

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. For this audit, we reviewed one MA organization, Tufts Health Plan, Inc. (Tufts), and focused on seven groups of high-risk diagnosis codes.

Our objective was to determine whether selected diagnosis codes that Tufts submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 212 unique enrollee-years with the high-risk diagnosis codes for which Tufts 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 \$746,427.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Tufts Health Plan (Contract H2256) Submitted to CMS

What OIG Found

Most of the selected diagnosis codes that Tufts submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 58 of the 212 sampled enrollee-years, the medical records validated the reviewed Hierarchical Condition Categories (HCCs). However, for the remaining 154 enrollee-years, the diagnosis codes were not supported in the medical records. These errors occurred because the policies and procedures that Tufts had to ensure compliance with CMS's program requirements, as mandated by Federal regulations, could be improved. As a result, the HCCs for some of the high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Tufts received at least \$3.7 million of net overpayments for these high-risk diagnosis codes in 2015 and 2016.

What OIG Recommends

We recommend that Tufts: (1) refund to the Federal Government the \$3.7 million 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) continue to improve its existing compliance procedures to identify areas where 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.

Tufts did not concur with our findings and recommendations. Tufts stated that we should not have included the errors associated with 5 enrollee-years in our calculation of total net overpayments because, according to Tufts, it had already submitted corrections to CMS. Tufts did not specifically comment on the errors associated with the other 154 enrollee-years. Tufts disagreed with our sampling and review methodologies and stated that our report reflected misunderstandings of legal and regulatory requirements underlying the MA program.

After consideration of Tufts' comments, we maintain that our findings and recommendations are valid. However, we revised our findings for the 5 enrollee-years and considered the impact of the budget sequestration reduction; therefore, we reduced our first recommendation from \$4,013,034 to \$3,758,335 for our final report. We also revised the beginning of our third recommendation in recognition of Tuft's past efforts to improve its compliance program.