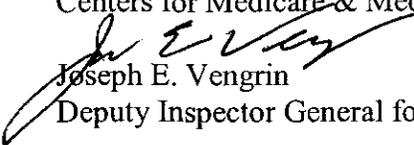




OCT 25 2004

**TO:** Wynethea Walker  
Acting Director, Audit Liaison Staff  
Centers for Medicare & Medicaid Services

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

**SUBJECT:** Review of Blue Shield of California's Modifications to Its 2001 Adjusted Community Rate Proposal Under the Benefits Improvement and Protection Act of 2000 (A-09-03-00051)

Attached is an advance copy of our final report on Blue Shield of California's (Blue Shield) 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 Blue Shield 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 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.

Blue Shield's revised proposal reflected an increase in Medicare capitation payments of about \$17 million for contract year 2001.

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

Of the \$17 million capitation payment increase in Blue Shield's revised proposal, \$12.5 million was used in a manner consistent with BIPA requirements and was properly supported. However, Blue Shield could not document, nor could we determine, how much of the remaining \$4.5 million for increased fee-for-service costs was used in a manner consistent with BIPA requirements. Also, Blue Shield could not support the estimated \$4.5 million increase for fee-for-service costs in its revised proposal.

We recommend that Blue Shield work with CMS to determine how much of the \$4.5 million increase for fee-for-service costs was used in a manner consistent with BIPA requirements. Any funds not used in a manner consistent with BIPA requirements should be refunded to CMS or, as an alternative, deposited in a benefit stabilization fund for use in future years. We also recommend that Blue Shield ensure that estimated costs in future proposals are properly supported.

In its written comments on our draft report, Blue Shield disagreed with our finding of \$4.5 million in unsupported estimates for fee-for-service costs. Blue Shield officials believed that they provided adequate documentation during our audit to support these estimates. Further, they stated that the \$4.5 million was based on their best judgment and conservative assumptions about fee-for-service cost trends.

Our recommendation regarding the \$4.5 million was based on Blue Shield's inability to document whether the additional capitation payments were used in a manner consistent with BIPA requirements, as detailed in Blue Shield's cover letter transmitting its revised proposal. In addition, Blue Shield did not adequately support the modifications to its 2001 proposal. Even though Blue Shield stated that it used its best judgment and conservative assumptions, it could not support the fee-for-service cost trend applied to each of its seven plans. The adjusted increases were based not on actual trends but on unsupportable estimates.

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-09-03-00051 in all correspondence.

Attachment



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

Report Number: A-09-03-00051

OCT 29 2004

Mr. Kirk Clove  
Vice President  
Finance, Underwriting and Government Programs  
Blue Shield of California  
6300 Canoga Avenue  
Woodland Hills, California 91367

Dear Mr. Clove:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Blue Shield of California'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 named below 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 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.

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 contained therein is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-09-03-00051 in all correspondence.

Sincerely,

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

Mr. Jeff Flick  
Regional Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
75 Hawthorne Street, 4<sup>th</sup> Floor  
San Francisco, California 94105

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF BLUE SHIELD OF  
CALIFORNIA'S MODIFICATIONS TO  
ITS 2001 ADJUSTED COMMUNITY  
RATE PROPOSAL UNDER THE  
BENEFITS IMPROVEMENT AND  
PROTECTION ACT OF 2000**



**OCTOBER 2004  
A-09-03-00051**

# *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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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. Blue Shield of California (Blue Shield) submitted a revised proposal that reflected an increase in Medicare capitation payments of about \$17 million for contract year 2001.

### **OBJECTIVES**

Our objectives were to determine whether Blue Shield (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 MCOs to support proposal revisions.

Of the \$17 million capitation payment increase in Blue Shield's revised proposal, \$12.5 million was used in a manner consistent with BIPA requirements and was properly supported. However, Blue Shield could not document, nor could we determine, how much of the remaining \$4.5 million increase for fee-for-service costs was used in a manner consistent with BIPA requirements. Also, Blue Shield could not support the estimated \$4.5 million increase for fee-for-service costs in its revised proposal.

### **RECOMMENDATIONS**

We recommend that Blue Shield work with CMS to determine how much of the \$4.5 million increase for fee-for-service costs was used in a manner consistent with BIPA requirements. Any funds not used in a manner consistent with BIPA requirements should be refunded to CMS or, as an alternative, deposited in a benefit stabilization fund for use in future years. We also recommend that Blue Shield ensure that estimated costs in future proposals are properly supported.

## **BLUE SHIELD COMMENTS**

Blue Shield disagreed with our finding of \$4.5 million in unsupported estimates for fee-for-service costs. Blue Shield officials believed that they provided adequate documentation during our audit to support these estimates. Further, they stated that the \$4.5 million was based on their best judgment and conservative assumptions about fee-for-service cost trends.

Blue Shield's comments on our draft report are included as an Appendix to this report. We excluded the last three pages of Blue Shield's response from the Appendix because they contained proprietary data.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Our recommendation regarding the \$4.5 million was based on Blue Shield's inability to document whether the additional capitation payments were used in a manner consistent with BIPA requirements, as detailed in Blue Shield's cover letter transmitting its revised proposal.

In addition, we found that Blue Shield did not adequately support the modifications to the 2001 proposal. Even though Blue Shield stated that it used its best judgment and conservative assumptions, it could not support the fee-for-service cost trend applied to each of its seven plans. Our audit disclosed that the adjusted increases were based not on actual trends but on unsupportable estimates.

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**BLUE SHIELD 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 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 (1) submit cover letters summarizing how they would use the increased payments and (2) support entries that changed from the original (pre-BIPA) filing.

Blue Shield submitted the required proposal under contract number H0504 for each of its seven plans.

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

### **Objectives**

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

### **Scope**

Blue Shield submitted a revised proposal under contract number H0504 for each of its seven plans. However, Blue Shield did not properly compute the average payment rates for the seven plans. At our request, Blue Shield recalculated the average payment rates and modified its revised proposals to comply with CMS's instructions. Accordingly, we reviewed the recalculated payment rates and the modifications to the revised proposal.

Based on Blue Shield's modifications to the revised proposal, we determined that its Medicare capitation payments increased by about \$17 million for contract year 2001. The modifications to the revised proposal increased direct medical care cost estimates by \$19.2 million and decreased additional revenue estimates by \$2.2 million.

Blue Shield proposed to use the additional funds to cover increased provider payments for network enhancement and stabilization. Therefore, we focused our work on the provider payment increases included in the direct medical care cost projections.

Our objectives did not require us to review the internal control structure of Blue Shield. We conducted audit work from June 2003 through May 2004, which included visits to Blue Shield's office in Woodland Hills, CA.

### **Methodology**

To accomplish our objectives, we:

- reviewed applicable Federal laws and regulations
- reviewed the cover letter Blue Shield 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 for changes in membership projections indicated in the revised proposal
- reviewed the supporting documentation for the revised average payment rates using the new payment rates
- reviewed support for the seven plans' revised direct medical care cost projections

- reviewed selected Blue Shield contracts to verify that payment terms for selected providers were renegotiated
- reviewed Blue Shield's contract terms for selected providers to verify that payments made were based on a percentage of CMS's capitation payment
- recalculated Blue Shield's provider payment projections using its methodology
- verified the mathematical accuracy of the revised seven plans' direct medical care cost projections
- verified whether provider payment increases were used in a manner consistent with BIPA requirements
- interviewed Blue Shield officials
- calculated the increase in 2001 Medicare capitation payments using Blue Shield's actual membership, which we reconciled with data obtained from CMS

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

### **FINDINGS AND RECOMMENDATIONS**

Of the \$17 million capitation payment increase in Blue Shield's revised proposal, \$12.5 million was used in a manner consistent with BIPA requirements and was properly supported. However, Blue Shield could not document, nor could we determine, how much of the remaining \$4.5 million for increased fee-for-service costs was used in a manner consistent with BIPA requirements. Also, Blue Shield could not support the estimated \$4.5 million increase for fee-for-service costs in its revised proposal.

### **USE OF ADDITIONAL BIPA FUNDS**

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 benefits stabilization fund for use in future years, or stabilize or enhance beneficiary access to providers.

Blue Shield proposed to use the additional BIPA funds to increase provider payments for network enhancement and stabilization. In its proposal, Blue Shield stated that it would use the increased capitation payments to cover higher payments to providers who are paid based on (1) the percentage of CMS's premium received by the plan and (2) a fee-for-service model. Thus, Blue Shield's proposal to enhance its provider network took a twofold approach: the automatic increase in provider payments as a result of percentage-of-premium contracts and an increase in provider payments for fee-for-service claims.

## **Percentage-of-Premium Contracts**

The majority of the cost increase (\$12.5 million) in Blue Shield's revised proposal related to percentage-of-premium contract increases. These providers were paid based on contractual percentages applied to Blue Shield's Medicare premium revenue. As a result of the Medicare premium increase from BIPA, payments to providers automatically increased in compliance with BIPA requirements.

## **Fee-for-Service Claims**

In accordance with section 604(c) of BIPA, Blue Shield proposed to use about \$4.5 million of the \$17 million increase in its revised proposal to enhance and stabilize provider networks by increasing payments to providers for fee-for-service claims. However, Blue Shield could not document that the \$4.5 million increase in capitation payments was used in a manner consistent with BIPA requirements.

Blue Shield had two types of payment arrangements for fee-for-service claims, depending on whether services were rendered by a contracted or noncontracted provider. Contracted providers were paid based on contractual agreements with Blue Shield, and noncontracted providers were paid based on applicable Medicare fee schedules. BIPA provided some increases for Medicare fee-for-service payments for 2001.

Although fee-for-service payments increased, Blue Shield could not differentiate between fee-for-service increases for contracted and noncontracted providers. As a result, based on available records, we could not determine how much of the \$4.5 million increase related to each type of provider. Without being able to distinguish between payments to contracted and noncontracted providers, Blue Shield could not document, nor could we determine, how much of the \$4.5 million proposed increase in fee-for-service costs was used in a manner consistent with BIPA requirements.

## **SUPPORT FOR REVISED PROPOSAL**

Medicare regulations at 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 for the revised proposal required that MCOs support entries that changed from the original (pre-BIPA) filing.

In its revised proposal, Blue Shield supported the \$12.5 million increase related to percentage-of-premium contract increases. However, Blue Shield could not support the estimated \$4.5 million increase for fee-for-service costs.

Blue Shield officials initially stated that they used trend data to project the 2001 fee-for-service cost increase for both the initial and revised BIPA proposals. They projected a 6-percent increase for contracted providers and a 5.4-percent increase for noncontracted providers. However, when we requested support for the fee-for-service increases based on these trends, Blue Shield could not quantify the projected increases using the trend data. In a memo to the

Office of Inspector General dated December 1, 2003, Blue Shield officials indicated that “the fee-for-service portion of the increase was ‘plugged’ to balance the ACR worksheet [proposal].” Thus, Blue Shield calculated the estimated increase in fee-for-service costs as the difference between (1) the estimated increase in total costs for direct medical care and (2) the estimated increase in payments to providers paid based on percentage-of-premium contracts.

## **CONCLUSION**

Blue Shield could not document, nor could we determine, how much of the increase for fee-for-service costs was used in a manner consistent with BIPA requirements. In addition, Blue Shield could not support the modifications in its revised proposal related to estimated increases for fee-for-service costs. By overstating its direct medical care cost projections by \$4.5 million, Blue Shield understated its excess of expected revenues over expected costs. Blue Shield should have used this amount to reduce member premiums or cost sharing, enhance benefits, contribute to a stabilization fund, or stabilize or enhance beneficiary access to providers.

## **RECOMMENDATIONS**

We recommend that Blue Shield work with CMS to determine how much of the \$4.5 million increase for fee-for-service costs was used in a manner consistent with BIPA requirements. Any funds not used in a manner consistent with BIPA requirements should be refunded to CMS or, as an alternative, deposited in a benefit stabilization fund for use in future years. We also recommend that Blue Shield ensure that estimated costs in future proposals are properly supported.

## **BLUE SHIELD COMMENTS**

Blue Shield disagreed with our finding of \$4.5 million in unsupported estimates for fee-for-service costs. Blue Shield officials believed that they provided adequate documentation during our audit to support these estimates. Further, they stated that the \$4.5 million was based on their best judgment and conservative assumptions about fee-for-service cost trends.

Blue Shield officials stated that the trend data used in the initial proposal for 2001, which projected a 6-percent increase in fee-for-service costs, was too conservative. Therefore, Blue Shield used a new trend projection of 15 percent for fee-for-service costs for contracted hospitals. However, by looking at individual providers in each plan, Blue Shield was not confident that the 15-percent trend would continue through 2001; thus, it reduced the 15-percent trend for each plan. Blue Shield stated, “These reduced or scaled back trend figures were then used in revising the [proposal] as the fee-for-service trend to balance the ACR [rate] without having to make changes to the additional revenue.”

Blue Shield’s comments on our draft report are included as an Appendix to this report. We excluded the last three pages of Blue Shield’s response from the Appendix because they contained proprietary data.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Our recommendation regarding the \$4.5 million was based on Blue Shield's inability to document whether the additional capitation payments were used in a manner consistent with BIPA requirements, as detailed in Blue Shield's cover letter.

In addition, we found that Blue Shield did not adequately support the modifications to the 2001 proposal. Even though Blue Shield stated that it used its best judgment and conservative assumptions, it could not support the fee-for-service cost trend applied to each of its seven plans. Our audit disclosed that the adjusted increases were based not on actual trends but on unsupportable estimates.

# **APPENDIX**



**Blue Shield**  
of California

An Independent Member  
of the Blue Shield Association

July 13, 2004

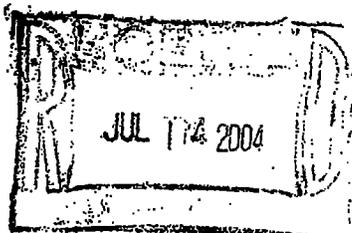
Department of Health & Human Services  
Office of Inspector General  
Region IX  
Office of Audit Services  
Attn: Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
50 United Nations Plaza, Room 171  
San Francisco, California, 94102

Re: Blue Shield of California Response to OIG Audit Report – 2001 BIPA ACR  
Report # A-09-03-00051

Dear Ms. Ahlstrand:

Blue Shield of California is responding to the draft report dated June 30, 2004 from the Office of Inspector General's "Review of Blue Shield of California's Modification to its 2001 Adjusted Community Rate Proposal (ACR) Under the Benefits Improvement Act of 2000 (BIPA)". One of the fundamental issues we have with the OIG report goes back to the basics of what the ACR represents -- an estimate of future cost trends. Healthcare cost trends are volatile and not static. As a Medicare+Choice Organization (M+CO) we must factor in not only trends from contracted physicians and hospitals within the M+CO provider network, but we must also forecast the costs associated with new technology, cancer treatment and chemotherapeutic agents, new medications to treat illnesses such as Alzheimer's, updated transplant procedures, extended life-spans, and a myriad of other new prescription drugs and medications.

With the additional funding provided through BIPA, Blue Shield of California (Blue Shield) refreshed or updated the cost trend information and assumptions that went into the original ACR with an additional 6 months of experience. The use of updated cost trends was allowable according to the ACR instructions and provided a more accurate forecast of the projected costs for enrollees. Blue Shield used trend information that was valid and applicable towards the use of BIPA funds according to our understanding of the CMS guidance and best estimates. Blue Shield has reviewed the OIG's draft audit report for the 2001 BIPA ACR and we do not concur with the findings in the report that "... the \$4.5 million increase in Blue Shield's modifications to its revised proposal was not supported in accordance with CMS's instructions."



## **Background**

The Benefits Improvement and Protection Act of 2000 provided additional funding to the M+COs in the form of higher capitation payments (AAPCC/risk adjustment) beginning March 1, 2001. M+COs were required to resubmit their ACRPs in January 2001 for any plan where the payment rates increased as a result of implementation of the Act. The revised ACRPs were required to reflect the higher payment rate as well demonstrate how the additional funding was used for each plan. M+COs were only allowed to use the additional funding for the following purposes:

- Reduce beneficiary premiums
- Reduce beneficiary cost sharing
- Enhance benefits
- Contribute to a stabilization fund, or
- Stabilize or enhance beneficiary access to providers.

## **Blue Shield of California's 2001 BIPA ACRP Filing**

As indicated in Blue Shield of California's cover letter that accompanied the BIPA ACRP in January 2001, Blue Shield prepared and submitted our ACRP "... as required by BIPA and HCFA's instructions in accordance with its good faith understanding of the applicable requirements". CMS continues to advise plans to use their best estimates of applicable costs under the ACR. CMS again used this terminology as recently as the June 24, 2004 ACR training seminar for health plans. These are the same seminars that the OIG auditors should be attending so that they have the same understanding of the requirements and information being provided to the M+C Plans from CMS. The OIG must also appreciate the fact that while the audit and review process had the luxury of several months of time, the actual BIPA ACR instructions were released allowing plans only a few weeks to compile their revised ACR's. Blue Shield specifically identified in the ACR cover letter that since the initial 2001 ACRP filing, our hospital costs had increased significantly due to provider contract terminations, demands for increased payment to physicians, and hospitals, provider bankruptcies, IPA and Medical Group closures, and state mandated and overseen loans to providers. Because of these dynamics, we indicated that Blue Shield "intend(ed) on using the increased funds from BIPA for provider enhancement and stabilization". (Attachment I)

According to CMS guidance, M+COs were allowed to update their cost estimates and trends (Attachment II). In preparation for the January 2001 BIPA filing, we re-examined our fee-for-service hospital trends, having an additional six (6) months of claims data, and found that our contracted hospital trends had increased substantially. In fact, based on our actuarial analysis, we projected a 15% trend for the revised 2001 fee-for-service hospital (contracted medical claim) projections. This trend was what was used as the basis for estimates in the BIPA filing Attachments III and IV were provided to OIG during the audit supporting the original and revised trend estimates. The primary drivers of this trend were increased utilization of services and medical cost increases in addition to providers demanding higher payments for contracted services. A significant component of the BIPA provisions was that M+C Plans be allowed to use the funds to help stabilize networks and avert additional service area reductions.

Contracted provider demands for increases from the M+C Plans were due to a number of market forces. Had Blue Shield of California ignored these provider demands, we would have experienced high provider terminations, which would have reduced member's access to care.

Blue Shield's historical experience has demonstrated that trends are very volatile due to the numerous factors which affect health care costs (e.g. utilization of services, new technology, provider contracting, member mix, acuity mix, etc.). As explained to the OIG Auditors, while preparing the BIPA ACRP, the ACR instructions allowed plans to update cost trends based on review of an additional 6 months of claims data and experience. Blue Shield noted that the 6% trend originally used in the pre-BIPA filing was much too conservative considering the increased cost trends we experienced from June 2000 to November 2000. As previously noted, the new actuarial trend projections for 2001 fee-for-service hospital (contracted medical claims) were revised to 15%. In essence, documentation supporting a revised 15% trend was provided and had we applied the revised 15% trend across each of the plans without further adjustments, we would have documentation to support all of the estimates in the BIPA ACR.

#### **Argument in Opposition of OIG Finding**

Our understanding of the issue that the OIG has taken with our BIPA ACR occurs here, Blue Shield had provided documentation to support an increased trend of 15%. The actuarial trend was subsequently refined or rather scaled down from the 15% actuarial trend for each of the M+C Plans. This was done by looking at the individual providers in each of the plan segments, talking to the Provider Relations staff about our relationship with those providers, and based on those discussions, we were not confident that a 15% trend would continue for full-year 2001 given the efforts we were taking to mitigate the cost increases. Consequently, Blue Shield of California used its best judgement, as regularly advised to do so by CMS, and conservatively assumed rather than the full 15% trend based on the actual estimate, that the remaining BIPA funding would be used by the increased fee-for-service trend. These reduced or scaled back trend figures were then used in revising the ACRP as the fee-for-service trend to balance the ACR without having to make changes to the additional revenue. The actual fee-for-service trend used in the BIPA ACR ranged from 6.32% to 13.92%, with our core market (Plan ID #007 - Los Angeles/Orange) representing approximately 78% of membership, trended at 9.43%, well below the 15%.

While we realize now that using a fixed trend (between 6% and 15%) across all plans and lowering the additional revenues would have been more accurate in the filing, the fact that Blue Shield completed its ACR in good faith and used lower trend figures than the 15% updated trend number based on actual experience does not invalidate the updated trend of 15%. Discarding our use of judgement and lower trend numbers for each segment is inconsistent with the verbal guidance we have received from CMS and is irrational given the fact that our actuarial trends provided during the audit were higher than what we used in the ACR. Blue Shield believes we adequately substantiated to the OIG auditors that a higher fee-for-service trend (of up to 15%) was appropriate for use in the BIPA filing. Since the issue is substantiation not of the 15% trend but rather of our use of a trend lower than 15% in each of the segments, then we must point back to the data supporting our use of a 15% trend as a valid and reasonable application under BIPA. Had Blue Shield used a trend higher than 15%, we

could understand a request for repayment, however, because we used a trend lower than the 15% revised actuarial trend, we disagree with the OIG finding and recommendation to refund \$4,555,992.

### Closing Summary

The OIG's opinion is that Blue Shield was unable to substantiate the trend used in the BIPA ACRP. Blue Shield of California's position is that we adequately substantiated the increased trend (up to 15%) to OIG during the audit and therefore the statement that Blue Shield of California "... overstated its direct medical costs by \$4,555,992.." and "... understated its excess of expected revenue over expected costs" is unfounded and inconsistent with our understanding from CMS instructions. By adjusting costs downward from the 15% trend, Blue Shield exercised its best judgement in completion of a revised filing within very tight timeframes. Additionally, Blue Shield requested the auditors to review the projections in the context of reality. A finding related to a projection that has no basis in reality and is inflating a substantiated trend is one thing. In this case, we have a projection that was based on actual trend provided and reducing the trend to a lower number was invalidated. We further submit that our trend was indeed based on "reality". Relative to the BIPA ACR, Blue Shield underestimated the trends significantly and it should also be noted that during the period where our projected trends were noted as "unsubstantiated" we experienced a staggering financial loss for our Blue Shield 65 Plus product in 2001.

We appreciate the opportunity to respond to the draft report from the Office of Inspector General's "Review of Blue Shield of California's Modification to its 2001 Adjusted Community Rate Proposal (ACR) Under the Benefits Improvement Act of 2000 (BIPA)" as well as your attention to our response. If you have any questions or need further information, please do not hesitate to contact me at (818) 228-2633.

Sincerely,



Kirk Clove

VP, Finance, Underwriting and Government Programs

CC: Lisa Rubino, SR VP & CEO, Individual and Government Programs  
Donovan Ayers, Director, Compliance & Government Programs  
John O'Neil, Senior Manager, Strategic Planning & HealthCare Economics

### Enclosures:

- I BIPA ACR Cover Letter
- II Excerpt from the BIPA Q&A (BIPA 2001 Questions and Answers - January 9, 2001)
- III 6% Trend Estimate (Pre-BIPA filing)
- IV 15% Trend Estimate (BIPA filing)
- V Blue Shield Medicare+Choice 2001 Financial Statement



January 18, 2001

LMI  
Attn: ACRP  
2000 Corporate Ridge  
McLean, VA 22102-7805

Re: Blue Shield of California Contract #H0504 CY 2001 ACRP Refiling per Benefits Improvement and Protection Act (BIPA) of 2000

Blue Shield of California (BSC) is re-submitting its CY 2001 ACRP as required by BIPA and HCFA's instructions in accordance with its good faith understanding of the applicable requirements. Given the limited amount of time afforded M+COs to obtain clarification from HCFA on the filing requirements, BSC has made certain assumptions in several areas including (1) the meaning of certain terms used by HCFA in the BIPA materials; (2) HCFA's expectations regarding certain requirements; and (3) what changes are permitted and what changes are required. In order to facilitate HCFA's review and understanding of this filing, BSC wishes to notify HCFA of the following with respect to this submission:

**Background:**

The new regulations enacted by the BBA, BBRA, and BIPA, along with the many new HCFA operational policy changes, have destabilized the status quo of the provider networks and prior business under the Medicare Risk contract model and created business dynamics that continue to evolve. Some hospitals have demanded fee-for-service payments above the Medicare allowable or DRG amounts in order to remain contracted, and regulations require we retain a contracted provider network.

Since the prior ACR filing, BSC has been challenged by provider contract terminations, demands for increased payment to physicians, and hospitals, provider bankruptcies, IPA and Medical Group closures, and state mandated and overseen loans to providers. Needless to say, this dynamic had a significant impact to the plan on various levels – movement of members to new personal physicians and physician groups, consolidation of network hospitals, and increased internal customer service and medical management staff. In addition there was a separate trend of hospitals moving from fix cost or capitation to a fee-for-service of per diem reimbursement, which significantly changed plan experience relative to the cost of medical care. Because of these dynamics, BSC intends on using the increased funds from BIPA for provider enhancement and stabilization.

- Blue Shield of California maintains provider contracts that stipulate provider payments based upon a percentage of the HCFA revenue received by the plan. These contracts included or encompass almost all Medicare Part B services through contracted IPA's or Medical Groups. Additionally, a substantial percentage of the BSC membership is under similar arrangements for hospital services. Overall, the increased revenue is required to flow through provider contracts as increased provider payments, consuming over half of the overall increase. Failure to pay according to established contract terms would result in a breach of contract and network destabilization.

- Hospital costs in 2000 carrying forward into 2001 have increased significantly due to various dynamics noted under the background above. The unexpected conversion of many hospital contracts from a fixed cost and fixed utilization to fee-for-service had two dynamics that the additional funding will help stabilize. First, the number of hospitals in the BSC network is shrinking due to payment demands. A portion of the additional revenue will be utilized for increased hospital payments. Second, as contracts convert from a capitated model, where hospitals were managing cost and monitoring patient stays, hospitals under the fee-for-service model are incentivized to maximize length of stay. This has led to increased provider costs to fund hospitalists by BSC and plan providers.
- Bankruptcies and provider closures have increased plan costs in two ways. First, physician costs that were prepaid or capitated have increased and, in some cases, payments were made twice for the services, once to the IPA and once to the rendering provider. Second, BSC had to contract with new providers, negotiate terms, and resolve transition of care issues. A portion of the funds will be used to pay for provider network stabilization and enhancement.
- There has also been significant provider pushback related to operational requirements that are being pushed down to providers without additional funding. The most demanding of these for 2001 is the data required to be submitted for physician and outpatient risk adjustment from encounter data submission. For IPA & Medical Group partners, this involves systems and IT costs, along with staffing costs to fully reconcile and capture data according to the HCFA requirements. Because many of the current systems do not gather the level of detail required by HCFA, BSC and other plans have been asked to assist in funding these costs. Based upon the feedback from the National IPA Coalition (NIPAC), the implementation of the physician risk adjuster will require new staff to be hired by the providers, for which in turn, providers will be looking for funding and assistance from the plans.

Noting the above, we are submitting our revised ACR proposal with the intent of spending the allocated increase on provider payments and items noted as necessary for network enhancement and stabilization.

To the best of my knowledge and belief, this proposal contains true and correct statements prepared from the books and records of the contracting organization in accordance with applicable instructions, except as noted below:

BSC has made good faith efforts to follow the HCFA instructions, requirements and guidance in updating the prior approved ACR according to the changes required by BIPA. The prior base ACR filing was used as the basis for updating cost and utilization assumptions in the applicable adjustment worksheets. Accompanying this filing are attachments summarizing how the increased payments will be used.

Sincerely,



Lisa Rubino  
Chief Executive and Senior Vice President  
Medicare and Government Programs

cc: Philip Doerr, Health Care Financing Administration

**Attachment II**

**Excerpt from the BIPA Q&A (BIPA 2001 Questions and Answers - January 9, 2001)**

**8. Q: Are M+COs permitted to update their currently approved ACRs with more recent and accurate data?**

**A: To the extent changes would result in stabilizing or enhancing access to providers or relate to new benefits, such changes to direct medical costs are permitted. For example, updates to direct medical costs could include revised utilization, unit cost, demographic, enrollment, and trend assumptions. Increases to administrative costs are prohibited unless the increase has a significant direct relationship to stabilizing or enhancing beneficiary access to providers or directly related to enhanced benefits. Changes in assumptions concerning additional revenue are not permitted unless directly related to enhanced benefits. Changes to the base period costs on Worksheet B or the financial data on Worksheet B-1 are also not permitted.**

# ACKNOWLEDGMENTS

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

Jerry McGee, *Audit Manager*

Danuta Biernat, *Senior Auditor*

Bernard Urabe, *Auditor-in-Charge*

Patricia Morgan, *Auditor*

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