DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

July 12, 2010

Report Number: A-05-09-00019

Vinod Mohan
Vice President and Chief Financial Officer, Consumer Business
Community Insurance Company
1 WellPoint Way
Thousand Oaks, CA 91362

Dear Ms. Mohan:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Institutional Medicare Beneficiaries' Minimum Data Set Classification for Community Insurance Company (Contract Number H3655, Plan 13) for Calendar Year 2008*. We will forward a copy of this report to the HHS action official noted below.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-05-09-00019 in all correspondence.

Sincerely,

/James C. Cox/
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Timothy B. Hill, Deputy Director
Centers for Drug and Health Plan Choice (CPC)
Centers for Medicare & Medicaid Services
Mail Stop C5-19-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INSTITUTIONAL MEDICARE BENEFICIARIES' MINIMUM DATA SET CLASSIFICATION FOR COMMUNITY INSURANCE COMPANY (CONTRACT NUMBER H3655, PLAN 13) FOR CALENDAR YEAR 2008

Daniel R. Levinson
Inspector General

July 2010
A-05-09-00019

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

INTRODUCTION

BACKGROUND

Medicare Program

Under the Medicare Advantage (MA) Program, the Centers for Medicare & Medicaid Services (CMS) makes monthly capitated payments to Medicare Advantage (MA) organizations for beneficiaries enrolled in the organizations' health care plans.

Payments to Medicare Advantage Organizations

For capitated payments to MA organizations, CMS uses a risk adjustment approach with separate models for long-term institutional beneficiaries and beneficiaries residing in the community. Separate models were necessary because there are significant cost differences between the traditional community-based MA beneficiary population and the long-term institutional beneficiary with the same disease profile. An adjustment for the place of residence improves the payment accuracy of risk adjustment. Federal regulations (42 CFR § 422.2) define institutionalized, for the purpose of defining a special needs individual, as an MA eligible individual who continuously resides or is expected to continuously reside for 90 days or longer in a long-term care facility such as a skill nursing facility (SNF). A community resident MA enrollee is a beneficiary who generally resides in the community such as his/her home or in an institution for less than 90 days.

Skilled Nursing Facility Institutional Reporting

Sections 1819 and 1919 of the Social Security Act (the Act) and implementing regulations (42 CFR § 483.20) provide that SNFs participating in Medicare and Medicaid must assess the clinical and functional status of residents and submit assessment records to States for inclusion in the CMS national Minimum Data Set (MDS) Repository.

Once SNFs complete and send assessments to the States, CMS uses this MDS data to identify resident status. Once beneficiaries are identified as institutionalized, they remain in long-term institutional status until discharged home for more than 14 days. Depending on the resident status, CMS uses the appropriate institutionalized or community payment rate. The accuracy and completeness of the assessment data determines the correct MA payment rate.

Community Insurance Company

Community Insurance Company (Community), an organization located in Mason, Ohio, entered into contract number H3655 with CMS as a health maintenance organization. Our audit covered Plan 13 under the contract. In Plan 13, 929 unique Medicare beneficiaries were identified as having institutional status during the period January 1, 2008, through December 31, 2008. Community was paid $9,717,731 for the 929 unique Medicare beneficiaries.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether beneficiaries, for which Community received Medicare capitated payments using the long-term institutional resident's model, were correctly classified as institutional.

Scope

We reviewed a sample of 100 institutionalized Medicare beneficiaries in which Community received Medicare capitated payments totaling $1,397,822 during our audit period of January 1, 2008, through December 31, 2008. We limited our scope to reviewing MDS documentation in determining whether beneficiaries were correctly classified as institutional and did not review Medicare beneficiaries' risk scores used in calculating CMS payments to Community.

We conducted our fieldwork at 81 SNFs located in Ohio from November 2009, through February 2010.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and guidelines,
- held discussions with Community officials to obtain an understanding of its policies and procedures for institutional reporting,
- held discussions with State of Ohio MDS officials to gain an understanding of MDS reporting,
- identified 929 institutionalized Medicare beneficiaries from Community's H3655 Plan 13 and selected a random sample of 100 beneficiaries,
- reviewed MDS data provided by CMS for the 100 sampled beneficiaries, and
- visited nursing homes for the sampled beneficiaries and reviewed MDS documentation to determine if the beneficiary met Federal criteria to be correctly classified as institutional.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

RESULTS OF AUDIT

We determined that beneficiaries reviewed were correctly classified as institutional during our audit period of January 1, 2008, through December 31, 2008. As a result, this report contains no recommendations.