DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

DEC 21 2005

Report Number: A-04-05-06007

Todd Farha
Chief Executive Officer
WellCare of Florida, Inc.
P.O. Box 26011
Tampa, Florida 33623-6011

Dear Mr. Farha:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "2004 Adjusted Community Rate Proposal Modifications Submitted as a Result of the Medicare Prescription Drug, Improvement, and Modernization Act." Should you have any questions or comments concerning the matters discussed in this report, please direct them to the HHS official named below.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5). As such, within 10 business days after the final report is issued, it will be posted on the World Wide Web at http://oig.hhs.gov.

To facilitate identification, please refer to report number A-04-05-06007 in all correspondence.

Sincerely,

Lori S. Pilcher
Regional Inspector General
for Audit Services, Region IV

Enclosures

Direct Reply to HHS Action Official:

Cynthia Moreno, Director
Medicare Plan Accountability Group
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard, C4-21-14
Baltimore, Maryland 21244-1850

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

2004 ADJUSTED COMMUNITY RATE PROPOSAL MODIFICATIONS SUBMITTED AS A RESULT OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT

Daniel R. Levinson
Inspector General

DECEMBER 2005
A-04-05-06007

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid Fraud Control Units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 (Public Law 105-33) established Part C of the Medicare program offering beneficiaries a variety of health delivery models including Medicare+Choice organizations. These organizations assume responsibility for providing all Medicare-covered services, except hospice care, in return for a predetermined capitation payment.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) revised Medicare Part C, including a program name change from Medicare+Choice to Medicare Advantage (MA). One immediate provision of the MMA increased payment rates to Medicare Advantage organizations (MAOs) in March 2004. MMA required MAOs with plans for which payment rates increased as a result of MMA to submit revised adjusted community rate (ACR) proposals to show how they would use the increase during contract year 2004. MAOs had to use the increase to:[1]

- reduce beneficiary premiums,
- reduce beneficiary cost sharing,
- enhance benefits,
- contribute to a benefit stabilization fund, or
- stabilize or enhance beneficiary access to providers.

Additionally, MMA allowed MAOs to offer exclusive Medicare discount drug cards as a benefit to MAO plan members. Federal regulations (42 CFR § 422.310 (c)(5)) require that MAO proposal rates be supported.

WellCare of Florida, Inc. (WellCare, formerly Well Care HMO) submitted a revised proposal for contract year 2004 that reflected an increase of approximately $2.6 million in Medicare capitation payments that were provided by the MMA legislation. WellCare planned to use the $2.6 million increase in capitation payments to reduce beneficiary cost sharing, enhance benefits, and cover the administrative costs of a Medicare discount drug card benefit.

OBJECTIVE

The objective of our review was to determine whether WellCare's use of its MMA payment increase was adequately supported and allowable under MMA.

[1]Section 211 of the MMA, and section 604 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 are incorporated by reference.

SUMMARY OF FINDINGS

WellCare appropriately used the MMA payment increase to reduce beneficiary cost sharing for basic radiology services, to enhance over-the-counter drug benefits, to stabilize beneficiary access to providers through increased provider payments, and to cover the administrative costs of offering exclusive Medicare discount drug cards to plan members. WellCare's use of its increased MMA payments was adequately supported and allowable. Therefore, we are not making any recommendations.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Advantage

Under Title XVIII of the Social Security Act, the Medicare program provides health insurance to Americans age 65 and over, those who have permanent kidney failure, and certain people with disabilities. Within the Department of Health and Human Services, the Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS).

The Balanced Budget Act of 1997 (Public Law 105-33) established Part C of the Medicare program offering beneficiaries a variety of health delivery models including Medicare+Choice organizations. These organizations assume responsibility for providing all Medicare-covered services, except hospice care, in return for a predetermined capitation payment.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) revised Medicare Part C, including a program name change from Medicare+Choice to Medicare Advantage (MA).

Proposal Requirements

At the time of our review, Medicare regulations required each Medicare Advantage organization (MAO) participating in the Medicare Advantage program to complete, for each plan, an annual adjusted community rate (ACR) proposal that contains specific information about benefits and cost sharing. MAOs had to submit their ACR proposals to CMS before the beginning of each contract period.

CMS used the annual ACR proposals to estimate the average rate each MAO would receive per person per month. CMS also used the ACR proposals to determine whether the estimated capitation paid to each MAO exceeded what the MAO would charge in the commercial market for Medicare-covered services, adjusted for the utilization patterns of the Medicare population. MAOs had to use any excess to:[1]

- reduce beneficiary premiums,
- reduce beneficiary cost sharing,
- enhance benefits,
- contribute to a benefit stabilization fund, or
- stabilize or enhance beneficiary access to providers.

[1]Section 211 of the MMA, and section 604 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 are incorporated by reference.

Additionally, MMA allowed MAOs to offer exclusive Medicare discount drug cards as a benefit to MAO plan members. Because MAOs do not incur direct medical expenses for the card, CMS allowed MAOs to include in the ACR proposals the administrative costs related to any discount card enrollment up to $2.50 per member per month (PMPM). Federal regulations (42 CFR § 422.310 (c)(5)) require that MAO proposal rates be supported.

MMA Requirements

Under MMA, one immediate provision increased payment rates to MAOs in March 2004. The CMS instructions required MAOs with plans that had payment rate increases to submit revised proposals by January 30, 2004. The CMS instructions for the revised proposals required MAOs to submit (1) a cover letter summarizing how they would use the increased payments and (2) supporting documentation for changes to the original filing.

WellCare's Revised Proposal

For contract year 2004, WellCare of Florida, Inc. (WellCare), an MAO, submitted the required revised proposal for contract number H1032, plan 002. The revised proposal reflected a $2.6 million increase in Medicare capitation payments, or $35.93 PMPM. WellCare planned to use the $2.6 million increase in capitation payments to reduce beneficiary cost sharing, enhance benefits, and cover the administrative costs of an exclusive Medicare discount drug card benefit.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether WellCare's use of its MMA payment increase was adequately supported and allowable under MMA.

Scope

Our review covered the $2.6 million estimated increase in contract year 2004 capitation payments for plan 002.

Our audit objective did not require us to review the internal control structure of WellCare.

We conducted our audit work at WellCare's central office in Tampa, FL.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- reviewed the cover letter WellCare submitted with its revised proposal, in which it stated how it would use the MMA payment increase;

- compared the initial proposal with the revised proposal to determine the modifications;
- reviewed the supporting documentation for the proposed use of the MMA payment increase;
- reviewed the supporting documentation for the actual use of the MMA payment increase; and
- interviewed WellCare officials.

We performed our review in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

WellCare appropriately used the MMA payment increase to reduce beneficiary cost sharing for basic radiology services, to enhance over-the-counter drug benefits, to stabilize beneficiary access to providers through increased provider payments, and to cover the administrative costs of offering exclusive Medicare discount drug cards to plan members. WellCare's use of its increased MMA payments was adequately supported and allowable. Therefore, we are not making any recommendations.