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

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cariten Health Plan, Inc., (Contract H4461) Submitted to CMS

Why OIG Did This Audit

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

To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

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

How OIG Did This Audit

We sampled 270 unique enrollee-years with the high-risk diagnosis codes for which Cariten 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 $750,508.

What OIG Found

With respect to the nine high-risk groups covered by our audit, most of the selected diagnosis codes that Cariten submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 206 of the 270 enrollee-years, the diagnosis codes that Cariten submitted to CMS were not supported in the medical records and resulted in net overpayments of $557,250.

These errors occurred because the policies and procedures that Cariten had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of our sample results, we estimated that Cariten received at least $9.2 million in net overpayments for these high-risk diagnosis codes in 2016 and 2017.

What OIG Recommends and Cariten Comments

We recommend that Cariten (1) refund to the Federal Government the $9.2 million 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) examine its existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.

Cariten disagreed with our findings and recommendations. Cariten provided additional information for 12 sampled enrollee-years which, according to Cariten, supported either the reviewed diagnosis code or a related diagnosis code. Cariten also stated that our audit methodology departed from governing statistical and actuarial principles and the statutory requirements of the MA program. Additionally, Cariten disagreed that it should perform audits of high-risk diagnoses and stated that its compliance program satisfies all legal and regulatory requirements. After reviewing Cariten's comments and additional information that it provided, we revised the number of enrollee-years in error from 208 to 206 for this final report. We also revised the amount of our first recommendation from $9.3 million (in our draft report) to $9.2 million but made no change to our other recommendations. We followed a reasonable audit methodology and correctly applied applicable Federal requirements underlying the MA program.