DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 25 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Ochsner Health Plan of Louisiana's Adjusted Community Rate Proposal Modifications for Contract Year 2004 (A-06-06-00093)

Attached is an advance copy of our final report on Ochsner Health Plan of Louisiana's (Ochsner) Adjusted Community Rate Proposal modifications for contract year 2004. We will issue this report to Humana, Inc. (Humana), which acquired Ochsner, within 5 business days.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. No. 108-173) (117 Stat. 2066) increased capitation payment rates to Medicare Advantage organizations (MAO) under Medicare Part C beginning March 2004. The Centers for Medicare & Medicaid Services (CMS) required MAOs to submit revised adjusted community rate proposals (proposals) showing how they planned to use the increased payments and documentation supporting changes in the original filings for contract year 2004. Ochsner submitted revised proposals that reflected an estimated increase in capitation payments totaling about $41 million, or $112.52 per member per month (PMPM), for three of its plans. Ochsner proposed to use the additional funding to reduce premiums and cost sharing, enhance benefits, stabilize or enhance beneficiary access to providers, update cost projections, and correct a cost-sharing error.

Our objective was to determine whether Ochsner's proposed uses of its MMA payment increase were adequately supported and allowable under the MMA and CMS guidance.

Ochsner's proposed uses of approximately $36 million of the $41 million estimated MMA payment increase in contract year 2004 for three plans were supported and allowable under the MMA. However, Ochsner's proposed uses of $4,664,482 for plan number 006 were not allowable because, contrary to CMS instructions, these funds related to mandatory supplemental benefits. In addition, because of a clerical error, Ochsner overstated by an estimated $94,901 ($0.33 PMPM) its proposed use of the payment increase to enhance benefits for plan number 001.

We recommend that Ochsner follow CMS instructions and guidance when preparing future proposals (now referred to as "bids") and ensure that amounts included in the proposals are allowable.

In written comments on our draft report, Humana did not agree that Ochsner's proposed uses of $4,664,482 of the MMA payment increase for mandatory supplemental benefits were unallowable. Humana did not address our finding that Ochsner overstated proposed enhanced benefits by $94,901. Because Humana believed that Ochsner followed CMS guidance in preparing its revised proposal, Humana did not agree with our recommendation.

Humana did not provide any additional information that would cause us to change our findings or recommendation. CMS guidance provided to MAOs as "MMA Questions and Answers" stated: "The [increased capitation] payment received from CMS covers Medicare-covered and additional benefits, but not mandatory supplemental or optional supplemental benefits." Accordingly, we maintain that Ochsner proposed using $4,664,482 of the MMA payment increase for unallowable purposes.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-9206 or through e-mail at Gordon.Sato@oig.hhs.gov. Please refer to report number A-06-06-00093.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Audit Services

Region VI
1100 Commerce, Room 632
Dallas, TX 75242

JUN 30 2009

Report Number: A-06-06-00093

Ms. Karen Kline-Levine
Chief Internal Auditor
Humana Health Plan
500 West Main Street
Louisville, Kentucky 40202

Dear Ms. Kline-Levine:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Ochsner Health Plan of Louisiana's Adjusted Community Rate Proposal Modifications for Contract Year 2004." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Cheryl Blackmon, Audit Manager, at (214) 767-9205 or through e-mail at Cheryl.Blackmon@oig.hhs.gov. Please refer to report number A-06-06-00093 in all correspondence.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Mr. Jonathan Blum
Acting Director
Center for Drug and Health Plan Choice
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW.
Mail Stop C5-19-16
Washington, DC 20201

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OCHSNER HEALTH PLAN OF LOUISIANA'S ADJUSTED COMMUNITY RATE PROPOSAL MODIFICATIONS FOR CONTRACT YEAR 2004

Daniel R. Levinson
Inspector General

June 2009
A-06-06-00093

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

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.

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 (P.L. No. 105-33) established Medicare Part C, which gave beneficiaries the option of receiving Medicare benefits through private health insurers referred to as "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 of 2003 (MMA) (P.L. No. 108-173) (117 Stat. 2066) revised Medicare Part C and changed the name of the program from Medicare+Choice to Medicare Advantage.

Beneficiaries enrolled in Medicare Part C are eligible for two classes of benefits: basic and supplemental. Basic benefits include all Medicare-covered services, except hospice services, as well as additional benefits that are not covered under Medicare Part A or B. Supplemental benefits may include mandatory or optional benefits that are not covered under Medicare Part A or B. Beneficiaries may be required to pay an additional premium, as well as cost sharing, for supplemental benefits.

The MMA increased capitation payment rates to Medicare Advantage organizations (MAO) beginning March 2004. The Centers for Medicare & Medicaid Services (CMS) required MAOs to submit revised adjusted community rate proposals (proposals) showing how they planned to use the increased payments and documentation supporting changes in the original filings for contract year 2004. Ochsner Health Plan of Louisiana (Ochsner) submitted revised proposals that reflected an estimated increase in capitation payments totaling about $41 million, or $112.52 per member per month (PMPM), for three of its plans. Ochsner proposed to use the additional funding to reduce premiums and cost sharing, enhance benefits, stabilize or enhance beneficiary access to providers, update cost projections, and correct a cost-sharing error.

Humana, Inc. (Humana), acquired Ochsner on April 1, 2004.

OBJECTIVE

Our objective was to determine whether Ochsner's proposed uses of its MMA payment increase were adequately supported and allowable under the MMA and CMS guidance.

SUMMARY OF FINDINGS

Ochsner's proposed uses of approximately $36 million of the $41 million estimated MMA payment increase in contract year 2004 for three plans were supported and allowable under the MMA. However, Ochsner's proposed uses of $4,664,482 for plan number 006 were not allowable because, contrary to CMS instructions, these funds related to mandatory supplemental benefits:

- Ochsner proposed using $3,102,892 ($52 PMPM) of its estimated payment increase to reduce the mandatory supplemental benefits premium.

- Ochsner proposed using $899,839 ($15.08 PMPM) of its estimated payment increase to update the projected prescription drug costs in its original proposal. This update related to a mandatory supplemental benefit.

- Ochsner proposed using $661,751 ($11.09 PMPM) of its estimated payment increase to correct a cost-sharing error in its original proposal related to a mandatory supplemental benefit.

In addition, because of a clerical error, Ochsner overstated by an estimated $94,901 ($0.33 PMPM) its proposed use of the payment increase to enhance benefits for plan number 001.

RECOMMENDATION

We recommend that Ochsner follow CMS instructions and guidance when preparing future proposals (now referred to as "bids") and ensure that amounts included in the proposals are allowable.

HUMANA COMMENTS

In written comments on our draft report, Humana did not agree that Ochsner's proposed uses of $4,664,482 of the MMA payment increase for mandatory supplemental benefits were unallowable. Humana did not address our finding that Ochsner overstated proposed enhanced benefits by $94,901. Because Humana believed that Ochsner followed CMS guidance in preparing its revised proposal, Humana did not agree with our recommendation. Humana's comments, with the exception of the enclosures, are included as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Humana did not provide any additional information that would cause us to change our findings or recommendation. CMS guidance provided to MAOs as "MMA Questions and Answers" which CMS confirmed carried the same weight as CMS manual instructions, stated: "The [increased capitation] payment received from CMS covers Medicare-covered and additional benefits, but not mandatory supplemental or optional supplemental benefits." Accordingly, we maintain that Ochsner proposed using $4,664,482 of the MMA payment increase for unallowable purposes. We modified our recommendation to encompass the need to comply with not only instructions but also guidance on preparing proposals.

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INTRODUCTION

BACKGROUND

Medicare Program

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance to people age 65 and over, people with permanent kidney failure, and people with certain disabilities. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

The Balanced Budget Act of 1997 (P.L. No. 105-33) established Medicare Part C, which gave beneficiaries the option of receiving Medicare benefits through private health insurers referred to as "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 of 2003 (MMA) (P.L. No. 108-173) (117 Stat. 2066) revised Medicare Part C and changed the name of the program from Medicare+Choice to Medicare Advantage.

Beneficiaries enrolled in Medicare Part C are eligible for two classes of benefits: basic and supplemental. Basic benefits include all Medicare-covered services, except hospice services, as well as additional benefits that are not covered under Medicare Part A or B. Supplemental benefits may include mandatory or optional benefits that are not covered under Medicare Part A or B. Beneficiaries may be required to pay an additional premium, as well as cost sharing, for supplemental benefits.

Proposal Requirements

During our audit period, Medicare regulations (42 CFR § 422.310) required each participating Medicare Advantage organization (MAO) to complete, for each plan that it offered, an adjusted community rate proposal (proposal)[1] that contained specific information about benefits and cost sharing.[2] MAOs were required to submit their proposals to CMS before the beginning of each contract period.

CMS used the proposals to determine whether the estimated capitation payments paid to the MAOs exceeded what the MAOs would charge in the commercial market for Medicare-covered services, adjusted for the utilization patterns of the Medicare population. Pursuant to 42 CFR § 417.592(a)–(c), MAOs were required to use any such excess amounts to offer additional benefits, accept capitation payment reductions, or contribute to a benefit stabilization fund administered by CMS. The proposal process was designed to ensure that Medicare beneficiaries were not overcharged for the benefit packages that MAOs offered.

[1]As of contract year 2006, bids replaced proposals (P.L. No. 108-173, 117 Stat. 2194 (Dec. 8, 2003)).

[2]MAOs were not required to submit proposals for medical savings account plans.

Medicare Prescription Drug, Improvement, and Modernization Act Requirements

The MMA increased capitation payment rates to MAOs beginning March 2004. CMS required MAOs to submit revised proposals by January 30, 2004, and to include with their proposals a cover letter summarizing how they planned to use the increased payments and documentation supporting changes in the original filings.

Ochsner Health Plan of Louisiana

For contract year 2004, Ochsner Health Plan of Louisiana (Ochsner) submitted the required revised proposals for contract number H1951, which comprised plan numbers 001, 005, 006, and 801. We reviewed plan numbers 001, 005, and 006, for which Ochsner received an estimated MMA payment increase of about $41 million, or $112.52 per member per month (PMPM). The total monthly membership in these three plans averaged 30,347 enrollees during contract year 2004.

Ochsner's revised proposals stated that Ochsner would use the MMA payment increase to reduce beneficiary premiums, reduce beneficiary cost sharing, enhance benefits, stabilize or enhance beneficiary access to providers, update cost projections, and correct a cost-sharing error.

Humana, Inc. (Humana), acquired Ochsner on April 1, 2004. Humana was not involved in preparing Ochsner's revised proposals. Therefore, to address questions that arose during our review, Humana relied on the actuary with whom Ochsner had contracted to prepare the revised proposals. We refer to the auditee as "Ochsner" in this report.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Ochsner's proposed uses of its MMA payment increase were adequately supported and allowable under the MMA and CMS guidance.

Scope

Our review covered the estimated $41 million increase in contract year 2004 Medicare capitation payments provided by the MMA for plan numbers 001, 005, and 006. Our objective did not require us to review Ochsner's overall internal control structure.

We conducted our fieldwork at Ochsner in Metairie, Louisiana.

Methodology

To accomplish our objective, we:

- interviewed Ochsner officials;

- reviewed applicable Federal laws, regulations, and guidance;

- reviewed the cover letter that Ochsner submitted with its revised proposals;

- compared the initial proposals with the revised proposals to identify the modifications;

- reviewed supporting documentation for the proposed uses of the MMA payment increase; and

- reviewed supporting documentation for the actual uses of the MMA payment increase and verified that they were consistent with the proposed uses.

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 audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

Ochsner's proposed uses of approximately $36 million of the $41 million estimated MMA payment increase in contract year 2004 for three plans were supported and allowable under the MMA. However, Ochsner's proposed uses of $4,664,482 for plan number 006 were not allowable because, contrary to CMS instructions, these funds related to mandatory supplemental benefits:

- Ochsner proposed using $3,102,892 ($52 PMPM) of its estimated payment increase to reduce the mandatory supplemental benefits premium.

- Ochsner proposed using $899,839 ($15.08 PMPM) of its estimated payment increase to update the projected prescription drug costs in its original proposal. This update related to a mandatory supplemental benefit.

- Ochsner proposed using $661,751 ($11.09 PMPM) of its estimated payment increase to correct a cost-sharing error in its original proposal related to a mandatory supplemental benefit.

In addition, because of a clerical error, Ochsner overstated by an estimated $94,901 ($0.33 PMPM) its proposed use of the payment increase to enhance benefits for plan number 001.

FEDERAL REQUIREMENTS

Section 211(i) of the MMA applied section 604 of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000[3] (P.L. No. 106-

[3]This Act is known as BIPA.

554-App. F) (114 Stat. 2763A-555) to the increased capitation payments, thereby limiting MAOs to use MMA payment increases for the following purposes:

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

Chapter 4 of CMS's "Managed Care Manual" (the Manual) provides that mandatory supplemental benefits are Medicare Advantage plan benefits that are not covered under Medicare Part A or B but are available to anyone who enrolls in a Medicare Advantage plan offering mandatory supplemental benefits.[4] Chapter 8 of the Manual states that mandatory supplemental benefits are those that beneficiaries must purchase as a condition of plan enrollment and that MAOs may charge enrollees premiums, cost sharing, or both for these benefits. The instructions for revised proposals, which CMS provided to MAOs as "MMA Questions and Answers," stated: "The [increased capitation] payment received from CMS covers Medicare-covered and additional benefits, but not mandatory supplemental or optional supplemental benefits."

UNALLOWABLE PROPOSED USES OF MEDICARE PAYMENT INCREASE

Reduction of Mandatory Supplemental Benefits Premium

For plan number 006, Ochsner proposed using $3,102,892 ($52 PMPM) of the MMA payment increase to reduce the premium for mandatory supplemental benefits. This reduction was not allowable because the MMA payment increase could not be used for mandatory supplemental benefits.

Mandatory Supplemental Benefit Cost Update

The cover letter of Ochsner's revised proposal for plan number 006 stated that, since the original 2004 proposal was prepared, more recent information had become available to project the claim costs for calendar years 2003 and 2004 and to measure the value of the change in the mandatory supplemental prescription drug benefit from 2003 to 2004. This new information led Ochsner to increase costs in the revised proposal by $899,839 ($15.08 PMPM).

Ochsner's actuary said that the cost update was allowable under CMS's "Instructions for the DIMA [MMA] 2004 ACRP [proposal] Season" (the Instructions), which stated that MAOs could update cost projections in their revised proposals. However, the Instructions did not contain any explanation of the types of cost projections to which the increase could apply. CMS's "MMA

[4]All references in this report to the Manual relate to the version that was in place during our audit period.

Questions and Answers"[5] specifically prohibited the use of increased capitation payments for supplemental benefits. Accordingly, the MMA payment increase should not have been used to fund the proposed cost update because it related to a mandatory supplemental benefit.

Correction of Mandatory Supplemental Benefit Cost-Sharing Error

The cover letter of Ochsner's revised proposal for plan number 006 explained that the beneficiary cost-sharing amounts originally submitted for one of its mandatory supplemental benefits were incorrect because they exceeded the estimated cost of providing the benefit. Ochsner proposed using $661,751 ($11.09 PMPM) of its MMA payment increase to correct this error.

Ochsner's actuary said that the correction was allowable based on the Instructions, which stated that MAOs could correct errors in previously approved proposals. However, CMS's "MMA Questions and Answers" stated that the MMA payment increase did not cover supplemental benefits. Although corrections were allowable, the proposed cost-sharing correction should not have been funded by the MMA payment increase because the correction related to a mandatory supplemental benefit.

OVERSTATED BENEFIT ENHANCEMENT

In the cover letter of its revised proposal for plan number 001, Ochsner indicated that it planned to enhance certain benefits that were funded, in part, by beneficiary cost sharing. However, Ochsner's actuary did not reduce the cost of the enhanced benefits by the amount of related cost sharing when calculating the amount that the MMA payment increase would cover. According to an Ochsner official, the actuary made this clerical error when preparing the revised proposal. As a result, Ochsner overstated the amount of the MMA payment increase to be used for enhanced benefits by $94,901 ($0.33 PMPM).

RECOMMENDATION

We recommend that Ochsner follow CMS instructions and guidance when preparing future proposals (now referred to as "bids") to ensure that amounts included in the proposals are allowable.

HUMANA COMMENTS

In written comments on our draft report, Humana did not agree that Ochsner's proposed uses of $4,664,482 of the MMA payment increase for mandatory supplemental benefits were unallowable. Humana did not address our finding that Ochsner overstated proposed enhanced benefits by $94,901.

With respect to mandatory supplemental benefits, Humana stated that the Instructions did not preclude MAOs from reducing beneficiary premiums, updating costs and projections, or

[5]We confirmed with CMS that the "MMA Questions and Answers" were released through the CMS Health Plan Management System to providers and had the same weight as CMS manual instructions.

correcting errors identified in the original proposal. Because Humana believed that Ochsner followed CMS guidance in preparing its revised proposal, Humana did not agree with our recommendation.

Humana's comments, with the exception of the enclosures, are included as the Appendix. We did not include the enclosures because they contained proprietary information.

OFFICE OF INSPECTOR GENERAL RESPONSE

Humana did not provide any additional information that would cause us to change our findings or recommendation. CMS guidance provided to MAOs as "MMA Questions and Answers" which CMS confirmed carried the same weight as CMS manual instructions, stated: "The [increased capitation] payment received from CMS covers Medicare-covered and additional benefits, but not mandatory supplemental or optional supplemental benefits." Accordingly, we maintain that Ochsner proposed using $4,664,482 of the MMA payment increase for unallowable purposes. We modified our recommendation to encompass the need to comply with not only instructions but also guidance on preparing proposals.

APPENDIX

HUMANA
Guidance when you need it most

March 18, 2009

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Report Number: A-06-06-00093

Dear Mr. Sato:

Your letter of January 23, 2009, addressed to Ms. Karen Kline-Levine, regarding the draft report entitled "Ochsner Health Plan of Louisiana's Adjusted Community Rate Proposal Modifications for Contract Year 2004, has been referred to me. I am the person now responsible for coordination of audits with Federal governmental bodies. By the time this report reached me, more than 30 days had elapsed from the date of your letter. I spoke with Ms. Cheryl Blackmon of your office explaining the circumstances of the delay. She granted us an extension to March 27, 2009 to provide our response. (Copy of e-mail enclosed.)

This letter responds to the issues raised in and to the recommendation contained your draft report.

Summary of Findings

Ochsner's proposed uses of approximately $36 million of the $41 million estimated MMA payment increase in contract year 2004 for three plans were supported and allowable under MMA. However, Ochsner's proposed uses of $4,664,482 for plan number 006 were not allowable because, contrary to CMS instructions, these funds related to mandatory supplemental benefits.

Humana's General Response to the Summary of Findings

Page 8 of the DRAFT "Instructions to Medicare+Choice Organizations for the DIMA 2004 ACRP Season" dated December 11, 2003 ("the Instructions") identifies the changes that M+C organizations can make. The changes are summarized into two categories as follows:

DIMA-related changes

- Reduce beneficiary premiums
- Reduce beneficiary cost sharing
- Enhance benefits

- Contribute to a benefit stabilization fund
- Stabilize or enhance beneficiary access to providers

Not related to DIMA

- Update 2004 cost projections in Worksheet D to reflect effects from matters such as "run-out" of base period costs
- Updated demographic and enrollment projections used to calculate the average payment rate
- Correct errors in previously approved ACRP(s)

Finding 1: Ochsner proposed using $3,102,892 ($52 PMPM) of its estimated payment increase to reduce the mandatory supplemental benefits premium.

Humana's Response to Finding 1: Disagree - This item falls under the "DIMA – Related Changes" section. The Instructions for the DIMA 2004 ACR do not limit beneficiary premium reductions to basic Medicare benefits. The intent of DIMA was to allow for enhanced benefits, reduced beneficiary cost sharing and/or reduced beneficiary premiums. Since benefit enhancement could only occur through improving mandatory supplemental benefits, the parallel for a reduction in beneficiary premiums would be for those premiums attributable to mandatory supplemental benefits. This is especially the case, given that there was no beneficiary premiums associated with basic benefits in the original ACR filing. In our cover letter to CMS, which accompanied the DIMA 2004 ACR filing, the reduction in member premium of $52.00 was noted on page 7.

Finding 2: Ochsner proposed using $899,839 ($15.08 PMPM) of its estimated payment increase to update the projected prescription drug costs in its original proposal. This update related to a mandatory supplemental benefit.

Humana's Response to Finding 2: Disagree - This item falls under the "Not Related to DIMA" category. Page 9 of the Instructions discusses the update of direct medical costs and projections (i.e., prescription drug cost update). The Instructions do not preclude updating costs and projections related to mandatory supplemental benefits. In our cover letter to CMS, which accompanied the DIMA 2004 ACR filing, the Rx projected cost update of $15.08 was noted on page 7.

Finding 3: Ochsner proposed using $661,751 ($11.09 PMPM) of its estimated payment increase to correct a cost-sharing error in its original proposal related to a mandatory supplemental benefit.

Humana's Response to Finding 3: Disagree - This item also falls under the "Not Related to DIMA" category. Page 10 of the Instructions discusses the handling of corrections. The Instructions do not preclude the correction of errors related to mandatory supplemental benefits. In our cover letter to CMS, which accompanied the

DIMA 2004 ACR filing, the corrected cost sharing amount of $11.09 was noted on page 7.
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All three of the items discussed above, the Rx projected cost update ($15.08), the correction of the POS cost sharing ($11.09), and the reduction of member premium ($52.00), were specifically highlighted and discussed on Pages 6 and 7 of the cover letter. Enclosed with this response is a copy of relevant excerpts from those pages of the cover letter submitted to CMS that accompanied the DIMA 2004 ACR filing and was subsequently approved by CMS.

Recommendation: We recommend that Ochsner follow CMS instructions when preparing future proposals (now referred to as "bids") and ensure that amounts included in the proposals are allowable.

Humana's Response to Recommendation: Disagree – Implicit in this recommendation is the presumption that we did not follow DIMA instructions, with which we do not agree. Humana always strives to comply with instructions related to both bid and ACR preparation. As it relates to the above Findings, we do not agree that we haven't followed all such instructions.

Sincerely yours,

Carl B Wright, FSA, MAAA
Senior Actuarial Director

Enclosures (2)