

Report in Brief

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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 each enrollee's health status. 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. CMS then maps certain diagnosis codes into Hierarchical Condition Categories (HCCs), based on similar clinical characteristics and severity and cost implications. CMS makes higher payments for enrollees who receive diagnoses that map to HCCs.

For this audit, we reviewed one of the contracts that CarePlus Health Plans, Inc., has with CMS with respect to the diagnosis codes that CarePlus submitted. Our objective was to determine whether CarePlus submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

How OIG Did This Audit

We selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. CarePlus provided medical records as support for 1,656 HCCs associated with these enrollees. We used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

Medicare Advantage Compliance Audit of Diagnosis Codes That CarePlus Health Plans, Inc. (Contract H1019) Submitted to CMS

What OIG Found

CarePlus 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 CarePlus submitted were supported in the medical records and therefore validated 1,210 of the 1,656 sampled enrollees' HCCs, the remaining 446 HCCs were not validated and resulted in overpayments. These 446 unvalidated HCCs included 64 HCCs for which we identified 64 other HCCs for more and less severe manifestations of the diseases. Second, there were an additional 52 HCCs for which the medical records supported diagnosis codes that CarePlus should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,656 HCCs. Rather, the risk scores should have been based on 1,326 HCCs (1,210 validated HCCs plus 64 other HCCs plus 52 additional HCCs) and resulted in \$641,467 in net overpayments. On the basis of our sample results, we estimated that CarePlus received at least \$117.3 million in net overpayments for 2015. As demonstrated by the errors found in our sample, CarePlus'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 CarePlus Comments

We recommend that CarePlus refund to the Federal Government \$641,467 of net overpayments and ensure that its policies and procedures have been adequately designed and implemented to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments. CarePlus disagreed with our findings and recommendations and provided additional information to validate specific HCCs. CarePlus also questioned our audit and statistical sampling methodologies and said that we misunderstood certain legal and regulatory requirements underlying the MA program.

After reviewing CarePlus's comments and the additional information provided, we revised our findings and the associated net overpayment amount in our first 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 changed the amount of the recommended refund to include only the net overpayments of \$641,467. We made no changes to our second recommendation.