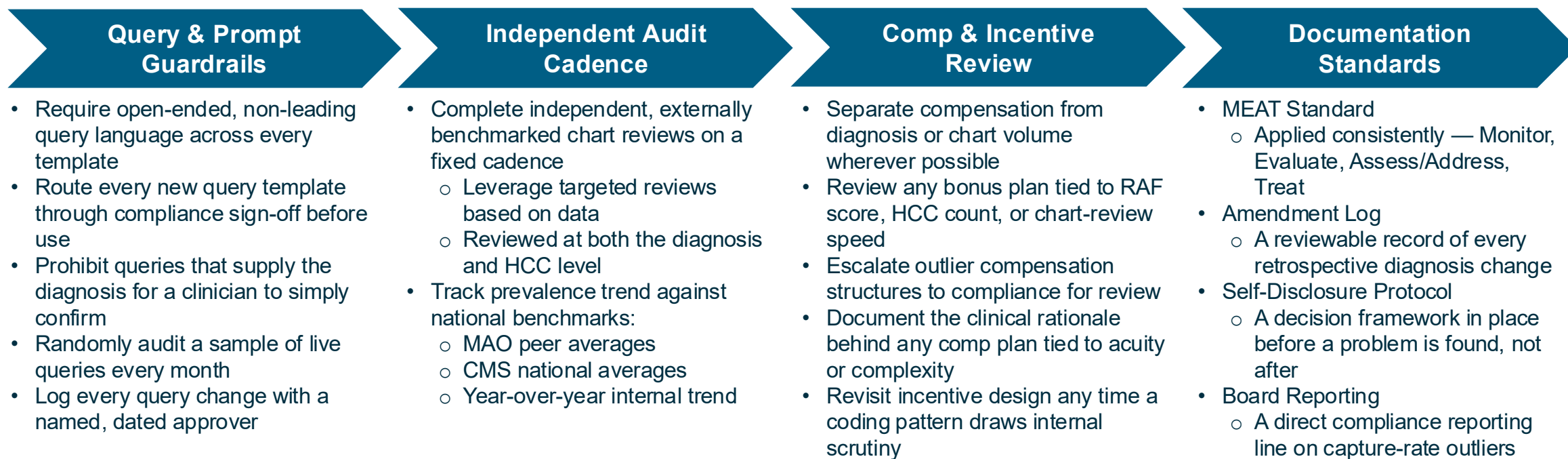
Extrapolation Lawsuits

- Current court rulings initially struck down the push for extrapolating impact findings, but they are not dead yet
- Will CMS or Congress write extrapolation penalties into law?

Four Moves to Make Now

Each of these recommendations tie directly to the reports highlighted today. These are the start, not the end, of a compliant risk adjustment program.

The Blueprint



How Norwood Helps

The same infrastructure that would have caught each of today's issues before an OIG letter or a whistleblower complaint arrived.

Capability	What It Solves	Applies To
CDI Program Assessments or Builds	Helps ensure your documentation program is robust and compliant to drive accurate risk adjustment	Organizations in risk and/or those focused on HCC capture
Independent Chart Audits	Targeted sample, HCC-level review that surfaces mining patterns before OIG does	Every risk-adjustment coding program
Query & Documentation Review	Flags leading query language and MEAT gaps before they reach a claim	CDI teams, Coding teams, healthcare providers, and payers
Compensation Structure Review	Identifies incentive plans that reward volume over documentation	Organizations tying compensation plans to risk adjustment or HCC capture
Ongoing Monitoring	Continuous benchmarking against MA and CMS averages to catch outliers early	Health plans and delegated risk entities
Combined Result		A defensible program built before enforcement arrives — not after

Ready to See Where Your Program Stands?

Norwood helps risk-adjustment programs find these patterns — before the OIG or DOJ does.



Jason Jobes, Senior Vice President
Norwood Solutions

Jason@Norwood.com

www.Norwood.com

Link to my LinkedIn Profile Below



Questions?

Jason Jobes · SVP, Solutions

Jason@Norwood.com

Norwood Solutions



Links to Today's Source Documents

Settlement or Report	Link
The Villages Health DOJ Settlement	https://www.justice.gov/opa/pr/villages-health-system-llc-agrees-5415m-settlement-resolve-false-claims-act-allegations
Complete Health DOJ Settlement	https://www.justice.gov/opa/pr/medicare-advantage-provider-complete-health-pay-14100000-settle-false-claims-act-suit
OIG Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UnitedHealthcare of Wisconsin, Inc. (Contract H5253) Submitted to CMS	https://www.oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-unitedhealthcare-of-wisconsin-inc-contract-h5253-submitted-to-cms/
OIG Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HumanaChoice (Contract H5216) Submitted to CMS	https://www.oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-humanachoice-contract-h5216-submitted-to-cms/
OIG Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UnitedHealthcare Benefits of Texas, Inc. (Contract H0609), Submitted to CMS	https://www.oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-unitedhealthcare-benefits-of-texas-inc-contract-h0609-submitted-to-cms/

In Case You Missed It- 2026 Acute Care Audit Findings

In August Norwood hosted a webinar about the OIG's recent inpatient audits. Those findings showed a 27% error rate for the cases reviewed. During the webinar we broke down exactly where the errors come from, shared how we benchmarked every organization, and have even created a custom report for all hospitals.

Inpatient Audit Storm Clouds: OIG Reports Expose Threat to Hospitals Nationwide

A briefing on the regulatory pattern behind three 2026 OIG audit findings — and how to assess your organization's exposure

3 Key Takeaways

- 1) The OIG has recently audited acute care organizations and found a 27% error rate for inpatient cases
- 2) 21 DRGs have been in focus, of which 4 have been in every report
- 3) Norwood has created a personalized OIG risk profile for every hospital.

If you missed it or want to talk about your facility's OIG risk profile, please email Jason@Norwood.com

Our Next Scheduled Webinar

On Tuesday, October 20th Norwood will be hosting **Metabolic Syndrome and the Intersection of Medicare Advantage**. We hope you can join us!

Overview

Metabolic syndrome is challenging to diagnose and equally expensive to treat. Ideally, healthcare organizations should develop cost effective solutions that drive outcomes and simultaneously provide a positive, seamless patient care experience.

The reality is often different.

In this 30-minute webinar, Norwood Senior Director of Solutions Rose Bernards brings to bear 30 years of experience in value-based care to help your organization identify these patients, capture their full breadth of complexity in coded data and quality databases, and simultaneously improve the health of the patient and your organization's bottom line.

This show has something for mid-revenue cycle professionals at all levels.

Agenda

- Define metabolic syndrome including clinical presentation, prevalence, and treatment cost
- Describe a typical patient and how his/her needs drive care, quality scores, and revenue
- Explain a working model for achieving better patient care and quality outcomes

Presenter: Rose Bernards, MBA

Date/time: Tuesday, Oct. 20, 1-1:30 p.m. EST

Audience

- Mid-revenue cycle leadership (HIM, CDI, revenue, compliance)
- Risk adjustment coding professionals
- Quality improvement and HEDIS professionals

Link to register- <https://my.demio.com/ref/LrJTpKR7znus4E5R>