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

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

October 14, 2011

Report Number: A-05-11-00086

Mr. Blair W. Todt
Senior Vice President and Chief Compliance Officer
WellCare Health Plans, Inc.
8735 Henderson Road
Renaissance One, Third Floor
Tampa, FL 33634

Dear Mr. Todt:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Institutional Medicare Beneficiaries' Minimum Data Set Classification for Harmony Health Plan of Illinois, Inc. (Contract Number H1416) for Calendar Year 2008*. We will forward a copy of this report to the HHS action official noted on the next page.

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-05-11-00086 in all correspondence.

Sincerely,

/Sheri L. Fulcher/
Regional Inspector General
for Audit Services

Enclosure

cc:

Mr. Christopher Price
Director Compliance Audit and Monitoring
WellCare Health Plans, Inc.
8735 Henderson Road
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Tampa, FL 33634

HHS Action Official:

Timothy B. Hill, Deputy Director
Centers for Drug and Health Plan Choice (CPC)
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INSTITUTIONAL MEDICARE BENEFICIARIES' MINIMUM DATA SET CLASSIFICATION FOR HARMONY HEALTH PLAN OF ILLINOIS, INC. (CONTRACT NUMBER H1416) FOR CALENDAR YEAR 2008

Daniel R. Levinson
Inspector General

October 2011
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Office of Inspector General

http://oig.hhs.gov

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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.

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 Advantage 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 are 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 regulation (42 CFR § 422.2) defines 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 skilled nursing facility (SNF) or nursing facility (NF). A community resident MA enrollee is a beneficiary who generally resides in the community such as his/her home, an assisted living facility, or in an institution for less than 90 days.

Skilled Nursing Facility and Nursing Facility Institutional Reporting

Sections 1819 and 1919 of the Social Security Act (the Act) and implementing regulation (42 CFR § 483.20) provide that SNFs and NFs 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 and NFs complete and send assessments to the States, CMS uses this MDS data to identify resident status and determine an appropriate payment. 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.

Harmony Health Plan of Illinois, Inc.

Harmony Health Plan of Illinois, Inc. (Harmony), a wholly-owned indirect subsidiary of WellCare Health Plans, Inc., an organization headquartered in Tampa, Florida, entered into contract number H1416 with CMS as a point-of-service health maintenance organization. Our audit covered all plans under the contract that identified 62 unique Medicare beneficiaries as having institutional status during the period January 1, 2008, through December 31, 2008. During this period, CMS paid Harmony $873,329 for these 62 unique Medicare beneficiaries.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether all 62 beneficiaries, for which Harmony received Medicare capitated payments using the long-term institutional resident's model, were correctly classified as institutional.

Scope

We reviewed all 62 institutionalized Medicare beneficiaries for which Harmony received Medicare capitated payments totaling $873,329 during our audit period of January 1, 2008, through December 31, 2008. We limited our scope to reviewing MDS documentation and other nursing home documentation in determining whether beneficiaries were correctly classified as institutional and did not review Medicare beneficiaries' risk scores used in calculating CMS payments to Harmony.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and guidelines,
- held discussions with Harmony officials to obtain an understanding of its policies and procedures for institutional reporting,
- held discussions with State of Illinois MDS officials to gain an understanding of MDS reporting,
- identified all 62 institutionalized Medicare beneficiaries from Harmony's contract number H1416,
- reviewed MDS data provided by CMS for the 62 beneficiaries, and
- visited nursing homes for the 62 beneficiaries and reviewed MDS documentation to determine if the beneficiaries 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 all 62 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.