Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

ADDITIONAL BENEFITS OFFERED TO MEDICARE ENROLLEES FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 2000

M- CARE
ANN ARBOR, MICHIGAN

JANET REHNQUIST
Inspector General

OCTOBER 2002
A-05-01-00089

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

October 29, 2002

Common Identification Number: A-05-01-00089

Greg Hawkins
Chief Financial Officer
M-Care
2301 Commonwealth Blvd.
Ann Arbor, Michigan 48105-2945

Dear Mr. Hawkins:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of the Inspector General (OIG), Office of Audit Services (OAS) report entitled "Additional Benefits Offered to Medicare Enrollees for the Period January 1 through December 31, 2000." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

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

In accordance with the principles of the Freedom or Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5).

To facilitate identification, please refer to Common Identification Number A-05-01-00089 in all correspondence relating to this report.

Sincerely yours,

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply *to* HHS Action Official:

Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

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Mr. Greg Hawkins
Chief Financial Officer
M-Care
2301 Commonwealth Blvd.
Ann Arbor, Michigan 48105-2945

Dear Mr. Hawkins:

This final report provides the results of our review of additional benefits offered by M-Care in the Contract Year (CY) 2000 Adjusted Community Rate Proposal (ACRP). The contract year covered the period January 1 to December 31, 2000. During this period, M-Care provided managed care services under two Medicare+Choice contracts, the Senior Plan and Senior Plan Prestige, to Medicare beneficiaries in southeastern Michigan.

The objectives of our review were to determine whether:

- additional benefits proposed in M-Care's ACRP were available to Medicare beneficiaries and were in agreement with M-Care's marketing materials;
- estimated costs in the ACRP for the additional benefits were reasonable when compared to the costs actually incurred; and
- additional benefits offered were properly valued when compared to non-Medicare benefits.

The review covered M-Care's additional benefits offered under the "Senior Plan" and "Senior Plan Prestige" for CY 2000. The additional benefits offered under these plans are listed below, by category, and further described by types of services in Appendix A to this report.

Senior Plan
Preventive Services
Prescription Drugs
Vision Exams/Lenses
Hearing Aids/Exams

Senior Plan Prestige
Healthcare Professional Services
Preventive Services
Prescription Drugs
Dental Services
Vision Exams/Lenses
Hearing Aids/Exams

Although M-Care provided additional benefits as proposed in its ACRP and advertised in its marketing brochures, our review disclosed problems with understated and overstated costs in the

ACRP. We also found accounting and payment errors made during the contract year that had some effect on the value that Medicare enrollees received. Specific findings are that M-Care:

- spent more than the estimated total amount for additional benefits under both Medicare+Choice plans.

- provided healthcare professional services to Medicare beneficiaries under the Senior Plan but did not include estimated costs on the ACRP.

- overestimated the ACRP costs for dental services under the Senior Plan Prestige, which contracted for the services at a fixed monthly fee per Medicare enrollees.

- counted two drugs that are covered under Medicare Part B toward enrollees' prescription drug caps, thereby increasing their out-of pocket costs.

- reimbursed some medical providers at rates that did not correspond to negotiated fee schedules or contracts.

These errors had a negative impact on M-Care and on Medicare enrollees. In CY 2002, M-Care discontinued the Senior Plan Prestige and drastically reduced the prescription drug cap, from $1,200 to $200 under the Senior Plan. Medicare enrollees now have fewer choices and prescription drug coverage is minimal.

We are recommending that M-Care reimburse Medicare beneficiaries that paid out of pocket costs, totaling approximately $77,000, for Part B covered drugs and monitor payments to vendors to ensure that payments are in accordance with the appropriate fee schedules and contracts.

The M-Care agreed with our recommendation to monitor payments but did not concur in the recommendation to reimburse beneficiaries. M-Care also submitted several additional comments. The comments are summarized, together with an OIG response, in the body of this report and are attached as Appendix B.

INTRODUCTION

BACKGROUND

The Medicare ACRP process is designed for Medicare+Choice Organizations (MCOs) to present their estimates of the funds needed to cover the medical and administrative costs of providing a package of covered services to any enrolled Medicare beneficiary. The ACRP process also provides the Centers for Medicare and Medicaid Services (CMS) with estimates of additional benefits (e.g., drugs, eyeglasses, and hearing aids) that the MCO plans to offer its Medicare enrollees.

An MCO must complete a separate ACRP for each coordinated care or private fee-for-service plan offered to Medicare beneficiaries. To compute the ACRP, the MCO must calculate an initial rate that represents the average commercial (non-Medicare) premium that the MCO would

charge its general non-Medicare-eligible population for the benefits covered under its plan. The MCO should also calculate a separate initial rate, using the same approach, for each optional supplemental benefit offered in conjunction with a plan. These initial rates are then modified to account for differences in utilization between Medicare and non-Medicare enrollees. The MCO must submit the ACRP to CMS on standardized worksheets with supporting schedules.

Additional benefits are health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services. Additional benefits are specified by the MCOs and are offered to Medicare beneficiaries at no additional premiums. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACRP. An excess amount is created when the average payment rate (estimated monthly capitation payment received from CMS) exceeds the adjusted community rate (as reduced by the actuarial value of co-insurance, co-payments, and deductibles under Parts A and B of Medicare). If there is an adjusted excess amount for the plan it offers, the MCO must provide additional benefits not covered by Medicare and/or reduce charges otherwise allowed for Medicare-covered services. The MCO must provide those benefits uniformly to all Medicare beneficiaries enrolled in the plan.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objectives of our review were to assess whether:

- additional benefits proposed in M-Care's ACRP were available to Medicare beneficiaries and were in agreement with M-Care's marketing materials;

- estimated costs in the ACRP for the additional benefits were reasonable, when compared to costs actually incurred; and

- additional benefits offered were properly valued, when compared to non-Medicare benefits.

To accomplish our objective, we reviewed:

- M-Care's ACRP submission and compared it with M-Care's marketing materials to ensure consistency of the dollar limits and co-payments.

- M-Care's actual costs and compared these costs with the proposed costs for additional benefits in the ACRP.

- A sample of claims from each plan, Senior Plan and Senior Plan Prestige, for additional benefits to determine if:

    - beneficiaries were enrolled in the Senior Plan or Senior Plan Prestige,
    - beneficiaries made the correct co-payment for additional benefits,
    - volume discounts and rebates were included in the prescription drug costs,
    - drug caps were properly applied and excluded Medicare Part B covered drugs,

- M-Care paid the best price for prescription drugs in comparison to the average wholesale price (AWP),
- M-Care paid the pharmacy network in accordance to the contract provisions, and
- M-Care's "Medication Formulary Guide" of preferred generic and brand name medications was reasonable.

We did not perform a detailed audit of M-Care's ACRP or financial records, nor did we conduct a review of the plan's internal controls. These steps were not considered necessary to achieve our objectives.

Field work was performed at M-Care in Ann Arbor, Michigan and at the Indianapolis, Indiana field office during the time period July 2001 through November 2001.

FINDINGS AND RECOMMENDATIONS

Our review disclosed that M-Care provided additional benefits as proposed in its ACRP and as advertised in its marketing brochures. We found that M-Care made errors in preparing the ACRP having negative consequences for Medicare enrollees and for M-Care itself. We did find that the costs for additional benefits were consistent with non-Medicare business and consider the additional benefits to be properly valued. We reviewed each area of additional benefits in our audit but concentrated our efforts on prescription drugs, which represented about 97 percent (Senior Plan) and 64 percent (Senior Plan Prestige) of the additional benefits on the ACRP.

ADDITIONAL BENEFITS AVAILABLE TO MEDICARE BENEFICIARIES

Additional benefits proposed by M-Care in the ACRP were available to all enrolled Medicare beneficiaries in Michigan. In addition, we determined that the additional benefits agreed with the levels and co-payments advertised in its marketing materials.

ACTUAL COSTS EXCEEDED ESTIMATES IN THE ACRPs

Our review of actual costs indicated that M-Care expended more than the estimated amounts included in the ACRP for all categories of additional benefits except dental benefits. M-Care underestimated the total cost for additional benefits resulting in financial losses. The chart below shows ACRP monthly cost estimates per enrollee and the actual costs incurred.

	Senior Plan		Senior Plan Prestige	
Additional Benefit Category	ACRP	Actual Costs	ACRP	Actual Costs
Healthcare Professionals	$0	$0.86	$0.84	$1.05
Preventive Services	0.04	0.33	0.04	0.42
Prescription Drugs	18.08	70.80	31.30	106.63
Dental	0	0	16.32	15.31
Vision Exams and Lenses	0.73	1.50	0.37	2.04
Hearing Exams and Aids	0.20	0.38	0.10	0.16

Major differences caused an overall understatement of costs. For example, M-Care provided Healthcare Professional Services for Senior Plan members but did not list these services as an additional benefit on the ACRP. Prescription drug costs increased dramatically over the estimates that were based on 1998 experience. In addition, estimates for the new Senior Plan Prestige were flawed because M-Care overestimated the number of existing plan members who would switch to the new, higher priced plan.

The costs of dental benefits for the Senior Plan Prestige were actually less than the projected amount shown on the ACRP. The estimates were fee for service based, but M-Care entered a capitation contract with Delta Dental and paid a fixed fee per enrollee regardless of the number of services provided during the year.

The various conditions noted above resulted in an overall financial loss to M-Care. We believe that the underestimate of costs and the overestimate of enrollees for the Senior Plan Prestige caused M-Care to discontinue this Plan and to reduce the Senior Plan prescription drug benefits from $1200 to $200 per year in CY 2002.

VALUE OF ADDITIONAL BENEFITS

Generally, we determined that additional benefits provided were valued fairly when compared with non-Medicare benefits. However, we found that M-Care counted the costs of two drugs covered and separately reimbursable by Medicare Part B toward the ceiling or "cap" on drugs provided as additional benefits. This increased the beneficiaries' out of pocket costs. In addition, we noted that M-Care does not have controls in place to verify the accuracy of payments to the providers of additional benefits and reimbursed some of its medical providers at rates that did not correspond to negotiated fee schedules or contracts. Prescription drugs were the largest component of additional benefits.

Exclusion of Medicare Part B Drugs from the Annual Drug Cap. M-Care's prescription drug benefit included an annual limit per enrollee of $1,200 for the Senior Plan and $1,600 for the Senior Plan Prestige. Our review disclosed that two Medicare covered Part B drugs were not excluded from the beneficiary's annual drug limit (cap). We randomly selected 100 claims from each of the two plans and found that the Medicare covered drugs, Metoclopramide HCL and Miacalcin, were incorrectly deducted from the beneficiary's drug cap. M-Care agreed that errors were made and that these two drugs should not have been applied to the cap.

M-Care staff explained that the errors were discovered during a provider audit in the fourth quarter of 2000. The estimated dollar value of the error was approximately $77,000. However, M-Care did not retroactively adjust the error because M-Care did not believe that the dollar value of the error was material. As a result, no adjustments were made to the beneficiaries that incurred additional costs.

Comparison of M-Care's Payments for Drugs to Contract Prices and Average Wholesale Prices (AWP). M-Care had contracts with several pharmacies that belonged to the "Advanced PCS Network" (Advanced). We reviewed seven of the M-Care's pharmacy contracts and determined the pricing agreements between M-Care and the pharmacies for brand name and

generic drugs. We determined that all pharmacies had a contract rate of AWP less 15%, with the exception of CVS pharmacy, which had a rate of AWP less 14%. In addition to the AWP based rate, M-Care paid all pharmacies, except CVS, a dispensing fee of $2.00 for every prescription filled. The CVS pharmacy dispensing fee was $2.25.

To compare the payments to contract prices and AWP amounts, we randomly selected 200 claims, 100 from each of the two plans. We found that M-Care paid in excess of the contract prices for 52 percent, or 104 of the sampled claims. However, when all the sample claims were "netted," M-Care paid $633 less than the contracted prices.

The primary reason for the discrepancy between contacted rates and payments is that M-Care does not have internal controls in place that monitor the accuracy of payments to Advanced for prescription drugs. In 2002, M-Care is contracting with an external auditor to audit the Advanced drug claims for CY 2001.

Analysis of M-Care's 2000 Prescription Drug Formulary Guide. Based on our review of M-Care's "Prescription Drug Therapeutic Selection Guide," which lists the generic and brand name medications available for both plans, M-Care's formulary was reasonable in its coverage. M-Care has an open formulary and is not all-inclusive. Therefore, drugs available to plan member might not be included in the guide.

CONCLUSIONS

Although our review disclosed that M-Care provided additional benefits as proposed in its ACRP and as advertised in it marketing materials, M-Care made errors that had a negative impact on both the Medicare beneficiaries enrolled in the plans and on M-Care itself. M-Care expended more on the additional benefits projected in the ACRP for both plans, with the exception of dental benefits. The combined effect of M-Care's errors caused a financial loss in providing additional benefits and resulted in M-Care dropping the Senior Prestige Plan in CY 2002 and drastically reducing the annual drug cap for Senior Plan enrollees.

In addition, several enrollees were faced with higher out of pocket costs when drugs that are reimbursable under Medicare Part B were included in the drug cap for CY 2000. We also determined that payments to vendors for prescription drugs were not always consistent with contract prices although the aggregate costs of drugs appeared reasonable.

RECOMMENDATIONS

We recommend that M-Care:

1. reimburse Medicare beneficiaries for out of pocket costs totaling about $77,000.

2. monitor payments to vendors to ensure that payments are in accordance with the appropriate fee schedules and contracts.

AUDITEE COMMENTS and OIG RESPONSE

M-Care provided written comments on our draft report, concurring with our recommendation to monitor payments and disagreeing with the recommendation that beneficiaries be reimbursed for out of pocket costs. M-Care's additional comments are contained in Appendix B and are summarized, as follows:

M-Care Comment
The combined understatement of estimated medical expense, excluding prescription drugs, amounted to $436,000 or .4 percent of the Senior Plan's total expenses, excluding prescription drugs, in calendar year 2000.

OIG Response
The scope of our audit was limited to additional benefits provided and their costs. M-Care agreed with our determined understatement of additional benefits but attempts to minimize its impact by relating the understatement to the Senior Plan's **total** medical expenses. The $436,000 understatement actually represents 71 percent of additional benefit costs, a percentage that we consider significant.

M-Care Comment
M-Care officials believe that estimated pharmacy costs listed in the draft report were incorrect. They believe their proposed pharmacy costs were much higher.

OIG Response
We used the figures in M-Care's ACRP submitted to CMS. The reason for the difference is that M-Care reported only the co-pay amounts on the ACRP, inadvertently omitting their own costs.

M-Care Comment
The decision to discontinue the Senior Plan Prestige, reduce prescription drug benefits in the Senior Plan, and reduce the service area was attributed to the payment gap between the rising medical expenses and the M+C payments.

OIG Response
A review of the M+C payment levels was beyond the scope of our audit. Nevertheless, the understatement of costs for additional benefits caused a financial loss to M-Care

M-Care Comment
The underestimate of cost actually benefited M+C enrollees by causing M-Care to continue the higher annual limit for prescription drug benefits in 2001. The benefits would have been reduced in 2001, if M-Care more accurately estimated costs. The underestimate of cost on the ACRP had no effect on the amount of payment from CMS.

OIG Response
Any small benefit received by beneficiaries in 2001, due to errors made by M-Care, was more than cancelled out the following year. In 2002, prescription drug benefits were drastically reduced for the Senior Plan and enrollees no longer had a choice of plans when the Senior

Plan Prestige was discontinued that same year. We agree that underestimating the costs of additional benefits would not effect the payments received from CMS; nevertheless, M-Care would not have had a financial loss on additional benefits if estimates had been complete and accurate.

M-Care Comment

M-Care officials stated that two prescription drugs were covered under Medicare Part B only in very limited circumstances. They believed the $77,000 cited in this report is immaterial when viewed in the context of total prescription drug costs.

OIG Response

Enrollees paid additional out of pocket expenses of $77,000 to receive medically necessary prescription drugs that should have been excluded from the beneficiaries' annual drug cap. We believe that M-Care should reimburse the enrollees for these costs.

M-Care Comments

M-Care disagreed that 104 prescription drug claims were paid incorrectly, because their pharmacy network (Advanced) used First DataBank, Inc. as source for AWP, instead of the OIG's source, The Redbook.

OIG Response

We also reported that when payments for all of the 200 sampled claims were "netted", M-Care paid $633 less than the contracted price.

APPENDIXES

Appendix A

Services Included in the ACRP Categories

Healthcare Professional Services:
- Adult physical exams
- Chiropractic services

Preventive Health Services:
- Health education and counseling
- Health promotion classes
- Immunizations

Prescription Drugs:
- Outpatient drugs
- Prescription drugs

Dental Services:
- Dental exams
- Dental services

Vision Exams/Lenses:
- Eye exams
- Eye glasses &/or lenses

Hearing Aids/Exams:
- Hearing and speech exams
- Hearing aids

MCARE

June 20, 2002

Ms. Lynn Barker
Senior Auditor
Department of Health and Human Services
Office of Audit Services
101 West Ohio, Suite 750
Indianapolis, IN 46204

RE: Draft Audit Report of Additional Benefits Offered to Medicare Enrollees,
Calendar 2000
Common Identification Number A-05-01-00089

Dear Ms. Barker:

We have received the draft audit report referenced above along with your letter dated May 22, 2002. We appreciate the opportunity to respond to the findings and conclusions of that report. There are five specific audit findings of the draft report. These five findings fall into three categories; differences between actual incurred cost and prospective estimates included in the Adjusted Community Rate Proposal (ACRP), prescription drugs covered under Medicare Part B and payments for prescripton drug benefits. Our comments, which follow, will address each of these three categories.

1. Differences in actual cost and estimates included in the ACRP

The draft report includes the following table which illustrates differences between actual retrospectively determined costs and prospective estimates of those same costs reported in the ACRP.

	Senior Plan			Senior Plan Prestige		
Additional Benefit Category	ACRP	Actual Costs	Difference	ACRP	Actual Costs	Difference
Healthcare Professionals	$0	$0.86		$0.84	$1.05	
Preventive Services	$0.04	$0.33		$0.04	$0.42	
Dental	$0	$0		$16.32	$15.31	
Vision Exams and Lenses	$0.73	$1.50		$0.37	$2.04	
Hearing Exams and Aids	$0.20	$0.38		$0.10	$0.16	
Subtotal	$0.97	$3.07	$2.10	$17.67	$18.98	$1.31
Prescription Drugs	$18.08	$70.80	$52.72	$31.30	$106.63	$75.33

Our version of this table includes subtotals of medical expenses excluding prescription drugs. Theses subtotals reflect a $2.10 difference per member per month (pmpm) in medical expense excluding prescription drugs for the Senior Plan and a $1.21 pmpm difference in Senior Plan Prestige. In calendar year 2000, M-CARE incurred combined Senior Plan medical expenses excluding prescription drugs of $100.8 million. The combined understatement of estimated medical expense excluding prescription drugs referenced on the above table amounts to $436,000 or .4 percent of the total.

In addition, we disagree with the amounts reflected for the gross pharmacy expenses estimated on the ACRP. Our review of the ACRP indicates that the estimated gross pharmacy expenses equal $70.88 PMPM for Senior Plan and $80.32 PMPM for Senior Plan Prestige. We believe that the difference between actual and estimated ACRP gross pharmacy cost equals $0.08 PMPM for Senior Plan and ($26.31) PMPM for Senior Plan Prestige, not the amounts referenced in the above table.

The report notes the following with respect to prescription drug costs: "...Prescription drug costs increased dramatically over the estimates that were based on 1998 experience. In addition, estimates for the new Senior Plan Prestige were flawed because M-CARE overestimated the number of existing plan members who would switch to the new, higher priced plan...."

These comments are correct and highlight one of the difficulties health plans encounter with participation in the Medicare+Choice (M+C) program. The ACRP for calendar 2000 was submitted to the Centers for Medicare and Medicaid Services (CMS) on July 1, 1999. The experience period drawn upon was, as stated in the report, calendar year 1998. With such a time lag many factors can contribute to a variance between estimated and actual expenses. The Senior Plan membership for the plan year (2000) was different than that upon which the claim experience was based (1998). It is very difficult to predict the morbidity characteristics of an unknown population, therefore the corresponding utilization for this population is difficult to accurately predict. A second factor contributing to the difference between ACRP estimated and actual incurred expenses is provider reimbursement terms. Very few provider contracts were complete on July 1, 1999, for calendar 2000. Changes in provider contract terms, demanded by providers subsequent to the ACRP filing date adversely impact the ACRP estimates. It should be noted that the ACRP is strictly an estimate and one made under adverse conditions, the early filing requirements of the M+C program.

The report also states "...We believe that the underestimate of costs and the overestimate of enrollees for the Senior Plan Prestige caused M-CARE to discontinue this Plan and to reduce the Senior Plan prescription drug benefits...". In our view this conclusion is incorrect and ignores the financial facts, not only for M-CARE but for many health plans participating in the M+C program. Since 1998, annual increases to M+C payments for M-CARE have been 2 percent, with the exception of 2001. In 2001, payments increased 3 percent, not for the full year, but for the period of March through December. During this same timeframe actual expenditures increased 7 to 10 percent for medical expenses

excluding prescription drugs and 18 to 20 percent for prescription drugs expenses. This gap between payments and cost cannot be ignored and was the major factor in M-CARE's decision to discontinue Senior Plan Prestige, reduce prescription drug benefits in the Senior Plan and reduce its M+C service area.

Additionally, we contend that the underestimate of cost actually benefited M+C enrollees by causing M-CARE to continue the higher annual limit on prescription drug benefits in 2001. Had M-CARE more accurately estimated cost it is likely that we would have reduced benefits in 2001 instead of 2002. The underestimate of cost on the ACRP, in our case had no effect on the amount of payment from CMS. Payments from CMS were the same with the underestimated cost as they would have been with a more accurate estimate. As a result M-CARE enrollees actually benefited from the underestimate.

2. Exclusion of Medicare Part B Drugs from the Annual Drug Cap.

The report cites two drugs, Miacalcin and Metoclopramide HCL, as being inappropriately included in the accumulation of beneficiaries' annual drug cap or limit. These two drugs are covered under Medicare Part B in very limited circumstances. Miacalcin is a drug used for the treatment of osteoporosis. It is covered under Part B only for post menopausal homebound women under the care of a physician who are incapable of self administering the drug. Metoclopramide HCL is covered as a Part B benefit only when necessary for the administration of an anti-cancer medication. Metoclopramide HCL used to reduce the side effects of nausea for cancer patients beyond the administration necessary to achieve drug absorption are not covered by Medicare Part B. The drug must also be self administered within two hours of the administration of a chemotherapeutic agent and may not be continued beyond 48 hours after the time of administration of a chemotherapeutic agent. Patients receiving either of these drugs under circumstances other than those specifically referenced above were covered under M-CARE's Senior Plan and Senior Plan Prestige benefits and not covered under Medicare Part B.

Obviously the administration of benefits for these two drugs is very complicated. In calendar 2000, M-CARE's expenditures for prescription drug benefits for M+C beneficiaries was $11.1 million. The $77,000 cited in the report as being inappropriately included in the accumulation of beneficiaries' annual drug cap represents an error rate of .7 percent or approximately $.33 pmpm. We believe this amount is immaterial when viewed in the context of total prescription drug costs. For that reason M-CARE elected to make no adjustment to beneficiaries' annual drug cap.

3. Comparison of M-CARE's Payments for Drugs to Contract Prices and Average Wholesale Prices (AWP).

The report references audit procedures performed wherein individual prescription drug claims were compared to contractual payment terms. 200 claims were sampled with 104, or 52 percent of the sampled claims, found to be inconsistent with contract terms. The report states that: "...The primary reason for the discrepancy between contracted rates

and payments is that M-CARE does not have internal controls in place that monitor the accuracy of payments to Advanced for prescription drugs. In 2002, M-CARE is contracting with an external auditor to audit the Advanced drug claims for CY 2001...."

We disagree with the audit finding that payments on the 104 claims were paid incorrectly. M-CARE's contract with Advanced PCS (Advanced) provides for payment based on discounts from average wholesale prices (AWP). The audit findings were based upon a review of AWP from The Redbook, an annual publication of Thomson Medical Economics with monthly updates. AWP, as defined in the Advanced contract is based upon First DataBank, Inc. In addition, M-CARE's contract with Advanced provides for weekly updates of AWP. The Redbook publication of AWP does provide a valid accounting of AWP for purposes of verifying the contractual payment terms of M-CARE's contract with Advanced. We believe that had the First DataBank, Inc. AWP been utilized, a different audit result would have been achieved.

We agree that M-CARE has not established controls internal to the corporation to monitor the accuracy of payments to Advanced. Such controls would require M-CARE to internally maintain an AWP data base. We do not believe that such an action would be administratively cost effective. For that reason we have retained Pharmacy Outcomes Specialist, Inc (POS) to provide an audit and control function of contractual payments to Advanced on our behalf. POS will perform a claim specific audit of M-CARE payments to Advanced for 2000 and 2001. Accordingly, we agree with the recommendations of the report that M-CARE monitor payments to vendors to ensure that payments are in accordance with the appropriate fee schedules and contracts.

In closing, we wish to reemphasize our disagreement with the conclusions of the report that: "...The combined effect of M-CARE's errors caused a financial loss in providing additional benefits and resulted in M-CARE dropping the Senior Prestige Plan ... and drastically reducing the annual drug cap for Senior Plan enrollees....". Instead it is our contention that the underestimates of cost on the ACRP had no impact on the amount of funding from CMS, that the underestimates actually benefited M-CARE Senior Plan enrollees by causing M-CARE to continue to provide benefits in 2001 that it otherwise may have discontinued and that inadequate funding of the M+C program was the major factor in M-CARE's decisions to drop the Senior Prestige Plan, reduce the annual cap for Senior Plan enrollees and ultimately reduce its M+C service area.

If you have any questions regarding our response to this report, please call me at 734-332-2221.

Sincerely,

Gregory A. Hawkins (BC)

Gregory A. Hawkins, CPA
Vice President and Chief Financial Officer