Memorandum

Date JAN 18 2000

From June Gibbs Brown
Inspector General

Subject Review of the Administrative Cost Component of the Adjusted Community Rate Proposal at Nine Medicare Managed Care Organizations for the 1997 Contract Year (A-03-98-00046)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

The attached final report presents the consolidated results of an Office of Inspector General (OIG) review of the administrative cost component of the Adjusted Community Rate Proposal (ACRP) submitted to the Health Care Financing Administration (HCFA) by nine managed care organizations (MCOs) with Medicare risk-based contracts for the 1997 contract year. Reports outlining the audit results at each of the nine MCOs have previously been submitted to HCFA.

The objectives of our review were to examine the administrative cost component of the ACRP submitted by each MCO, and assess whether: (1) the proposed administrative costs included in the ACRP were reasonable when compared to the actual costs incurred; and (2) the actual administrative costs incurred were appropriate when considered in light of the Medicare program's general principle of paying only reasonable costs. This report includes results of our audits of nine MCOs, one each located in California, Florida, Maryland, Massachusetts, Minnesota, Missouri, New York, Pennsylvania, and Texas.

The Medicare ACRP process is designed for MCOs to present to HCFA their estimate of the funds needed to cover the costs of providing the Medicare package of covered services to any enrolled Medicare beneficiary. The ACRP is integral to pricing an MCO's benefit package, computing savings (if any) from Medicare payments, and determining additional benefits or premiums that could be charged to Medicare beneficiaries. Administrative costs, which are one component of the ACRP, include non-medical costs associated with facilities, marketing, taxes, depreciation, reinsurance, interest, non-medical compensation, and profit.

In a prior OIG audit report issued July 27, 1998 (*Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated, A-14-97-00202*), we concluded that the ACRP process enabled MCOs to exploit the use of medical utilization factors when computing their proposed administrative costs. We estimated that MCOs overestimated their administrative costs by about $1 billion a year for the years 1994 through 1996. This current final audit report presents information

relative to overstated estimates of proposed administrative costs by five MCOs (five of the nine reviewed had accounting records to allow for this analysis), and specific types of administrative costs incurred by nine MCOs.

Our review of the proposed administrative costs included in the ACRP substantiated our previous conclusion that the methodology for developing the ACRP resulted in Medicare paying a disproportionate share of the costs. By following HCFA's ACRP methodology, five of the nine MCOs reviewed overestimated their administrative costs by an average of 100 percent. The five MCOs proposed costs totaling $231.9 million and incurred costs totaling only $115.7 million, for an excess of $116.2 million. Our conclusion is based on a comparison of the proposed administrative costs included in the ACRPs and the administrative costs actually incurred by the five MCOs according to their own accounting records. We were unable to determine if the remaining four MCOs (of the nine in our audit) overestimated their proposed administrative costs because they did not segregate Medicare and non-Medicare costs.

Accomplishing the second part of our audit objective, to review the actual administrative costs incurred by the nine MCOs included in our reviews, disclosed that costs totaling $66.3 million would have been recommended for disallowance by us had the MCOs been required to follow Medicare's general principle of paying only reasonable costs. Since there is no statutory or regulatory authority governing allowability of costs in the ACRP, the MCOs were not required to adhere to this principle. We recommended that HCFA consider:

- ❶ Pursuing legislation concerning MCOs' administrative costs which would require MCOs to follow Medicare's general principle of paying only reasonable costs (in this case Part 31 of the Federal Acquisition Regulation). An acceptable alternative would be for HCFA to establish a cap on administrative costs similar to the cap imposed on universities under the Office of Management and Budget Circular A-21 "Cost Principles for Academic Institutions." The Circular limits the reimbursed administrative expenses to a percentage of direct costs.

- ❷ Publishing the administrative cost rates of all MCOs participating in the Medicare program. This would supplement HCFA's already strong efforts at providing information to Medicare beneficiaries aimed at helping them become educated consumers of medical services.

In response to our draft report, HCFA acknowledged again that the previous ACRP methodology resulted in overstated administrative costs. The HCFA, however, did not concur with our recommendations. The HCFA noted that it recently revised the ACRP methodology to require MCOs to report costs actually incurred in treating Medicare beneficiaries. The HCFA stated that these procedures will be reviewed to ensure the effectiveness of reducing the administrative burdens on MCOs.

We disagree with HCFA. We believe that MCOs will be able to continue to include in their ACRPs costs that would be unallowable under Medicare's general principle of paying only reasonable costs. We also believe that it would be useful for the beneficiary to know how much of their premium is spent on administrative costs and how much is spent on health care.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have further questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-03-98-00046 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE ADMINISTRATIVE COST COMPONENT OF THE ADJUSTED COMMUNITY RATE PROPOSAL AT NINE MEDICARE MANAGED CARE ORGANIZATIONS FOR THE 1997 CONTRACT YEAR

JUNE GIBBS BROWN
Inspector General

JANUARY 2000
A-03-98-00046

EXECUTIVE SUMMARY

OBJECTIVES

The objectives of our review were to examine the administrative cost component of the Adjusted Community Rate Proposal (ACRP) submitted by each managed care organizations (MCO), and assess whether: (1) the ***proposed administrative costs*** included in the ACRP were reasonable when compared to the actual costs incurred; and (2) the ***actual administrative costs*** incurred were appropriate when considered in light of the Medicare program's general principle of paying only reasonable costs. This report includes results of our audits of nine MCOs, one each located in California, Florida, Maryland, Massachusetts, Minnesota, Missouri, New York, Pennsylvania, and Texas.

BACKGROUND

The Medicare ACRP process is designed for MCOs to present to the Health Care Financing Administration (HCFA) their estimate of the funds needed to cover the costs of providing the Medicare package of covered services to any enrolled Medicare beneficiary. The ACRP is integral to pricing an MCO's benefit package, computing savings (if any) from Medicare payments, and determining additional benefits or premiums that could be charged to Medicare beneficiaries. Administrative costs, which are one component of the ACRP, include non-medical costs associated with facilities, marketing, taxes, depreciation, reinsurance, interest, non-medical compensation, and profit.

In a prior Office of Inspector General (OIG) audit report,[1] we concluded that the ACRP process enabled MCOs to exploit the use of medical utilization factors when computing their proposed administrative costs. We estimated that MCOs overestimated their administrative costs by about $1 billion a year for the years 1994 through 1996. We recommended that HCFA revise its criteria to require MCOs to allocate their administrative cost estimates following the same concepts used throughout the Medicare program to help ensure that non-Medicare costs are not borne by Medicare. We also recommended that HCFA introduce legislation that would allow Medicare to recover the excessive amount presently being paid for administration.

In its response to our prior report, HCFA agreed that the current process almost certainly resulted in overstated administrative costs, but stated that its efforts in revising the ACRP process will produce a more realistic allocation of administrative costs that better reflect differences between Medicare and commercial enrollees. The HCFA did not agree to introduce legislation but stated that it may be appropriate to reassess our recommendation once it has had the opportunity to fully assess the impact of the Balanced Budget Act (BBA) of 1997 that mandated payment changes and ACRP audits.

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[1] Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated (A-14-97-00202), July 27, 1998.

This current final audit report presents information relative to overstated estimates of proposed administrative costs by five MCOs (five of the nine reviewed had accounting records to allow for this analysis), and specific types of administrative costs incurred by nine MCOs.

FINDINGS

Our review of the ***proposed administrative costs*** included in the 1997 ACRP substantiated our previous conclusion that the methodology for developing the ACRP resulted in Medicare paying a disproportionate share of the costs. By following HCFA's ACRP methodology, five of the nine MCOs reviewed overestimated their administrative costs by an average of 100 percent. The five MCOs proposed costs totaling $231.9 million and incurred costs totaling only $115.7 million, for an excess of $116.2 million. Our conclusion is based on a comparison of the proposed administrative costs included in the ACRPs and the administrative costs actually incurred by the five MCOs according to their own accounting records. We were unable to determine if the remaining four MCOs (of the nine in our audit) overestimated their proposed administrative costs because they did not segregate Medicare and non-Medicare costs within their accounting records.

Accomplishing the second part of our audit objective, to review the ***actual administrative costs*** incurred by the nine MCOs included in our reviews, disclosed that costs totaling $66.3 million would have been recommended for disallowance by us had the MCOs been required to follow Medicare's general principle of paying only reasonable costs. Since there is no statutory or regulatory authority governing allowability of costs in the ACRP, the MCOs were not required to adhere to this principle. The $66.3 million of costs included:

- $4.7 million for costs unallowable under Part 31 of the Federal Acquisition Regulation (FAR) "Contract Cost Principles and Procedures" which are required to be followed by other organizations that participate in Medicare but not by risk-based MCOs.[2] The costs related to entertainment, gifts, and employee morale; lobbying and public relations; contributions and sponsorships; bad debts; fines and penalties; travel; and miscellaneous items. All nine MCOs reported at least one of these cost elements.

- $3.2 million reported by five MCOs for costs that should not have been allocated to the Medicare program, and

- $58.4 million in unsupported costs reported by five MCOs.

[2]The FAR is the primary regulation for use by all Federal Executive agencies in their acquisition of supplies and services with appropriated funds. Part 31 contains cost principles and procedures for (a) the pricing of contracts, subcontracts, and modifications to contracts and subcontracts whenever cost analysis is performed and (b) the determination, negotiation, or allowance of costs when required by a contract clause.

CONCLUSION AND RECOMMENDATIONS

Our previous audit report concluded that risk-based MCOs have been allowed to include on their ACRPs excessive amounts of administrative costs. This current report supports that conclusion. In just one year at five MCOs, the proposed administrative costs included on their ACRPs exceeded actual administrative costs incurred by $116.2 million. In addition, the costs incurred by the nine MCOs reviewed included $66.3 million that we would have questioned had the MCOs been subject to Part 31 of the FAR.

The HCFA believes that its revised ACRP methodology will more accurately reflect administrative costs for Medicare beneficiaries and should result in a lesser amount of administrative costs being allocated to Medicare enrollees. We agree that the revised methodology is an improvement over the prior version; however, we believe that more can be done to reduce the administrative cost burden to the Medicare program.

We recommend that HCFA consider:

- Pursuing legislation concerning MCOs' administrative costs which would require risk-based MCOs to follow Medicare's general principle of paying only reasonable costs (in this case Part 31 of the FAR). An acceptable alternative would be for HCFA to establish a cap on administrative costs similar to the cap imposed on universities under the Office of Management and Budget (OMB) Circular "Cost Principles for Academic Institutions." The Circular limits the reimbursed administrative expenses to a percentage of direct costs.

- Publishing the administrative cost rates of all MCOs participating in the Medicare program. This would supplement HCFA's already strong efforts at providing information to Medicare beneficiaries aimed at helping them become educated consumers of medical services.

In response to our draft report, HCFA acknowledged again that the previous ACRP methodology has resulted in overstated administrative costs. The HCFA, however, did not concur with our recommendations. The HCFA noted that it has recently revised the ACRP methodology to require MCOs to report costs actually incurred in treating Medicare beneficiaries. The HCFA stated that these procedures will be reviewed to ensure the effectiveness of reducing the administrative burdens on MCOs. We have summarized HCFA's comments and the OIG response to those comments beginning on page 13. The HCFA comments to our draft report are included in their entirety in the Appendix to this report.

We disagree with HCFA. We believe that MCOs will be able to continue to include in their ACRPs costs that would be unallowable under Medicare's general principle of

paying only reasonable costs. We also believe that it would be useful for the beneficiary to know how much of their premium is spent on administrative costs and how much is spent on health care.

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INTRODUCTION

Background

Under Title XVIII of the Social Security Act, the Medicare program provides health insurance to 37 million Americans age 65 and over and those who have permanent kidney failure and certain people with disabilities. Within the Department of Health and Human Services, the Medicare program is administered by HCFA. Medicare includes two related health insurance programs, hospital insurance or Part A, and supplementary medical insurance, Part B. Part A includes inpatient hospital, skilled nursing, rehabilitation, home health, and hospice services. Part B includes physician and outpatient hospital services and durable medical equipment.

Section 1851-1859 of the BBA of 1997 implemented Part C of the Medicare program, Medicare+Choice. Beginning in November 1999, the Medicare+Choice program will offer Medicare beneficiaries a variety of health delivery models, including coordinated care MCOs such as Health Maintenance Organizations, Preferred Provider Organizations, Provider Sponsored Organizations, Medical Savings Accounts, and private fee-for-service Medicare.

Medicare Managed Care

The MCOs can serve Medicare beneficiaries through three types of contracts: risk, cost, and health care prepayment plans. All Medicare MCOs receive a monthly payment from the Medicare program. In December 1996, more than 4.7 million Medicare beneficiaries were enrolled in a total of 335 MCOs, 241 risk, 36 cost, 49 Health Care Prepayment Plans, and 9 other demonstration plans. As of December 31, 1998, more than 6.5 million Medicare beneficiaries were enrolled in a total of 394 MCOs, 295 risk, 48 cost, 14 Health Care Prepayment Plans, and 37 other demonstration plans.

Risk-based plans are paid a per capita premium set at approximately 95 percent of the projected average costs for fee-for-service beneficiaries in a given county. The plans assume full financial risk for all care provided to Medicare beneficiaries, and must provide all Medicare-covered services. Most plans offer additional services, such as prescription drugs and eyeglasses. The nine MCOs included in our review are risk-based plans.

Cost-based plans are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the costs. Cost plans must provide all Medicare-covered services but may not provide the additional services that some risk plans offer. Beneficiaries can also obtain Medicare-covered services outside the plan without limitation. When a beneficiary goes outside the plan, Medicare pays its traditional share of those costs and the beneficiary pays Medicare's coinsurance and deductibles.

Health Care Prepayment Plans are paid in a similar manner as cost plans but only cover part of the Medicare benefit package (generally Part B). These plans do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice, and some home health care).

Adjusted Community Rate Proposal

Risk-based contractors are required by section 1876 of the Social Security Act to compute an ACRP and submit it to HCFA prior to the beginning of their contract period. The HCFA encourages the MCOs to support their ACRP with the most current data available. At HCFA central office, the Health Plan Purchasing and Administrative Group (formerly the Office of Managed Care) reviews the ACRP for correctness. The ACRP itemizes the amounts for the benefit package provided by the MCO, including administrative costs. The ACRP is designed to help both the MCO and HCFA recognize and evaluate the revenue requirements needed to cover the proposed costs. The ACRP is intended to ensure that Medicare beneficiaries are not overcharged for the benefit package offered.

The MCO calculates its ACRP, using as a basis, its commercial rates adjusted to account for differences in cost and use of services between Medicare and commercial enrollees. There are several steps in this process. This process was in effect during our period of review. The changes brought about by BBA of 1997 are detailed in a later paragraph.

❶ The development of a ***base rate*** is the first step of the process. The base rate is the amount that the MCO will charge its non-Medicare enrollees during the contract period.

❷ The next step in the process is to develop adjustments to arrive at the ***initial rate*** which is the rate the MCO would have charged its commercial members if the commercial package was limited to Medicare coverage. The adjustments eliminate the value of those services not covered by Medicare that were included in the base rate or add the value of covered Medicare services not included in the base rate.

❸ The next step is to calculate the ***ACRP*** by multiplying the initial rate by utilization factors to reflect differences between Medicare members and non-Medicare members with regard to volume, intensity, and complexity of services.

Medicare payments to risk-based MCOs are based on a prepaid capitation rate. This rate reflects the estimated costs that would have been incurred by Medicare on behalf of enrollees of the MCO if they received their covered services under fee-for-service Medicare.

If the average Medicare payment amount is greater than the ACRP, a savings is noted. During the period of our audit, MCOs were required to use this savings to either improve their benefit package to Medicare enrollees, reduce the Medicare enrollees' premium, contribute to a benefit stabilization fund, or accept a reduced capitation payment. With regard to the inclusion of costs, according to the Health Maintenance Organization Manual, all assumptions, cost data, revenue requirements, and other elements used by MCOs in the ACRP calculations must be consistent with calculations used for premiums charged to non-Medicare enrollees.

An administrative cost rate is applied to the total at each step of the process to determine the administrate cost portion of the proposal. According to 42 CFR 417.594, general and administrative rates "must be consistent" with rates used by MCOs when calculating premiums for non-Medicare enrollees. If a MCO does not apply a rate in computing its administrative costs for its non-Medicare enrollees, then it must use the same method in calculating administrative costs on the ACRP. Reinsurance costs must be included in the administration calculation.

The MCO cost data will be especially important due to the changes in the ACRP brought about by the BBA of 1997. In January 1998, HCFA proposed a revised ACRP methodology for the Calender Year (CY) 2000 ACRP cycle. The revised ACRP, Form HCFA-R-228, requires the Medicare+Choice plan to "show the actual amounts of administration actually incurred." One ACRP must be submitted for each plan the organization intends to market. Administrative costs will be determined using a "relative cost ratio" based on actual administrative costs incurred for Medicare beneficiaries in a base year to actual administrative costs incurred for commercial enrollees in the same base year. The "relative cost ratio" is applied to estimated commercial administrative costs for the year being reported upon to arrive at Medicare administrative costs.

Prior OIG Report Identifies Flaws in Administrative Cost Methodology

In a prior audit report (see footnote 1), we concluded that the methodology used prior to the CY 2000 ACRP enabled MCOs to exploit the use of medical utilization factors when computing their anticipated administrative costs. We estimated that about $1 billion a year could be saved if the allocation of the category within the ACRP termed "administration" was determined in accordance with the Medicare program's longstanding principle that Medicare only pay its applicable or fair share of needed health care costs. We recommended that HCFA: (1) amend its criteria to require MCOs to allocate their planned administrative costs on their ACRPs on a more realistic allocation methodology; and (2) introduce legislation to capture the savings that would be achieved by any changes in accounting for administrative costs.

The HCFA agreed that the then current ACRP format almost certainly resulted in overstated administrative costs, but believed that the new ACRP format brought about by the BBA of 1997 will more accurately reflect administrative costs. Although not agreeing to introduce corrective legislation, HCFA stated that it may be appropriate to reassess this recommendation in the future once they have an opportunity to fully assess the impact of the BBA of 1997 that mandated payment changes and ACRP audits.

Objectives, Scope, And Methodology

The objectives of our review were to examine the administrative cost component of the ACRP for the 1997 Medicare contract year submitted by nine MCOs and assess whether: (1) the ***proposed administrative costs*** included in the ACRP were reasonable when compared to the actual costs incurred; and (2) the ***actual administrative costs*** incurred were appropriate when

considered in light of Medicare program's general principle of paying only reasonable costs. We did not review medical costs including any additional benefits offered by the MCOs.

In December 1996, HCFA contracted with 241 risk based plans with enrollment of 4.1 million beneficiaries, or 86 percent of managed care enrollees. From these 241 plans, we judgementally selected for review nine MCOs from each of the OIG regions, throughout the country, one each located in California, Florida, Maryland, Massachusetts, Minnesota, Missouri, New York, Pennsylvania, and Texas. We did not project the results to all 241 MCOs. However, our selection included a broad scope of plans throughout the country. Our recommendations are based on the significance of the findings in the nine MCOs we reviewed and the fact that each of the nine had similar significant findings.

We used each MCO's accounting records as support for the 1997 ACRP. Administrative costs included the non-medical costs such as facilities, marketing, taxes, depreciation, reinsurance, interest, non-medical compensation, and profit. We reviewed applicable laws and regulations, and discussed with MCO officials their ACRP process and how their administrative costs were derived. We compared proposed costs included on the ACRP to the costs reported on the MCOs accounting records. We then judgementally selected categories of administrative costs which traditionally have been shown to be problematic areas in the Medicare fee-for-service program. Because of this, our results cannot be considered representative of the universe of administrative costs submitted by each MCO. We evaluated the selected costs against the cost principles of Part 31 of the FAR and the guidelines of the MCO contract.

Our review was performed in accordance with generally accepted government auditing standards. The objective of our review did not require us to review the internal control structure at the MCOs. Our work was performed at each MCO's administrative headquarters. Our reviews began in August 1997 and were completed in January 1999. Reports outlining the audit results at each of the nine MCOs have previously been submitted to HCFA.

FINDINGS AND RECOMMENDATIONS

Proposed Administrative Costs Overstated by $116.2 million at Five MCOs

The prior methodology for developing the ACRP resulted in excessive estimates of the proposed administrative costs being included on the ACRPs. Following this methodology, five of the nine MCOs, where we were able to conduct this portion of the review, overestimated their 1997 proposed administrative costs by an average of 100 percent or $116.2 million. The remaining four MCOs did not segregate their administrative costs between their Medicare and non-Medicare lines of business. This segregation of costs will be required under the revised ACRP process being implemented as part of the BBA of 1997.

In developing their administrative cost estimates for the ACRP, the MCOs applied the percentage methodology used for commercial lines of business for the Medicare business. The percentage methodology was acceptable to HCFA because the only requirement regarding the inclusion of costs on the ACRP proposal was that all assumptions, cost data, revenue requirements, and other elements used by MCOs in the ACRP calculations must be consistent with the calculations used for the premiums charged to non-Medicare enrollees. We found allocating administrative costs based on a percentage computation, however, grossly inflated the MCOs' administrative needs for Medicare. The reason was that this methodology took advantage of the effect of medical utilization factors on the administrative component. The result was that the amounts for administration tend to be a product of the medical premium rather than reflecting what is needed to cover administrative costs.

This gross inflation is clearly demonstrated by a comparison of the proposed administrative costs included on the ACRPs to the actual costs incurred per the accounting records of the MCOs. For each of the five MCOs, we computed the proposed costs by multiplying the total Medicare member months by the proposed per member per month (PMPM) administrative cost amount shown in the ACRP. As shown in the following table, the proposed costs of the five MCOs totaled about $231.9 million, or about double the $116.2 million of administrative costs that were eventually incurred and reported on the MCOs' accounting records.

COMPARISON OF PROPOSED AND ACTUAL 1997 ADMINISTRATIVE COSTS

MCO	Proposed	Actual	Excess	Percent of Excess
1	$41,489,647	$25,083,247	$16,406,400	65%
2	$54,006,778	$38,780,558	$15,226,220	39%
3	$11,100,530	$8,795,348	$2,305,182	26%
4	$95,776,830	$32,792,397	$62,984,433	192%
5	$29,485,849	$10,247,940	$19,237,909	188%
Total	**$231,859,634**	**$115,699,490**	**$116,160,144**	**100%**

Overestimating the proposed administrative costs had a significant impact on the administrative cost component of the monthly capitation fee proposed by the five MCOs. As shown below, on a PMPM basis, the five MCOs proposed, on average, $44.59 per month for each of their enrolled beneficiaries more than the costs that they actually incurred on behalf of these beneficiaries.

COMPARISON OF PROPOSED AND ACTUAL PMPM 1997 ADMINISTRATIVE COSTS			
MCO	**Proposed**	**Actual**	**Excess**
1	$93.49	$56.52	$36.97
2	$79.31	$56.95	$22.36
3	$83.03	$65.79	$17.24
4	$88.07	$30.15	$57.92
5	$113.94	$39.60	$74.34
Weighted Average	**$89.01**	**$44.42**	**$44.59**

The MCOs were aware that the methodology used to develop the proposed administrative costs for the ACRP led to inflated proposals. For example, MCO number 4 in the above tables proposed to provide to enrolled Medicare beneficiaries three optional plans of additional health care related services in addition to basic Medicare coverage. The MCO claimed that it would incur a loss for each of these three plans, but waived its request to HCFA for additional premiums to cover these projected losses. The MCO was able to satisfy HCFA's insolvency concerns (which are normally raised by HCFA personnel when it appears an MCO will not have sufficient revenue to deliver the MCO's planned health care services) by adding a "Statement of Solvency" to its ACRP, which included a statement indicating that the MCO believed it would incur Medicare administrative costs lower than the amount proposed using the ACRP methodology. As shown in the preceding tables, the MCO was correct in its assumptions. Its proposed administrative costs exceeded actual costs by 192 percent or almost $63 million. However, neither the MCO nor HCFA attempted to reduce the ACRP rate to more accurately reflect projected expenses.

Actual Administrative Costs Included Costs Generally Considered Unallowable

Under the prior ACRP methodology, there was no statutory or regulatory authority governing allowability of costs in the ACRP for risk MCOs, unlike other areas of the Medicare program. For example, regulations covering cost-based MCOs provide specific parameters delineating allowable administrative costs for enrollment and marketing. Likewise, Medicare carriers and intermediaries are required to comply with Part 31 of the FAR. Risk-based MCOs, like the nine included in our review, however, were not required to follow these guidelines. Had these nine MCOs been required to follow these guidelines, we would have questioned $66.3 million of administrative costs that they incurred in 1997. These costs include:

- $4.7 million for costs unallowable under Part 31 of the FAR which is required to be followed by other organizations that participate in Medicare but not by risk-based MCOs. The costs relate to entertainment, gifts, and employee morale; lobbying and public relations; contributions and sponsorships; bad debts; fines and penalties; travel; and miscellaneous items. All nine MCOs reported at least one of these cost elements.

- $3.2 million reported by five MCOs for costs that should not have been allocated to their Medicare lines of business, and

- $58.4 million in unsupported costs reported by six MCOs.

Administrative Costs Unallowable Under the FAR

We identified about $4.7 million of administrative costs that did not comply with guidelines that are required to be followed by other Medicare program participants. We categorized these costs as follows.

Entertainment, Gifts, and Employee Morale Costs--$1,569,965

Nine MCOs reported on their accounting records a total of $1,569,965 for costs related to entertainment, gifts, and employee morale. Four of the MCOs accounted for about $1.3 million of this amount while the remaining five MCOs reported cost ranging from $18,074 to $95,038. Examples of these costs are:

- $249,283 in meeting costs that included food, gifts, and alcoholic beverages at one MCO,

- $190,417 for a sales award meeting in Puerto Rico for one MCO,

- $157,688 for a party celebrating a MCO's parent company's 150th anniversary,

- $25,057 for leasing a luxury box suite at a professional sports arena by one MCO,

- $106,490 for sporting events and/or theater tickets at four MCOs,

- $69,700 for holiday parties at three MCOs,

- $37,303 for wine gift baskets, flowers, gifts, and gift certificates for customers, insurance brokers, and employees at one MCO, and

- $3,133 for various items including use of a massage therapist at an employee function at one MCO.

Medicare carriers and intermediaries are prohibited from claiming these types of costs by two provisions of the FAR. According to 31 FAR section 205-13(b), (c) & (d), costs of employee gifts and recreation and losses sustained for food services furnished without charge are unallowable. Section 205-14 states that costs of amusement, diversion, social activities, and any directly associated costs, such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities are unallowable. Costs of membership in social, dining, or country clubs or other organizations having the same purpose are also unallowable.

Lobbying and Public Relations Costs--$1,069,340

Seven MCOs reported on their accounting records a total of $804,950 in lobbying costs. Two of the MCOs accounted for $634,321 of this amount while the other five MCOs reported costs ranging from $2,900 to $92,856. We also found $264,390 paid by three MCOs to trade associations. One group, representing health care organizations, conducted a media campaign to promote the State's health maintenance organization industry.

Article 9, section D of the MCO contract with HCFA prohibits the use of HCFA funds to influence legislation or appropriation. This contract provision incorporated section 205-22 of the FAR which states that costs associated with lobbying and political activity are unallowable. Furthermore, section 205-1(f)(1) states that unallowable public relations and advertising costs include disseminating messages calling favorable attention to the contractor for purposes of enhancing the company image. Although there was a contract provision prohibiting lobbying costs, legal advice we obtained concluded that this provision was not enforceable due to the nature of the MCO risk contract.

Contributions and Sponsorship Costs--$1,230,413

Eight MCOs reported a total of $1,230,413 in contributions and sponsorship costs. Four of the MCOs accounted for about $1,070,104 of this amount while the remaining four MCOs reported costs ranging from $19,667 to $91,862. Contribution and sponsorship expenditures include donations to local schools and charitable organizations such as the Special Olympics, YMCA, Boy Scouts of America, the Urban League, an Alzheimer's association, and a camp for children with asthma. Several MCOs also reported sponsorship costs for golf tournaments; some included alcohol. The 31 FAR 205-8 and 205-1(f)(3) prohibit such costs. Specifically, contributions or donations, including cash, property and services, regardless of recipient, are unallowable. The costs of sponsoring special events when the purpose of the event is other than disseminating technical information is unallowable.

Bad Debts--$365,000

One MCO reported $365,000 in bad debt costs. These costs are unallowable under a MCO cost reimbursement contract, and 31 FAR 205-3 which states that bad debts, including actual or estimated losses arising from uncollectible accounts receivable due from customers and other claims, and any directly associated costs such as collection costs, and legal costs are unallowable.

Fines and Penalties--$48,011

Two MCOs reported a total of $48,011 in fines and penalties primarily paid to the Internal Revenue Service. Federal taxes are allowable according to 31 FAR 205-41(a)(1). However, fines and penalties are not considered taxes. The costs of fines and penalties resulting from violations of, or the failure of the contractor to comply with Federal, State, local, or foreign laws and regulations, are unallowable except when incurred as a result of compliance with specific terms and conditions of the contract according to section 205-15.

Travel Costs--$313,407

Three MCOs reported a total of $313,407 in travel costs that exceeded Federal travel limits. One MCO had $309,277 in automobile allowances that exceeded the maximum mileage rate; one MCO reported $3,278 in charges in excess of the maximum per diem rates; and one MCO incurred $852 in excessive hotel costs incurred by a marketing manager while attending a conference at Disney World in Orlando, Florida. According to 31 FAR 205-46(a)(2), costs incurred for lodging, meals, and incidental expenses shall be considered reasonable and allowable only to the extent that they do not exceed the maximum per diem rates in effect at the time of travel as set forth in the Federal Travel Regulations.

Miscellaneous Costs--$59,615

Four MCOs reported other types of unallowable costs totaling $59,615. For example, one MCO reported purchasing $14,282 in artwork for executive offices and rental and maintenance of artificial plants for its lobby. This same MCO also reported $12,887 in rental costs to reserve parking spaces for its executives. These special services, we believe, are not reasonable and would not be allowed under 31 FAR 201-3. Another MCO reported $1,452 in interest costs on loans. According to 31 FAR 205-20, interest on borrowing (however represented) is unallowable except for interest assessed by State and local taxing authorities under certain conditions.

Misallocated Costs

We identified a total of $3,207,779 in costs reported by five MCOs that should not have been allocated to the Medicare program. According to 31 FAR 201-4, a cost is allocable if it (a) is

incurred specifically for the contract; (b) benefits both the contract and other work, and can be distributed in reasonable proportion to the benefits received; or (c) is necessary to the overall operation of the business. We believe the costs shown below do not meet this criteria.

- One MCO reported $2,106,246 in broker commissions for its commercial lines of business. However, broker commissions are service fees that are paid to agents for soliciting and securing enrollees in the MCO.

- One MCO reported $565,472 in reinsurance costs from a related organization. The reinsurance contract ceased coverage of the MCO's Medicare members effective January 1, 1996. However, the MCO charged its administrative costs throughout 1996.

- One MCO reported $352,854 in unallocable costs. This amount consisted of: $213,572 incurred by another Medicare plan it operated in another State; $48,285 incurred by its other lines of business; and $90,997 in overcharges due to a miscalculation in reinsurance methodology.

- One MCO reported $217,241 in unallocable costs. This amount consisted of: $170,594 in Medicaid costs reported as a Medicare expenditure; $31,308 for office expenses related to a foundation the MCO created; and $15,339 in insurance premiums paid by the MCO on behalf of another corporation.

- One MCO had a negative $34,034 in net cost allocation errors. Allocation errors resulted in a $84,454 net undercharge to the MCO's Medicare line of business and a $118,488 net overcharge to non-Medicare lines of business. The net effect of the allocation errors was an overcharge of $34,034 to the MCO's non-Medicare lines of business.

Allocation errors could have a significant effect when developing the revised ACRP under the Medicare+Choice program. Under the revised ACRP methodology, administrative costs are developed by multiplying the non-Medicare PMPM administrative costs by a "relative cost ratio". This ratio divides Medicare costs by non-Medicare costs. Therefore, an allocation error resulting in an overcharge to Medicare and an undercharge to non-Medicare costs will inflate the relative cost ratio and lead to an inflated Medicare administrative cost rate.

Unsupported Costs

Five MCOs did not provide the necessary documentation to enable us to determine the nature of a total of $58.4 million in costs. The unsupported costs consist of $53,389,799 of related party costs reported by three MCOs; and $5,010,391 of other administrative costs reported by five MCOs. According to 31 FAR 201-2(d) a contractor is responsible for accounting for costs

appropriately and for maintaining records, including supporting documentation, adequate to demonstrate that costs claimed had been incurred, are allocable to the contract, and comply with applicable costs principles.

Related Party Costs--$53,389,799

The vast majority of the total unsupported costs we found, almost $53.4 million, pertained to related party costs reported by three MCOs. At one MCO, we identified $10,909,164 in related party transactions for management fees and reinsurance expenses. The management fees and reinsurance expenses were based on negotiated agreements between related parties. The MCO was unable to identify the related parties' costs. At another MCO, we identified $3,301,726 in related party-costs to the plan's commercial line of business. The MCO could not provide an allocation methodology between the plan's commercial and Medicare lines of business. At a third MCO, we identified $39,178,909 in charges from a related entity--the MCO's parent organization--that were allocated to the MCO. Prior to completion of audit field work the MCO ceased providing documentation that we deemed necessary to fully evaluate the related party costs, therefore, we were unable to make a final determination on these costs.

While related party costs are allowable under Medicare fee-for-service, Medicare limits the provider's reimbursement to the related party's costs (42 CFR 417.536(k)). Moreover, Medicare requires cost-based MCOs to allocate allowable costs of a separate entity or department that performs administrative services in reasonable proportion to the benefits received (42 CFR 417.564(b)(2)(i)). Due to the MCOs not providing us sufficient information, we were unable to determine whether the $53.4 million in allocated related party costs: (1) represented actual cost to the related party, (2) were distributed on the basis of benefits received or other reasonable allocation methodology, and (3) included costs that would not be allowable if existing Medicare regulations applied to risk based MCOs.

Other Administrative Costs--$5,010,391

Five MCOs provided inadequate documentation to support a total of over $5 million in administrative costs. **One** MCO reported $847,335 in reinsurance costs but provided no support to justify the charges. This MCO also did not provide the documentation to support 33 sampled cost items totaling $116,251. **One** MCO also did not provide documentation to support 107 of the 289 sampled transactions totaling $1,066,833. These costs related primarily to travel and auto, meetings and dues, and miscellaneous and consulting. The documentation to support these charges was either missing or not sufficient to support the costs charged. **One** MCO reported $113,461 in travel and entertainment costs and $54,725 in repairs and maintenance for which there was no support. **One** MCO reported $680,037 for advertising, printing and other expenses. The MCO did not provide sufficient documentation that was needed to fully evaluate the reasonableness of these costs. **One** MCO reported $2,131,749 in unsupported costs for

management fees, commissions, administrative expenses, rental/lease costs, interest on long-term debt, and other miscellaneous items. Due to lack of documentation, we could not determine the reasonableness of these costs.

Conclusion and Recommendations

Our previous audit report concluded that MCOs have been allowed to include on their ACRPs excessive amounts of administrative costs. This report supports that conclusion. In just 1 year at five MCOs, the proposed administrative costs included on their ACRPs exceeded actual administrative costs incurred by $116.2 million. In addition, the costs incurred by the nine MCOs reviewed included $66.3 million that we would have questioned had the MCOs been subject to Part 31 of the FAR. The HCFA believes that its revised ACRP methodology will more accurately reflect administrative costs for Medicare beneficiaries and should result in a lesser amount of administrative costs being allocated to Medicare enrollees. We agree that the revised methodology is an improvement over the prior version; however, we believe that more can be done to reduce the administrative cost burden on the Medicare program.

Under the prior ACRP methodology, Medicare administrative cost rates expressed as a percentage of Medicare medical costs, ranged from 16.56 percent to 44.30 percent, for the nine MCOs included in our review. For the 241 MCOs that had risk-based contracts in 1997, the administrative cost rates ranged from 3.29 percent to 47.28 percent. Nineteen of the 241 MCOs had administrative cost rates exceeding 30 percent while 16 MCOs had rates lower than 10 percent. This widespread variance indicates to us that some MCOs apparently did not consider cost reduction efforts to be a priority.

We believe this variance in administrative cost rates may continue under the revised ACRP methodology because: (1) risk-based MCOs can continue to include in their ACRPs costs that are unallowable under Medicare's general principle of paying only reasonable costs; and (2) Medicare beneficiaries are not provided information on administrative cost rates to help them select their health care under Medicare, thus marketplace influences may not be present to help limit administrative costs.

With regard to published information, we noted that HCFA provides, particularly through its Internet site, much information to Medicare beneficiaries in an effort to help make them educated consumers of medical services. Beneficiaries can access various HCFA publications that explain managed care and how to choose a Medicare health plan. The HCFA's Internet site also offers "Medicare Compare", an interactive database which includes detailed information on Medicare's health plan options. Medicare Compare allows beneficiaries to comparison shop and find a plan in their area that best suites their needs. Beneficiaries can look at plans in a few different ways. They can make side-by-side plan comparisons of the costs of premiums and the benefits being offered, or they can compare the quality of care offered.

Beneficiaries are not, however, provided information on plans' administrative cost rates to enable them to identify those plans that spend a higher percentage of their Medicare revenues on providing medical services. This is unlike the information made available to Federal employees prior to their participation in the Combined Federal Campaign (CFC), an annual charity drive sponsored by the Federal government. Employees have available to them the administrative cost rate of every charity eligible to participate in the CFC. The premise is that an employee would find it very useful to know what percentage of funds received by an organization go to overhead versus what percentage of funds are directed to the organization's primary mission--charity. The same premise may hold true for Medicare beneficiaries, that is, they may find it useful to know what percentage of funds paid to an MCO is diverted from its primary mission of providing medical services to administrative areas.

We recommend that HCFA consider:

- ❶ Pursuing legislation requiring MCOs' to follow the Medicare cost principle of paying only reasonable costs (in this case Part 31 of the FAR). An acceptable alternative would be for HCFA to establish a cap on administrative costs similar to the cap imposed on universities under the OMB Circular "Cost Principles for Academic Institutions." The Circular limits the reimbursed administrative expenses to a percentage of direct costs.

- ❷ Publishing the administrative cost rates of all MCOs participating in the Medicare program. This would supplement HCFA's already strong efforts at providing information to Medicare beneficiaries aimed at helping them become educated consumers of medical services.

HCFA Comments

In its comments to our draft report, HCFA acknowledged again that the previous ACRP methodology has resulted in overstated administrative costs. The HCFA noted that it recently revised the ACRP methodology to require MCOs to report costs actually incurred in treating Medicare beneficiaries. The HCFA stated that these procedures will be reviewed to ensure the effectiveness of reducing the administrative burdens on MCOs. The HCFA, however, did not concur with our recommendations.

Regarding our first recommendation, HCFA stated that it does not believe that the current Social Security Act would allow for limits on the adjusted community rate values. The statute recognizes the ACR value not as one based on fee-for-service cost reimbursement principles, but on the non-Medicare price for services modified for differences in utilization for Medicare enrollees. It also believed that the BBA of 1997 required audits will enable HCFA to be better able to identify reasonable costs. The HCFA believes that administrative caps would be difficult to establish given the variances in costs between types of MCOs and that caps could further eliminate incentives for MCOs to have cost-effective utilization systems.

The HCFA disagreed with our second recommendation stating that publishing the administrative cost rate for MCOs would not be meaningful at this time. The HCFA believed that administrative costs vary greatly based on organization type. Without providing specific examples, HCFA stated that a staff model MCO should have higher administrative costs than an Independent Practice Association (IPA) model. Similarly, a group model MCO should have lower administrative costs than an IPA. Therefore, any comparison would be misleading. The HCFA also questioned whether publishing a rate is meaningful to the beneficiary. Beneficiaries are interested in low premiums/cost-sharing and high benefits. The administrative rate might complicate a beneficiary's decision.

Additional OIG Comments

We disagree with HCFA's non-concurrence with our recommendations and encourage HCFA to reconsider its position. We agree that present statute precludes HCFA from (1) requiring MCOs to follow Medicare cost principles when completing their ACRP, or (2) establishing a cap on administrative costs. That is why we recommended that HCFA pursue legislation to enable it to effect those changes. Our audits of nine MCOs demonstrated that significant amounts of administrative costs incurred by these MCOs would have been unallowable under Medicare cost principles. Moreover, HCFA's new ACRP methodology and the BBA of 1997 do not require MCOs to follow Medicare cost principles when preparing their ACRPs. Therefore, we believe that MCOs can continue to include in their ACRPs costs that would be unallowable under Medicare's general principle of paying only reasonable costs.

We do not disagree with HCFA's comment that an HMO's administrative cost can vary based on organizational type. Of the nine MCOs we reviewed, eight were IPAs and the other was a staff model. Our review did not include any group model MCOs. Medicare administrative costs rates expressed as a percentage of Medicare medical costs ranged from 16.56 percent to 26.77 percent for the eight IPA MCOs included in our review. The one staff model MCO had an administrative cost rate of 44.30 percent. Since our review did not include a representative sample of MCO types, we cannot comment on the differences in the level of administrative costs among the different MCO types. We believe that HCFA has collected this type of information over the last several years from its MCOs. We would not object to HCFA using that information to establish caps based on organizational type.

We disagree with HCFA's comments to our second recommendation. In those instances where a beneficiary is having difficulty choosing among several MCOs, we believe that it would be useful for the beneficiary to know how much of their premium is spent on administrative costs and how much is spent on health care.

Finally, we added additional detail to the Objectives, Scope And Methodology section of the report to address HCFA's technical comments.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: OCT 22 '98

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Review of the Administrative Cost Component of the Adjusted Community Rate Proposal at Nine Medicare Managed Care Organizations for the 1997 Contract Year," (A-03-98-00046)

We appreciate the OIG's review of the administrative cost component of the Adjusted Community Rate Proposal (ACRP) submitted to the Health Care Financing Administration (HCFA) by nine managed care organizations (MCOs) with Medicare risk-based contracts for the 1997 contract year. The report found that the methodology for developing the ACRP resulted in Medicare paying a disproportionate share of the costs.

HCFA has acknowledged that the previous ACRP methodology has resulted in overstated administrative costs. We have recently revised our ACRP methodology to more closely account for these costs and the ACRPs for the 2000 contract year are the first proposals being submitted under this new methodology. The new procedures will be determined using costs actually incurred in treating Medicare beneficiaries during the previous calendar year. These procedures will then be reviewed to ensure the effectiveness of reducing administrative burdens on managed care plans.

We do not concur with the report recommendations. Our detailed comments followed:

OIG Recommendation 1

HCFA should pursue legislation concerning MCO's administrative costs which would require MCOs to follow Medicare's general principle of paying only reasonable costs (in this case Part 31 of the FAR). An acceptable alternative would be for HCFA to establish a cap on administrative costs similar to the cap imposed on universities under the Office of Management and Budget Circular A-21 "Cost Principles for Academic Institutions." The Circular limits the reimbursed administrative expenses to a percentage of directs costs.

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HCFA Response

We do not concur. We do not believe that the current sections of the Social Security Act, 1876 (e)(3) and 1854 (f)(3), allow HCFA to place limits on the adjusted community rate (ACR) values. The statute recognizes the ACR value not as one based on fee-for-service or cost reimbursement principles, but on the non-Medicare price for services modified for differences in utilization for Medicare enrollees. In addition, the Balanced Budget Act of 1997 requires HCFA to audit one-third of the organizations submitting ACRs. Through these audits, HCFA will be better able to identify reasonable costs and be able to modify future proposals by the MCOs. Establishing a cap on administrative costs, with variances in costs between types of MCOs, both model types and organizational age, prohibit an accurate and meaningful cap limit. Caps could further eliminate the incentives for MCOs to have cost-effective utilization systems.

Finally, we have just begun to require plans to use new guidelines when determining their administrative costs for their ACR proposals. Until plans have become more familiar with this new method and we have information on the variation in administrative costs under it, we believe it would be premature to determine that a ceiling is appropriate.

OIG Recommendation 2

HCFA should publish the administrative cost rates of all MCOs participating in the Medicare program. This would supplement HCFA's already strong efforts at providing information to Medicare beneficiaries aimed at helping them become educated consumers of medical services.

HCFA Response

We do not concur. We believe that publishing the administrative cost rate for Medicare contractors would not be meaningful at this time. Administrative costs for MCOs vary greatly based on the organizational type. A staff model MCO should have higher administrative costs than an Independent Practice Association (IPA) model; similarly, a group model MCO should have lower administrative costs than an IPA, any comparison would be misleading. We also question whether publishing a rate is meaningful to the beneficiary. The past has shown that Medicare beneficiaries are interested in low premiums/cost-sharing and high benefits. The manner in which the administrative rate would factor into this decision is unknown; but, might complicate the decision.

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Technical Comments

1. The OIG should define "judgmental selection" and indicate how this type of selection might influence their results (it was noted on page 4 paragraph 3 regarding the selection of administrative costs but not for the selection of the MCOs themselves).

2. In addition, the study does not indicate if the selected MCOs offered additional benefits, and if so, what the additional benefits were and how these benefits compared to other plans.