U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Why OIG Did This Audit

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

To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS. For this audit, we reviewed one MA organization, MCS Advantage, Inc., and focused on nine groups of high-risk diagnosis codes.

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

How OIG Did This Audit

We sampled 280 unique enrollee-years with the high-risk diagnosis codes for which MCS received higher payments for 2016 through 2017. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $402,073.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That MCS Advantage, Inc. (Contract H5577) Submitted to CMS

What OIG Found

With respect to the nine high-risk groups covered by our audit, most of the selected diagnosis codes for the sampled enrollee-years that MCS submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 183 of the 280 sampled enrollee-years, the diagnosis codes were not supported in the medical records, resulting in $220,577 of net overpayments.

These errors occurred because MCS's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations could be improved. On the basis of our sample results, we estimated that MCS received at least $6.2 million of net overpayments for these high-risk diagnosis codes in 2016 and 2017.

What OIG Recommends and MCS Comments

We recommend that MCS (1) refund to the Federal Government the $220,577 of net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.

MCS disagreed with some of our findings, provided additional information for four sampled enrollee-years, and requested that we withdraw our recommendations. MCS stated that our recommendations are (1) based on flawed audit sampling and review methodologies, (2) inconsistent with the Social Security Act's actuarial equivalence mandate and CMS's data accuracy and compliance requirements, and (3) not supported by the factual record.

After reviewing MCS's comments and the information that MCS provided, we revised the number of sampled enrollee-years in error from 186 to 183 for this final report. After we had issued our draft report, CMS updated regulations for audits in its risk adjustment program to specify that extrapolated overpayments could only be recouped beginning with payment year 2018. Because our audit period covered payment years 2016 and 2017, we changed our first recommendation to specify a refund of only the net overpayments for the sampled enrollee-years. We made no changes to our second and third recommendations.