



Office of Audit Services, Region III
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December 22, 2005

Report Number: A-03-05-00011

Jeff Saeger, Director of Finance
HealthAmerica Pennsylvania, Inc.
3721 TecPort Drive
P.O. Box 67103
Harrisburg PA 17106-7103

Dear Mr. Saeger:

Enclosed are two copies of the 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 for HealthAmerica Inc., Harrisburg, Pennsylvania." Should you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS official named below.

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Should you have any questions or comments concerning the matters commented in this report, please do not hesitate to call me at (215) 861-4470 or your staff may contact Bernard Siegel, audit manager, at (215) 861-4484 or through e-mail at bernard.siegel@oig.hhs.gov. Please refer to report number A-03-05-00011 in all correspondence.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky".

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures
Copy: Pauline Degenfelder

Direct Reply to HHS Action Official

Nancy B. O'Connor
Regional Administrator Region III
Centers for Medicare & Medicaid Services
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Philadelphia, Pennsylvania 19106-3499

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**

**HEALTHAMERICA, INCORPORATED
HARRISBURG, PENNSYLVANIA**



**Daniel R. Levinson
Inspector General**

**DECEMBER 2005
A-03-05-00011**

Office of Inspector General

<http://oig.hhs.gov>

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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, for which they receive a pre-established amount, called a capitation payment, for each enrolled beneficiary.

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 provision of the MMA increased capitation payments to Medicare Advantage Organizations (MAOs) beginning March 1, 2004.

For plans with increased capitation payments, MMA required MAOs to submit revised proposals by January 30, 2004, identifying how they would use the increased payments during contract year 2004. HealthAmerica Pennsylvania Incorporated (Health America) submitted a revised proposal for plan 001 that reflected an increase in Medicare capitation payments of \$6.3 million, or \$36.22 per member per month, as provided by the MMA legislation.

OBJECTIVE

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

RESULTS OF REVIEW

Section 211 of MMA (and section 604 of the Medicare, Medicaid, and State Children's Health Insurance Program 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.

The Centers for Medicare & Medicaid Services (CMS) provided instructions to implement the provisions of MMA. These instructions allowed MAOs to make the following proposal changes not related to MMA:

- update 2004 cost projections,
- update demographic and enrollment projections, or
- correct errors in previously approved proposals.

Additionally, Federal regulations (42 CFR § 422.310(c)(5)) require that MAO proposal rates be supported.

HealthAmerica proposed to use the increased capitation payments provided under MMA to reduce beneficiary premiums, reduce beneficiary cost sharing, and stabilize beneficiary access to providers. HealthAmerica reduced the enrolled beneficiary premium from \$58 to \$50 and eliminated the \$100 beneficiary copayment for inpatient stays. By eliminating the beneficiary copayment for inpatient stays, plan officials anticipated that increased use of inpatient services would eventually result in increased payments to providers. HealthAmerica classified this potential increase in payments as “stabilizing beneficiary access to providers,” but CMS defined stabilizing beneficiary access to providers as “retaining providers in the MAO’s network.”

Consequently, HealthAmerica did not stabilize beneficiary access to providers by directly increasing provider payments in order to retain those providers in the MAO’s network. Alternately, HealthAmerica eliminated the beneficiary copayment in order to increase inpatient services. HealthAmerica increased payments to providers only after inpatient services increased.

Although we disagree with HealthAmerica’s definition of stabilizing beneficiary access to providers by “increasing provider payments,” CMS instructions do allow cost projection updates as allowable non-MMA modifications. Therefore, this report contains no recommendations for corrective action.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Program.....	1
Proposal Requirements	1
Medicare Prescription Drug, Improvement, and Modernization Act Requirements	1
HealthAmerica’s Revised Proposal	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	2
RESULTS OF REVIEW	3

INTRODUCTION

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act established Medicare as a broad health insurance program that covers persons 65 years of age and older, along with those under 65 who are disabled or who have end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare includes two health insurance programs: hospital insurance (Part A) and supplemental hospital insurance (Part B). Part A includes inpatient hospital, skilled nursing, home health and hospice services. Part B includes physician and outpatient hospital services, and medical equipment and supplies.

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, for which they receive a pre-established amount, called a capitation payment, for each enrolled beneficiary.

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

Proposal Requirements

At the time of our review, Medicare regulations required Medicare Advantage Organizations (MAO) to complete an annual adjusted community rate proposal (proposal) for each plan participating in the Medicare Advantage program. Each MAO included specific information about benefits and cost sharing in its proposals and submitted them to CMS before each contract period. CMS used the proposals to determine if the capitation payment would exceed the MAOs' commercial charge for Medicare-covered services. The proposal process ensured that MAOs used excess capitation payments as prescribed by law and did not overcharge Medicare beneficiaries for the offered benefit package. Allowed uses include offering additional benefits, reducing members' premiums, accepting a capitation payment reduction for the excess amount, or depositing funds in a stabilization fund administered by CMS.

Medicare Prescription Drug, Improvement, and Modernization Act Requirements

Beginning March 1, 2004, MMA increased capitation payments to MAOs. For plans with increased capitation payments, MMA required MAOs to submit revised proposals, identifying how they would use the increased payments during contract year 2004. CMS required that the revised proposal include: (1) a cover letter summarizing how the MAO would use the increased payments and (2) a schedule supporting each change to the original proposal.

HealthAmerica's Revised Proposal

For contract year 2004, the HealthAmerica Pennsylvania Incorporated (HealthAmerica) plan submitted the required revised proposals for contract number H3959. The cover letter for the revised proposal for plan 001 reflected an increase in Medicare capitation payments of \$6.3 million, or \$36.22 per member per month (PMPM).

The cover letter stated that plan 001 for HealthAmerica would use the increased capitation payment allowed by MMA to:

- reduce beneficiary premiums by \$6.42 PMPM,
- reduce beneficiary cost sharing by \$4.84 PMPM, and
- stabilize beneficiary access to providers by \$24.96 PMPM.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our review covered the \$6.3 million increase in capitation payments provided by MMA for contract year 2004 for plan 001.

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

We performed this review at HealthAmerica in Harrisburg, PA, from June to July 2005.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance,
- reviewed the cover letter HealthAmerica submitted with its revised proposal,
- compared the initial proposal with the revised proposal to determine the modifications,
- reviewed the supporting documentation for the proposed and actual use of the MMA payment increase, and
- interviewed HealthAmerica officials.

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

RESULTS OF REVIEW

Section 211 of MMA (and section 604 of the Medicare, Medicaid, and State Children's Health Insurance Program 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.

CMS provided instructions to implement the provisions of MMA. These instructions allowed MAOs to make the following proposal changes not related to MMA:

- update 2004 cost projections,
- update demographic and enrollment projections, or
- correct errors in previously approved proposals.

Additionally, Federal regulations (42 CFR § 422.310(c)(5)) require that MAO adequately support rates submitted to CMS in the proposal.

HealthAmerica proposed to use the increased capitation payments provided under MMA to reduce beneficiary premiums, reduce beneficiary cost sharing, and stabilize beneficiary access to providers. HealthAmerica reduced the enrolled beneficiary premium from \$58 to \$50 and eliminated the \$100 beneficiary copayment for inpatient stays. By eliminating the beneficiary copayment for inpatient stays, plan officials anticipated that increased use of inpatient services would eventually result in increased payments to providers. HealthAmerica classified this potential increase in payments as "stabilizing beneficiary access to providers," but CMS defined stabilizing beneficiary access to providers as "retaining providers in the MAO's network." Consequently, HealthAmerica did not stabilize beneficiary access to providers by directly increasing provider payments in order to retain those providers in the MAO's network. Alternately, HealthAmerica eliminated the beneficiary copayment in order to increase inpatient services. HealthAmerica increased payments to providers only after inpatient services increased.

Although we disagree with HealthAmerica's definition of stabilizing beneficiary access to providers by "increasing provider payments," CMS instructions do allow cost projection updates as allowable non-MMA modifications. Therefore, this report contains no recommendations for corrective action.

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.