DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

August 8, 2005

Report Number: A-05-05-00039

Mr. Ronald W. Berry, CFO
Health Alliance Plan of Michigan
2850 W. Grand Boulevard
Detroit, Michigan 48202

Dear Mr. Berry:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General report entitled "Review of Medicare Prescription Drug, Improvement, and Modernization Act Modifications To Calendar Year 2004 Proposal." A copy of this report will be forwarded 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), Office of Inspector General reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5).

If you have any questions or comments about this report, please do not hesitate to call me at (312) 353-2618 or Frank Polasek, Audit Manager, at (312) 353-7896. Please refer to report number A-05-05-00039 in all correspondence.

Sincerely yours,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

HHS Action Official

Mr. David DuPre
Acting Regional Administrator
Centers for Medicare and Medicaid Services
Department if Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT MODIFICATIONS TO CALENDAR YEAR 2004 PROPOSAL

HEALTH ALLIANCE PLAN OF MICHIGAN DETROIT, MICHIGAN

Daniel R. Levinson
Inspector General

AUGUST 2005
A-05-05-00039

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

OIG's 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 the Department.

Office of Evaluation and Inspections

OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, Congress, and the public. The findings and recommendations contained in the inspections reports 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

OIG's 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 the Department. 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 Medicare Prescription Drug, Improvement, and Modernization Act

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

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) established the Medicare Advantage (MA) program. The MA program incorporates the Part C program and new provisions, including enhanced payment rates to Medicare Advantage Organizations (MAOs) effective March 1, 2004.

Adjusted Community Rate Proposal Requirements

The MMA requires MAOs to complete an annual Adjusted Community Rate Proposal (ACRP) for each plan in 2004 and submit it to Centers for Medicare and Medicaid Services (CMS) prior to the beginning of the contract period. CMS used the proposal to determine if the estimated capitation paid to the MAO exceeded what the MAO would charge in the commercial market for Medicare-covered services, adjusted for the utilization patterns of the Medicare population. Any excess must be used as prescribed by law, including offering additional benefits, reducing members' premiums, accepting a capitation payment reduction for the excess amount, or depositing funds into a stabilization fund administered by CMS. The ACRP is designed to ensure that Medicare beneficiaries are not overcharged for the benefit package being offered.

For 2004, MAOs were required to submit a revised ACRP by January 30, 2004. MAOs were also required to submit a cover letter containing a summary of how the increased payments would be used. The increased payment rates were effective March 1, 2004. However, MAOs received the increased payments retroactively for January and February 2004 enrollment.

Health Alliance Plan of Michigan

Health Alliance Plan of Michigan was established in 1956 and is a subsidiary corporation of the Henry Ford Health System. The Henry Ford Health System is a Michigan not-for-profit corporation. CMS contracted with Health Alliance as an M+C organization to provide health care coverage to approximately 15,500 Medicare enrollees during our audit period.

OBJECTIVE

The objective of our review was to determine whether the Health Alliance's use of its MMA payment increases was adequately supported and allowable under the Act.

RESULTS OF REVIEW

Section 211 of MMA (and section 604 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 incorporated by reference) allows MAOs to use the MMA payment increases to:

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

Additionally, Federal regulations at 42 CFR § 422.310(c)(5) require that ACR payment rates are supported.

We determined that the increased MMA payments were used to enhance beneficiary access to providers and to increase the drug benefits. With MMA funds provided by Health Alliance, Henry Ford enhanced beneficiary access by opening up seven new sites and enrollment increased by approximately 3,000 new Medicare members for 2004. Additionally, the drug coverage limit was increased from $200 to $400 for 2004. Therefore, this report contains no recommendations for corrective action.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Overview

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).

Medicare includes two related health insurance programs; hospital insurance, or Part A, and supplemental medical insurance, or Part B. Part A includes inpatient hospital, skilled nursing facility, home health, and hospice services. Part B includes physician services, outpatient hospital services, medical equipment, and supplies.

The Medicare Prescription Drug, Improvement, and Modernization Act

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

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) established the Medicare Advantage (MA) program. The MA program incorporates the Part C program and new provisions, including enhanced payment rates to Medicare Advantage Organizations (MAOs) effective March 1, 2004.

Adjusted Community Rate Proposal Requirements

The MMA requires MAOs to complete an annual Adjusted Community Rate Proposal (ACRP) for each plan in 2004 and submit it to Centers for Medicare and Medicaid Services (CMS) prior to the beginning of the contract period. CMS used the proposal to determine if the estimated capitation paid to the MAO exceeded what the MAO would charge in the commercial market for Medicare-covered services, adjusted for the utilization patterns of the Medicare population. Any excess must be used as prescribed by law, including offering additional benefits, reducing members' premiums, accepting a capitation payment reduction for the excess amount, or depositing funds into a stabilization fund administered by CMS. The ACRP is designed to ensure that Medicare beneficiaries are not overcharged for the benefit package being offered.

For 2004, MAOs were required to submit a revised ACRP by January 30, 2004. MAOs were also required to submit a cover letter containing a summary of how the increased payments would be used. The increased payment rates were effective March 1, 2004. However, MAOs received the increased payments retroactively for January and February 2004 enrollment.

Health Alliance Plan of Michigan

Health Alliance Plan of Michigan was established in 1956 and is a subsidiary of the Henry Ford Health System. The Henry Ford Health System is a Michigan not-for-profit corporation. CMS contracted with Health Alliance as an M+C organization to provide health care coverage to approximately 15,500 Medicare enrollees during our audit period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether Health Alliance's use of its MMA payment increases was adequately supported and allowable under the Act.

Scope

Our review covered Health Alliance's ACRP for 2004. Our objective did not require us to review the internal control structure of Health Alliance Plan. We conducted our fieldwork from May through July 2005 at Health Alliance's office in Detroit, MI.

Methodology

To accomplish our objective, we:

- reviewed Federal regulations, policies, and procedures relevant to MMA requirements;
- consulted with CMS officials to understand CMS's instruction for the M+C program;
- reviewed the cover letters submitted by Health Alliances;
- reviewed the supporting documentation for the revised average payment rate; and
- interviewed Health Alliance's staff.

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

RESULTS OF REVIEW

Section 211 of MMA (and section 604 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 incorporated by reference) allows MAOs to use the MMA payment increases to:

- reduce beneficiary premiums,

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

Additionally, Federal regulations at 42 CFR § 422.310(c)(5) require that ACR payment rates are supported.

We determined that the increased MMA payments were used to enhance beneficiary access to providers and to increase the drug benefits. With MMA funds provided by Health Alliance, Henry Ford enhanced beneficiary access by opening up seven new sites and enrollment increased by approximately 3,000 new Medicare members for 2004. Additionally, the drug coverage limit was increased from $200 to $400 for 2004. Therefore, this report contains no recommendations for corrective action.