DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

AUG - 9 2004

Report Number: A-04-03-06017

Mr. David Schandel
Chief Operation Officer/Assoc. CEO
Florida Health Care Plan
1340 Ridgewood Avenue
Holly Hill, Florida 32117

Dear Mr. Schandel:

Enclosed are two copies of the Office of Inspector General (OIG) final report entitled *Calendar Year 2001 Adjusted Community Rate Proposal Modifications Under the Benefit Improvement Protection Act Submitted by Florida Health Care Plan, Holly Hill, Florida* (Medicare+Choice contract number H1035, plan number 002).

Final determination as to actions taken an all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We request that you respond to the HHS action 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.

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Please refer to report number A-04-03-06017in all correspondence.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure - as stated

HHS ACTION OFFICIAL
Dale Kendrick, Associate Regional Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALENDAR YEAR 2001 ADJUSTED COMMUNITY RATE PROPOSAL MODIFICATIONS UNDER THE BENEFIT IMPROVEMENT PROTECTION ACT SUBMITTED BY FLORIDA HEALTH CARE PLAN, HOLLY HILL, FLORIDA

August 2004
A-04-03-06017

Office of Inspector General

http://oig.hhs.gov

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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 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. Florida Health Care Plans (Florida Health) submitted a revised proposal that reflected an increase in Medicare capitation payments of about $6.9 million for contract year 2001.

OBJECTIVES

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

SUMMARY OF FINDINGS

According to Section 604(c) of BIPA, MCOs were required to use the additional amounts 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. In addition, Centers for Medicare & Medicaid Services (CMS) instructions required that revisions be supported.

About $1.2 million of the $6.9 million increase in Florida Health's revised proposal was not used in a manner consistent with BIPA requirements or was not supported:

- $1,207,670 was not associated with stabilizing or enhancing access to providers.
- $39,550 of administration costs was unsupported.

RECOMMENDATIONS

We recommend that Florida Health refund $1,247,220 to CMS or, as an alternative, deposit this amount in a benefit stabilization fund for use in future years. We also recommend that Florida Health ensure that estimated costs in future proposals are properly supported.

FLORIDA HEALTH'S COMMENTS

Florida Health's officials agreed with our recommendation to deposit $1,247,220 in a benefit stabilization fund for use in future years. However, they disagreed with our explanation that $1,207,670 difference resulted because Florida Health did not renegotiate its hospital provider contracts to increase provider payment rates. In their response, the officials indicated that it was not their intention to renegotiate such contracts nor did they indicate any intent to do so in the revised proposal. Regarding the $39,550 of unsupported administration costs, Florida Health's officials believe it was a good-faith estimate and the OIG requirements to support this amount were too restrictive.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Florida Health's position on provider contract renegotiation does not affect the amount of our audit finding or our recommendation. We believe, and Florida Health agreed in their written response, that provider payments were overestimated by $1,207,670 on the revised proposal.

Further, CMS instructions for the revised proposal indicated that MCOs were not permitted to increase administration costs unless the increase had a significant direct relationship to stabilizing or enhancing beneficiary access to providers or was directly related to enhanced benefits. While it was not our position to establish supporting documentation requirements for the proposal, it was our objective to determine if the proposal modifications were supported according to CMS instructions. We restate that Florida Health did not have sufficient or adequate support to establish that $39,550 of the increase in administration cost was related to the revised proposal.

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FLORIDA HEALTH'S COMMENTS

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. 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 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.

BIPA Requirements

BIPA provided for an additional $11 billion in increased capitation payments to MCOs effective March 1, 2001. MCOs with plans whose payment rates increased under BIPA were required by BIPA to submit revised proposals by January 18, 2001 to show how they would use the increase during contract year 2001. CMS instructions for the revised proposals required MCOs to submit a cover letter summarizing how they would use the increased payments.

Florida Health submitted the required proposal for contract number H 1035 plan 002.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

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

Scope

Based on Florida Health's revised proposal, its Medicare capitation payments increased by about $6.9 million for contract year 2001. On a per member per month basis, the revised proposal reduced beneficiary premiums by $16.50, increased direct medical care costs by $18.50, increased cost by $1.32 for additional coverage, increased administrative costs by $.28, and contributed $1.73 to the Medicare benefit stabilization fund for a net increase of $38.33 per member per month.

Our objectives did not require us to review the internal control structure of Florida Health.

Methodology

To accomplish our objectives, we:

- reviewed applicable laws and regulations
- reviewed the cover letter Florida Health 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
- reviewed support and verified the mathematical accuracy of the plan's cost projections
- reviewed provider contracts in effect in 2001 to determine if Florida Health had renegotiated its contracts in accordance with the supporting documentation for the revised proposal
- recalculated Florida Health's provider payment projections based on the actual contract terms
- interviewed Florida Health personnel

We performed our review in accordance with generally accepted government auditing standards, except for the limited testing of data from computer-based systems. We neither assessed the completeness of Florida Health's data files nor evaluated the adequacy of the input controls. We conducted audit work from July through December 2003 at Florida Health's offices in Holly Hill, FL and our Miami field office.

FINDINGS AND RECOMMENDATIONS

Of the $6.9 million capitation payment increase in Florida Health's revised proposal, the majority was used in compliance with BIPA. However, about $1.2 million was not used in a manner consistent with BIPA requirements or was not supported:

- $1,207,670 was not associated with stabilizing or enhancing access to providers.
- $39,550 of administration costs was unsupported.

COMPLIANCE WITH BIPA REQUIREMENTS

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

Florida Health's revised proposal stated that it would use the additional BIPA funds to, among other things, stabilize its hospital provider network by increasing provider compensation. Florida Health also increased administration costs and stated that the increase was directly related to notifying beneficiaries about premium reductions and newly enhanced benefits.

Stabilization of Hospital Provider Network

About $1.9 million ($10.57 per member per month) cost increase in Florida Health's revised proposal related to the stabilization of two hospital providers with contractual payment terms set as a percentage of CMS premiums. Providers were paid based on contractual percentages applied to Florida Health's Medicare premium revenue. However, according to the contract terms, in no instance should the increase in premiums be greater than 5 percent.

Our review disclosed that Florida Health did not use $1,207,670 of the $1.9 million increase to stabilize or enhance beneficiary access to hospital providers as indicated in their revised proposal.

Although Florida Health proposed to increase its hospital provider payment rates by 6.74 and 6.65 percent respectively, Florida Health did not renegotiate the contracts to reflect the provider payment assumptions in the revised proposal. In addition, they estimated the premium increase for one of the providers using incurred inpatient, outpatient, per diem, and emergency room claims between September 1999 and August 2000 paid through December 2000. The modified rate schedule between Florida Health and the provider showed that only per diem and emergency room rates were increased, thus, the full amount of the increase reported on the revised proposal was not passed to the provider.

Florida Health officials acknowledged that the contractual premium increase to hospitals was set at a percentage not greater than 5 percent of premiums at the time of the revised proposal submission. However, officials estimated payment rates above 5 percent because they anticipated the increase being retroactive to January 1, 2001. The increase did not become effective until the BIPA effective date of March 1, 2001 resulting in Florida Health officials overestimating the cost variation on the revised proposal.

Additional Administration Costs

CMS instructions for the revised proposal indicated that MCOs were not permitted to increase administration costs unless the increase had a significant direct relationship to stabilizing or enhancing beneficiary access to providers or was directly related to enhanced benefits.

Florida Health could not support a $20,000 increase in employee salaries and overstated $19,550 related to the cost of printing and mailing enhanced benefits material to Medicare beneficiaries. Although Florida Health adequately documented that $10,794 of the estimated $50,344 administration cost increase was directly related to notifying beneficiaries of premium reductions and enhanced benefits under BIPA, there was not sufficient or adequate support to establish that the remaining $39,550 was related to the revised proposal.

Florida Health did not keep records to support the time its employees spent on tasks that related to the proposal changes, and the processing and mailing costs of updated material sent to beneficiaries was less than the amount reported for additional funding. Florida Health did not have a time recording system that identified the time its employees spent on tasks or assignments. As a result, Florida Health could not support the estimates for time spent in the development and review of printed material related to the revised proposal, handling beneficiaries' telephone calls related to changes in benefits, and reimbursing premiums paid in advance by Medicare beneficiaries. In addition, Florida Health overstated previous year cost information used to estimate the cost to produce and mail enhanced benefit notifications and revised payment coupons to beneficiaries.

CONCLUSION

By overstating its direct medical care and administration costs projections by $1,247,220 ($6.55 per member per month), Florida Health understated its excess of expected revenues over expected costs. Florida Health should have used this amount to further reduce member premiums or cost sharing, enhance benefits, contribute to a stabilization fund, or to stabilize or enhance beneficiary access to providers.

RECOMMENDATIONS

We recommend that Florida Health refund $1,247,220 to CMS or, as an alternative, deposit this amount into a benefit stabilization fund for use in future years. We also recommend that Florida Health ensure that costs in future proposals are properly supported.

FLORIDA HEALTH'S COMMENTS

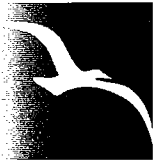
Florida Health's officials agreed with our recommendation to deposit $1,247,220 in a benefit stabilization fund for use in future years. However, they disagreed with our explanation that $1,207,670 difference resulted because Florida Health did not renegotiate its hospital provider contracts to increase provider payment rates. In their response, the officials indicated that it was not their intention to renegotiate such contracts nor did they indicate any intent to do so in the revised proposal. Regarding the $39,550 of unsupported administration costs, Florida Health's officials believe it was a good-faith estimate and the OIG requirements to support this amount were too restrictive.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Florida Health's position on provider contract renegotiation does not affect the amount of our audit finding or our recommendation. We believe, and Florida Health agreed in their written response, that provider payments were overestimated by $1,207,670 on the revised proposal.

Further, CMS instructions for the revised proposal indicated that MCOs were not permitted to increase administration costs unless the increase had a significant direct relationship to stabilizing or enhancing beneficiary access to providers or was directly related to enhanced benefits. While it was not our position to establish supporting documentation requirements for the proposal, it was our objective to determine if the proposal modifications were supported according to CMS instructions. We restate that Florida Health did not have sufficient or adequate support to establish that $39,550 of the increase in administration cost was related to the revised proposal.

APPENDIX



Florida Health Care Plans

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JUL 23 2004
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July 21, 2004

Mr. Charles J. Curtis
Regional Inspector General for
Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

Report Number: A-04-03-06017

Dear Mr. Curtis:

We are in receipt of your report dated July 2, 2004. This letter constitutes our formal response to that report.

Your report listed the following findings:

> "About $1.2 million of the $6.9 million increase in Florida Health's revised proposal was not used in a manner consistent with BIPA requirements or was not supported:
>
> - $1,207,670 was not associated with stabilizing or enhancing access to providers because Florida Health did not renegotiate its hospital provider contracts to increase provider payment rates as indicated in its revised proposal.
> - $39,550 of administration costs was unsupported."

Regarding the $1,207,670, we disagree that this difference resulted, as stated above, "because Florida Health did not renegotiate its hospital provider contracts to increase provider payment rates as indicated in its revised proposal." It was not Florida Health's intent to renegotiate such contracts nor did we indicate any intent to do so in our revised proposal. Our intent was to increase provider payment rates as allowed by contract terms that were already in place. The difference noted above resulted from an error in the application of those contract terms.

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As such, payment projections were made by our actuarial department based on an understanding (in error) that the maximum increase allowed by contract (5%) would apply to all hospital services, both inpatient and outpatient, and that the effective date of the increase would be January 1, 2001 rather than March 1, 2001. However, the actual terms in the hospital provider contract required that rate increases only be applied to per diems and emergency room rates. This misunderstanding by our actuarial department resulted in an over-estimation of provider payments by the $1,207,670 noted above.

Regarding the $39,550, this amount was estimated based on trends of such costs and is believed to be reasonable compared to administrative costs in total and by line of business.

In conclusion, we agree with the $1,207,670 difference, but we disagree with your explanation of how it arose. Regarding the $39,550 difference, we believe we made a good-faith estimate of the costs associated with the BIPA implementation and that the methodology employed to do so was reasonable. Unfortunately, your support requirements for these amounts are far more restrictive than could be reasonably expected.

It is our preference that the entire difference of $1,247,220 be permitted to be deposited in a benefit stabilization fund for use in future years.

Sincerely,

David C. Schandel
Chief Operating Officer/Assoc. CEO

ACKNOWLEDGMENTS

This report was prepared under the direction of Charles J. Curtis, Regional Inspector General for Audit Services, Region IV. Other principal Office of Audit Services staff who contributed include:

Mary Ann Moreno, *Audit Manager*
Lourdes Puntonet, *Senior Auditor*
Jaime Alustiza, *Auditor*

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