Memorandum

Date MAR 26 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of the Administrative Costs Submitted by an Ohio Based Medicare+Choice Organization in the 2000 Adjusted Community Rate Proposal (A-05-00-00040)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of the Administrative Costs Submitted by an Ohio Based Medicare+Choice Organization in the 2000 Adjusted Community Rate Proposal." This audit was part of a nationwide review of administrative costs at multiple Medicare+Choice organizations (MCO). The objective of our review was to determine if general administrative costs, submitted by the Ohio based MCO in their adjusted community rate (ACR) proposal, were reasonable, necessary, and allocable.

In an Office of Inspector General (OIG) audit report[1] issued in January 2000, we identified $66.3 million of administrative costs that were included in the ACR proposals submitted by nine MCOs that would have been unallowable had the MCOs been required to follow Medicare's general principle of paying only reasonable costs. We recommended that the Health Care Financing Administration (HCFA) pursue legislation requiring managed care organizations to follow this reasonable cost principle. In the response to our report, HCFA did not concur with the recommendation, noting that it had recently revised the ACR methodology. Based on the results of our audits, HCFA requested that OIG conduct additional reviews to determine, if under the new ACR methodology, MCOs were still including administrative costs deemed unallowable under Medicare's reasonable cost principles in their ACR proposals. This review is in response to HCFA's request.

We reviewed the Ohio based MCO's documentation for the proposed administrative costs and discussed with plan officials the allocations of certain costs to Medicare. In addition, we examined selected invoices from categories of costs that have traditionally been problem areas in the Medicare fee-for-service program.

We identified $629,429 in administrative costs that would be considered unreasonable if HCFA's general principle of paying only reasonable costs were used to determine those administrative costs that may be included in the ACR proposal. The $629,429 included

[1] 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)

direct marketing costs (meetings and souvenirs) of $50,439 and allocated costs of $40,954 for bad debts, amortization of contract purchases, and lobbying. The remaining costs of $538,036 represented excess allocations of salaries and other administrative expenses to Medicare based on a subjective weighting of employee effort by department managers. The need for weighted allocations was not objectively determined using measurable data. We also noted that section 4414 of the Health Maintenance Organization Manual related to cost MCOs, which do not currently apply to risk MCOs, disallowed weighted allocations unless they were used to apportion compensation costs related to direct patient care.

Officials from the MCO disagreed with our findings related to the marketing costs associated with sponsoring meetings and providing souvenirs to the public. The MCO's response to our audit report stated that these marketing costs were allowable under current guidance provided by HCFA. The MCO officials also believed that the allocation of additional costs to Medicare based on the subjective weighting was supported by statistics provided in their response. The MCO's response further stated that Federal regulations which limit the use of weighted allocations to only the apportionment of compensation costs for direct patient care did not conflict with the weighted allocation used by the MCO.

Since regulations do not currently exist stating what costs are or are not allowable in the ACR proposals, we had to judge the reasonableness of administrative costs based on Federal regulations which do not currently apply to risk MCOs. It was not surprising that MCO officials took exception to findings based on non-applicable regulations. We believe our findings are correct under the regulations used for this review, consequently, our findings as presented were not changed.

Because of the lack of applicable criteria defining allowable ACR proposal costs, no recommendations were made to the Ohio based MCO. The purpose of this review was to gather facts highlighting weaknesses in the ACR system. We invite HCFA comments as our nationwide review at the multiple MCOs proceeds.

If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-05-00-00040 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE ADMINISTRATIVE COSTS SUBMITTED BY AN OHIO BASED MEDICARE+CHOICE ORGANIZATION IN THE 2000 ADJUSTED COMMUNITY RATE PROPOSAL

MARCH 2001
A-05-00-00040

Memorandum

Date MAR 26 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of the Administrative Costs Submitted by an Ohio Based Medicare+Choice Organization in the 2000 Adjusted Community Rate Proposal (A-05-00-00040)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides the results of our review of the administrative cost component of the adjusted community rate (ACR) proposal, submitted by an Ohio based Medicare+Choice organization (MCO) to the Health Care Financing Administration (HCFA) for Contract Year 2000. This audit was part of a nationwide review of ACR administrative costs at multiple MCOs. The objective of our review was to determine if general administrative costs, submitted by the Ohio based MCO in its ACR proposal, were reasonable, necessary, and allocable.

We reviewed the MCO's documentation for the administrative costs proposed and discussed with plan officials the allocations of certain costs to its Medicare line-of-business. In addition, we examined selected invoices from categories of costs that have traditionally been problem areas in the Medicare fee-for-service program.

We identified $629,429 in administrative costs that would be considered unreasonable if HCFA's general principle of paying only reasonable costs were used to determine those administrative costs that may be included in the ACR proposal. The $629,429 included direct marketing costs (meetings and souvenirs) of $50,439 and allocated costs of $40,954 for bad debts, amortization of contract purchases, and lobbying. The remaining costs of $538,036 represented excess allocations of salaries and other administrative expenses to Medicare based on a subjective weighting of employee effort by department managers. The need for weighted allocations was not objectively determined using measurable data. We also noted that section 4414 of the Health Maintenance Organization Manual related to cost MCOs, which did not currently apply to risk MCOs, disallowed weighted allocations unless they were used to apportion compensation costs related to direct patient care.

Officials from the MCO disagreed with our findings related to the marketing costs associated with sponsoring meetings and providing souvenirs to the public. The MCO's response to our audit report stated that these marketing costs were allowable under current guidance provided by HCFA. The MCO officials also believed that the allocation of additional costs to Medicare based on the subjective weighting was supported by statistics provided in their response. The MCO's response further stated that Federal regulations

which limit the use of weighted allocations to only the apportionment of compensation costs for direct patient care did not conflict with the weighted allocation used by the MCO.

Since regulations do not currently exist to establish what costs are or are not allowable in the ACR proposals, we had to judge the reasonableness of administrative costs based on Federal regulations which do not currently apply to risk MCOs. It was not surprising that MCO officials took exception to findings based on non-applicable regulations. We believe our findings are correct under the regulations used for this review, consequently our findings as presented were not changed.

Because of the lack of applicable criteria defining allowable ACR proposal costs, no recommendations were made to the Ohio based MCO. The purpose of this review was to gather facts highlighting weaknesses in the ACR system. We invite HCFA comments as our nationwide review at multiple MCOs proceeds.

INTRODUCTION

BACKGROUND

The Balanced Budget Act (BBA) of 1997, Public Law 105-33, added sections 1851 through 1859 to the Social Security Act, establishing the Medicare+Choice Program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. The options available to beneficiaries under the program include coordinated care plans, medical savings account plans, and private fee-for-service plans. Coordinated care plans have a network of providers under contract to deliver a health benefits package which has been approved by HCFA. Types of coordinated care organizations include health maintenance organizations, provider sponsored organizations, and preferred provider organizations. Beneficiaries eligible to enroll in the new MCOs must be entitled to Part A and enrolled in Part B.

Section 1854 of the Social Security Act requires that an ACR proposal be submitted to HCFA annually by each MCO coordinated care plan. The ACR process allows MCOs to present the estimated funds needed to cover the costs of providing Medicare services to enrolled beneficiaries. The ACR is integral to pricing an MCO's benefit package, computing excess (if any) from Medicare capitation payments, determining additional and supplemental benefits, and/or estimating premiums/copayments that could be charged to Medicare beneficiaries. The BBA of 1997 required that the pricing of ACRs more accurately represent actual costs. In response, HCFA issued revised instructions for completing Year 2000 ACR proposals, which required MCOs to use actual costs for Medicare beneficiaries in the ACR calculation.

Administrative costs, one component of the ACR, include costs associated with facilities, marketing, taxes, depreciation, reinsurance, interest, non-medical compensation, and profit. The ACR revisions, initiated by HCFA in response to the BBA of 1997, changed the way Medicare administrative costs are calculated. The portion of total costs proposed for Medicare is calculated by applying the percentage of costs applicable to Medicare in a prior base year to the estimated costs for all enrollees in the year covered by the proposal. The base year is generally the most recently ended calendar year before the ACR proposal is submitted.

SCOPE

Our audit was performed in accordance with generally accepted government auditing standards. The objective of our review was to determine if general administrative costs, submitted by the Ohio based MCO in its ACR proposal, are reasonable, necessary, and allocable to Medicare.

The MCO used 1998 financial records as their basis for the 2000 ACR proposal. The proposal included 1998 administrative costs charged directly to Medicare and costs which were allocated between the Medicare plan and its other lines of business. Direct administrative costs included salaries, fringe benefits, advertising projects, office supplies, and other miscellaneous expenditures. The allocated administrative costs included salaries and general and administrative costs. The allocations of costs to Medicare were usually based on the ratio of Medicare member months to total MCO member months.

We reviewed the MCO's documentation supporting the administrative costs and discussed the allocations of certain costs to Medicare with MCO officials. We also examined selected invoices from categories of administrative costs which have traditionally been problem areas in the Medicare fee-for-service program. The objective of our review did not require a review of the MCO's internal control structure. Our field work was performed at the MCO's offices in Ohio and at our field office in Columbus, Ohio.

RESULTS OF AUDIT

We identified $629,429 in administrative costs that would be considered unreasonable if HCFA's general principle of paying only reasonable costs was used to determine those administrative costs that may be included in the ACR proposal. The $629,429 included direct costs of $50,439 for marketing and allocated costs of $40,954 for bad debts, amortization of contract expenses, and lobbying. The remaining $538,036 of administrative costs resulted from MCO staff allocating salary costs to Medicare based on managers assigning a heavier weighting to the effort of employees working on Medicare. We consider the weighted allocation to Medicare unreasonable because the weighting used was not

objectively determined using measurable data, and such weighting would be patently unallowable if governed by standard Medicare cost principles.

Direct Marketing Costs - $50,439

The MCO's ACR proposal included marketing costs for sponsorship of meetings and special events totaling $27,437. The cost of sponsoring meetings and special events was unallowable under Federal regulations, unless the principal purpose of the activity was to provide technical information. These same regulations would not permit $23,002 for souvenirs, buttons, and other mementos provided to customers or the public.

Allocated Administrative Costs - $40,954

The MCO staff allocated $21,192 of bad debt expense to Medicare. Since the MCO did not charge Medicare beneficiaries premiums in 1998, there was no bad debt expense and the allocation was unreasonable. The MCO's proposed costs also included amortization expense resulting from the purchase of membership contracts from another MCO. Because none of the purchased contracts were for Medicare beneficiaries, we believe the allocation of $17,660 of the amortization expense to Medicare was unreasonable. Finally, MCO staff allocated $2,102 to Medicare for lobbying costs that were part of dues paid to a professional association. The costs associated with lobbying activities were unallowable under Federal regulations.

Allocation Rate - $538,036

Administrative costs shared by the MCO's Medicare, Medicaid, and commercial plans were generally allocated based on the number of months that individuals were enrolled in each of the plans during 1998. However, staff at the MCO weighted the months for Medicare beneficiaries three-to-one when allocating compensation costs for employees in the claims, member services, and case management departments. The weighting caused an additional $538,036 of administrative costs to be allocated to Medicare.

We concluded that the three-to-one weighting was unreasonable because it was based on subjective estimates, by department managers, of the time expended by employees working on individual Medicare claims or cases. Reasonable cost allocations are based on objective, verifiable data. It should be noted that section 4414 of the Health Maintenance Organization Manual related to cost MCOs, which do not currently apply to risk MCOs, disallowed weighted allocations unless they were used to apportion compensation costs related to direct patient care.

Recommendations

Regulations do not currently exist stating what costs are or are not allowable in the ACR proposals. As a result, we are making no recommendations to the MCO based on our review. This audit is part of a continuing nationwide review of the ACR process. Based on the results of this and other reviews, we will be making recommendations to HCFA so that appropriate legislative changes can be considered.

MCO Comments

Officials from the MCO disagreed with our findings related to the marketing costs associated with sponsoring meetings and special events, and the costs of providing souvenirs and mementos to the public. The MCO officials stated that these marketing costs were allowable under current guidance provided by HCFA.

The MCO officials agreed that the amounts for bad debt and the purchase of membership contracts should not have been allocated to Medicare. The officials also agreed that lobbying costs included in dues paid to professional associations should not be charged to Medicare.

Finally, officials from the MCO believed that the allocation of additional costs to Medicare, based on the subjective three-to-one weighting, was supported by statistics provided in their response. The officials also stated that Federal regulations, which limited the use of weighted allocations to only the apportionment of compensation costs for direct patient care, did not conflict with the weighted allocation used by the MCO.

The full text of the MCO's response is included with this report as APPENDIX A.

OIG Response

Regulations do not currently exist to establish what costs are or are not allowable in the ACR proposals. We had to judge the reasonableness of administrative costs based on Federal regulations which do not currently apply to risk MCOs. It was not surprising that MCO officials took exception to findings based on non-applicable regulations. We believe our findings are correct under the regulations used for this review. Consequently, our findings as presented were not changed.

OIG NOTE: All information identifying the name and address of the MCO was deleted from the MCO's response.

December 8, 2000

David Shaner
HHS/OIG Office of Audit Services
Two Nationwide Plaza, room 710
280 North High Street
Columbus, Ohio 43215

CIN A-05-00-00040

Dear Mr. Shaner:

The following represents [redacted] response to the draft Review of Administrative Costs in the 2000 Adjusted Community Rate Proposal (ACR) performed during May of this year.

Direct Marketing Costs

In your findings, you identified $50,439 of direct costs for marketing, consisting of $27,437 of costs to sponsor meetings and special events, and $23,002 spent on souvenirs, buttons, and other mementos provided to customers or the public.

According to guidelines published in the Medicare Managed Care National Marketing Guide, the Medicare +Choice Organization may do the following:

- Assist in the planning of local Health Fairs.
- Distribute health plan brochures.
- Have a booth at the Health Fair.
- Distribute items with a total retail value of no more than $10. These items MUST be offered to everyone, (e.g. organizations can not give gifts to only those individuals who show interest).
- Have any personnel present as long as they adhere to these guidelines.
- Contribute funding for any Health Fair costs (i.e. purchasing of food; drawings, raffles, or door prizes for attendees which exceed the $10 nominal value requirement) as long as the recognition of the donation is to a number of entities (not just one particular M+C Organization).

[redacted] has complied with HCFA guidance regarding the sponsorship for health fairs, health promotion events, and Section 2211 of the HMO/CMP Manual. The marketing chapter of the National Marketing Guidelines permits the practice of providing gifts of nominal value (defined as an item worth $10 or less, based upon the retail purchase price of the item). These marketing items were provided whether or not the individual enrolled in the plan. Lastly, all documents distributed

at health fairs and events were approved by the HCFA Regional Office prior to use as required by the Marketing Guide.

We believe these costs are appropriate and reasonable to be included in the M+C Program and should not be reported as unallowable costs in your report to HCFA.

Allocated Administrative Costs

Your draft report identifies three specific cost allocations deemed inappropriate. In 1998, [redacted] allocated bad debts of $21,192, amortization expense of $17,660, and lobbying costs of $2,102. We would agree that based on the underlying assets generating bad debt expense and amortization, these expenses should not be charged to the M+C Program. This recommendation was taken under advisement in the preparation of the 2001 budget and such costs were not included in the allocated administrative costs for the Medicare HMO.

The lobbying costs relate to dues paid to the national and state associations for managed care organizations. While these organizations do provide legislative support in their operations, numerous other services are provided, including seminars and other educational opportunities. We would propose only a portion of these dues are unallowable, which could be calculated through an estimation of lobbying costs provided by these organizations.

Allocation Rate

Your findings identified $538,036 of administrative expenses inappropriately allocated to Medicare. The allocation methodology includes components that distribute costs based on relative membership levels as well as estimates by department managers of time dedicated to the M+C Program functions. In preparing these allocations, [redacted] follows a weighting methodology that charges costs at a rate of three to one (as compared to a Commercial HMO member) for direct operational departments – claims, members services, and case management. All other departments use an estimate of man-hours (as a percent of total) expended in each department for maintaining the M+C Program.

In your draft report, exception is taken to the three-to-one weighting methodology in the direct operational departments. Your conclusion appears to be based on the fact that subjective estimates were made by department managers of the time expended by employees working on individual Medicare claims or cases. While no specific documentation was provided during the audit, the following facts support this weighting methodology:

- In the member services department call statistics reflect a volume of 485 calls/1,000 members for the commercial products and 2,468 calls/1,000 members for the M+C Program. This reflects a relative call volume for the Medicare product of over five times that of commercial.

- The Utilization/Care Management department is directly impacted by medical utilization, particularly hospital use. Medical utilization statistics per 1,000 members reflect average admissions for commercial members of 58/1,000 compared to 277/1,000 admissions for Medicare members, a rate of 4.8 to 1. Hospital days per 1,000 members reflect a higher ratio, with 213 days/1,000 for Commercial members and 1,391 days/1000 for Medicare members, a rate of 6.5 to 1.

- In the claims department, the average number of claims paid per 1,000 members amounts to 16,920/1,000 for commercial members compared to 47,150/1,000 for Medicare members, a rate of just under three to one.

- The overall medical cost for a commercial member averages about $142 per member per month, as compared to about $527 per member per month for Medicare members. This equates to medical costs for a Medicare member in excess of nearly four times that of a commercial member and further supports the overall higher cost structure for the M+C Program

Based on these measures, it would appear that the weighting methodology of three to one is appropriate and, in fact, somewhat conservative.

We recognize that a formal policy should be established for each operational area regarding the allocation of costs. Documented and supportable statistics need to be part of this policy to support an objective weighting methodology. We will begin immediately with the development of such policy.

Finally, your findings comment on the disallowance of weighted allocations "unless they are used to apportion compensation costs related to direct patient care." While this rule currently applies only to health care delivery entities, it is our position that the operational departments of claims processing, customer service, and case management represent "direct service" activities provided by the HMO for the benefit of [redacted] members and are analogous to "direct patient care" activities in a patient care setting. We would encourage any future rules applicable to M+C HMO's to consider this point.

Based on the above information, we believe the entire $538,036 deemed to be unallocable is appropriate. The cost of doing business in the M+C Program is greater than commercial business. Allocating operating costs is a reasonable method to appropriately include administrative expenses in the related product line. Using a weighting methodology is necessary in instances of programs that use a disproportionate share of direct operation resources.

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The above responses should adequately address the findings resulting from the administrative audit. We appreciate your comments and will implement the necessary corrective actions.