

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, HealthAssurance Pennsylvania, Inc. (HealthAssurance), and focused on nine groups of high-risk diagnosis codes. Our objective was to determine whether selected diagnosis codes that HealthAssurance submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We selected a stratified random sample of 269 unique enrollee-years with the high-risk diagnosis codes for which HealthAssurance (administered by Aetna, a CVS Health company) received higher payments for 2018 and 2019. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$966,561.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HealthAssurance Pennsylvania, Inc. (Contract H5522) Submitted to CMS

What OIG Found

With respect to the nine high-risk groups covered by our audit, most of the selected diagnosis codes that HealthAssurance submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 222 of the 269 sampled enrollee-years, the medical records that HealthAssurance provided did not support the diagnosis codes and resulted in \$657,744 in overpayments.

As demonstrated by the errors found in our sample, HealthAssurance'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 HealthAssurance received at least \$4.2 million in overpayments for 2018 and 2019.

What OIG Recommends and HealthAssurance Comments

We recommend that CVS Health: (1) refund to the Federal Government the \$4.2 million in 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; 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 (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

HealthAssurance, through CVS Health, disagreed with some of our findings, did not concur with our recommendations, and provided additional explanations for certain sampled enrollee-years. HealthAssurance disagreed with our audit methodology and our overpayment estimation methodology. HealthAssurance also stated that our recommendation to identify similar instances of noncompliance does not align with Federal requirements and that its compliance program satisfies all legal and regulatory requirements.

After reviewing HealthAssurance's comments and the explanations it provided, we reduced the number of enrollee-years in error and revised the amount in our first recommendation. We maintain that our second and third recommendations remain valid.