

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 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, Humana Health Plan, Inc. (Humana), and focused on eight groups of high-risk diagnosis codes (high-risk groups). Our objective was to determine whether Humana's submission of selected diagnosis codes 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 240 unique enrollee-years with the high-risk diagnosis codes for which Humana received higher payments for 2017 through 2018. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$642,816.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Humana Health Plan, Inc. (Contract H2649) Submitted to CMS

What OIG Found

For the eight high-risk groups covered by our audit, most of Humana's submissions of the selected diagnosis codes to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 202 of the 240 sampled enrollee-years, the diagnosis codes that Humana submitted to CMS were not supported by the medical records and resulted in \$497,225 in overpayments. As demonstrated by the errors found in our sample, Humana'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 Humana received at least \$13.1 million in overpayments for 2017 and 2018. Because of Federal regulations that limit the use of extrapolation in Risk Adjustment Data Validation audits for recovery purposes to payment years 2018 and forward, we are reporting the overall estimated overpayment amount but are recommending a refund of \$6.8 million (\$274,151 for the sampled enrollee-years from 2017 and an estimated \$6,503,234 for 2018).

What OIG Recommends and Humana Comments

We recommend that Humana (1) refund to the Federal Government the \$6.8 million of estimated 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 to 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.

Humana disagreed with some of our findings and all of our recommendations. Specifically, Humana did not agree with our findings for 33 of the 206 enrollee-years identified as errors in our draft report and provided additional information for our consideration. Additionally, Humana did not agree with our audit methodology or overpayment estimation methodology. After reviewing Humana's comments and additional information that it provided, we reduced the number of enrollee-years identified as errors and revised the amount in our first recommendation. We maintain that our second and third recommendations remain valid.