

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, Healthfirst Health Plan, Inc. (Healthfirst), and focused on seven groups of high-risk diagnosis codes. Our objective was to determine whether selected diagnosis codes that Healthfirst submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 240 unique enrollee-years with the high-risk diagnosis codes for which Healthfirst 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 \$787,928.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., (Contract H3359) 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 Healthfirst submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 155 of the 240 enrollee-years, the diagnosis codes that Healthfirst submitted to CMS were not supported in the medical records and resulted in net overpayments of \$516,509.

These errors occurred because the policies and procedures that Healthfirst had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of our sample results, we estimated that Healthfirst received at least \$5.2 million in net overpayments for these high-risk diagnosis codes in 2015 and 2016.

What OIG Recommends and Healthfirst Comments

We made a series of recommendations to Healthfirst, including that it: refund to the Federal Government the \$5.2 million of net overpayments; identify, for the diagnosis codes described 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 continue its examination of 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 and take the necessary steps to enhance those procedures.

Healthfirst objected to all of our recommendations; however, it did not object to any of the errors we identified. Instead, Healthfirst requested we limit our recommended recovery to the overpayments identified in our sample—not the extrapolated value of those overpayments. Healthfirst stated that OIG lacked the authority to use extrapolation to recommend a repayment and disagreed with our extrapolation methodology. It also stated that our audit methodology did not account for a payment principle known as "actuarial equivalence" and disagreed that it should perform audits of high-risk diagnoses or enhance its compliance program. After reviewing Healthfirst's comments, we maintain that our findings and recommendations are valid. No statutory authority limits our use of extrapolation to estimate a recovery and we correctly applied Federal requirements underlying the MA program.