

Report in Brief

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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 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 higher risk for being miscoded, which may result in overpayments from CMS.

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

How OIG Did This Audit

We sampled 210 unique enrollee-years with the high-risk diagnosis codes for which HumanaChoice received higher payments for 2015 and 2016. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$694,939.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HumanaChoice (Contract H6609) Submitted to CMS

What OIG Found

With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that HumanaChoice submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 157 of the 210 sampled enrollee-years, the diagnosis codes that HumanaChoice submitted to CMS were not supported in the medical records and resulted in \$480,295 of net overpayments for the 210 enrollee-years. These errors occurred because the policies and procedures that HumanaChoice had 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 HumanaChoice received at least \$27.3 million of net overpayments for 2015 and 2016.

What OIG Recommends and HumanaChoice Comments

We recommend that HumanaChoice: (1) refund to the Federal Government the \$480,295 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 that diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.

HumanaChoice disagreed with our findings and recommendations and provided additional information for certain sampled enrollee-years. HumanaChoice disagreed with our audit methodology and how we estimated overpayments. HumanaChoice also stated that our recommendation to identify similar instances of noncompliance does not align with CMS's requirements and that its compliance program satisfies all legal and regulatory requirements.

After reviewing HumanaChoice's comments and the additional information that it provided, we revised the number of enrollee-years in error. 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 2015 and 2016, 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.