

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. Based on similar clinical characteristics and severity and cost implications, CMS then maps certain diagnosis codes into Hierarchical Condition Categories (HCCs). CMS makes higher payments for enrollees who receive diagnoses that map to HCCs. For this audit, we reviewed one CMS contract with Cigna HealthSpring of Florida, Inc.

Our objective was to determine whether Cigna HealthSpring submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

How OIG Did This Audit

We sampled 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. Cigna HealthSpring provided medical records as support for 1,470 HCCs associated with these enrollees.

Medicare Advantage Compliance Audit of Diagnosis Codes That Cigna HealthSpring of Florida, Inc. (Contract H5410) Submitted to CMS

What OIG Found

Cigna HealthSpring did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, although most of the diagnosis codes that Cigna HealthSpring submitted were supported in the medical records and therefore validated 1,401 of the 1,470 sampled enrollees' HCCs, the remaining 69 HCCs were not validated and resulted in overpayments. These 69 unvalidated HCCs included 7 HCCs for which we identified 7 other, replacement HCCs for more and less severe manifestations of the diseases. Second, there were an additional 18 HCCs for which the medical records supported diagnosis codes that Cigna HealthSpring should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,470 HCCs. Rather, the risk scores should have been based on 1,426 HCCs (1,401 validated HCCs + 7 other HCCs + 18 additional HCCs). As a result, Cigna HealthSpring received \$39,612 of net overpayments for 2015 for the sampled enrollees. As demonstrated by the errors found in our sample, Cigna HealthSpring's policies to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

What OIG Recommends and Cigna HealthSpring Comments

We recommend that Cigna HealthSpring refund to the Federal Government the \$39,612 of net overpayments and improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

In written comments on our draft report, Cigna HealthSpring disagreed with our findings and both of our recommendations. Cigna HealthSpring provided additional medical record documentation that it said substantiated specific HCCs. Cigna HealthSpring also questioned our audit and statistical sampling methodologies as well as our medical review process and stated that our report reflected misunderstandings of legal and regulatory requirements. After reviewing Cigna HealthSpring's comments and the additional documentation provided, we revised our findings and recommendations as appropriate. We maintain that our methodologies were reasonable and properly executed and that we correctly applied the Federal requirements.