DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date AUG 12 1992

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Administrative Costs Claimed Under Part A of the Health Insurance for the Aged and Disabled Program - Blue Cross and Blue Shield of Virginia (A-03-90-00053)

To
William Toby
Acting Administrator
Health Care Financing Administration

This is to alert you to the issuance on August 17, 1992, of our final report. A copy is attached.

During the period October 1, 1984 through September 30, 1989, Blue Cross/Blue Shield of Virginia (BCBSV) claimed $27,382,876 for administering the Medicare Part A program. The audit showed that about $1.4 million of the costs claimed were unallowable.

The Health Care Financing Administration (HCFA) contracted with BCBSV to administer the Medicare Part A program in the State of Virginia. Under the provisions of the contract, BCBSV is required to receive, disburse, and account for Federal funds in making payments for services furnished to eligible Medicare beneficiaries. The BCBSV's responsibilities also include determinations as to coverage of services and the reasonableness of charges, furnishing timely information and reports to HCFA, and maintaining records to ensure the correctness and verification necessary for the administration of the contract.

The BCBSV is entitled to reimbursement of all administrative costs claimed, provided that the provisions of the Medicare agreement have been met and that the costs were incurred in accordance with Federal regulations. The audit showed that about $1.4 million of the claimed costs were not in accordance with Federal regulations. The unallowable claimed costs consisted of:

- Costs incurred and claimed ($153,293) in excess of budgeted amounts. The BCBSV exceeded the Medicare approved budget in 3 of the 5 years of our review. The BCBSV did not seek nor did HCFA provide approval for the costs overruns.

- Unallowable costs ($621,354) allocated to the Medicare program such as nonapproved productivity investment projects and leased equipment which could not be supported by BCBSV accounting records.

- Cost offsets ($712,565) known as complementary credits. We found that BCBSV has not implemented the 1986 revisions to the Intermediary Manual which required contractors to identify complementary credits on a cost allocation basis. The BCBSV determined complementary credits utilizing a standard rate for each claim transferred. We recomputed the complementary credits using the revised Medicare guidelines. Following this methodology, we computed allowable Medicare complementary credits of $898,014 or $712,565 more than computed by BCBSV for Fiscal Years 1987 through 1989.

The problems we identified with the Medicare costs were tempered by the fact that BCBSV did not claim all costs incurred. We noted that BCBSV made arbitrary adjustments to reduce costs claimed by about $3.1 million in order to lower the cost per claim.

We recommended that BCBSV make several procedural improvements. Our recommendations for financial adjustments should take into account the costs incurred but not claimed. The BCBSV disagreed with the recommended adjustments. The operating division officials agreed with the findings and recommendations contained in this report except the HCFA regional office is working with HCFA's Office of Financial Operations on the agency's position pertaining to complementary credits.

For further information, contact:

Gervus A. Rafalko
Regional Inspector General
for Audit Services, Region III
(215) 596-6744

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ADMINISTRATIVE COSTS CLAIMED UNDER PART A OF THE HEALTH INSURANCE FOR THE AGED AND DISABLED PROGRAM - BLUE CROSS AND BLUE SHIELD OF VIRGINIA

AUGUST 1992 A-03-90-00053

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Our Reference: Common Identification Number A-03-90-00053

Mr. Norwood Davis Jr.
President
Blue Cross and Blue Shield of Virginia
2015 Staples Mill Road
Post Office Box 27401
Richmond, Virginia 23279

Dear Mr. Davis:

Enclosed for your information and use are two copies of an HHS/OIG Office of Audit Services report entitled REVIEW OF ADMINISTRATIVE COSTS CLAIMED UNDER PART A OF THE HEALTH INSURANCE FOR THE AGED AND DISABLED PROGRAM - BLUE CROSS AND BLUE SHIELD OF VIRGINIA FOR FISCAL YEARS 1985 THROUGH 1989. Your attention is invited to the audit findings and recommendations contained in the report.

Final determination as to actions to be taken on all matters will be made by the HHS official named below. The HHS action official will contact you to resolve the issues in this audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time. A copy of this report has been provided to the Blue Cross Association.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), the HHS/OIG Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

To facilitate identification, please refer to the referenced common identification number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to:

Associate Regional Administrator
Division of Medicare
Health Care Financing Administration
Region III

SUMMARY

The Blue Cross and Blue Shield of Virginia (BCBSV) claimed $27,382,876 on Final Administrative Cost Proposals (FACP) for the period October 1, 1984 through September 30, 1989 (Fiscal Years (FYs) 1985 through 1989) for work related to the processing of Medicare Part A claims. Our review of BCBSV's accounting records revealed that most of the costs claimed were allowable. We noted, however, three problems associated with Medicare Part A costs.

One problem was that the costs claimed on the FACPs exceeded the budgets approved by the Health Care Financing Administration (HCFA) by $316,791. Of the excess, $163,498 resulted from projects mandated by HCFA. The remaining excess of $153,293 did not result from projects mandated by HCFA nor was it approved by HCFA. Since BCBSV did not fully comply with Article VI of the Medicare Agreement, we are questioning the $153,293.

The second problem was that BCBSV allocated $621,354 of unallowable costs to Medicare. This consisted of $603,784 for leased equipment which could not be supported by BCBSV accounting records and $17,570 for two productivity investments that were not approved by HCFA.

The third problem involved cost offsets known as complementary credits. These are credits due Medicare for work performed for the mutual benefit of Medicare and a complementary insurance program operated by BCBSV. We found that BCBSV had not implemented the 1986 revisions to the Intermediary Manual which required contractors to identify complementary credits on a cost allocation basis. The BCBSV determined complementary credits utilizing a standard rate for each claim transferred.

We recomputed the complementary credits using the revised Medicare guidelines. We developed cost allocation percentages, identified Medicare cost centers that benefited BCBSV's complementary insurance program, and applied the percentages to the total costs of these centers. We used total costs since BCBSV was not in compliance with Medicare guidelines and had not developed a method to identify specific costs that did not benefit its complementary insurance program. Following this methodology, we computed Medicare complementary credits of $898,014 or $712,565 more than computed by BCBSV for FYs 1987 through 1989.

The problems we identified with Medicare costs were tempered by the fact that BCBSV did not claim all costs incurred. We noted that BCBSV made arbitrary adjustments to reduce costs claimed by about $3.1 million in order to lower the cost per claim.

We are making recommendations in this report for procedural improvements. Our recommendations for financial adjustments should take into account the costs incurred but not claimed by BCBSV. On February 14, 1991, BCBSV responded to a draft of this report. The BCBSV generally disagreed with our findings and recommendations, and provided additional information on HCFA-approved budgets and complementary credits. Based on this response and additional information obtained from HCFA, we have made changes to this report.

The BCBSV response has been incorporated into this report along with auditors' comments. We have included the response in its entirety as an appendix to this report.

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INTRODUCTION

BACKGROUND

The Health Insurance for the Aged and Disabled program (Medicare), Title XVIII of the Social Security Act, provides for a hospital insurance program (Part A) and a related medical insurance program (Part B). Medicare covers: (1) eligible persons aged 65 and over, (2) disabled persons under 65 who have been entitled to Social Security or railroad retirement benefits for at least 24 consecutive months, and (3) individuals under age 65 who have chronic kidney disease and are insured by or entitled to Social Security benefits.

Medicare is administered by HCFA. Under an agreement with the Secretary of the Department of Health and Human Services (HHS), Blue Cross Association (BCA) participates in the administration of the Medicare Part A program. The BCBSV, under a sub-contract with BCA, is responsible for the receipt, review, audit, and payment of Medicare Part A claims submitted by the providers it services.

The BCBSV is entitled to reimbursement for the allowable administrative costs incurred in carrying out its responsibilities under the Medicare sub-contract with BCA. From October 1, 1984 to September 30, 1989, BCBSV claimed administrative expenses of $27,382,876 for processing Medicare Part A claims totaling more than $4.5 billion.

SCOPE OF AUDIT

Our audit was made in accordance with generally accepted government auditing standards. Initially, our primary objective was to determine whether BCBSV's Medicare Part A FACPs for FYs 1985 through 1989 presented fairly the allowable costs of administration in conformity with the reimbursement principles contained in chapter 1, part 31 of the Federal Acquisition Regulation (FAR), as interpreted and modified by the Medicare sub-contract and the Medicare Intermediary Manual published by HCFA.

We noted, however, that the specific costs claimed per the FACPs could not be traced to the Medicare "booked" costs per the accounting records because BCBSV placed an arbitrary "cap" on costs charged to Medicare Part A. The BCBSV "capped" claimed costs to lower the costs per claim so that HCFA's annual contractor review would result in a favorable evaluation. As illustrated below, BCBSV's "booked" costs totaled $30,464,773 and claimed costs totaled $27,382,876 or $3,081,897 less than "booked" for the 5-year period of our review.

"Booked" Costs Versus Claimed Costs

Fiscal Year	"Booked" Costs	"CAP" Adjustments	Claimed Costs
1985	$4,737,174	$477,400	$4,259,774
1986	6,006,481	1,077,741	4,928,740
1987	6,060,386	757,445	5,302,941
1988	6,093,388	0	6,093,388
1989	7,567,344	769,311	6,798,033
Total	$30,464,773	$3,081,897	$27,382,876

As a result of BCBSV's practice of arbitrarily "capping" claimed costs, we were unable to trace the adjustments to either specific operations or specific cost centers. Therefore, we audited the allowability of the "booked" costs of $30,464,773 and not the claimed costs of $27,382,876. The BCBSV may offset allowable costs not claimed against costs questioned in this report, with one exception. We were able to determine that adjustments were made from BCBSV's claims processing operation and not the productivity investment (PI) projects. Therefore, costs questioned relative to PI projects should not be offset by allowable costs which were not claimed.

We also reviewed the accuracy, reasonableness, and allowability of Medicare complementary credits computed by BCBSV. Because Medicare guidelines for computing these credits were revised in May 1986, we limited our review of complementary credits to FYs 1987 through 1989.

Our review of BCBSV's automated cost accounting system was limited to evaluating the Corporate Audit Division's (CAD) review of the system and reviewing various reports generated specifically for the Medicare program. In 1989, CAD evaluated the adequacy and effectiveness of internal controls over the cost accounting system and analyzed the extraction of cost data from the general ledger and the allocation of costs to the various lines of business. The CAD concluded that material controls were in operation and that minor control weaknesses identified were compensated for by other controls. The CAD performed a follow-up review to ensure that corrective action was implemented.

Our audit dealt primarily with allowability of costs. We did not audit either the effectiveness or efficiency of BCBSV's operation. Our review was performed during the period of January 1990 through August 1990 at BCBSV's corporate offices in Richmond, Virginia and its Medicare division offices in Roanoke, Virginia.

FINDINGS AND RECOMMENDATIONS

COSTS CLAIMED IN EXCESS OF BUDGET

The HCFA has approved Medicare budgets for BCBSV totaling $27,080,312 in administrative costs for FYs 1985 through 1989. For 3 years of this 5-year period, BCBSV claimed on its FACPs $316,791 more than approved by HCFA. Eight PI projects mandated by HCFA but not included in the annual budgets accounted for $163,498 of the budget overruns. Since these PI projects costs were incurred as a result of HCFA mandates, BCBSV cannot be held accountable for that portion of the budget overruns. We are, however, questioning budget overruns of $153,293 because BCBSV did not obtain HCFA's approval to incur the costs.

According to Article VI "Cost of Administration" of the Medicare agreement, paragraph I, the Secretary will pay allowable costs that exceed the budget amount provided that the requirements of paragraph H have been met by the intermediary. Paragraph H stipulates that if at any time it appears that the approved budget amounts will not be sufficient to cover administrative costs for the FY, the intermediary shall notify the Secretary. In no event should the notification be less than 60 calendar days prior to the date in which it is estimated that the budgeted amount will be exhausted, unless the intermediary can demonstrate that such notice could not have been given within that time frame. The notification should also contain the intermediary's proposals as to how costs expected to be incurred may be reduced.

Our review showed that BCBSV did not comply with the requirements of paragraph H in any of the 3 years in which the budget was exceeded. We have increased the approved budgets by $163,498 which is the amount of the eight PI projects mandated by HCFA. This raises the approved budget amount for the 5-year period from $27,080,312 to $27,243,810. As shown in the following chart, BCBSV had budget overruns totaling $153,293.

FY	Budget	Claimed	Overrun
1985	$4,243,630	$4,259,774	$16,144
1986	4,829,124	4,928,740	99,616
1987	5,317,168	5,302,941	0
1988	6,093,388	6,093,388	0
1989	6,760,500	6,798,033	37,533
Total	$27,243,810	$27,382,876	$153,293

As can be seen in the above chart, BCBSV actually claimed $14,227 less than the approved budget in FY 1987. An underrun

in 1 budget year, however, cannot be used to offset an overrun in another budget year. The $153,293 in budget overruns included $108,716 associated with the normal processing of Medicare claims and $44,577 associated with PI projects that were either not approved by HCFA (two projects totaling $17,570); or that exceeded the approved amount (seven projects totaling $27,007).

Conclusions and Recommendations

For FYs 1985 through 1989, BCBSV claimed $316,791 more than the budgeted amounts approved by HCFA. A portion of the budget overruns, $163,498, was allowable as costs were incurred on HCFA mandated PI projects. The remaining overruns totaling $153,293 were unallowable because BCBSV, contrary to provisions of the Medicare agreement, did not obtain HCFA's approval to exceed the annual budgeted amounts.

We, therefore, recommend that BCBSV reduce the FACPs by $153,293.

BCBSV Response and Auditors' Comments

The BCBSV did not agree with our findings and recommendations. The BCBSV stated that, with the exception of FY 1989, the annual budgeted amounts cited in the draft report were incorrect. Based on data received from HCFA, BCBSV contended that there were no cost overruns in FYs 1985 and 1986.

We reviewed the material furnished by BCBSV and obtained additional information from HCFA. According to the latest information available from HCFA, the approved annual budgets are as shown in this final report, considering the $163,498 that we added to compensate for HCFA-mandated PI projects. The BCBSV, therefore, had unapproved budget overruns totaling $153,293.

UNALLOWABLE COSTS ALLOCATED TO MEDICARE

Our review identified $621,354 of "booked" costs allocated to Medicare that were either unsupported or unallowable. This amount consists of:

- $603,784 associated with leased electronic data processing (EDP) equipment that could not be supported by BCBSV's accounting records.
- $17,570 for PI projects which were neither approved nor mandated by HCFA.

Leased EDP Equipment

During the period of our review, BCBSV entered into lease agreements for EDP equipment with various vendors. The BCBSV allocated to Medicare $603,784 associated with the leasing of EDP equipment for which support was not available. Therefore, the $603,784 for lease payments is unallowable.

Our review showed that BCBSV did not maintain adequate documentation to support the allocation of EDP lease costs to Medicare. The BCBSV, during the period of our review, did not maintain lease files in a centralized location nor was one employee within BCBSV responsible for the accounting and retention of lease agreements. This lack of control became evident when we requested that BCBSV furnish us a listing of all leased EDP equipment costs allocated to Medicare during the period of our review. Our purpose was to identify the equipment and to determine whether or not it was used in the Medicare operation. The BCBSV, however, was unable to provide a listing of the equipment or otherwise identify the leased EDP equipment costs allocated to Medicare.

Through an analysis of the account "EDP Equipment Leases," however, we were able to identify 27 vendors that had costs allocated to the Medicare program during the period of our review. The BCBSV was able to furnish us agreements for 10 of these vendors. The leasing costs for the 10 vendors accounted for $349,328, or about 58 percent of the costs allocated to Medicare.

We reviewed the available lease agreements for the 10 vendors. The information contained in the agreements was so general that we were not able to identify specific items of equipment. For example, one agreement, which accounted for $329,421 of the costs, was for general computer services and became effective on April 17, 1980. The lease did not specify the term of the lease, the equipment to be leased, the monthly lease payment, or the expiration date. There was no indication in the agreement how Medicare was to benefit from it.

The BCBSV has taken action to improve controls over lease agreements. Effective February 1, 1989, BCBSV instituted financial policies regarding the maintenance of a centralized lease file. However, at the time of our review, this policy did not apply to those leases entered into before February 1, 1989. As a result, the $603,784 associated with leased equipment could not be supported by BCBSV's records, nor could BCBSV demonstrate that the equipment was used in support of the Medicare program. Therefore, these costs are unallowable.

Productivity Investment Projects

During our audit period, BCBSV allocated to Medicare over $1.6 million for PI projects. We believe that $17,570 is unallowable because two PI projects were neither approved nor mandated by HCFA.

The HCFA authorizes intermediaries to perform special PI projects that are outside the realm of normal processing of Medicare Part A claims. The PI projects are reimbursed through the FACPs. Since PI projects are not included in the regular budget process, the projects and the budget for the projects must be approved by HCFA.

Our review of BCBSV's files and budgets approved by HCFA as well as discussions with HCFA staff showed that the following PI projects claimed by BCBSV were neither approved nor mandated by HCFA.

FY	PI Project	Amount Claimed
1985	Medicare Audit Support	$8,570
1987	Magnetic Tape	9,000
Total		$17,570

Conclusions and Recommendations

Our review of "booked" costs for FYs 1985 through 1989 showed that BCBSV allocated to the Medicare program unsupported costs of $603,784 associated with leased EDP equipment, and unallowable costs of $17,570 for two PI projects neither mandated nor approved by HCFA.

In considering the affect of these findings on Medicare costs, however, one also must consider BCBSV's practice of "capping" the costs claimed. As shown on page 2 of this report, the BCBSV did not include all booked costs on the FACPs. The BCBSV can, therefore, apply the unclaimed allowable costs against our questioned costs, except for costs associated with the PI projects.

We, therefore, recommend that BCBSV:

1. Strengthen internal controls to ensure that adequate documentation is maintained to support the costs of leased equipment allocated to the Medicare program.

2. Obtain HCFA approval for all projects that are not mandated by HCFA.

3. Coordinate with HCFA any effort to offset allowable costs not claimed on FACPs against the remaining unallowable costs of $603,784 identified in this report.

4. Coordinate with HCFA the need to reduce the FY 1985 FACP by $8,570 and the FY 1987 FACP by $9,000 for PI projects not approved by HCFA and not affected by "cap" adjustments.

BCBSV Response and Auditors' Comments

In its response, BCBSV addressed the leased EDP equipment finding but did not respond to the finding on the PI projects. The BCBSV responded that it will review its leasing procedures that were placed in effect on February 1, 1989 to ensure that they are being followed. The BCBSV also agreed that it had not originally gone back and gathered leases prior to that date. However, BCBSV had provided the auditors with a year-to-year transaction listing which detailed every entry to the lease amounts, and had found and provided to the auditors all of the leases except the highly immaterial ones.

The BCBSV assumed that the example cited in the report related to a contract specifically entered into to provide Medicare with a Hospital Cost Report. It stated that possibly the agreement would have been better classified as an "outside service." The BCBSV stated that it could not respond to the remaining disputed EDP lease agreements without additional information.

We believe that the new procedures, if properly implemented, will improve controls over EDP leasing. We agree that BCBSV provided us with the year-to-year transaction listing and that we used this document to identify vendors who received lease payments from BCBSV. We do not agree, however, that BCBSV provided all the material leases to the auditors.

The listing provided by BCBSV identified 27 vendors during the period of our review. However, BCBSV provided lease agreements for only 10 of these vendors that represented 58 percent, or $349,328 of the total cost. The agreements were too general to identify specific items of equipment or how Medicare was to benefit. We believe 17 lease agreements, totaling $254,456, that were not provided were indeed, material. These costs include $112,414 of lease payments to specific vendors and $142,042 of lease payments for which BCBSV could not even identify the vendor.

Regarding the example cited in our draft report, neither the agreement nor other documentation available at BCBSV supported the allocation of costs to the Medicare program. For this agreement to be considered an "outside service" as suggested by BCBSV, it would have to document that the contract was procured in accordance with the Federal Acquisition Regulation and the Medicare agreement.

The BCBSV has been provided with the information that we have developed during our audit. We will provide our working papers to HCFA should BCBSV require additional information.

Although BCBSV did not respond to our finding on PI projects, HCFA provided us additional information. As a result of this information, we have reduced the number of unapproved PI projects that was cited in our draft audit report.

COMPLEMENTARY CREDITS

The BCBSV reported complementary credits of $185,449 on the FACPs for FYs 1987, 1988, and 1989 ($50,376, $63,358, $71,715 respectively) based on a standard rate of $0.25 for every Medicare claim transferred to the complementary insurance program. This method was not in compliance with 1986 revisions to the Medicare guidelines which required a full cost allocation for any routine transfer of information.

Since the revised Medicare guidelines were not implemented, there was no assurance that BCBSV was paying its fair share of the cost of activities that benefited both Medicare and its complementary insurance program. To determine if BCBSV's complementary insurance program was paying its fair share of these costs, we recomputed the complementary credits on the basis of cost allocation as required by the revised Medicare guidelines.

In doing so, we developed cost allocation percentages, identified costs centers that benefited both Medicare and the complementary insurance program, and applied these percentages to the total costs of the Medicare cost centers that we identified. We used the total costs of these centers since BCBSV was not in compliance with the revised Medicare guidelines and had not developed an allocation method to identify specific costs in the cost centers that did not benefit the complementary insurance program. Using this methodology, we determined that the complementary credits should have been as much as $898,014, or $712,565 more than reported by BCBSV.

Complementary credits to Medicare result from Medicare sharing claimant data with a complementary insurance program. The BCBSV operated a complementary insurance program that provided Medicare beneficiaries with insurance coverage for the 20 percent coinsurance cost not reimbursed by Medicare. In operating the complementary insurance program, BCBSV used a totally integrated claims processing system under which claimant data on the Medicare claim forms was transferred by magnetic tape to BCBSV's complementary program for payment.

Sharing of claimant data is authorized as long as the costs of activities that benefit Medicare and the complementary insurance program are shared equitably by both programs. Section 1600-1601, part 1 of the Medicare Intermediary Manual as revised in May 1986 by HCFA Transmittal No. 111, provides cost accounting guidelines for identifying and recording the costs of transferring Medicare claimant data to the intermediary's own complementary insurance program.

The HCFA transmittal eliminated the standard charge to complementary insurers for the routine transfer of Medicare information and instead required full cost allocation for any routine transfer of Medicare information to complementary insurers. The revised Medicare guidelines specifically state that when using a totally integrated system, such as the system used by BCBSV, charges to the complementary insurer will be determined by cost allocation. The revised guidelines further stipulate that:

- The term allocation means to distribute all costs to Medicare and the complementary insurance program in such proportion as to reflect the benefits received by each program.

- When both programs derive mutual benefits from an activity, full cost sharing is required.

- A cost center will be allocated if its activities benefit the complementary claims process. An activity benefits complementary insurance if that activity would have been necessary to fulfill the terms of the complementary contract or its normal claims processing requirements.

Our review showed that, contrary to the revised Medicare guidelines of May 1986, BCBSV did not implement a cost allocation system to compute complementary credits, but continued to charge its complementary insurance program a standard rate of $0.25 for each Medicare claim transferred to the complementary program during FYs 1987 through 1989. We recomputed the complementary credits using the revised Medicare guidelines as shown below.

Cost Allocation Percentages

We based our cost allocation percentages on a claims processed ratio that was used by a Medicare carrier in Region III.[1] We identified the total number of Medicare claims transferred to the complementary insurance program during each FY included in our audit and compared this number to the total number of Medicare claims processed and complementary claims transferred during the same FY. Our allocation formula is illustrated below.

$$\frac{\text{Medicare Claims Transferred}}{\text{Total Medicare Claims + Claims Transferred}} = \text{Allocation Percentage}$$

Using this cost allocation methodology for FYs 1987, 1988, and 1989, we determined that BCBSV's complementary insurance program should have been allocated 15.2 percent, 16.5 percent, and 16.6 percent, respectively, of the costs of Medicare cost centers that benefited the complementary program.

Identification of Cost Centers

The next step in our recomputation was to identify Medicare cost centers that benefited BCBSV's complementary insurance program. The BCBSV established 10 Medicare cost centers. We reviewed the functions and activities performed in these cost centers and determined that five of the centers also benefited the complementary insurance program. The cost centers were: (1) Medicare Claims Processing (MCP), (2) Medical and Utilization Review (MUR), (3) Medicare Secondary Payer (MSP), (4) Medicare Director (MD), and (5) Government Operation Officer (GOO). A brief description of the functions performed in each of these centers follows.

Medicare Claims Processing

The MCP cost center was responsible for all aspects of the Medicare claims processing operation. These responsibilities included the coding and entry of claims into the automated system, as well as performing other automated procedures in support of the claims processing operation such as edit and validity checks, duplicate checks, and file updating. This

[1] We recently audited the Pennsylvania Blue Shield and determined that the claims processed methodology it used to allocate costs between Medicare and its complementary insurance program was fair and equitable.

cost center was also responsible for preparing the Medicare claimant data to be transferred to the complementary program.

The MCP activities were normal claims processing activities that BCBSV would have had to conduct had the activities not been performed under the Medicare sub-contract. These activities assured that claimant data transferred to the complementary insurance program was accurate, thereby eliminating the need for similar activities on the part of the complementary program. Therefore, the cost of this activity should be shared by the complementary insurance program.

Medical and Utilization Review

The MUR cost center performed all of the medical review functions for BCBSV's Medicare department. These functions ranged from coverage of services, to exclusions, to appeals. The MUR activities assured that the medical service claimed for payment was covered by Medicare and was necessary and appropriate. As a result of the MUR activities, Medicare claims were either accepted and paid, or denied. In addition, this cost center also reviewed providers' utilization patterns and identified aberrant patterns of use.

The functions performed in this cost center were normal claims processing requirements that BCBSV would have had to perform for its complementary program had they not been performed under the Medicare sub-contract. These activities provided assurance to the complementary program that the services being claimed for payment were eligible for payment.

Medicare Secondary Payer

The MSP cost center, which was mandated by HCFA to ensure savings to the Medicare trust fund, was responsible for determining if Medicare was the primary payer for all claims. Activities performed in this cost center included research and development to obtain other payer information, such as automobile medical insurance, liability insurance, and employer group health plan coverage. During FYs 1987, 1988, and 1989, BCBSV reported Medicare savings of over $72 million as a result of the MSP activities.

We believe the activities of the MSP cost center benefited BCBSV's complementary insurance program and would have had to have been performed by BCBSV for its program had the activities not been performed under the Medicare sub-contract. Every Medicare claim identified by this cost center as being the

responsibility of another primary payor did not have to be paid by BCBSV's complementary insurance program.

Medicare Director

The MD cost center was responsible for the day to day operation and administration of the Medicare program and had overall responsibility for eight cost centers. Three of these cost centers--MCP, MUR, and MSP--benefited the complementary program. Since a portion of the costs incurred by the MD cost center resulted from its administration of three centers that benefited the complementary insurance program, we believe that a portion of the MD costs should be allocated to the complementary program.

Government Operation Officer

The GOO cost center, established in FY 1988, included the Executive Officer who was responsible for all Federal programs, including Medicare. Since this cost center had management responsibility for all Medicare cost centers, including the four cost centers mentioned above that also benefited the complementary insurance program, we believe a portion of the costs in this cost center should be allocated to the complementary insurance program.

Applying Cost Allocation Percentages to Costs of Identified Cost Centers

The final step in recomputing the complementary credits using the revised Medicare guidelines was applying the cost percentages that we developed to the costs of the five identified centers. We used the total costs of these five centers because BCBSV had not implemented the revised Medicare guidelines nor developed a method for identifying costs in these centers that did not benefit Medicare. The BCBSV charged Medicare $6,460,062 for costs generated by the five cost centers. Using these costs, we calculated the Medicare complementary credits for the 3-year period at $898,014 as shown below.

RECOMPUTED COMPLEMENTARY CREDITS				
Cost Center	FYs			
	1987	1988	1989	Total
MCP	$172,279	$196,950	$202,599	$571,828
MUR	21,801	32,767	36,455	91,023
MSP	32,032	41,140	51,365	124,537
MD	21,546	33,749	45,809	101,104
GOO	0	919	8,603	9,522
Total	$247,658	$305,525	$344,831	$898,014

Conclusions and Recommendations

The BCBSV was not in compliance with revised Medicare guidelines which required the costs of activities benefiting both Medicare and its complementary insurance program to be allocated to both programs. Instead of complying with the revised guidelines, BCBSV continued to base its complementary credits to the Medicare program on a flat fee per claim transferred. As a result, BCBSV understated the Medicare complementary credits by as much as $712,565 ($898,014 - $185,449) in FYs 1987 through 1989.

We therefore, recommend that BCBSV:

1. Implement procedures to allocate costs between the Medicare and its complementary insurance program as required by the revised Medicare guidelines.

2. Coordinate with HCFA any effort to offset allowable costs not claimed on FACPs against the understated complementary credits of $712,565. This amount may be adjusted depending on whether BCBSV can specifically identify costs in the five costs centers that did not benefit the complementary insurance program.

BCBSV Response and Auditors' Comments

The BCBSV did not agree with our findings and recommendations pertaining to complementary credits. Its primary disagreements centered on: (1) there is no law or regulation that supports section 1600-1601 of the Medicare Intermediary Manual and (2) that we used the total costs of the five cost centers in recomputing the complementary credits.

The BCBSV stated that there were many costs in the five cost centers that did not benefit Medicare and gave several examples of these costs. The BCBSV estimated the "...actual value to the complementary program allocated from the five Medicare cost

centers to be no more than $482,404..." as compared to the $898,014 cited in the draft report. The BCBSV further suggested a more reasonable and acceptable method for determining cost allocation to complementary insurance programs be utilized, such as a national fee.

We have reviewed BCBSV's response to this finding and have made several changes to this final version. We do not agree with BCBSV's first major point. The fact is that BCBSV was not in compliance with provisions of the Medicare Intermediary Manual for computing complementary credits. The BCBSV continued to charge a standard rate rather than allocate costs that benefit both Medicare and the complementary insurance program. In our opinion, intermediaries are required to comply with all provisions of the Medicare Intermediary Manual, including those governing the computation of complementary credits, regardless of whether or not they are supported by law or regulations.

We agree that BCBSV's second major point concerning our use of total costs has some validity. Because BCBSV was not in compliance with Medicare guidelines and had not identified costs that did not benefit the complementary program, we used total costs to determine the maximum amount of complementary credits. It now appears from the response to our draft report that BCBSV has subsequently identified costs in the five cost centers that did not benefit the complementary insurance program.

If this is the case and if BCBSV's computation is accurate, complementary credits would be reduced from the $898,014 cited in this report to the $482,404 cited in BCBSV's response. The understated complementary credits would be reduced from $712,565 to $296,955. We have revised the wording in our recommendation to take this into account. The BCBSV should provide its calculations to HCFA during the audit settlement process.

Blue Cross
Blue Shield
of Virginia

Federal Medicare
Intermediary

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February 14, 1991

Mr. G. A. Rafalko
Regional Inspector General
for Audit Services
Department of Health & Human Services
P. O. Box 13716, Mail Stop 9
Philadelphia, PA 19101

Dear Mr. Rafalko:

The following is Blue Cross and Blue Shield of Virginia's (BCBSVA) response to your draft audit Common Identification Number A-03-89-00053.

We have adjusted the cost figures on Page 6 of the draft audit to more accurately reflect final HCFA and BCBSVA records. We have also included comments on Leased EDP Equipment and Complimentary Credits. Relative to the complimentary credits we strongly disagree with the approach and results of the OIG audit. As explained in our comments, the OIG approach effectively passes Medicare administrative expense to the Beneficiary and forces complimentary insurers to revert to processing from Hard Copy EOMB's, resulting in more cost to the Medicare Program and more confusion to the Beneficiary.

Please call me if you have any comments or questions about our response.

Sincerely,

Paul Keyser
Vice President of Operations

PK/mw

Encl.

FEB [illegible] 1991

COSTS CLAIMED IN EXCESS OF BUDGET

We do not agree with the conclusions specified in the report. The "Approved Budget" for fiscal years 1985 through 1989, as shown on page 6, does not agree with the amounts we have been able to obtain from the HCFA Regional Office in Philadelphia.

The only fiscal year in which our findings agree with the report is 1989. We have received conflicting information from the Regional Office and Central Office of HCFA on the other four years. Both offices have been very helpful in providing us information, but conflicts remain. Based on our findings, we believe there is no overrun in 1985 and possibly 1986.

Confusing this issue is the fact that we returned "prepaid expense" monies in 1987, for the prior fiscal years. We can find no adjustment reflected in the FACP's for those years.

In summary, this area needs another review. We will be available to visit your offices to work through this, to come to a final resolution of what was approved, what can be claimed, and if any, the net overrun.

LEASED EDP EQUIPMENT

- The draft comment states that BCBSVA is not in compliance with internal operating lease policies regarding the maintenance of a centralized lease file (Financial Policy IV-1). These policies were approved on February 1, 1989. When the auditors arrived they were provided lease agreements entered into since that date. While we originally did not go back and gather leases entered into before the policy approval date, we disagree with the statement that internal policies are not being complied with.

- The draft comment states "BCBSVA was unable to provide a listing of the equipment or otherwise identify the leased EDP equipment whose costs were allocated to Medicare". We provided the auditors with a Year-To-Date Transaction Listing for the years under audit which details every entry to the lease amounts. Line Of Business for each entry was also on the report which determines cost allocation methodology.

- We were provided with a list of 23 vendors for which a lease agreement was not originally provided. All these leases were entered into prior to 2/1/89. Of these leases all but highly immaterial ones were found and forwarded to the auditors.

- We assume the $227,451 not allowed for general computer services (effective 4/17/80) is related to General Electric. This contract was entered into to specifically provide Medicare with a Hospital Cost Report. In summary, BCBSVA used General Electric EDP equipment and software to calculate and produce these cost reports. Possibly the agreement would have better been classified as an "outside service" rather than a lease. There were no terms in the agreement because we could cancel at anytime. No equipment was installed at BCBSVA. Payments were based upon CPU usage, not a set amount each month. The costs associated with this service agreement should all be allowed by Medicare.

- It is very difficult to respond to the remaining $376,333 of disputed EDP lease payments. We do not know how the number was derived or what issues need to be addressed. Until this information is provided, we must continue to consider these costs as reimbursable. Specifically, we need to know which payments, by vendor, are at issue.

We will review our procedures to ensure policy is being followed. We also understand any nonallowed cost will be offset by the difference between "booked" and claimed cost for the period covered by this audit.

COMPLEMENTARY CREDITS

Blue Cross and Blue Shield of Virginia (BCBSVA) does not agree with the OIG finding for Complementary Credits to the HCFA for the following reasons:

- There is no law or regulation supporting Section 1600-1601 of the Medicare Intermediary Manual.

- There is no basis or precedent or other evidence for the OIG interpretation of the manual section.

- The OIG has incorrectly determined cost center cost to be used for the allocation to BCBSVA's complementary insurance program.

- The OIG has made incorrect assumption as to the benefit of MSP cost center to the Complementary insurance program.

- OIG's methodology is contrary to our understanding of OBRA 89 and HCFA initiatives to improve service and simplify the Medicare Program for beneficiaries.

- There is no law or regulation supporting Section 1600-1601 of the Medicare Intermediary Manual. We believe this section is open to interpretation depending on who is reading the section since there is no regulatory back-up. There are not generally acceptable accounting procedures that support the logic of allocating routine administrative cost to another entity simply because data are passed. These administrative cost are incurred for processing Medicare claims regardless of whether the data are passed to the complementary insurer or not. It is reasonable for the Medicare Program to charge a reasonable fee for this service however.

- There is no basis or precedent or other evidence for the OIG interpretation of this manual section. We believe the OIG position is inconsistent with the Medicare Intermediary Manual, Section 1601 which states, "An activity benefits complementary insurance if that activity would have been necessary to fulfill the terms of the complementary contract or its normal claims processing requirements." The normal claims processing requirements of the complementary insurance does not change regardless of where the data comes from. The only difference between a hard copy EOMB versus electronic receipt is the electronic receipt eliminates coding, data entry, and mail handling cost. All other complementary claims processing requirements such as complementary eligibility checking, coinsurance, or deductible calculations, etc., must be accomplished for hard copy or electronic claims.

  We consider the OIG interpretation to also mean that Medicare should pay for any information used in processing Medicare claims obtained from Blue Cross such as Medicare Secondary Payor information. If the OIG interpretation is effectual, BCBSVA will establish a rate to charge Medicare for information provided, consistent with the OIG's interpretation.

- The OIG has incorrectly determined cost center cost to be used for the allocation to BCBSVA's complementary insurance program. The OIG, in identifying cost centers, failed to identify actual cost within the cost center either as interpretated by OIG or as interpretated by BCBSVA. Rather the OIG considered all cost in a cost center as associated with complementary claims.

The first cost center, Medicare Claims Processing (MCP) includes many cost not associated with the complementary program such as postage for correspondence, EOMB's, checks and remittances, completes cost associated with generation of these forms, telephone cost for provider and beneficiary inquiries, cost of provider and beneficiary inquiry unit, and provider relations representatives. Cost for required HCFA projects and ongoing computer cost (claims processing timeliness, OBRA, etc). Cost to process claims not covered by complementary coverage. Furthermore, any cost in the MCP cost center not directly associated with coding, data entry or mail handling as we indicated above should not be considered or allocated to complementary coverage.

The Medicare Utilization Review (MUR) cost center cost are largely for the review of claims for statutory requirements, only some outpatient and SNF claims are reviewed for medical necessity. Again, the complementary program also reviews claims for statutory requirements. The OIG did not reduce the cost of the MUR cost center for these non-beneficial cost to the complementary program.

These are a number of issues with the Medicare Secondary Payor (MSP) cost center. The OIG did not consider reducing MSP cost allocated to the Complementary Program for activities not benefited to the complementary program. For example, there are substantial cost in MSP associated with BCBSVA's performance as a Regional Data Exchange Manager (RDEM) for HCFA, cost for BCBSVA's performance as national maintenance of the RDEM software, no cost reduction or allowance for MSP information furnished to Medicare from BCBSVA, and no reduction of cost associated with MSP Outreach HCFA requirements.

- <u>The OIG has made incorrect assumptions as to the benefit of MSP cost center to the complementary insurance program.</u> The draft audit on page 19 indicates "Every Medicare claim identified by this center is being the responsibility of another primary payor did not have to be paid by BCBSVA's complementary insurance program." As previously stated, the complementary insurance processing area must determine if any and how much payment is due on each claim. The fact the beneficiary has complementary coverage does not mean there is payment due. For example, after the inpatient deductible a beneficiary has 60 day inpatient coverage. Also, there is no coinsurance charge for outpatient clinical diagnostic laboratory services. If the complementary insurance processing department determines the beneficiary is no longer eligible for complementary coverage, no payment is made. There are a large number of claims passed to the complementary insurance program for which no payment is made.

The draft audit on page 19 further states, "For every Medicare dollar saved on claims that would have been transferred to the complementary program, twenty cents were saved by the complementary insurance program (since this program covered the Medicare beneficiaries coinsurance liability)." This is a totally inaccurate statement. Twenty percent coinsurance only applies to certain outpatient and Medicare Part B claims. Inpatient there is $628 deductible per benefit period, then 60

full covered days, then 30 coinsurance days at $157 per day, then 60 lifetime reserve days at $314 per day. SNF admissions covered in full first 20 days then $78.50 coinsurance 21st through 100th day. It is apparent the OIG is not familiar with Medicare coverage, coinsurance and deductibles since the 20% only applies to certain outpatient and Part B claims. Large dollar inpatient and SNF claims may or may not have a deductible and or coinsurance amount which in any event is not associated with a percent of covered or billed charges. These facts based on Medicare coverage regulations make the OIG estimated $2.3 million savings to BCBSVA's complementary program invalid. This also invalidates the OIG's estimated $2.2 million cost savings as a result of MSP activities.

- OIG's methodology is contrary to our understanding of OBRA 89 and HCFA initiatives to improve service and simplify the Medicare Program for beneficiaries. The cost for complementary coverage to the beneficiary is determined, in part, by cost to the program for processing claims. Any Medicare administrative cost passed to the complementary program will be passed to the beneficiary. This only results in the beneficiary subsidizing Medicare administrative cost. Furthermore, if HCFA and OIG insist on this unreasonable approach, the complementary program will further burden the beneficiary or provider by requesting a hard copy EOMB for processing. This will eliminate any cost savings to the Medicare Program and in fact increase cost for duplicate EOMB's and NOU's requested by providers and beneficiaries.

In conclusion, we estimate the actual value to the complementary program allocated from the 5 Medicare cost centers to be no more than $482,404. This estimate is based on reduction on non-related cost indicated in the preceding narrative. Furthermore, we strongly suggest a more reasonable and acceptable method for determining cost allocation to complementary insurance programs be utilized, such as a national fee. It is not worthy to point out the Medicare Part B Carrier charges the complementary insurance program $.46 per claim, which is not more or less beneficial to the complementary program, so why $1.21 per claim for Part A claims information?

When the new Section 1600-1601 was published, we reviewed our cost and based on our interpretation the only direct cost we were incurring for complementary claims was the computer run time for the crossover program. This amounted to $60 to $75 per month. Based on the number of crossover claims, this cost amounted to only 2 or 3 cents per claim. We believed that the remaining 22 to 23 cents per claim would more than cover any indirect cost for the Medicare Program.