

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.

For this audit, we reviewed one MA organization, WellCare of Florida, Inc. (WellCare), and focused on seven groups of high-risk diagnosis codes.

Our objective was to determine whether selected diagnosis codes that WellCare submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 250 unique enrollee-years with the high-risk diagnosis codes for which WellCare received higher payments for 2015 through 2016, respectively. We limited our audit to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled \$689,234.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That WellCare of Florida, Inc., (Contract H1032) 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 WellCare submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 97 of the 250 sampled enrollee-years, the medical records supported the diagnosis codes that WellCare submitted to CMS. However, for the remaining 153 enrollee-years, the diagnosis codes were not supported in the medical records and resulted in net overpayments of \$410,110. These errors occurred because the policies and procedures that WellCare had to prevent, 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 WellCare received at least \$3.5 million of net overpayments in 2015 and 2016.

What OIG Recommends and WellCare Comments

We recommend that WellCare: (1) refund to the Federal Government the \$3.5 million of estimated net overpayments; (2) identify, for the high-risk diagnoses included 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 (3) continue its examination of existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

WellCare disagreed with some of our findings and with our first recommendation. WellCare did not agree with our findings for 4 enrollee-years identified in our draft report and did not directly address our findings for the remaining enrollee-years. WellCare also disagreed with our audit methodology and stated that we improperly implied that MA organizations are expected to assure that 100 percent of the diagnosis codes received from providers and submitted to CMS are accurate. WellCare added that it would consider our second and third recommendations to evaluate and enhance its compliance procedures. After reviewing WellCare's comments and coordinating with the independent medical review contractor, we revised the number of enrollee-years in error from 156 (in our draft report) to 153, and reduced the amount in our first recommendation from \$3.6 million to \$3.5 million, for this final report.