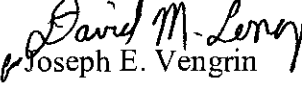




APR 22 2005

**TO:** Leslie V. Norwalk, Esq.  
Acting Director, Center for Beneficiary Choices  
Centers for Medicare & Medicaid Services

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

**SUBJECT:** Review of Regence HMO Oregon's Modifications to Its 2001 Adjusted  
Community Rate Proposal Under the Benefits Improvement and Protection Act of  
2000 (A-10-03-00011)

Attached is an advance copy of our final report on Regence HMO Oregon's (Regence) modifications to its 2001 adjusted community rate proposal (proposal) under the Benefits Improvement and Protection Act (BIPA) of 2000. We will issue this report to Regence BlueCross BlueShield of Oregon, as Regence is now known, within 5 business days. This is one of a series of reports on Medicare+Choice organizations' (MCO) use of the additional funding provided by BIPA.

Under Part C (Medicare+Choice) of the Medicare program, MCOs are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment. BIPA provided an estimated \$11 billion in increased capitation payments to MCOs effective March 1, 2001.

BIPA required MCOs with plans for which payment rates increased to submit a revised proposal to show how they would use the increase during 2001. According to section 604(c) of BIPA, MCOs were required to use the additional amounts under sections 601 and 602 to reduce beneficiary premiums or cost-sharing, enhance benefits, contribute to a stabilization fund for benefits in future years, or stabilize or enhance beneficiary access to providers.

Regence submitted a revised proposal that reflected an increase in Medicare capitation payments of about \$22.7 million for contract year 2001.

Our objectives were to determine whether Regence (1) supported the modifications to the 2001 proposal and (2) used the additional capitation payments in a manner consistent with BIPA requirements.

Of the approximate \$22.7 million capitation payment increase in Regence's revised proposal, about \$15.4 million was supported in the proposal's modifications and was used in a manner consistent with BIPA requirements. However, Regence did not provide adequate support for approximately \$6.8 million in increased payments in the proposal's modifications and we could not determine how much of the amount was used in a manner consistent with BIPA requirements. The remaining increase in payments (about

\$0.5 million) was supported in the proposal's modifications but not used in a manner consistent with BIPA requirements. Specifically, we found:

- approximately \$6.8 million of unsupported direct medical care cost increases for changes in plan membership and inflation and
- approximately \$0.5 million of direct medical care cost increases was not used to stabilize or enhance access to providers because Regence did not renegotiate its contracts to increase hospital inpatient and outpatient fees for Marion and Polk Counties to the extent indicated in its revised proposal.

We recommended that Regence work with the Centers for Medicare & Medicaid Services to determine what portion of the about \$6.8 million of unsupported direct medical care cost increases was not used in a manner consistent with BIPA requirements and refund that amount to the Federal Government. We also recommended that Regence refund about \$0.5 million to the Federal Government that was not used to stabilize or enhance access to providers, and ensure that all estimated costs in future proposals are properly supported and used in a manner consistent with Federal requirements.

In its written comments on the draft report, Regence disagreed with our findings and recommendation for a refund. Regence did not comment on our recommendation that it ensure estimated costs in future proposals are properly supported.

Regence disagreed that it did not support direct medical care cost increases for changes in plan membership and inflation. Regence also disagreed that it did not use funds in a manner consistent with BIPA requirements when renegotiating contracts for provider payments.

Where appropriate, we made changes to this final report to reflect Regence's comments to our draft report. However, we do not concur with Regence's comments that it (1) supported approximately \$6.8 million in direct medical care cost increases for changes to plan membership and inflation, and (2) used approximately \$0.5 million in a manner consistent with BIPA requirements when renegotiating contracts for provider payments. As a result, Regence understated its excess of expected revenues over expected costs. Any excess of expected revenues should have been used by Regence to reduce beneficiary premiums or cost sharing, enhance beneficiary benefits, or stabilize or enhance beneficiary access to providers. Thus, the issues noted concerning the revised proposal may have adversely impacted the Medicare beneficiaries enrolled in Regence's plan.

If you have any questions or comments about this report, please do not hesitate to call me, or have your staff call George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Lori A. Ahlstrand, Regional Inspector General for Audit Services, at (415) 437-8360. Please refer to report number A-10-03-00011 in all correspondence.

Attachment



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

APR 26 2005

Report Number: A-10-03-00011

Ms. Karen Williams  
Manager, Regulatory Review and Implementation  
Regence BlueCross BlueShield of Oregon  
P.O. Box 12625  
Salem, Oregon 97309-0625

Dear Ms. Williams:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Regence HMO Oregon's Modifications to Its 2001 Adjusted Community Rate Proposal Under the Benefits Improvement and Protection Act of 2000." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

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

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the 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-10-03-00011 in all correspondence.

Sincerely,

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

R. J. Ruff, Jr.  
Regional Administrator  
Centers for Medicare & Medicaid Services, Region X  
Department of Health and Human Services  
2201 6<sup>th</sup> Ave, MS-40, Room 911  
Seattle, Washington 98121

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF REGENCE HMO  
OREGON'S MODIFICATIONS TO ITS  
2001 ADJUSTED COMMUNITY RATE  
PROPOSAL UNDER THE BENEFITS  
IMPROVEMENT AND PROTECTION  
ACT OF 2000**



**APRIL 2005  
A-10-03-00011**

# *Office of Inspector General*

<http://oig.hhs.gov>

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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:

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The 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.

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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. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The 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*

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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 (Medicare+Choice) of the Medicare program, Medicare+Choice organizations (MCO) are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment. The Benefits Improvement and Protection Act (BIPA) of 2000 provided an estimated \$11 billion in increased capitation payments to MCOs effective March 1, 2001.

BIPA required MCOs with plans for which payment rates increased to submit a revised adjusted community rate proposal (proposal) to show how they would use the increase during 2001. Regence HMO Oregon (Regence) submitted a revised proposal that reflected an increase in Medicare capitation payments of about \$22.7 million for contract year 2001.<sup>1</sup>

### OBJECTIVES

Our objectives were to determine whether Regence (1) supported the modifications to the 2001 proposal and (2) used the additional capitation payments in a manner consistent with BIPA requirements.

### SUMMARY OF FINDINGS

Medicare regulations and Centers for Medicare & Medicaid Services (CMS) instructions, dated January 9, 2001, required MCOs to support their revised proposals. In addition, according to section 604(c) of BIPA, MCOs were required to use the additional amounts to reduce beneficiary premiums or cost sharing, enhance beneficiary benefits, contribute to a stabilization fund for benefits in future years, or stabilize or enhance beneficiary access to providers.

Of the approximate \$22.7 million capitation payment increase in Regence's revised proposal, about \$15.4 million was supported in the proposal's modifications and was used in a manner consistent with BIPA requirements. However, Regence did not provide adequate support for approximately \$6.8 million in increased payments in the proposal's modifications and we could not determine how much of the amount was used in a manner consistent with BIPA requirements. The remaining increase in payments (about \$0.5 million) was supported in the proposal's modifications but not used in a manner consistent with BIPA requirements. Specifically, we found:

- approximately \$6.8 million of unsupported direct medical care cost increases for changes in plan membership and inflation and
- approximately \$0.5 million of direct medical care cost increases was not used to stabilize or enhance access to providers because Regence did not renegotiate its contracts to increase hospital inpatient and outpatient fees for Marion and Polk Counties to the extent indicated in its revised proposal.

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<sup>1</sup>Regence HMO Oregon is now Regence BlueCross BlueShield of Oregon.



## RECOMMENDATIONS

We recommend that Regence:

- work with CMS to determine what portion of the \$6,798,287 of unsupported direct medical care cost increases was not used in a manner consistent with BIPA requirements and refund that amount to the Federal Government,
- refund \$522,327 to the Federal Government that was not used to stabilize or enhance access to providers, and
- ensure that all estimated costs in future proposals are properly supported and used in a manner consistent with Federal requirements.

## REGENGE COMMENTS

In its written comments on the draft report, Regence disagreed with our findings and recommendation for a refund.<sup>2</sup> Regence did not comment on our recommendation that it ensure estimated costs in future proposals are properly supported.

Regence disagreed that it did not support direct medical care cost increases for changes to plan membership and inflation. Regence also disagreed that it did not use funds in a manner consistent with BIPA requirements when renegotiating contracts for provider payments.

Regence's comments are included as an appendix to this report. We excluded Appendixes A, B, and C from Regence's comments because they contained proprietary data.

## OFFICE OF INSPECTOR GENERAL RESPONSE

Where appropriate, we made changes to this final report to reflect Regence's comments to our draft report. However, we do not concur with Regence's comments that it (1) supported approximately \$6.8 million in direct medical care cost increases for changes to plan membership and inflation, and (2) used approximately \$0.5 million in a manner consistent with BIPA requirements when renegotiating contracts for provider payments. As a result, Regence understated its excess of expected revenues over expected costs. Any excess of expected revenues should have been used by Regence to reduce beneficiary premiums or cost sharing, enhance beneficiary benefits, or stabilize or enhance beneficiary access to providers. Thus, the issues noted concerning the revised proposal may have adversely impacted the Medicare beneficiaries enrolled in Regence's plan.

---

<sup>2</sup>The draft report recommended a refund of \$7,719,725. Based on additional documentation provided by Regence and our further analysis, we (1) set aside for CMS determination the \$6,798,287 of unsupported direct medical care cost increases for changes in plan membership and inflation, and (2) reduced the recommended refund for renegotiated contracts from \$921,438 to \$522,327.

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## **INTRODUCTION**

### **BACKGROUND**

#### **Medicare+Choice**

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

The Balanced Budget Act of 1997 (Public Law 105-33) established Part C (Medicare+Choice) of the Medicare program, which offers Medicare beneficiaries a variety of health delivery models, including Medicare+Choice organizations (MCOs), such as health maintenance organizations, preferred provider organizations, and provider-sponsored organizations. MCOs are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment.

#### **Proposal Requirements**

Medicare regulations require each MCO participating in the Medicare+Choice program to complete, for each plan, an annual proposal that contains specific information about benefits and cost sharing. The MCO must submit the proposal to CMS before the beginning of each contract period. CMS uses the proposal to determine if the estimated capitation paid to the MCO exceeds what the MCO would charge in the commercial market for Medicare-covered services, adjusted for the utilization patterns of the Medicare population. MCOs must 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 are not overcharged for the benefit package being offered.

#### **Benefits Improvement and Protection Act Requirements**

BIPA provided for an additional \$11 billion in capitation payments to MCOs effective March 1, 2001. MCOs with plans whose payment rates increased under the Benefits Improvement and Protection Act (BIPA) of 2000 were required by BIPA to submit revised proposals by January 18, 2001, to show how they would use the increase during contract year 2001. The CMS instructions for the revised proposals, dated January 9, 2001, required MCOs to (1) submit a cover letter summarizing how they would use the increased payments and (2) support entries that changed from the original (pre-BIPA) filing.

Regence HMO Oregon (Regence) submitted the required proposals for each of its three plans under contract number H-3856.

## **OBJECTIVES, SCOPE, AND METHODOLOGY**

### **Objectives**

Our objectives were to determine whether Regence (1) supported the modifications to the 2001 proposal and (2) used the additional capitation payments in a manner consistent with BIPA requirements.

### **Scope**

Based on Regence's revised proposal for plan 010, its Medicare capitation payments increased by about \$22.7 million for contract year 2001. On a per-member-per-month basis, the revised proposal increased cost estimates for direct medical care by \$73.14 and decreased additional revenue estimates by \$3.15, for a net increase of \$69.99 per member per month.

Regence's revised proposal for plan 010 stated that it would use the additional funds to reduce member premiums by \$13 per member per month and stabilize the network by increasing payments to providers. Therefore, we focused our work on the areas of premium reduction and payment increases to providers.

We did not review the revised proposals for the remaining two plans under contract number H-3856 because the proposal modifications were immaterial in amount. For both plans, the combined capitation payment increase was less than \$320,000.

We did not assess Regence's overall internal controls; we limited our review to gaining an understanding of those controls related to the modifications to the 2001 proposal. Our fieldwork included visits to Regence's office in Portland, OR.

### **Methodology**

To accomplish our objectives, we:

- reviewed applicable Federal laws and regulations;
- reviewed the cover letter Regence submitted with its revised proposal, in which it stated how it would use the additional funds in the contract year;
- compared the initial proposal with the revised proposal to determine the modifications;
- compared the provider payment assumptions used in the initial proposal with those in the revised proposal;
- reviewed support for the revised cost projections for direct medical care;

- reviewed provider contracts in effect in 2001 to determine if Regence had renegotiated its contracts in accordance with the supporting documentation for the revised proposal;
- recalculated Regence’s provider payment projections based on the actual contract terms in effect for 2001, using Regence’s cost projection methodology;
- verified the mathematical accuracy of the plan’s cost projections for direct medical care;
- verified whether provider payment increases were used in a manner consistent with BIPA requirements;
- verified that Regence reduced member premiums by \$13 per member per month;
- interviewed Regence officials; and
- calculated the increase in 2001 Medicare capitation payments using actual membership data obtained from CMS.

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

## **FINDINGS AND RECOMMENDATIONS**

Of the approximate \$22.7 million capitation payment increase in Regence’s revised proposal, about \$15.4 million was supported in the proposal’s modifications and was used in a manner consistent with BIPA requirements.<sup>3</sup> However, Regence did not provide adequate support for approximately \$6.8 million in increased payments in the proposal’s modifications and we could not determine how much of the amount was used in a manner consistent with BIPA requirements. The remaining increase in payments (about \$0.5 million) was supported in the proposal’s modifications but not used in a manner consistent with BIPA requirements. Specifically, we found:

- approximately \$6.8 million of unsupported direct medical care cost increases for changes in plan membership and inflation and
- approximately \$0.5 million of direct medical care cost increases was not used to stabilize or enhance access to providers because Regence did not renegotiate its contracts to increase hospital inpatient and outpatient fees for Marion and Polk Counties to the extent indicated in its revised proposal.

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<sup>3</sup>About \$15.4 million was properly supported and used to reduce member premiums by \$13 per member per month and to increase provider payments for network retention and stabilization.

## **SUPPORT FOR REVISED PROPOSAL**

Medicare regulations (42 CFR § 422.502(d)) required MCOs to maintain records sufficient to accommodate periodic auditing of the data related to computations in the proposals. In addition, CMS instructions, dated January 9, 2001, for the revised proposals (1) required MCOs to support entries that changed from the original (pre-BIPA) filing and (2) allowed MCOs the option to update direct medical care cost assumptions, including trend and demographic assumptions, to the extent the changes were supported and stabilized or enhanced the MCO's provider network.

Regence did not provide adequate support for \$6,798,287 in proposed cost increases for changes in plan membership and inflation.

For changes in plan membership, Regence did not adequately support direct medical care cost increases of \$4,947,374. Regence planned to discontinue services to Medicaid beneficiaries, some of whom were eligible for services under both plan 010 and the Medicaid program (dual eligibles). In its proposal, Regence increased costs but did not adjust for an expected decrease in membership, premiums, and costs associated with dropping dual eligibles. As a result of dropping dual eligibles, total membership would have decreased, which should have been reflected in the proposal. When membership decreases, it is reasonable to expect that overall direct medical care costs decrease rather than increase as Regence proposed. Since Regence did not provide adequate support for its rationale, we cannot determine how much of the \$4,947,374 was used in a manner consistent with BIPA requirements.

In addition, Regence did not adequately support direct medical care cost increases of \$1,850,913 because it used an inflation factor twice (duplicating cost increases) in estimating the increase in provider payments. Regence had previously included the increase in a 2-year trend computation applied to direct medical care cost estimates in another section of the revised proposal.

## **USE OF BENEFIT IMPROVEMENT AND PROTECTION ACT FUNDS**

Under section 604(c) of BIPA, MCOs were required to use the additional amounts (revenues) under sections 601 and 602 to reduce beneficiary premiums, reduce beneficiary cost sharing, enhance beneficiary benefits, contribute to a benefits stabilization fund for use in future years, or stabilize or enhance beneficiary access to providers.

Regence proposed to use a portion of the additional BIPA funds by increasing provider payments in the Oregon Counties of Clackamas, Columbia, Multnomah, Washington, Marion, and Polk. However, Regence did not renegotiate contracts to increase hospital inpatient and outpatient fees for Marion and Polk Counties to the extent set forth in its revised proposal. Using Regence's cost projection methodology, we recalculated provider payment projections using actual contract rates in effect for 2001 and determined that Regence did not use \$522,327 in a manner consistent with BIPA requirements; that is, increased payments to providers.

## **CONCLUSION**

Of the approximate \$22.7 million capitation payment increase in Regence's revised proposal, about \$15.4 million was supported in the proposal's modifications and was used in a manner consistent with BIPA requirements. However, Regence did not provide adequate support for approximately \$6.8 million in increased payments in the proposal's modifications and we could not determine how much of the amount was used in a manner consistent with BIPA requirements. The remaining increase in payments (about \$0.5 million) was supported in the proposal's modifications but not used in a manner consistent with BIPA requirements.

Based on our review, Regence understated its excess of expected revenues over expected costs. Any excess of expected revenues should have been used by Regence to reduce beneficiary premiums or cost sharing, enhance beneficiary benefits, or stabilize or enhance beneficiary access to providers. Thus, the issues noted concerning the revised proposal may have adversely impacted the Medicare beneficiaries enrolled in Regence's plan.

## **RECOMMENDATIONS**

We recommend that Regence:

- work with CMS to determine what portion of the \$6,798,287 of unsupported direct medical care cost increases was not used in a manner consistent with BIPA requirements and refund that amount to the Federal Government,
- refund to the Federal Government \$522,327 that was not used to stabilize or enhance access to providers, and
- ensure that all estimated costs in future proposals are properly supported and used in a manner consistent with Federal requirements.

## **REGENGE COMMENTS**

In its written comments on the draft report, Regence disagreed with our findings and recommendation for a refund (see footnote 2 on page II). Regence did not comment on our recommendation that it ensure that estimated costs in future proposals are properly supported.

Regence disagreed that it did not support direct medical care cost increases in the proposal's modifications by not adjusting the proposal for changes in plan membership. Regence stated that it decided to change plan membership by dropping dual eligibles from the plan. Regence stated that, when calculating the revised proposal, it conservatively left the dual eligibles in the calculation for the entire year. In addition, Regence indicated it adjusted the proposal for the estimated increase in costs associated with Medicare-only enrollees. Regence believed that it should not be penalized for not precisely calculating the uncertain timing of dual eligible enrollment or its impact on the plan's experience and the outcome of complicated interactions of Medicaid and Medicare eligibility.

Regence disagreed that it duplicated costs for proposed inflation factors. Regence asserted that one inflation factor adjusted for normal inflation trends between 1999 and 2001, and the other inflation factor accounted for an increase in the payments made to providers in 2001.

Regence disagreed that it did not use direct medical care cost increases to stabilize or enhance access to providers to the extent indicated in its revised proposal. Regence stated that it renegotiated contracts for provider payments for Marion and Polk Counties.

Finally, Regence disputed that it owes a refund to the Federal Government because Regence believes that the adjusted community rate is an estimate. Regence believes it was unreasonable to demand certainty in the assumptions and estimates in the proposal.

Regence's comments are included as an appendix to this report. We excluded Appendixes A, B, and C from Regence's comments because they contained proprietary data.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Where appropriate, we made changes to this final report to reflect Regence's comments to our draft report. However, we do not concur with Regence's comments that it (1) supported approximately \$6.8 million in direct medical care cost increases for changes to plan membership and inflation, and (2) used approximately \$0.5 million in a manner consistent with BIPA requirements when renegotiating contracts for provider payments. As a result, Regence understated its excess of expected revenues over expected costs. Any excess of expected revenues should have been used by Regence to reduce beneficiary premiums or cost sharing, enhance beneficiary benefits, or stabilize or enhance beneficiary access to providers. Thus, the issues noted concerning the revised proposal may have adversely impacted the Medicare beneficiaries enrolled in Regence's plan.

Regence's assertion that direct medical care costs would increase about \$4.9 million because it decided to change plan membership by dropping about 4,000 dual eligibles was not based on sound financial data or well-founded assumptions. We are questioning the rationale of the estimate, not the precision of the calculation. It was unreasonable for Regence to include these members in the calculation of total direct medical care cost increases when it knew they would be dropped from plan 010. Thus, Regence included unsupported direct medical care cost increases of about \$4.9 million in the revised proposal.

It is not reasonable to apply two inflation factors to the same cost estimate. We accepted the inflation factor calculation that adjusted for normal inflation trends between 1999 and 2001. However, we did not accept a second inflation factor calculation because Regence did not provide sound financial data to support additional inflation costs. As a result of applying two inflation factors, Regence included unsupported direct medical care cost increases of about \$1.9 million in the revised proposal.

We agree that Regence renegotiated contracts for physician fees for Marion and Polk Counties. We reviewed additional documentation provided by Regence and determined that about \$0.4 million of the approximate \$0.9 million recommended for refund in our draft report was



supported for physician fee increases. Therefore, we adjusted our final report to reflect that about \$0.5 million proposed for hospital inpatient and outpatient fee increases was not used in accordance with BIPA requirements.

We agree with Regence's comments that the adjusted community rate is an estimate of a plan's total costs and in no way affects CMS's payment amounts. However, the adjusted community rate process directly affects beneficiary premiums or cost sharing, benefits, or access to providers. The proposal process is one of the main administrative tools that CMS uses to determine if it is obtaining good value from the Medicare risk-contracting program. The proposal process (1) establishes the minimum benefits that a plan may offer; (2) provides a payment safeguard, requiring plans to demonstrate that payments received from Medicare are used to provide services to Medicare beneficiaries; and (3) provides a check on the financial soundness of the proposed premiums and benefits offered.

Therefore, Regence needs to work with CMS to determine what portion of about \$6.8 million of unsupported direct medical care cost increases was not used in a manner consistent with BIPA requirements and refund that amount to the Federal Government. In addition, Regence should refund to the Federal Government about \$0.5 million that was not used to enhance or stabilize access to providers as proposed, and ensure that all estimated costs in future proposals are properly supported and used in a manner consistent with BIPA requirements.

# **APPENDIX**



100 Southwest Market Street  
PO Box 1271  
Portland, Oregon 97207-1271  
(503) 225-5221 1 (800) 452-7278  
www.or.regence.com

August 16, 2004

BY FACSIMILE AND OVERNIGHT MAIL

Lori A. Ahlstrand  
Office of Inspector General – Region IX  
Office of Audit Services  
50 United Nations Plaza  
Room 171  
San Francisco, CA 94102

RE: Cover letter to the Regence response to Report No. A-10-03-00011

Dear Ms. Ahlstrand:

Enclosed herein is Regence HMO Oregon's (now Regence BlueCross BlueShield of Oregon) response to your above audit report. We've tried to get this to you as quickly as possible due to the circumstances and hope that you'll consider our response before issuing a final report.

We understand that Regence's response letter may be made public, but please note that we consider all of the attached exhibits and their contents as confidential and respectfully request that they be kept confidential. If you have any questions about what information is considered confidential or you wish to discuss it, please contact us as advised in our response letter.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephanie C. Dreyfuss".

Stephanie C. Dreyfuss  
Vice President, Provider Affairs

cc: Janet Tursich, OIG

encl.



August 16, 2004

BY FACSIMILE AND OVERNIGHT MAIL

Lori A. Ahlstrand  
Office of Inspector General – Region IX  
Office of Audit Services  
50 United Nations Plaza  
Room 171  
San Francisco, CA 94102

100 Southwest Market Street  
PO Box 1371  
Portland, Oregon 97207-1271  
(503) 225-5221 1 (800) 452-7278  
www.or.regence.com

RE: Report No. A-10-03-00011

Dear Ms. Ahlstrand:

We thank you for the opportunity to respond to the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG"), Office of Audit Services ("OAS") on its initial draft report, titled "Review of Regence HMO Oregon's Modifications to Its 2001 Adjusted Community Rate Proposal Under the Benefits Improvement Protection Act [BIPA] of 2000, Contract Number H-3856, Plan Number 010" ("Draft Report").

In your letter of June 25, 2004 you gave us thirty days to respond but you kindly extended the deadline to August 10, 2004, confirmed by letter dated July 19, 2004. Janet Tursich and Teresa Kirkpatrick also informally agreed to an extension to August 24, 2004 to permit us to provide a thorough and comprehensive response in light of scheduling developments in our company. Unfortunately, we have learned that this extension could not be afforded. We are submitting this response as expeditiously as possible given our prior understanding that a later deadline had been agreed to. We thank you in advance for your willingness to consider this response in preparing a final report for CMS.

1. Payments to Providers

The Draft Report stated that \$2.8 million was not used in a manner consistent with BIPA requirements because Regence did not renegotiate all its provider contracts to increase provider payments as indicated in its revised proposal, and duplicated previous cost estimates. Regence disputes the audit finding of an overstatement of direct medical care cost by an additional \$2.8 million.

The Report specifically stated that \$900,000 was attributable to Regence's failure to renegotiate contracts for provider payments in Polk and Marion counties. Attached as Exhibit A is a copy of Regence's prior and updated provider contract with the Mid-Valley IPA, whose physicians are located in Marion and Polk counties, for both 2000 and 2001. Paragraph 8.1 of each contract contains the compensation rate, and shows that the physician fee schedule was increased for 2001 to a higher multiple of the Medicare RBRVS rate, compared to the prior year. The amendment with the increase was adopted in 2001, well after the plan's initial ACR proposal had already been submitted. The increase is supplemental to automatic increases reflected in any adjustment to the

RBRVS values in Medicare's own payment scheme. To our knowledge, virtually all physicians in Marion and Polk Counties participate in Mid-Valley IPA, therefore, this single contract is of sole significance for physicians in these counties. You'll notice other physician or IPA fees were increased in 2001 (see paragraphs 8.4 and 8.5 in Exhibit A). The increased fees were aimed at ensuring the continued participation of the IPA and IPA physicians, who are so important to serving members in these counties. On this basis, the plan objects to any conclusion that Regence overstated direct medical care cost estimates by \$900,000. 1

Regence also disputes the Draft Report's finding that it duplicated the use of an inflation factor. We are attaching as Exhibit B, an excerpt from the plan's ACR rate resubmission for 2001, specifically, Worksheet D – Expected Cost and Variation (in Dollars Per Member Per Month). As in the original ACR filing, Regence applied an inflation factor to the 1999 base period data to adjust for normal inflation trends between 1999 and 2001. This is shown in Line 1a, entitled "Trended Value Medicare-Covered Benefits." Separately, Regence applied an "inflation" factor to reflect the estimated increase in the costs due to the increased rate at which provider payments were to be made by Regence. This is shown in Line 1b(ev), entitled "Adjusted Value Medicare-Covered Benefits." The factor shown in this line, while denominated an "inflation" factor according to CMS instructions, accounts for an increase in the payments made to providers in 2001, which is not attributable to the normal "inflation" trending that is captured in Line 1a for the base period. Therefore, the two "inflation" factors are not duplicative, because each entry captures a separate source of cost increase – Line 1a for the base period trended forward, and Line 1b for the actual rate of increase to provider payments that was implemented in 2001.

## 2. Changes to Plan Membership

Regence disputes the OAS finding that Regence unreasonably overstated \$4.9 million of direct medical care costs resulting from changes to plan membership.

BIPA required a Medicare+Choice organization ("M+CO") with an approved 2001 M+C plan to resubmit its ACRP for 2001 if its payment rates were higher under BIPA than before the legislation. Under BIPA ACRP instructions issued by the Centers for Medicare and Medicaid Services ("CMS"), an M+CO could do any of the following in its ACRP resubmission: "reduce beneficiary premiums, reduce beneficiary, enhance benefits, contribute to a benefit stabilization fund, or stabilize or enhance beneficiary access to providers." *Instructions to Medicare+Choice Organizations for the BIPA 2001 ACRP Season* (BIPA ACRP Instructions) at p. 7. The instructions also provided that:

When submitting an ACR . . . , M+C organizations have the option to update direct medical cost assumptions and projections previously reported in [CMS] approved ACRs for CY 2001 to the extent these additional costs will help stabilize or enhance the M+CO's provider network. BIPA ACR Instructions at p. 8.

The above instructions contemplated that the submitting organization would estimate its expected future costs based on *assumptions* and *projections* developed from historical cost experience and update those assumptions and projections.

At the time that Regence submitted its original ACRP, Regence was a contractor with the State of Oregon to administer its Medicaid program, known as the Oregon Health Plan (OHP). In October 2000, Regence gave the State of Oregon Medicaid office, OMAP, notice that it would no longer administer its Medicaid program as of December 31, 2000. However, OMAP requested that Regence allow dual-eligibles (members entitled to both Medicare and Medicaid) to remain covered under the Medicare contract beyond December 2000 so that members could be transitioned to a new Medicaid health plan, and Regence agreed to do so.

When calculating the revised ACR proposal, Regence conservatively left the dual-eligibles in the calculation for the entire year. In addition, Regence adjusted the loss ratio for the Medicare-only (i.e., the non-dual eligible) enrollees in keeping with historical data on loss ratios associated with Medicare-only enrollee experience. Dual-eligible beneficiaries remained enrolled in substantially the same numbers from January 2001 through March 2001 (prior to the effective date of BIPA), but only approximately one-third of these members remained enrolled through April 2001. See Exhibit C attached hereto. All dual-eligibles disenrolled by May 2001, and CMS' payment to Regence for each dual-eligible member terminated as of the date the member was removed from the Regence contract.

At the time it was filed, the assumptions made by Regence in its revised ACRP resulted in a higher estimate than it otherwise would have in terms of both cost and revenues. However, the assumptions that Regence made as part of the BIPA revised ACRP were made in good faith and reasonably calculated to comply with CMS instructions. Regence should not be penalized because it did not precisely calculate the uncertain timing of dual eligible enrollment or its impact on the plan's experience and costs. One can, in retrospect, seek to identify better ways to predict or analyze the likely outcome of complicated interactions of Medicaid and Medicare eligibility. The audit process is not an appropriate means to impose after-the-fact changes to ACR build-up assumptions that were made in good faith.

### 3. Impact of Findings

We respectfully disagree with OAS's draft conclusions regarding the effect of any alleged inaccuracies in Regence HMO's revised 2001 ACRP under BIPA. The Executive Summary to the Draft Report recommends a \$7,719,725 "refund" to CMS, or the creation of a benefit stabilization fund.<sup>1</sup> We strongly dispute that Regence owes a refund to CMS. Even assuming there are inaccurate estimates in the ACR proposal, which contention we dispute, the ACR filing in no way affects how CMS paid Regence. The payment rate is established by law and adjusted by geographic area and the demographics of our Members. CMS paid Regence this fixed amount monthly and only for those

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<sup>1</sup> CMS will no longer permit additions to Benefit Stabilization Fund for calendar year 2006 use. In the most recent CMS instructions related to submitting the calendar year 2005 ACR filing, it states: "[t]he worksheet will allow withdrawals from but not additions to a stabilization fund. Under MMA, all monies in stabilization funds on January 1, 2006 will be forfeited to the Medicare trust funds."

Members who were part of the program. We were paid no more than what we were legally entitled to receive by law.

The ACR is an *estimate* of what a plan's total costs will be over the term of the contract, including claims and administrative expense, but the actual cost will vary depending on claims experience, fluctuation in membership, administrative expenses, and, no doubt, the foresight and logic of a plan's ACR work-up. The contract and regulations do not require, though, that plan's predictions be pinpoint, or even that their logic or foresight be faultless. Because the ACR in no way affects CMS' payment amount, Regence was paid exactly what it should have been paid, for the Members who participated. Nor do the contract or regulations provide for a plan being retrospectively required to refund monies to the government or to enrollees, in the form of enhanced future benefits, based on post hoc identifications of alleged flaws in the plan's foresight or reasoning.

In addition, as you know, Medicare plans were given a very short period of time in which to review, analyze and implement necessary program changes to comply with the increased funding made available under BIPA. The BIPA payment rates were announced January 1, 2001. The ACRP resubmission due date was January 18, 2001, and the effective date of the BIPA changes was March 1, 2001. BIPA ACRP Instructions at p. 3. In all cases, the ACRP is an estimate of the organization's costs in light of prior experience and expected changes to future costs, but given this short period of time to submit the revised ACRP, less than three weeks, it is even less reasonable to demand certainty in the assumptions and estimates made by the plan.

Both GAO and CMS acknowledge that Plans had a "compressed" amount of time in which submit the ACR.<sup>2</sup> Regence complied with CMS requirements for the increased funding by doing two things: lowering member premiums and increasing provider payments in all relevant counties, not just those identified in the report. Thus, it had an added burden of making system-wide changes to member premiums and provider contracts in order to implement changes and be fully compliant with BIPA.

Indeed, Regence's BIPA resubmission lowered by more than \$3 per member per month the \$7.77 per member per month profit (retention) factor in its original ACR proposal, in recognition of enhanced benefits and anticipated higher costs (please see Exhibit B, which is Worksheet D, line 24, "Additional Revenue," from both the original and revised ACR submissions). As costs rise, the ACR worksheet requires that a Plan's profit (retention) fall. Had its cost predictions been lower, Regence would likely have been able to maintain its profit retention factor at the original ACR level, rather than lowering it as it did in the revised ACRP. The Draft Report does not recognize or take into account this aspect of Regence's ACR adjustment.

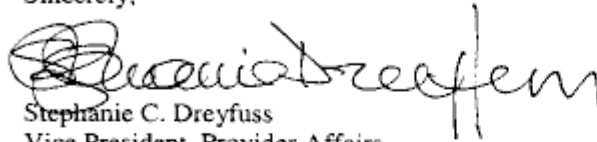
For the above reasons we respectfully request that you change the Draft Report to reflect that Regence complied with the terms of its contract and applicable regulations.

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<sup>2</sup> See. General Accounting Office (GAO) report, "Medicare+Choice: Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001" issued November 2001, GAO-02-202, at p.8.

that it made the system changes identified in the ACR, that Regence was paid what it was legally entitled to, and that no refund is required. We do appreciate the sharp focus the audit process has given to our rate and cost development work and are striving to maintain a consistent record of service to the program and to our enrollees. Thank you for your consideration, and please contact Dennis Tierney at (503) 553-5057 if you want to discuss it or need further information.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephanie C. Dreyfuss". The signature is fluid and cursive, with a large initial "S" and "D".

Stephanie C. Dreyfuss  
Vice President, Provider Affairs

cc: Janet Tursich, OIG

encl.