

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, 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, Aetna, Inc. (Aetna), and focused on seven groups of high-risk diagnosis codes.

Our objective was to determine whether selected diagnosis codes that Aetna 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 Aetna received higher payments for 2015 through 2016. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$856,818.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Aetna, Inc. (Contract H5521) 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 Aetna submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 155 of the 210 sampled enrollee-years, the medical records that Aetna provided did not support the diagnosis codes and resulted in \$632,070 in overpayments. On the basis of our sample results, we estimated that Aetna received at least \$25.5 million in overpayments for 2015 and 2016. As demonstrated by the errors found in our sample, Aetna's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

What OIG Recommends and Aetna Comments

We recommend that Aetna: (1) refund to the Federal Government the \$632,070 of overpayments; (2) determine, for the remaining 159 enrollee-years in the potentially mis-keyed diagnosis code high-risk group not reviewed as part of this audit, whether the medical records in each case support the diagnosis for the unrelated condition and refund any resulting overpayments to the Federal Government; (3) 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 (4) continue to examine and improve its compliance procedures.

Aetna did not concur with our recommendations or agree with our findings for 5 enrollee-years sampled. Aetna did not state whether it agreed or disagreed with our findings for the remaining enrollee-years. Aetna also disagreed with our audit methodology, medical record review process, and use of extrapolation.

After reviewing Aetna's comments and additional information that Aetna provided, we revised the number of enrollee-years in error from 156 to 155 for this final report. We also revised the wording for our fourth recommendation. 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. We, therefore, revised our first recommendation to request a refund of only the overpayments for the sampled enrollee-years.