Memorandum

JUL 15 2002

Date

From Michael Maygard for Janet Rehnquist
Inspector General

Subject Audit of Medicare Adjusted Community Rate Proposals Submitted by 55 Medicare+Choice Organizations for Contract Year 2000 (A-09-01-00051)

To
Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

Attached are two copies of our final report entitled, "Audit of Medicare Adjusted Community Rate Proposals Submitted by 55 Medicare+Choice Organizations for Contract Year 2000." The objective of our review was to summarize for the Centers for Medicare & Medicaid Services (CMS) the results of our reviews (made at CMS's request) of 186 adjusted community rate proposals (ACRP)[1] submitted by 55 Medicare+Choice (M+C) organizations for the Contract Year (CY) 2000.

In general, we found that:

- 49 percent of the ACRPs reviewed were not prepared in accordance with CMS's instructions.
- 66 percent of the ACRPs reviewed contained errors that affected at least one of the three components of the adjusted community rate.
- 36 percent of the ACRPs reviewed overstated the beneficiary premium/cost sharing amounts and/or the M+C organization should have offered extra additional benefits had the amounts for direct medical care, administration, average payment rate, and copayment amounts been properly calculated.

Our reviews found ACRPs that had calculation errors which affected, either positively or negatively, one or more of the components of the adjusted community rate. In several cases, these errors significantly increased or decreased the funds needed for direct medical care, administration of the plan, and additional revenues. To the extent that M+C organizations miscalculated their needed funds, there could have been a significant CY 2000 impact on the (i) payments made by the M+C organizations to their providers, (ii) out-of-pocket expenses of the beneficiaries, and (iii) amount of profits earned by the M+C organizations. Due to the variations among the individual ACRPs, we were not able to calculate an overall dollar effect of the miscalculated ACRPs. The potential impact for each individual ACRP needs to

[1]For purposes of this report, the ACRP refers to the worksheets used to develop the adjusted community rate.

be assessed to ensure that the Medicare managed care program is operating effectively and that M+C organizations do not have unexpected and/or undeserved profits or losses from servicing the medical needs of the Medicare beneficiaries.

We recommended that CMS officials:

- Reiterate to the M+C organizations the importance of following CMS's instructions in preparing the ACRPs. Emphasis should be placed on the issues noted in our individual reviews (e.g., use of actual base year costs).

- Work with the M+C organizations to have them develop corrective actions to address the deficiencies noted in our audits to ensure that future ACRP submissions are correct.

- As part of its biennial monitoring protocol, ensure that M+C organizations have accounting systems and procedures in place that would facilitate proper preparation of their ACRPs.

- Perform follow-up evaluations of the CY 2000 operations of M+C organizations where our audits identified significant errors in the ACRPs. The CMS should compare an M+C organization's actual Calendar Year 2000 expenses to their submitted ACRP for CY 2000. In circumstances where Medicare beneficiaries are affected or consistent problems occur, CMS should consider pursuing legal remedies against the M+C organization.

- Initiate, if necessary, the refund mechanism for the return of funds (based on our audit work) as described in 42 CFR 422.309(c) for those plans that overcharged their enrolled Medicare beneficiaries in CY 2000.

In written response to our draft report, CMS generally concurred with our recommendations. However, CMS stated it had concerns with a methodology, it perceived, the Office of Inspector General used in calculating the impact to Medicare beneficiaries for overcharges and/or for not being offered the proper amount of additional benefits. The complete text of CMS's comments is included as an Appendix to the report.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me or have your staff call George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-09-01-00051 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICARE ADJUSTED COMMUNITY RATE PROPOSALS SUBMITTED BY 55 MEDICARE+CHOICE ORGANIZATIONS FOR CONTRACT YEAR 2000

JANET REHNQUIST
Inspector General

JULY 2002
A-09-01-00051

Memorandum

Date JUL 15 2002

From Janet Rehnquist
Inspector General

Subject Audit of Medicare Adjusted Community Rate Proposals Submitted by 55 Medicare+Choice Organizations for Contract Year 2000 (A-09-01-00051)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

This final report presents the consolidated results of an Office of Inspector General (OIG) review of 186 adjusted community rate proposals (ACRP)[1] submitted to the Centers for Medicare & Medicaid Services (CMS), by 55 Medicare+Choice (M+C) organizations[2] for the Contract Year (CY) 2000. We previously issued reports to CMS outlining the individual audit results of the 186 ACRPs. The individual audits were conducted at CMS's request in accordance with an agreement[3] between CMS and OIG and were required to be conducted by statute.

For CY 2000, a new methodology was established for development of the adjusted community rate (ACR). This new methodology projected the Medicare ACR based on an initial rate that was adjusted by various factors described in the regulations, including the relative costs to Medicare beneficiaries incurred in a prior accounting period, to establish the characteristics of the Medicare population. The initial rate represented the "commercial premiums" the organization would charge its non-Medicare enrollees for services included in the managed care plan. The previous methodology adjusted the initial rate by the medical service utilization data and medical complexity factors through a comparison of the M+C organization's Medicare and commercial lines of business. The accuracy of the specific parts of the ACRP is a very important administrative tool within the overall framework of CMS ensuring value is received for Medicare funds expended as part of the M+C program. The ACRPs serve as a payment safeguard, requiring plans to demonstrate that the money received from Medicare is used to provide services to Medicare beneficiaries; and is used to verify compliance with the Medicare statute regarding required benefits and cost-sharing provisions.

---

[1]For purposes of this report, the ACRP refers only to the worksheets used in developing the adjusted community rate.

[2]For this report, an M+C organization is defined as a type of coordinated care plan (e.g., health maintenance organization, provider service organization, and preferred provider organization) offered by an M+C contractor.

[3]The agreement required OIG to conduct audits of financial records and/or the performance of agreed upon auditing procedures related to Medicare utilization, costs, and the computation of the ACRPs of M+C organizations during Fiscal Year 2000.

The objective of this review was to summarize for CMS the results of our ACRP audits and provide recommendations to address recurring problematic issues. The objective of our individual ACRP reviews was to evaluate the ACRPs and supporting documentation to determine whether the information was:

- supported by the M+C organizations' accounting records or other reliable documentation, and
- prepared in accordance with CMS's instructions.

In general, we found that:

- 49 percent of the ACRPs reviewed were not prepared in accordance with CMS's instructions.
- 66 percent of the ACRPs reviewed contained errors that affected at least one of the three components of the ACR.
- 36 percent of the ACRPs reviewed overstated the beneficiary premium/cost sharing amounts and/or the M+C organization should have offered extra additional benefits had the amounts for direct medical care, administration, average payment rate, and copayments been properly calculated.

We also noted in the OTHER MATTERS section of the report that some M+C organizations included in their base period, administrative costs management fees charged by parent organizations which were based upon Medicare and non-Medicare premium revenue amounts rather than the actual costs of services provided.

Our reviews found ACRPs that had calculation errors which affected, either positively or negatively, one or more of the components of the ACR. In several cases, these errors significantly increased or decreased the funds needed for direct medical care, administration of the plan, and additional revenues. To the extent that M+C organizations miscalculated their needed funds, there could have been a significant CY 2000 impact on the (i) payments made by the M+C organizations to its providers, (ii) out-of-pocket expenses of the beneficiaries, and/or (iii) amount of profits earned by the M+C organization. Due to the variations among the individual ACRPs, we were not able to calculate an overall dollar effect of the miscalculated ACRPs. The potential impact from each individual ACRP needs to be assessed to ensure that the Medicare managed care program is operating effectively and that M+C organizations do not have unexpected and/or undeserved profits or losses from servicing the medical needs of the Medicare beneficiaries.

We acknowledge that CY 2000 was the first year the M+C organizations were required to use a new ACRP methodology and there was a certain learning process that needed to take

place. However, the basic approach to be followed in developing the ACRP remained unchanged. That is, M+C organizations were required to use actual Medicare specific data when preparing their ACRPs.

We recommended that CMS officials:

- Reiterate to the M+C organizations the importance of following CMS's instructions in preparing the ACRPs. Emphasis should be placed on the issues noted in our individual reviews (e.g., use of actual base year costs).

- Work with the M+C organizations to have them develop corrective actions to address the deficiencies noted in our audits to ensure that future ACRP submissions are correct.

- As part of its biennial monitoring protocol, ensure that M+C organizations have accounting systems and procedures in place that would facilitate proper preparation of their ACRPs.

- Perform follow-up evaluations of the CY 2000 operations of M+C organizations where our audits identified significant errors in the ACRPs. The CMS should compare an M+C organization's actual Calendar Year 2000 expenses to their submitted ACRP for CY 2000. In circumstances where Medicare beneficiaries are affected or consistent problems occur, CMS should consider pursuing legal remedies against the M+C organization.

- Initiate, if necessary, the refund mechanism for the return of funds (based on our audit work) as described in 42 CFR 422.309(c) for those plans that overcharged their enrolled Medicare beneficiaries in CY 2000.

In written response to our draft report, CMS generally concurred with our recommendations. However, CMS stated it had concerns with a methodology, it perceived, the OIG used in calculating the impact to Medicare beneficiaries for overcharges and/or for not being offered the proper amount of additional benefits. The complete text of CMS's comments is included as an Appendix to this report.

INTRODUCTION

BACKGROUND

The Medicare+Choice Program

The Balanced Budget Act (BBA) of 1997 amended the Social Security Act (the Act) by establishing the M+C program under Part C of the Medicare program. The M+C program significantly expanded the health care options available to Medicare beneficiaries by enabling them to receive Medicare coverage from private health plans under contract with CMS. The M+C program provided beneficiaries with a range of options for the delivery of their health care beyond what is considered traditional Medicare coverage. These options included certain types of health maintenance organizations, medical savings account plans, and provider-sponsored organizations. Under the program, eligible Medicare beneficiaries may elect to receive Medicare coverage either through enrollment in a traditional risk-based managed care plan or in one of a variety of private health care plans comparable to those available through private insurance companies rather than the standard Medicare program or the managed care plans available under section 1876 of the Act.

ACRP Process

In order to participate in the M+C program, section 1854 of the Act requires the M+C organizations to prepare an ACRP and submit it to CMS prior to the beginning of the contract period. Each M+C organization must complete a separate ACRP for each coordinated care or private fee-for-service plan offered to the Medicare beneficiaries. The ACRP contains an ACR which reflects the organization's initial rate adjusted for various factors to reflect differences in the utilization characteristics of the organization's Medicare enrollees.

The BBA of 1997 required that the ACR more accurately represent actual costs. To assist with the implementation of this requirement, CMS issued revised instructions for completing the CY 2000 ACRPs. The M+C organizations were required to estimate, for their Medicare enrollees, future revenue requirements using relative cost ratios, which were to be based on actual historical data. Specifically, CY 2000 ACRPs were to be based on Calendar Year 1998 costs (base year) for services provided, the costs of administration actually incurred, and additional revenues collected and accrued. Beginning with the CY 2000 ACRP, the calculation of the ACR is presented on the series of Worksheets A through E. The computation of the CY 2000 ACR was as follows:

- **Worksheet A**, or the cover sheet for the ACRP, included the initial rate and the average payment rate (APR). The initial rate represented the average CY 2000 premium the M+C organization intended to charge its non-Medicare enrollees for all benefit packages offered for that type of plan (e.g., health maintenance organization with point-of-service option). The APR represented the estimated premiums (i.e., monthly capitation payments) the plan expected to receive from CMS for the CY 2000 contract period.

- **Worksheet B** presented the base period data used to calculate relative cost ratios. The base period was the most recently ended calendar year before the ACRP was submitted. Thus, for the CY 2000 ACRPs, the base period was Calendar Year 1998. The relative cost ratios compared an M+C organization's costs for its Medicare enrollees to its costs for its non-Medicare members. Separate ratios were calculated for direct medical care costs, administration costs, and additional revenues.

- **Worksheet B-1** provided the M+C organization's financial information for the base period to assist CMS in determining whether the M+C organization was financially able to support its risk-based Medicare plans.

- **Worksheet C** reflected the premiums and cost sharing that the M+C organization intended to charge for each of its benefit offerings. The cost sharing component included deductibles, copayments, and coinsurance that the enrollees must pay.

- **Worksheet D** reflected any expected variations in CY 2000 costs or revenues. This worksheet recorded any adjustments needed to make the ACR computation more closely approximate the costs that were expected to be incurred for the Medicare population. For example, Worksheet D could have been used to record changes in Medicare coverage subsequent to the base period, changes in trend factors, or corrections of errors in the ACR formulas.

- **Worksheet E** calculated the ACR for each benefit package offered and was based upon the amounts reported on the other worksheets. For example, the relative cost ratios developed in Worksheet B and the initial rate reported in Worksheet A were used to project the CY 2000 Medicare funds needed to offer the benefit package. This projection was then revised by the amount of any adjustments on Worksheet D. The adjusted projection and the data from Worksheet C were used to determine any additional benefits that could have been offered and the maximum amount (premiums and cost sharing) that the M+C organization could charge its Medicare enrollees for a particular benefit package.

The cost and revenue data on these worksheets was presented on a per member per month (PMPM) basis. The computation of costs and revenues on a PMPM basis was accomplished by dividing each amount by total member months.

The ACRP is integral to pricing an M+C organization's benefit package, computing excess amounts (if any) from Medicare capitation payments, and determining additional and supplemental benefits or premiums that could be charged to enrolled Medicare beneficiaries. An "excess" is the amount by which the estimated APR exceeds the estimated funds needed to provide Medicare covered services (less Medicare's deductibles, coinsurance, and copayments). The "excess" may be used to determine the extent of additional benefits offered and/or the cost sharing amounts charged to enrolled Medicare beneficiaries. More specifically, the ACRP is designed for an M+C organization to:

- accurately adjust its initial rate to reflect the characteristics of the Medicare population,
- compute the excess (if any) from Medicare capitation payments, and
- determine (if any) additional and mandatory benefits or premiums that could be charged to enrolled Medicare beneficiaries.

OIG Audits

The BBA of 1997 required that one-third of all ACRPs submitted be audited in any given year. Information submitted as part of the ACRP process is subject to audit by CMS or its designees, as required by Medicare regulations. For CY 2000, CMS contracted with OIG to conduct over 50 audits of Medicare ACRPs. We issued final ACRP reports to CMS on 55 M+C contracts which included 186 ACRPs.

The OIG reviewed 186 ACRPs submitted to CMS for CY 2000. The 186 ACRPs provided pricing data for plans that included projected Medicare monthly memberships ranging from 1 beneficiary to 260,399 beneficiaries. The 55 M+C contracts generated more than $10.9 billion in revenues for the M+C organizations providing these Medicare benefit packages.

Criteria

The principal guidelines for the preparation of ACRPs are found at 42 CFR 422.310, and in the *Instructions for Completing the Adjusted Community Rate Proposal* issued by CMS.

The 42 CFR 422.310(a)(5) states, in part, that, "...the M+C organization must have an adequate accounting system that is accrual based and uses generally accepted accounting principles to develop its ACR."

The 42 CFR 422.310(c) states, in part, that,

> "Adjustment factors are designed to adjust on a component basis the initial rate...to reflect differences in utilization characteristics of the M+C organization's Medicare enrollees electing an M+C plan using a relative cost ratio. Adjustment factors are as follows: (1) *Direct Medical Care*. The relative cost ratio for direct medical care for an M+C Organization is determined by comparing the direct medical care costs **actually incurred on an accrual basis** during the most recently ended calendar year prior to the submission of the ACR for Medicare enrollees that elected the M+C plan to the direct medical care costs of non-Medicare enrollees incurred over the same period...(2) *Administration*. The relative cost ratio for Administration for an M+C plan is determined by comparing the administrative costs **actually incurred on an accrual basis**...." (Emphasis added)

The CMS's *Instructions for Completing the Adjusted Community Rate Proposal* contains the following requirements with respect to *Worksheet B - Base Period Costs per Member-Month*:

> "Worksheet B reflects the base period data to be used for calculating relative cost ratios....The accounting system used to report base period entries should be accrual-based (an exception to the accrual method of accounting may be approved for certain governmental organizations)....Your accounting system must be able to produce cost figures consistent with the ACR format, as completed, in a manner that may be audited."

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of this review was to summarize for CMS the results of our ACRP audits and provide recommendations to address recurring problematic issues. The objective of our individual ACRP reviews was to evaluate the ACRPs and supporting documentation to determine whether the information was:

- supported by the M+C organizations' accounting records or other reliable documentation, and
- prepared in accordance with CMS's instructions.

Our reviews were conducted in accordance with generally accepted government auditing standards. To perform each of the audits, we used the procedures provided by CMS in the *Uniform Examination Program for the Adjusted Community Rate Submissions*.

We evaluated 186 ACRPs submitted under 55 M+C contracts for CY 2000. We did not audit the M+C organizations' financial statements for the ACRP base year because they had been audited by independent certified public accountants. Further, our reviews of the M+C organizations' internal controls were limited to those controls considered necessary to achieve our objectives.

The 186 ACRPs were prepared to cover both Parts A and B of the Medicare program. However, some M+C organizations provided services for Part B-only. Therefore, a portion of the ACRPs included the Part B-only information. Since no new enrollment is allowed under the statute for Part B-only coverage for risk-based M+C organizations and there were an insignificant number of Medicare beneficiaries enrolled in Part B-only plans, we did not include Part B-only plan information in this report.

During our reviews, 12 M+C organizations which submitted 44 ACRPs, did not provide OIG with acceptable written management representations. According to the American Institute of Certified Public Accountants codification of auditing standards, written representations from management are necessary to (i) confirm representations given to the auditor, (ii) indicate and document the continuing appropriateness of such representations, and (iii) reduce the possibility of any misunderstanding. Management's refusal to furnish written representations determined to be appropriate for an audit constituted a limitation on the scope of those reviews. Further, because of management's refusal to furnish such representations, the reliability of other management representations provided during the reviews was uncertain.

Our individual reviews were not full scope audits with fully developed audit findings or recommendations. Instead, the reports were for use by CMS to help manage the M+C program.

In accordance with our agreement with CMS, formal notifications of the findings were to be delivered to each of the M+C organizations by CMS. Therefore, formal written comments were not obtained from the M+C organizations during our reviews. However, our findings were discussed with M+C organization officials to the extent necessary to satisfy ourselves as to the validity and accuracy of our conclusions.

Our field work, conducted during the period February 2000 through December 2000, included site visits to each of the M+C organization's administrative offices. We previously submitted to CMS the reports outlining the audit results of the 186 ACRPs.

RESULTS OF REVIEW

In general, we found that:

- 49 percent of the ACRPs reviewed were not prepared in accordance with CMS's instructions.

- 66 percent of the ACRPs reviewed contained errors that affected at least one of the three components of the ACR; i.e., direct medical care, administration, and additional revenues.

- 36 percent of the ACRPs reviewed overstated the beneficiary premium/cost sharing amounts and/or the M+C organization should have offered extra additional benefits had the amounts for direct medical care, administration, average payment rate, and copayments been properly calculated.

COMPLIANCE WITH CMS'S INSTRUCTIONS

We identified errors in all 186 ACRPs (55 M+C contracts). Specifically, we found the ACRPs contained:

- **Incorrect Base Year Costs.** Base year costs used to prepare 127 ACRPs were either (i) estimated or (ii) based on data that could not be reconciled to the M+C organizations' accounting records.

- **Unsupported Items.** We found 144 ACRPs contained amounts or data that were not properly supported. The items most frequently found to be unsupported included: (i) trend factors, (ii) direct medical care and administration costs, (iii) membership months, (iv) coordination of benefits, and (v) cost sharing.

- **Other Errors.** We determined the ACRPs contained other errors such as, improperly calculated direct medical care and administration costs, incorrect APR calculations, mishandling of reinsurance costs, improper use of demographic data, and incorrect or improperly projected membership data. For example, the M+C organizations overstated membership data by (i) reporting in each individual ACRP a combined membership amount related to all the ACRPs, (ii) including membership amounts from other unrelated companies, or (iii) including membership from discontinued service areas and Part B-only ACRPs.

Although it was noted in our reports that all the ACRPs we reviewed had errors, several of the M+C organizations still generally complied with CMS's instructions. However, due to the significance of certain errors that were identified, we determined that 91 ACRPs (33 M+C contracts), or 49 percent of the ACRPs we reviewed, were not prepared in accordance with CMS's instructions.

In this regard, the following are four examples of M+C organizations which failed to follow CMS's instructions:

M+C Organization #1

This national M+C organization submitted 22 ACRPs covering a projected 89,537 Medicare beneficiaries. The M+C organization's accounting system was not designed to provide accounting data by Medicare plan for the base year. As a result, actual base year amounts by plan were not available to complete the ACRPs. Further, the M+C organization estimated its Medicare revenue requirements for CY 2000 based on established percentages of estimated Medicare revenues, rather than using relative cost ratios derived from base year data.

M+C Organization #2

This M+C organization submitted 3 ACRPs covering a projected 27,371 Medicare beneficiaries. This M+C organization's ACRPs included (i) inconsistent and unsupported membership data, (ii) overstated administration costs, and (iii) unsupported actuarial estimates. Additionally, direct medical care costs were not supported by an accrual-based accounting system or other supporting documentation and reinsurance recoveries were not included in the ACRPs.

M+C Organization #3

This M+C organization submitted 3 ACRPs covering a projected 19,095 Medicare beneficiaries. This M+C organization included financial and enrollment data from another M+C plan it operated under a separate contract with CMS. Further, the M+C organization could not provide documentation to support its beneficiary demographic information nor could it identify the end stage renal disease beneficiaries included in the APR calculations.

M+C Organization #4

This M+C organization submitted 3 ACRPs covering a projected 10,337 Medicare beneficiaries. The M+C organization reported paid claims for direct medical care costs in the base year period which could not be reconciled to costs reported on its year-end financial statements. Additionally, administration and additional revenues data were not based on actual amounts incurred, or amounts accrued or collected, respectively, in the base year.

CALCULATION ERRORS

Our reviews found that 122 ACRPs (32 M+C contracts), 66 percent of the ACRPs we reviewed, contained calculation errors which affected either positively or negatively, 1 or more of the 3 components of the ACR[4]. The three components are defined as follows:

- **Direct Medical Care.** An M+C organization determines its anticipated revenue needs to furnish direct medical care for all enrolled Medicare beneficiaries. The organization's records must support how these revenue needs were calculated.

- **Administration.** As with direct medical care costs, an M+C organization develops its anticipated revenue needs to cover its Medicare administration costs. These costs should represent expenditures for various items, such as rent, sales and marketing, medical management, reinsurance, and CMS user fees.

- **Additional Revenues.** Under the new ACRP process, an M+C organization is required to calculate a separate amount for additional revenues. Included in additional revenues are various items, such as profits, revenues in excess of expenses directly related to a benefit package, fund contributions to surplus

[4]It should be noted that we were unable to make any adjustments for 60 ACRPs because of the numerous errors for both Medicare and non-Medicare data that could not be (i) quantified, (ii) reconciled to the M+C organization's accounting system, or (iii) properly supported. Therefore, for these ACRPs, we were unable to calculate the effect on the three components of the ACRs.

pools, risk reserves to cover unanticipated medical costs, and any premium component not reflected in direct medical care and administration costs.

We were instructed by CMS, for our review of the CY 2000 ACRPs, to adjust estimated additional revenues for errors noted in direct medical care, administration costs, the APR, and projected CY 2000 copayment amounts. Where possible, we adjusted the ACRPs for the errors noted during our reviews. Subsequent to our reviews, CMS requested that we determine the effect on the ACRPs based on our findings without adjusting the estimated additional revenue amounts. (See the IMPACT ON BENEFICIARIES section for this analysis.)

Listed below are examples which illustrate the impact of our recommended adjustments to the estimated additional revenue amounts on the ACRPs submitted to CMS by four M+C organizations.

M+C Organization #5

This M+C organization submitted 2 ACRPs covering a projected 14,050 Medicare beneficiaries. Our recommended adjustments decreased the projected Medicare amounts for direct medical care and administration, and increased additional revenues. The adjustments eliminated the anticipated $1.4 million loss and resulted in a projected gain from operations totaling $6.7 million, a change of $8.1 million. Our adjustments also decreased the APR, or estimated premium expected from CMS.

M+C Organization #6

This M+C organization submitted 2 ACRPs covering a projected 33,500 Medicare beneficiaries. Our recommended adjustments decreased the projected Medicare amounts for direct medical care and administration, and increased additional revenues. The adjustments increased additional revenues by approximately $13 million and reduced the M+C organization's projected loss from $15.7 million to $2.7 million. Our adjustments also decreased the APR.

M+C Organization #7

This M+C organization submitted 1 ACRP covering a projected 10,500 Medicare beneficiaries. Our recommended adjustments decreased the projected Medicare amounts for direct medical care and administration, and increased additional revenues. The overall impact of the adjustments had the net effect of increasing the additional revenues by three times the original projected amount, or $1.4 million, from $0.7 million to $2.1 million.

M+C Organization #8

This M+C organization submitted 10 ACRPs covering a projected 115,285 Medicare beneficiaries. Our recommended adjustments increased the projected Medicare amounts for direct medical care and administration, and also increased additional revenues. Additional revenues increased because of significant adjustments to the APR for each ACRP. The adjustments increased the projected Medicare amounts for direct medical care by $7.1 million and additional revenues by $4.1 million.

It appeared that some M+C organizations may have been confused in preparing their ACRPs as evidenced by the errors that we noted (examples provided in the previous and subsequent sections of this report). As a result, these M+C organizations failed to properly justify their pricing structures for the benefit packages offered.

We are concerned that when M+C organizations materially understate their anticipated medical costs, they may not be financially equipped to fund the actual costs that are incurred. Therefore, these M+C organizations may experience solvency or delivery of service problems. The failure to properly estimate revenue requirements may also cause CMS, and others who influence policy, to misunderstand the actual financial burden on M+C organizations.

IMPACT ON BENEFICIARIES

Subsequent to our reviews and based on discussions with CMS staff, we evaluated whether our recommended adjustments could have affected the enrolled Medicare beneficiaries. We determined that 67 ACRPs, or more than one-third of the ACRPs reviewed, had errors that could have had a negative impact on enrolled Medicare beneficiaries. Additionally, we were unable to determine the impact of the errors identified in 60 ACRPs due to the lack of sufficient or reconcilable data. The errors on the remaining 59 ACRPs did not have an impact on the beneficiaries.

We determined how the errors noted in our audits may have affected the beneficiary premium/cost sharing amounts or the value of additional benefits offered by the M+C organization. As previously stated in the CALCULATION ERRORS section of this report, we were instructed to balance any audit adjustments through additional revenues. For the analysis of the impact on beneficiaries, we incorporated any adjustments into the ACRP without modifying the original additional revenue amounts[5] on Worksheet E of the ACRP.

Based on our recommended adjustments for 67 of the 186 ACRPs reviewed, we determined that beneficiaries enrolled in the 67 plans could have received either a reduction in their

[5]The original additional revenue amounts on Worksheet E were the amounts that the plans anticipated for the contract year.

premium/cost sharing amount and/or increased additional benefits. We do not know what action an M+C organization's management may have taken had they properly recorded their financial information in the ACRPs. However, we present the following discussion of our audit results as an indication of the impact that errors in ACRPs can have on beneficiaries. The 67 ACRPs were grouped into the following ranges which may provide a better depiction of the extent of the impact on enrolled Medicare beneficiaries.

Range of PMPM Adjustments	No. of ACRPs Affected
Less than $1.00	11
$1.00 - $9.99	26
$10.00 - $50.00	19
Greater than $50.00	11

Our impact to beneficiaries was limited to those adjustments made to the basic Medicare benefit package, including the additional benefits resulting from excess funds. According to the BBA of 1997, an excess amount exists when the APR exceeds the actuarial value of the Medicare covered services and must be used by the M+C organization to provide additional benefits, reduce premiums, or be placed in a stabilization fund. Therefore, any adjustments resulting from our audits that increased the excess amounts could have had a direct impact on enrolled Medicare beneficiaries.

Using the four M+C organizations discussed in the CALCULATION ERRORS section of this report, the following illustrates the negative impact of these errors on each of the M+C organization's enrolled beneficiaries. As can be seen from the examples, we found the beneficiaries could have received a reduction in projected premium/cost sharing amounts and/or increased additional benefits from the M+C organization as follows:

M+C Organization #5

For one of its ACRPs, this M+C organization intended to charge[6] an average PMPM premium/cost sharing amount of $25.96. Based on our adjustments, the plan should not have charged any premium/cost sharing amount and actually should have offered

[6]The premium and copayment amounts represent an average PMPM charge. Not all Medicare enrollees would incur a copayment amount.

extra additional benefits with a PMPM value of $27.86. The total negative impact to the beneficiary was $53.82 PMPM.

M+C Organization #6

For one of its ACRPs, this M+C organization intended to charge an average PMPM premium/cost sharing amount of $54.41. Based on our adjustments, the maximum average monthly premium/cost sharing amount should have been $22.70. The total negative impact to the beneficiary was $31.71 PMPM.

For its second ACRP, this same M+C organization intended to charge an average PMPM premium/cost sharing amount of $70.52. Based on our adjustments, the maximum average PMPM premium/cost sharing amount should have been $37.53. The total negative impact to the beneficiary was $32.99 PMPM.

M+C Organization #7

This M+C organization intended to charge an average PMPM premium/cost sharing amount of $1.02. Based on our adjustments, the plan should not have charged any premium/cost sharing amount and actually should have offered extra additional benefits with a PMPM value of $18.99. The total negative impact to the beneficiary was $20.01 PMPM.

M+C Organization #8

For the 10 ACRPs submitted, this M+C organization intended to charge an average PMPM premium/cost sharing amount ranging from $4.10 to $87.41. Based on our adjustments, the PMPM premium/cost sharing amounts in each of the 10 ACRPs were overstated, resulting in a negative impact to the beneficiary ranging from $1.03 to $13.75 PMPM.

For the 60 ACRPs which lacked sufficient supporting documentation, the impact of errors on the enrolled beneficiaries could not be determined. Without sufficient supporting documentation, the responsible M+C organizations failed to properly justify their pricing structures for the benefit packages offered. Consequently, Medicare beneficiaries enrolled in those plans were at risk of being overcharged.

CONCLUSION

We identified errors in all 186 plans (55 M+C contracts). Due to the significance of certain errors that were identified, we determined that 91 ACRPs (33 M+C contracts) were not prepared in accordance with CMS's instructions.

Our reviews found ACRPs that had calculation errors which affected, either positively or negatively, one or more of the components of the ACR. In several cases, these errors significantly increased or decreased the funds needed for direct medical care, administration of the plan, and additional revenues. To the extent that an M+C organization miscalculated its needed funds, there could have been a significant CY 2000 impact on the (i) payments made by the M+C organizations to its providers, (ii) out-of-pocket expenses of the beneficiaries, and/or (iii) amount of profits earned by the M+C organizations. Due to the variations among the individual ACRPs, we were not able to calculate an overall dollar effect of the miscalculated ACRPs. However, it appears that hundreds of millions of dollars in planned revenue needs reflected in the submitted ACRPs were involved in the miscalculations. The potential impact for each individual ACRP needs to be assessed to ensure that the Medicare managed care program is operating effectively and that M+C organizations do not have unexpected and/or undeserved profits or losses from servicing the medical needs of the Medicare beneficiaries. We also believe that CMS and others who influence policy, may not be fully informed about the actual financial needs of M+C organizations.

We acknowledge that CY 2000 was the first year the M+C organizations were required to use a new ACRP methodology and there was a certain learning process that needed to take place. The new methodology projects the Medicare ACR based on an initial rate that is adjusted by various factors described in 42 CFR 422.310, including the relative costs to Medicare beneficiaries incurred by the M+C organization in a prior accounting period. In contrast, the previous ACRP methodology adjusted the initial rate by the medical service utilization data and medical complexity factors through a comparison of the M+C organization's Medicare and commercial lines of business. Notwithstanding the differences in adjustments to the initial rate, the basic approach to be followed in developing the ACRP remained unchanged. That is, M+C organizations were required to use actual Medicare specific data when preparing their ACRPs. Therefore, we believe that the errors we found should not have been so prevalent among the ACRPs reviewed.

RECOMMENDATIONS

We recommended that CMS officials:

- Reiterate to the M+C organizations the importance of following CMS's instructions in preparing the ACRPs. Emphasis should be placed on the issues noted in our individual reviews (e.g., use of actual base year costs).

- Work with the M+C organizations to have them develop corrective actions to address the deficiencies noted in our audits to ensure that future ACRP submissions are correct.

- ➢ As part of the CMS biennial monitoring protocol reviews, ensure that M+C organizations have accounting systems and procedures in place that would facilitate proper preparation of their ACRPs.

- ➢ Perform follow-up evaluations of the CY 2000 operations of M+C organizations where our audits identified significant errors in the ACRPs. The CMS should compare an M+C organization's actual Calendar Year 2000 expenses to their submitted ACRP for CY 2000. In circumstances where Medicare beneficiaries are affected or consistent problems occur, CMS should consider pursuing legal remedies against the M+C organization.

- ➢ Initiate, if necessary, the refund mechanism for the return of funds (based on our audit work) as described in 42 CFR 422.309(c) for those plans that overcharged their enrolled Medicare beneficiaries in CY 2000.

In written response to our draft report, CMS generally concurred with our recommendations. However, CMS stated it had concerns with a methodology, it perceived, the OIG used in calculating the impact to Medicare beneficiaries for overcharges and/or for not being offered the proper amount of additional benefits. Below is a synopsis of the specific responses CMS made to our report and our resultant comments. The complete text of CMS's comments is included as an Appendix to the report.

CMS'S COMMENTS

Following the completion of the audit, CMS contracted with an independent firm (contractor) to review and analyze the audit findings and verify the estimate of beneficiary overcharges. The review found the OIG's findings were thoroughly documented. However, the CMS contractor employed an alternative methodology to that used by OIG to quantify the overcharges to the M+C organizations' enrolled beneficiaries. Using this alternative methodology, CMS determined Medicare enrollees were potentially overcharged $89 million for the benefit packages offered by the M+C organizations included in our review. In contrast, using OIG's audit results, CMS stated OIG determined that beneficiaries were potentially overcharged $214 million for the same benefit packages.

The CMS expressed its concerns regarding how OIG: (i) treated additional revenue adjustments, (ii) used projected enrollment levels, (iii) made certain "subjective" adjustments to the ACRP data, and (iv) did not consider mandatory supplemental benefits when calculating overcharges to beneficiaries. In response to OIG's recommendations for CMS to pursue actions against M+C organizations where consistent problems occur or where Medicare beneficiaries were overcharged for cost sharing amounts, CMS stated the use of inappropriate methodologies to levy sanctions against M+C organizations posed a high risk. As a result, CMS stated that a more reasonable and appropriate methodology of determining potential beneficiary overcharges needed to be developed. The CMS intends to

carefully consider the results of the ACRP audits and the new accountability requirements imposed by the Benefits Improvement and Protection Act of 2000 prior to the implementation of any sanctions.

Additionally, CMS stated that a process was in place for the M+C organizations to respond to OIG's individual ACRP reviews. The CMS also commented on its intention to develop a plan of action to address the findings in each of our individual reviews. The remedies may include corrective actions plans and repayments or enhanced benefits to account for the audit findings.

OIG RESPONSE

We disagree with CMS's comments regarding the methodology we used to determine the potential impact on enrolled Medicare beneficiaries. Although **CMS stated** OIG identified $214 million in potential overcharges, **we did not** compute a total beneficiary overcharge amount in our draft report. We feel the impact to an enrolled beneficiary should be viewed on a plan-by-plan basis and not combined since the plans are independent of one another. In determining the potential impact to enrolled beneficiaries, we wanted to highlight to CMS the need to take an active role in pursuing remedies where M+C organizations were submitting improper data that resulted in Medicare beneficiaries not receiving the additional benefits or reduced cost sharing amounts afforded by statute. However, while we disagree with CMS's depiction of our methodology, it is important to note that both CMS, through its contractor, and OIG identified where the preparation of the ACRPs resulted in potentially significant overcharges to the enrolled Medicare beneficiaries.

As stated earlier, we did not calculate the total beneficiary overcharge in our draft report, knowing the limitations of using the plans' estimated enrollment levels. We did not use membership information in our development of beneficiary overcharges because some M+C organizations overstated their membership data in the ACRP. Further, actual enrollment data was not available on a plan-by-plan basis.

One of the items considered by CMS's contractor was the inclusion of adjustments to mandatory supplemental benefits in the overpayment calculations that the contractor made. Some plans offered a mandatory supplemental benefit package to its enrolled beneficiaries, but a beneficiary had to purchase the package as a condition of enrollment in the plan. Since there is no statutory requirement for an M+C organization to provide mandatory supplemental benefits, nor account for any excess, we did not include any adjustments to mandatory supplemental benefit packages in our results. In addition, we do not believe the adjustments due to a mandatory supplemental benefits package error should be offset against the basic Medicare benefit package.

A second item treated differently by CMS's contractor, compared to OIG audit work, pertained to additional revenues which were part of the ACRP calculations. While our individual ACRP audits identified adjustments to additional revenues, we did not apply these adjustments in our calculations of potential overcharges. We kept the CY 2000 projected additional revenue amounts constant as presented in the ACRPs. Since M+C organizations had wide latitude in what they projected for additional revenues, we felt that the original projected additional revenue amounts represented what each M+C organization expected for CY 2000. In contrast, CMS's contractor applied our audit adjustments in its calculations which, in effect, altered what the M+C organizations chose for additional revenues for the contract year (i.e., CY 2000). We maintain that our treatment of additional revenues in our overcharge calculations was proper. We also believe our treatment of an M+C organization's CY 2000 additional revenues corresponds to CMS's instruction for treating additional revenues for future ACR audits and audit procedures that have been developed for CYs subsequent to CY 2000.

Regarding CMS's comment that we used "subjective" adjustments, all of our adjustments were made in accordance with CMS's *Uniform Examination Program for Adjusted Community Rate Submissions* for CY 2000 or instructions provided by CMS officials during the course of our individual reviews. Additionally, the findings resulting in adjustments to the ACRPs, were included in our individual reports which were reviewed by CMS and the M+C organizations in our review. We received no comments from CMS on our adjustments and the majority of the audited organizations agreed with our findings.

The CMS comments to our report indicate they agreed that the Medicare beneficiaries have been significantly impacted as a result of ill-prepared ACRPs. While the CMS contractor and our methodologies in determining a beneficiary impact may differ, we both agree that action needs to be taken to prevent Medicare beneficiaries from being overcharged, not receiving all the benefits to which they are entitled, and/or being misled.

Accurate ACRP data for all M+C organizations facilitates an evaluation of the financial needs of M+C organizations by CMS and others who influence policy, and is integral to determining the extent of additional benefits or reduced cost sharing amounts for enrolled Medicare beneficiaries. Given that nearly half of the ACRPs the OIG audited were not prepared in accordance with CMS instructions and two-thirds of the ACRPs reviewed contained calculation errors, we encourage CMS to promptly proceed to implement our recommendations. A decision should be made quickly by CMS in determining how to treat these ill-prepared individual ACRPs since we are approaching the fourth ACRP season under the requirements of the BBA and our report relates only to the first such season.

OTHER MATTERS

MANAGEMENT FEES

Some M+C organizations included management fees as part of their base period administration costs in their ACRPs. In several cases, these management fees were charges by the M+C organization's parent. We found that these fees were based upon revenues paid to the parent organization rather than the actual costs of services provided by the parent organization. For example, almost 90 percent of one M+C organization's administration costs were comprised of management fees paid to the parent organization. These management fees were based upon revenues received by that M+C organization and not actual costs. While the M+C organizations followed instructions in recording these costs and administrative services were provided, it could not be determined whether the revenues received by the parent organization accurately reflect the parent's true cost of providing those services. The CMS should consider revising its instructions to the M+C organizations that would address this and similar situations relative to "fees" paid to parent organizations.

We are quite concerned with issues related to excessive administration costs being included in the ACRP due to management fees and other related-party transactions. Previous OIG reviews and other studies have demonstrated the area of administration costs to be problematic and subject to possible abusive behavior. We plan to further examine this area of administration costs in future OIG initiatives.

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR 16 2002

TO: Janet Rehnquist
Inspector General

FROM: Thomas A. Scully
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Audit of Medicare Adjusted Community Rate Proposals (ACRPs) Submitted by 55 Medicare+Choice (M+C) Organizations for Contract Year 2000* (A-09-01-00051)

Thank you for the opportunity to review and comment on the above-referenced draft report, which summarizes the results of OIG's review of 186 ACRPs submitted by 55 M+C organizations for calendar year (CY) 2000.

The Centers for Medicare & Medicaid Services (CMS) remains concerned over the methodology used by OIG in the audit findings. Following the completion of the audit, CMS contracted with an independent firm to conduct an analysis of the findings and verify the estimate of overcharges. Although the review disclosed that OIG had thoroughly documented the findings, the methodology used in calculating possible enrollee overcharges was questionable. Using the alternative methodology, CMS found 63 plans with possible overcharge errors totaling about $89 million. In comparison, OIG had documented 49 plans with possible overcharges totaling about $214 million.

The OIG's methodology for calculating overcharges held M+C plans' additional revenue constant in the base period even when the auditor identified needed adjustments to make it reflect actual amounts. Additionally, the OIG incorporated certain subjective adjustments that did not meet CMS's criteria, used overstated projections of the number of Medicare enrollees in M+C plans, and did not consider mandatory supplemental benefits when calculating the audit results. The alternate methodology used by CMS made adjustments for the additional revenue in the base period, used an allocation to more closely resemble actual membership in M+C plans, and calculated the effects of the findings on mandatory supplemental benefits.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises. We look forward to working with OIG on this and other issues pertinent to M+C organizations. Our specific comments on the OIG recommendations follow.

We have grouped the recommendations into two distinct categories. The first set of recommendations is directed at processes that CMS should follow with regard to the adjusted community rate (ACR) findings. The second set of recommendations addresses implementation of OIG's findings.

Page 2 – Janet Rehnquist

OIG Recommendations

1. The CMS should reiterate to the M+C organizations that they are required to follow CMS instructions in preparing the ACRPs. Emphasis should be placed on the issues noted in OIG's reviews (e.g., use of actual base year costs, data needs to be adequately supported).

2. The CMS should require the M+C organizations to provide CMS with actions planned and/or taken to address the deficiencies noted in OIG's audits to ensure that future ACRP submissions are correct.

3. The CMS should, as part of its biennial monitoring protocol, ensure that M+C organizations have accounting systems and procedures in place that would facilitate proper preparation of their ACRPs.

CMS Response

The CMS has been informing M+C organizations about the findings from the ACR audits. Reports issued after the audits have included findings related to the accuracy of ACR computations and whether the ACRP was prepared according to CMS standards. The M+C organizations are required to inform CMS within 45 days of either concurrence or nonconcurrence with the audit findings. The CMS intends to formulate a plan of action and make final determinations about the audit findings. Remedies may include corrective action plans to ensure that future ACRPs are accurate, and repayments or enhanced benefits to account for the audit findings.

OIG Recommendations

4. The CMS should perform follow-up evaluations of the CY 2000 operations of M+C organizations where OIG's audits identified significant errors in the ACRPs. The CMS should compare an M+C organization's actual CY 2000 expenses to their submitted ACRP for CY 2000. In circumstances where Medicare beneficiaries are affected or consistent problems occur, CMS should consider pursuing legal remedies against the M+C organization.

5. The CMS should initiate the refund mechanism for the return of funds (based on OIG's audit work) as described in 42 Code of Federal Regulations 422.309(c) for those plans that overcharged their enrolled Medicare beneficiaries in CY 2000. The OIG will provide CMS officials with the listing of ACRPs that were affected.

CMS response

As mentioned previously, while OIG documented numerous issues with regard to the audit findings, CMS remains concerned over the methodology OIG used and the high risk of levying sanctions using an inappropriate methodology.

The CMS believes that efforts must be directed to develop a methodology that is reasonable and appropriate. Additional auditing requirements have also been imposed by the Benefits Improvement and Protection Act of 2000 (BIPA). Under BIPA, CMS is responsible for the review of the actuarial assumptions and data used by M+C organizations. The CMS is currently working to incorporate these reviews into the audit process. It is CMS's intent to carefully consider the results of these audits and accountability requirements under BIPA, prior to implementation of any sanctions.