



Memorandum

Date .OCT 18 2001

From Janet Rehnquist  
Inspector General

Subject Review of the Administrative Costs Component of the Adjusted Community Rate Proposals for a Mid-Atlantic Medicare+Choice Organization for Contract Year 2000 (A-03-01-00002)

To Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services

Attached are two copies of our final report entitled, "Review of the Administrative Costs Component of the Adjusted Community Rate Proposals for a Mid-Atlantic Medicare+Choice Organization for Contract Year 2000." The report provides you with the results of our review of a Medicare+Choice contractor (the Plan) in the Mid-Atlantic region.

The objective of the review was to determine if the administrative costs submitted by the Plan on its adjusted community rate (ACR) proposals were reasonable, necessary and allocable when compared to the Medicare program's general principle of paying only reasonable costs. The criteria used for our assessment of the Plan's administrative costs are not currently applicable to Medicare+Choice organizations (M+CO). However, the prior Administrator of the Health Care Financing Administration requested that we perform this type of review.

The Medicare ACR proposal process is designed for M+COs to present to the Centers for Medicare and Medicaid Services (CMS) their estimate of the funds needed to cover the benefit and administrative costs associated with providing medical services to Medicare members. Beginning with Medicare contract year (CY) 2000, M+COs were required to use their actual costs in developing their ACR proposals.

Under the existing ACR methodology, there is no statutory or regulatory authority governing the allowability of administrative costs in the ACR for M+COs, unlike other areas of the Medicare program. For example, when preparing their ACR proposals, M+COs are not required to adhere to cost principles that preclude the reporting of unreasonable, unnecessary, and unallocable costs. Also, regulations covering cost-based managed care organizations that provide specific parameters delineating allowable administrative costs for enrollment, marketing and other general and administrative costs that benefit the total enrollment of a cost-based plan do not apply to M+CO contracts.

Based on our review of (1) the Plan's methodologies for allocating administrative costs to Medicare and (2) a judgmentally selected sample of administrative costs, we found that \$36.4 million of base-year costs allocated to Medicare included such costs as:

- \$21.2 million in related-party costs for management fees that were based on a percentage of premium revenues and not actual costs. Under Medicare cost principles these types of expenses may be allowable, however, they are limited to the related party's actual costs. In this case, we question the revenue-based method of assigning these costs.
- \$5.5 million in unallocable costs consisting of commissions paid to brokers who sell non-Medicare insurance products.
- \$382,075 of costs relating to such items as bad debts, travel and entertainment, promotions, donations and tax penalties. These costs would not have been allowable if Medicare cost reimbursement principles were applicable to M+COs.
- \$59,977 of unsupported costs that would have been questioned had Medicare cost principles been applicable.
- \$9.3 million of general administrative expenses apportioned to Medicare using premium revenues that would have been disallowed had CMS required M+COs to follow Medicare cost-based managed care organization contract criteria. That criteria requires general administrative costs to be apportioned on the basis of a ratio of Medicare enrollment to total enrollment.

We calculated the impact of including such costs in the Plan's CY 2000 ACR proposals which resulted in an increase in administrative costs of between \$44.03 and \$50.27 per member per month<sup>1</sup> or \$39.6 million based on base-year enrollment levels. Therefore, the effect of including costs that would be unallowable under Medicare cost-based or cost reimbursement principles was an inflated administration amount that reduces the amount available to Medicare beneficiaries for additional benefits or reduced premiums.

In response to our draft report, the Plan generally disagreed with the premise of our audit and emphasized that Medicare cost principles do not apply to risk based organizations. The Plan stated that its administrative costs were calculated, submitted and accepted with rules and requirements specified by CMS for the Medicare+Choice program.

If you have any questions about the report, please contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. Please refer to Common Identification Number A-03-01-00002 in all correspondence related to this report.

#### Attachment

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<sup>1</sup> The Plan offered many benefit packages in CY 2000. Our findings affected all packages resulting in the range of per member per month administrative costs.



**Memorandum**

Date OCT 18 2001

From Janet Rehnquist  
Inspector General

Subject Review of the Administrative Costs Component of the Adjusted Community Rate Proposals for a Mid-Atlantic Medicare+Choice Organization for Contract Year 2000 (A-03-01-00002)

To Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services

**EXECUTIVE SUMMARY**

This final report presents the results of our review of the administrative cost component of the adjusted community rate (ACR) proposals submitted to the Centers for Medicare and Medicaid Services (CMS) by a Mid-Atlantic Medicare+Choice contractor (the Plan) for Contract Year (CY) 2000.

**Background**

The Medicare ACR process is designed for Medicare+Choice organizations (M+CO) to present to CMS their estimates of the funds needed to cover the costs of providing the Medicare package of covered services to enrolled Medicare beneficiaries. The M+CO's estimate includes medical and administrative costs for the upcoming year and must be supported by the M+CO's operating expenses. Beginning with CY 2000, CMS required M+COs to use their actual Medicare costs in developing the ACRs.

**Objective**

The objective of the review was to determine if the administrative costs submitted by the Plan on its ACR proposals were reasonable, necessary and allocable when compared to the Medicare program's general principle of paying only reasonable costs. The criteria used for our assessment of the Plan's administrative costs are not currently applicable to M+COs. We applied the criteria used for cost-based managed care organizations (MCO) and Medicare cost principles as they relate to the fee-for-service program.

**Summary of Findings**

Under the existing ACR methodology, there is no statutory or regulatory authority governing the allowability of administrative costs in the ACR for M+COs, unlike other areas of the Medicare program. For example, when preparing their ACR proposals, M+COs are not required to adhere to cost principles that preclude the reporting of unreasonable, unnecessary, and unallocable costs. Also, regulations covering cost-based MCOs that

provide specific parameters delineating allowable administrative costs for enrollment, marketing and other general and administrative costs do not apply to M+CO contracts.

Based on our review of the Plan's methodologies for allocating administrative costs to Medicare, and selected administrative costs, we found that \$36.4 million of base-year costs allocated to Medicare included such costs as:

- \$21.2 million in related-party costs for management fees that were based on a percentage of premium revenues and not actual costs. Under Medicare cost principles these types of expenses may be allowable, however, they are limited to the related party's actual costs. In this case, we question the revenue-based method of assigning these costs.
- \$5.5 million in unallocable costs consisting of commissions paid to brokers who sell non-Medicare insurance products.
- \$382,075 of costs relating to such items as bad debts, travel and entertainment, promotions, donations and tax penalties. These costs would not have been allowable if Medicare cost reimbursement principles were applicable to M+COs.
- \$59,977 of unsupported costs that would have been questioned had Medicare cost principles been applicable. The Plan did not provide the necessary documentation for us to determine the allowability of these costs.
- \$9.3 million of general administrative expenses apportioned to Medicare using premium revenues that would have been disallowed had CMS required M+COs to follow Medicare cost-based MCO contract criteria. That criteria requires general administrative costs to be apportioned on the basis of a ratio of Medicare enrollment to total enrollment.

We calculated the impact of including such costs in the Plan's CY 2000 ACR proposals which resulted in an increase in administrative costs of between \$44.03 and \$50.27 per member per month<sup>1</sup> (PMPM) or \$39.6 million. Therefore, the effect of including costs that would be unallowable under Medicare cost-based MCOs or cost reimbursement principles was an inflated administration amount that reduces the amount available to Medicare beneficiaries for additional benefits or reduced premiums.

Because of the lack of criteria for including administrative costs in the ACR, we did not develop recommendations to the Plan. This review is part of a nationwide review of administrative costs included in the ACR proposals that was requested by the prior Administrator of the Health Care Financing Administration. Based on the results of our reviews, we will be making recommendations to CMS so that appropriate legislative changes can be considered.

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<sup>1</sup> The Plan offered many benefit packages in CY 2000. Our findings affected all packages resulting in the range of PMPM administrative costs.

In response to our draft report, the Plan generally disagreed with the premise of our audit and emphasized that Medicare cost principles do not apply to risk based organizations. The Plan stated that its administrative costs were calculated, submitted and accepted with rules and requirements specified by CMS for the Medicare+Choice program. We summarized the Plan's comments and our response in the CONCLUSION section of the report. The Plan's entire response is included as an APPENDIX.

## **INTRODUCTION**

### **Background**

The Balanced Budget Act of 1997 established Part C of the Medicare program. Under the program, a contracted M+CO receives a monthly capitation payment for each of its Medicare members. In exchange for the capitation payments, the M+CO is required to provide all Medicare-covered services to its members.

Section 1854 of the Social Security Act requires an M+CO to submit an ACR to CMS each year. The Medicare ACR process requires an M+CO to present CMS with an estimate of the funds needed to cover the medical benefit and administrative costs associated with providing services to its Medicare members. All cost and revenue data in the ACR proposal is presented on a PMPM basis. The ACR is designed to ensure that Medicare beneficiaries are not overcharged for the benefit package offered. If the average Medicare payment exceeds the costs of providing Medicare covered services, the M+CO must use the excess funds to provide additional benefits, reduce premiums charged to Medicare members and/or contribute to a benefit stabilization fund.

Beginning with the ACR proposals for CY 2000, CMS required M+COs to use actual Medicare administrative costs when preparing their ACRs. The ACR calculates estimated administrative costs using a "relative cost ratio" based on actual administrative costs incurred for Medicare beneficiaries in the base-year relative to actual administrative costs incurred for non-Medicare enrollees in the same base-year. For CY 2000, the base-year was calendar year 1998. The CY 2000 Medicare administrative costs represent the estimated CY 2000 non-Medicare costs multiplied by the relative cost ratio and adjusted to reflect any costs not captured in the relative cost ratio.

Due to a lack of statutory or regulatory authority governing allowability of costs in the ACR process, the M+COs are not prohibited from including administrative costs not traditionally allowed under the Medicare fee-for-service program. The Medicare cost principles applicable to the fee-for-service program preclude the reporting of unreasonable, unnecessary, and unallocable costs. Additionally, regulations covering cost-based MCOs that contract with CMS on a cost reimbursement basis provide specific parameters delineating allowable administrative costs for enrollment, marketing and other general and administrative costs that benefit the total enrollment of a cost-based plan. These regulations, however, are not used in administering M+CO contracts.

In an Office of Inspector General (OIG) audit report issued in January 2000<sup>2</sup>, we identified \$66.3 million of inappropriate administrative costs that were included in the ACRs submitted by nine MCOs. These costs would have been unallowable had CMS required the MCOs to follow Medicare's general principle of paying only reasonable costs. We recommended that CMS pursue legislation concerning MCOs' administrative costs that would require MCOs to follow this principle. The CMS did not concur with the recommendation and noted that it had recently revised the ACR methodology and that the new procedures would be reviewed to ensure the effectiveness of reducing the administrative burdens on MCOs. However, based on the results of our audits at the nine MCOs, the OIG was requested to examine other MCOs to determine if they were including inappropriate costs in the ACRs under the revised format. This audit is part of a continuing nationwide review of the ACR process and is being performed at several other M+COs.

### **Objective, Scope, and Methodology**

The objective of our review was to determine if the administrative costs submitted by the Plan on its CY 2000 ACR proposals were reasonable, necessary, and allocable when compared to the Medicare program's general principle of paying only reasonable costs. The criteria used for our assessment of the Plan's administrative costs are not currently applicable to M+COs. We applied the criteria used for cost-based MCOs and Medicare cost principles as they relate to the fee-for-service program.

Our review was performed in accordance with generally accepted government auditing standards. The objective of our review did not require an understanding or an assessment of the Plan's internal control structure. To accomplish our objective, we:

- Reviewed applicable laws and regulations.
- Held discussions with the Plan's management officials about their ACR process and how their administrative costs were derived.
- Compared costs reported in the ACRs to the costs included in the Plan's accounting records for the base-year.
- Reviewed a sample of Medicare administrative cost items included in the Plan's ACR proposals.
- Tested the cost allocation methods used by (1) the parent company to allocate costs to the Plan, and (2) the Plan to allocate costs to its lines of business.
- Recomputed the administrative costs in the ACRs based on the results of our review.

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<sup>2</sup> 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 reviewed the Plan's financial records used to support the 2000 ACRs for the 12-month period ended December 31, 1998. The financial records included \$166 million in administrative costs derived from costs directly charged by the Plan or allocated from the Plan's parent company using membership data. The administrative costs included the non-medical costs associated with items such as advertising, compensation, management fees, rent, supplies, and travel and entertainment. For purposes of preparing (1) its annual statutory filing with the State Insurance Department and (2) its ACR proposals for CMS, the Plan allocated administrative costs to its various lines of business, including Medicare, based on premium revenues. Of the \$166 million, the Plan allocated \$121.1 million to non-Medicare lines of business and \$44.9 million to Medicare.

We judgmentally selected cost items from the administrative costs reported by the Plan. Our selection of transactions was based on types of costs that have been found to be problematic under prior ACR audits. Because of the judgmental selection, our results were not projected to the universe of costs submitted by the Plan. In addition to reviewing the selected cost transactions, we reviewed the allocation methodologies used by the Plan and its parent for purposes of allocating the administrative costs to Medicare.

Our field work was performed between October 2000 and May 2001 and included on-site work at the Plan's corporate offices.

## **FINDINGS**

Our review of the Plan's 2000 ACR proposals revealed that Medicare base-year administrative costs totaling \$36.4 million would have been unallowable had the Plan been required to follow Medicare's general principle of paying only reasonable costs. We calculated the questioned amounts based on our reviews of the sampled administrative costs and the allocation methods used to distribute the costs to the Medicare line of business.

### **REVIEW OF SAMPLED ADMINISTRATIVE COSTS**

Our review of the selected administrative cost entries showed that \$27.1 million of Medicare administrative costs would have been unallowable if CMS required the Plan to follow Federal regulations used in other areas of the Medicare program. The \$27.1 million included:

- ✓ \$21.2 million for related party management fees not based on actual expenses,
- ✓ \$5.5 million of costs allocated to the wrong lines of business,
- ✓ \$382,075 of costs traditionally not allowed by Medicare, and
- ✓ \$59,977 of costs not supported by source documentation.

### **Management Fees Not Based on Actual Expenses - \$21.2 Million**

The Plan's base period Medicare administrative costs included \$21.2 million for management fees to the parent company that were not based on actual incurred costs. We recognize that many of these costs may be allowable, but we question the use of negotiated rates based on premium revenues rather than the parent company's costs to calculate the Plan's share. Fee-for-service Medicare allows related party transactions, but limits the provider's reimbursement to the related party's cost. This criteria does not apply to M+COs.

The Plan calculated the total management fee based on an outdated contract between the Plan and its parent. The contract required that the Plan pay 5 percent of premiums to the parent for a variety of administrative services including maintaining accounting records, preparing the annual budget, providing management information systems, and supervising account collections. The management fees reported by the Plan were based on a percentage of premium calculation, not a portion of the parent's actual incurred expenses. We verified the accuracy of the 5 percent of premiums calculation. However, we could not determine if the rate was reasonable or what the parent's actual incurred costs were as required under Medicare fee-for-service cost principles. The Plan contended that the parent's intent was not to realize a profit, but we could not validate the parent's actual profit or loss without conducting an audit of the parent company's administrative costs.

In addition, the Plan stated that it was updating the management fee agreement to include additional services and a larger fee. The Plan indicated that the fee might increase from the current 5 percent to 12.5 percent of premium revenues. As a result, future ACRs submitted by the Plan will likely include a related party management expense based on a percentage of premium revenues that will represent the majority of the Plan's administrative expenses. Medicare cost principles, followed by cost contractors but not M+COs, allow reimbursement for related party costs up to the related party's actual costs. Without establishing criteria for limiting related party transactions to actual costs, CMS will not have assurance that this expense is reasonable.

### **Costs Allocated to Wrong Line of Business - \$5.5 Million**

We found \$5.5 million in net cost allocation errors caused by the allocation of non-Medicare costs to Medicare (and vice versa). According to Federal regulations, a cost is allocable to a Government contract if it is incurred specifically for the contract; benefits both the contract and other work and can be distributed to them in reasonable proportion to the benefits received; or is necessary to the overall operation of the business, although a direct relationship to any particular cost objective cannot be shown. We identified the following costs that the Plan improperly allocated to Medicare:

- \$5.5 million in commissions that the Plan paid to brokers who sell non-Medicare products and

- \$1,582 of net supplies, travel, and entertainment costs related to the non-Medicare line of business.

**Unallowable Costs - \$382,075**

The Medicare administrative expenses included \$382,075 of costs that would be unallowable under Federal regulations followed by other organizations that participate in Medicare, but not by M+COs. If CMS required M+COs to follow these Federal regulations, the following costs allocated to the Medicare line of business would have unallowable:

- Bad debt expenses of \$359,100 for the amount of group and individual premiums that the Plan estimated it would not collect;
- Travel and entertainment expenses of \$21,306 -
  - \$18,110 of premium seating and associated catering charges at professional sporting events and a golf event,
  - \$1,986 for a deposit on an Alaskan cruise for Plan and parent company managers and guests,
  - \$565 for travel expenses where the employees did not identify the purpose of the trip,
  - \$429 for tickets to “awards” dinners, and
  - \$216 for facials and massages at a California country club;
- Promotional items of \$1,503 – including buttons, shirts, and golf sponsorships; and,
- Miscellaneous items of \$166 - including donations to charitable organizations, professional association dues related to lobbying activities, and payroll tax penalties.

**Unsupported Costs - \$59,977**

The Plan did not provide sufficient documentation for \$59,977 in administrative costs. The classifications for these unsupported costs included promotions, general manager social dues, donations, miscellaneous profit/loss, and travel and entertainment. Federal regulations, followed by cost contractors but not M+COs, require that contractors appropriately account for costs and maintain adequate supporting documentation to demonstrate that costs claimed are allocable. Without additional documentation, we could not determine whether these costs would be allowable.

## **REVIEW OF ALLOCATION METHODOLOGY**

A total of \$9.3 million of administrative costs allocated to Medicare would have been disallowed had CMS required M+COs to follow Medicare rules for cost-based MCOs. To ensure that the costs of services furnished to Medicare enrollees is not borne by others, and vice versa, Federal regulations for cost-based contractors require apportionment of indirect costs benefiting total enrollment based on a ratio of Medicare enrollees to total enrollment. This criteria does not apply to M+COs. By apportioning the indirect costs based on revenue rather than enrollment, the Plan increased the Medicare administrative expenses from \$8.2 million to \$17.5 million.

Many of the Plan's administrative costs were indirect costs allocated from the Plan's parent company that benefited both non-Medicare and Medicare enrollees. The parent company generally allocated administrative costs to the Plan based on membership. However, the Plan then allocated these costs among its various lines of business based on premium revenue. Medicare premiums per member were significantly higher than non-Medicare premiums per member. Therefore, allocating indirect costs based on revenue inflated the Medicare administration costs. Specifically, the Plan allocated approximately 27 percent of its administrative costs to Medicare and 73 percent to its non-Medicare lines of business. However, only about 10 percent of the enrollees were Medicare beneficiaries, and 90 percent of the enrollees were enrolled in non-Medicare plans. Consequently, Medicare was allocated about 27 percent of the administrative costs even though Medicare accounted for only about 10 percent of the enrollees.

Cost-based contractors follow regulations that require the apportionment of allowable indirect costs (general costs not directly associated with providing medical care) and direct costs (costs directly associated with providing medical care). The regulations state that the indirect or general costs should be apportioned based on total enrollment. This criteria does not apply to M+COs, and the Plan did not distinguish between direct and indirect administrative costs in its general ledger. However, in its annual statement filed with the State Insurance Department, the Plan separated administrative costs between general (indirect) and health care related (direct).

Using the cost-based criteria to determine the amount of the excess allocation, we applied the Plan's indirect and direct percentages to the costs that remained after removing the questioned amounts related to management fees, incorrect allocations, and unallowable and unsupported costs. We calculated that had CMS required M+COs to follow the criteria mandating the apportionment of general administrative expenses based on enrollment, the Plan's Medicare costs would have decreased from \$17.5 million to \$8.2 million.

## **IMPACT ON THE ACR PROPOSALS**

Our review of the CY 2000 ACRs showed that as much as \$36.4 million would have been unallowable for allocation to Medicare had the Plan been required to follow Medicare's general principle of paying only reasonable costs. Administrative costs for the ACR proposals are determined using a "relative cost ratio" based on actual costs for Medicare beneficiaries in a base-year relative to actual administrative costs incurred for non-Medicare enrollees in the same base-year. For the CY 2000, the base-year was 1998.

The "relative cost ratio" was applied to estimated non-Medicare administrative costs for the year being reported upon to arrive at the Medicare administrative costs for CY 2000. As a result of including \$36.4 million in the base-year costs, we calculated that the impact of including such costs in CY 2000 resulted in an increase in the administrative rate between \$44.06 and \$50.27 PMPM, or about \$39.6 million based on the Plan's base-year Medicare enrollment.<sup>3</sup> The effect of including costs that would be questionable under Medicare cost-based MCO regulations or cost reimbursement principles resulted in overstated administrative costs that reduced the additional benefits that could have been offered to Medicare beneficiaries.

## **CONCLUSION**

Our review of the 2000 ACR submissions showed that \$36.4 million in Medicare base-year costs would have been unallowable had the M+CO been required to follow Medicare's general principle of paying only reasonable costs. The inclusion of such costs affects the computation of the potential excess from the Medicare payment amounts and adversely impacts the excess amount available to provide additional benefits and/or reduce premiums for Medicare beneficiaries. Unlike other areas of the Medicare program, we recognize that presently there is no statutory or regulatory authority governing the allowability of costs in the ACR process. Therefore, no recommendations are addressed to the Plan. This review is part of a nationwide review of administrative costs included in the ACR proposals. Based on the results of our reviews, we will be making recommendations to CMS so that appropriate legislative changes can be considered.

## **PLAN'S COMMENTS**

The Plan did not concur with our application of cost based principles to insurance-based risk contracts and our overall conclusion that including unallowable administrative amounts in the ACRs reduced the amounts available for additional benefits or reduced premiums. The Plan stated that its administrative costs were calculated, submitted and accepted with rules and requirements specified by CMS for the Medicare+Choice program. Under the

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<sup>3</sup>In CY 2000, the Plan offered many benefit packages. However, the Plan did not estimate 2000 membership for each of the plans as required in the ACR instructions. The Plan did provide membership statistics for all of the plans for the 1998 base period. Therefore, we calculated the effect by multiplying the OIG calculated PMPM amount by the 1998 enrolled member months.

Medicare+Choice program cost guidelines pertinent to the Medicare fee-for-service program are not applicable and therefore were not followed. The Plan also indicated that had it been required to account for costs differently, the underlying costs would still have been incurred, and the additional administrative requirements could have potentially increased overall costs, not eliminated them as the OIG report suggests.

With respect to the management fee, the Plan felt that CMS could gain assurance of the management fee rate because the rate is approved by the Insurance Department of the State in which the M+CO is located. The Plan also said that management fees would not be \$0 as our draft report implied.

Regarding the costs allocated to the wrong line of business and unallowable costs, the Plan commented that costs are allocated to Medicare on a total business basis, not at the invoice level. On an overall basis the Plan believes the administrative expenses reported were reasonable. As for unsupported costs, the Plan blamed time constraints indicating that it would have provided more documentation if given more time. Finally, the Plan believed that allocating costs based on enrollment does not recognize the higher costs of administering the Medicare program compared to the Commercial group business.

## **OIG RESPONSE**

We agree with the Plan's general comment that it followed current CMS guidelines in preparing its CY 2000 ACR proposals. However, we have stressed throughout this report that our objective was to determine if the Plan's proposed administrative costs were appropriate when compared to the Medicare program's general principle of paying only reasonable costs. We recognize that this criteria currently does not apply to M+COs, therefore, we make no recommendations to the Plan. Our conclusions regarding the application of excess revenues are based on CMS' ACR instructions. These instructions define the excess as the amount available to pay for additional services not covered by Medicare, reduce charges for Medicare covered services and/or contribute to a benefit stabilization fund.

We acknowledge that our draft report's summary of the management fee finding did not clearly indicate that some costs would be legitimate and have modified this report accordingly. We do not agree that the State Department of Insurance's approval of the contract is sufficient for CMS to gain assurance on the reasonableness of the management fee costs because the State does not require that the management fees be based on actual costs.

Although the Plan allocated costs to Medicare on a total business basis, its accounting system had the ability to allocate the individual costs/invoices. The Plan's general ledger allowed costs to be charged to a business line by entering a product code. The Plan currently used this system to account for its medical expenses by product.

The Plan's management was cooperative during the entire audit process; however, they were unable to locate documentation for some of our sampled costs. We believe that we provided Plan officials sufficient time to support the sample items by allowing them no less than one month to provide documentation for each sample item.

Finally, we agree with the Plan's comment that certain administrative costs may be higher for Medicare enrollees versus commercial enrollees. However, the Plan did not provide any additional information to support its use of revenue-based allocations that, as we described in this report, was contrary to the enrollment-based allocations used by the parent company.

## **APPENDIX**

### **General Comments**

The OIG recognizes that there is a "lack of criteria in including administrative costs in the ACR" and therefore "did not develop recommendations for [y]our organization". The OIG report recognizes that the recommendations that they will make to CMS (HCFA) with regard to a series of ACR audits would require "legislative changes". Our understanding is that these and similar recommendations have been made to CMS in other reports and CMS "did not concur" with the OIG recommendations. The OIG report also recognizes that the law and the Y2000 ACR requirements "did not require that M+COs adhere to cost principles" that are applicable under Federal Acquisition Regulations for cost type contracts. Such requirements are not appropriate, for a number of reasons, for insurance-based risk contracts.

The following represents our response to the 2000 Adjusted Community Rate Proposal (ACR) audit recently conducted by the Office of Inspector General.

### **Summary**

We respectfully disagree with your conclusion that the effect of including the amounts identified in your audit in the ACR resulted in "an inflated administration amount that reduces the amount available to Medicare beneficiaries for additional benefits or reduced premiums." Administrative costs were calculated, submitted and accepted with the rules and requirements specified by HCFA for the Medicare+Choice (M+C) program. Under the M+C program cost guidelines pertinent to the Medicare fee for service program are not applicable and therefore were not followed.

The unallowable cost calculations presented in the CONCLUSIONS AND RECOMMENDATIONS section of your report, incorrectly presume that a cost does not exist unless it is collected and documented in accordance with Medicare fee for service rules. Had we been required to segregate and collect expenses differently, the underlying costs would still have been incurred, and the additional administrative requirements could have potentially increased overall costs, not eliminated them as your recommendation suggests. In addition, your conclusion does not take into account other aspects of our ACR submission, such as the significant amount of premium waived for enrolled Medicare beneficiaries.

### **Management Fees Not Based on Actual Expenses**

Your report questions the use of a negotiated rate for services provided by the parent company rather than actual costs incurred. The terms and conditions of the administrative services agreement in question are in compliance with the guidance set forth by HCFA for the M+C program and have been accepted and approved by the State in which the M+CO is domiciled. The amounts charged to the M+CO under the contract represent our best estimate of the parent company's actual cost of providing the specified services, including information technology, finance, legal, billing and collection and cash disbursement processing. Your recommendations conclude that the cost of these services would be \$0 had we been "required to follow Medicare's general principle of paying only reasonable costs". As stated above, we believe the underlying cost of these services would essentially remain the same under the fee for service

rules, and overall costs could potentially increase if we were required to maintain a sophisticated cost accounting and collection system.

Your report also states that “without establishing criteria for limiting related party transactions to actual costs, HCFA will not have assurance that this expense is reasonable”. We suggest that HCFA can gain appropriate assurance that expenses are reasonable by recognizing that the Insurance Department of the State in which the M+CO is located has approved the contract and the method of charging costs to the entity.

### **Costs Allocated to Wrong Line of Business / Unallowable Costs**

In accordance with the guidance set forth by HCFA for the M+C program, costs are allocated to Medicare on a total business basis, not at the invoice level. On an overall basis we believe the administrative expenses reported were reasonable.

### **Unsupported Costs**

Due to time constraints we were unable to produce certain documentation. Had additional time been provided, we believe the supporting documentation could have been located.

### **Review of Allocation Methodology**

Administrative costs were allocated and reported in accordance with HCFA requirements for the M+C program. We believe that allocating expenses based on enrollment does not recognize the fact that underlying costs to provide services to a Medicare enrollee are significantly higher than the costs to administer a Commercial enrollee. Servicing individual Medicare membership requires more billing costs, more medical utilization/care management costs, additional claims processing, and more customer service time, when compared to the Commercial group business.

### **Conclusion**

Finally, we would like to restate the points that support our disagreement with your findings.

- The OIG report did not make any recommendations with respect to the M+C organization.
- The general cost contract principles applicable to cost contracts are not applicable to the Medicare + Choice program.
- As with other M+C organizations, the Plan was required and utilized the ACRP structure and formulas specified in the applicable HCFA (now CMS) requirements and rate instructions.
- A number of the administrative costs that were questioned reflect sales and retention activities under the Medicare + Choice program. Such costs do not apply in the Medicare fee for service contracts that are administered by CMS.
- The application of Medicare fee for service and other cost contract rules to a community rated HMO program where the M+C Organization bears insurance risk is not appropriate for many reasons.