**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 Keystone Health Plan East, Inc. (H3952) 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 heathier 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 diagnosis codes are at a higher risk for being miscoded, which may result in overpayments from CMS.

For this audit, we reviewed one MA organization, Keystone Health Plan East. Our objective was to determine whether selected diagnosis codes that Keystone 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 condition and payment years (enrollee-years) with the high-risk diagnosis codes for which Keystone received higher payments for 2016 and 2017. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $746,012 for our sample.

## What OIG Found

With respect to the nine high-risk groups covered by our audit, most of the selected diagnosis codes that Keystone submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 205 of the 270 sampled enrollee-years, the medical records that Keystone provided did not support the diagnosis codes and resulted in $550,391 in overpayments. As demonstrated by the errors in our sample, Keystone's policies and procedures to prevent, detect, and correct noncompliance with CMS program requirements could be improved. On the basis of our sample results, we estimated that Keystone received at least $11.3 million in overpayments for 2016 and 2017.

## What OIG Recommends and Keystone Comments

We recommend that Keystone: (1) refund to the Federal Government the $550,391 of overpayments; (2) identify, for the high-risk diagnoses included in the report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; (3) continue its examination of existing compliance procedures to identify areas in which improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures; and (4) ensure that it collects, for audits of risk adjustment data, medical records that comply with CMS requirements.

In written comments on our draft report, Keystone concurred with our third and fourth recommendations but did not fully agree with our findings and our first and second recommendations. Keystone provided additional information related to medical records it previously gave us.

After reviewing Keystone's comments and the additional information provided, we revised the number of enrollee-years in error from 207 to 205 for this final report. After we 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 revised our first recommendation to specify a refund of only the overpayments for the sampled enrollee-years. We made no changes to our other recommendations. We maintain that our methodologies were reasonable and properly executed.