DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Report Number: A-09-05-00056

Mr. Steve Lynch
President
Regional Health Plan of Oregon and California
Health Net, Inc.
21281 Burbank Boulevard, CA-900-03-01
Woodland Hills, California 91367

Dear Mr. Lynch:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General final report entitled "Review of Health Net of California's Modifications to Its 2004 Adjusted Community Rate Proposal Under the Medicare Prescription Drug, Improvement, and Modernization Act." If you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS action 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 are made available to members of the public to the extent information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-09-05-00056 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Cynthia E. Moreno
Director, Medicare Plan Accountability Group
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop C4-23-07
Baltimore, Maryland 21244-1850

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HEALTH NET OF CALIFORNIA'S MODIFICATIONS TO ITS 2004 ADJUSTED COMMUNITY RATE PROPOSAL UNDER THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT

Daniel R. Levinson
Inspector General

NOVEMBER 2005
A-09-05-00056

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

The 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 HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections 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

The 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 HHS. 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

Under Part C of the Medicare program, Medicare Advantage organizations (MAOs) are responsible 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) of 2003 provided increased capitation payments to MAOs effective March 1, 2004.

The MMA required MAOs with plans for which payment rates increased to submit revised adjusted community rate proposals (proposals) to show how they would use the increase during contract year 2004. Health Net of California, Inc. (Health Net) submitted a revised proposal for contract year 2004 that reflected an increase in Medicare capitation payments of $5.6 million.

Section 211 of the MMA 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 (42 CFR § 422.310(c)(5)) require that the proposed payment rates be supported.

OBJECTIVE

Our objective was to determine whether Health Net's use of its MMA payment increase was allowable and adequately supported under the MMA.

SUMMARY OF RESULTS

Health Net's use of its MMA payment increase of $5.6 million (or $42.88 per-member per-month) was allowable and adequately supported under the MMA. Specifically, Health Net used the increased MMA payments to reduce beneficiary cost sharing, enhance benefits, and stabilize beneficiary access to providers. Therefore, we are not making any recommendations to Health Net.

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 & Medicaid Services (CMS).

The Balanced Budget Act of 1997 (Public Law 105-33) established Part C of the Medicare program. Part C offered beneficiaries a variety of health delivery models, including Medicare+Choice organizations. These organizations assumed 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) of 2003 revised Part C, including changing the name Medicare+Choice to Medicare Advantage.

Proposal Requirements

At the time of our review, Medicare regulations required each Medicare Advantage organization (MAO) participating in the Medicare Advantage program to complete, for each plan, an annual adjusted community rate proposal (proposal) that contained specific information about benefits and cost sharing. The MAO had to submit the proposal to CMS before the beginning of each 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. MAOs had to use any excess as prescribed by law, including 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. The proposal process was designed to ensure that Medicare beneficiaries were not overcharged for the benefit package being offered.

MMA Requirements

The MMA provided increased capitation payments to MAOs effective March 1, 2004. The MMA required MAOs with plans whose payment rates increased to submit revised proposals by January 30, 2004, to show how they would use the increase during contract year 2004. The CMS instructions for the revised proposals required MAOs to (1) submit a cover letter summarizing how they would use the increased payments and (2) support entries that changed from the original filing.

Section 211 of the MMA 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 (42 CFR § 422.310(c)(5)) require that the proposed payment rates be supported.

Health Net's Revised Proposal

For contract year 2004, Health Net of California, Inc. (Health Net) submitted the required revised proposal for contract number H0562, plan 002. The revised proposal's cover letter reflected an increase in Medicare capitation payments provided by the MMA legislation of $5.6 million, or $42.88 per member per month (PMPM).

The cover letter stated that Health Net would use the MMA payment increase to:

- reduce member cost sharing,
- enhance benefits, and
- stabilize or enhance beneficiary access to providers.

Health Net began its operations in 1979 and is one of the largest health care networks in California. CMS contracted with Health Net as a MAO to provide health care coverage to approximately 13,000 Medicare enrollees during our audit period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Health Net's use of its MMA payment increase was allowable and adequately supported under the MMA.

Scope

Our review covered the $5.6 million increase in contract year 2004 Medicare capitation payments provided by the MMA legislation for contract number H0562, plan 002.

Our objective did not require us to review the internal control structure of Health Net.

We conducted our review from June through October 2005 and performed fieldwork at Health Net's office in Woodland Hills, CA.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the cover letter that Health Net submitted with its revised proposal, in which it stated how it would use the MMA payment increase;
- compared the initial proposal with the revised proposal to determine the modifications;
- reviewed the supporting documentation for the proposed use and actual use of the MMA payment increase; and
- interviewed Health Net officials.

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

RESULTS OF REVIEW

Health Net's use of its MMA payment increase of $5.6 million (or $42.88 PMPM) was allowable and adequately supported under the MMA. Specifically, Health Net used the increased MMA payments to reduce beneficiary cost sharing, enhance benefits, and stabilize beneficiary access to providers.

Of the $42.88 PMPM increase, Health Net used:

- $10.64 to reduce the beneficiary cost sharing,
- $13.45 to enhance benefits, by adding a drug discount card and nursing hotline and increasing the annual drug coverage limit from $500 to $750; and
- $18.79 to stabilize beneficiary access to providers.

Therefore, we are not making any recommendations to Health Net.