Memorandum

Date AUG 6 1992

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Audit of Medicare Administrative Costs Incurred Under Parts A and B for Arkansas and Part B For Louisiana (A-06-92-00071)

To William Toby
Acting Administrator
Health Care Financing Administration

This is to alert you to the issuance on August 7, 1992, of our final report. A copy is attached.

The firm of Sheffield, Behan and Company, Limited, Certified Public Accountants (CPA), under contract with the Office of Inspector General, conducted an audit of Medicare Administrative Costs incurred by Arkansas Blue Cross and Blue Shield, Inc. (the Plan). The Plan is the Intermediary/Carrier for the State of Arkansas and the Carrier for the State of Louisiana.

The audit covered the period October 1, 1986 through September 30, 1988 for Arkansas and the period January 1, 1985 through September 30, 1988 for Louisiana. For Arkansas, the Plan reported Medicare administrative costs of $6,706,232 for Part A and $14,216,931 for Part B. For Louisiana, the Plan reported Medicare administrative costs of $35,462,194 for Part B.

The CPA firm recommended audit adjustments totaling $1,441,937. Specifically, the Plan:

- did not properly calculate the cost of claims crossed over to private lines of business,
- claimed costs in excess of its notices of budget approval,
- claimed automobile costs in excess of amounts allowed by Federal guidelines, and

- claimed unallowable pension costs not funded by the income tax return filing date.

The Plan generally agreed with the audit findings.

For further information, contact:
Donald L. Dille
Regional Inspector General
for Audit Services, Region VI
(214) 767-8414

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF ADMINISTRATIVE COSTS INCURRED UNDER PARTS A AND B OF THE ARKANSAS MEDICARE PROGRAM FOR THE PERIOD OCTOBER 1, 1986 THROUGH SEPTEMBER 30, 1988 AND PART B OF THE LOUISIANA MEDICARE PROGRAM FOR THE PERIOD JANUARY 1, 1985 THROUGH SEPTEMBER 30, 1988 ARKANSAS BLUE CROSS AND BLUE SHIELD, INC. LITTLE ROCK, ARKANSAS

AUGUST 1992 A-06-92-00071

Department of Health and Human Services

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AUGUST 1992 A-06-92-00071

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 4E1A
Dallas, TX 75242

Common Identification Number: A-06-92-00071

George K. Mitchell, M.D.
President/Chief Executive Officer
Arkansas Blue Cross and Blue Shield, Inc.
P. O. Box 2181
Little Rock, Arkansas 72203-2181

Dear Dr. Mitchell:

Enclosed for your information and use are two copies of an HHS/OIG Office of Audit Services report entitled, "Report on the Audit of Administrative Costs Incurred Under Parts A and B of the Arkansas Medicare Program for the Period October 1, 1986 through September 30, 1988 and Part B of the Louisiana Medicare Program for the Period January 1, 1985 through September 30, 1988, Arkansas Blue Cross and Blue Shield, Inc., Little Rock, Arkansas." Your attention is invited to the audit findings and recommendations contained in the report.

Final determinations as to actions to be taken on all matters reported 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.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), 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,

Donald L. Dille

DONALD L. DILLE
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to:

M. J. Christenberry
Associate Regional Administrator
for Medicare
Health Care Financing Administration
1200 Main Tower Building, Room 2010
Dallas, Texas 75202

REPORT ON THE AUDIT OF ADMINISTRATIVE COSTS INCURRED UNDER PARTS A AND B OF THE ARKANSAS MEDICARE PROGRAM FOR THE PERIOD OCTOBER 1, 1986 THROUGH SEPTEMBER 30, 1988 AND PART B OF THE LOUISIANA MEDICARE PROGRAM FOR THE PERIOD JANUARY 1, 1985 THROUGH SEPTEMBER 30, 1988 ARKANSAS BLUE CROSS AND BLUE SHIELD, INC. LITTLE ROCK, ARKANSAS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of Sheffield, Behan and Company, Ltd., as concurred in by the HHS OIG Office of Audit Services. Final determinations on these matters will be made by authorized HHS operating division officials.

CONTRACT DISCLOSURE STATEMENT

This report is made pursuant to Contract 160-89-003 with Sheffield, Behan and Company, Ltd., 1837 Wehrli Road, Naperville, Illinois 60565. The dollar amount of this contract with the Department of Health and Human Services, Office of Inspector General, for work resulting in this and two other reports is not to exceed $163,815. This contract was a competitive award. The project officer was Mr. William G. Shrigley, Jr., HHS, Office of Inspector General, Region VI, Three Financial Centre, Suite 510, 900 South Shackleford Road, Little Rock, Arkansas 72211.

The names of the persons, employed by Sheffield, Behan and Company, Ltd., with managerial or professional responsibility for such work, or for the content of the report, are, as follows:

Roger Sheffield, MBA, CPA
Kevin Rodgers, CPA
Richard Behan, CPA

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SUMMARY

Arkansas Blue Cross and Blue Shield, Inc. (the Plan) is the Intermediary/Carrier for the State of Arkansas and the Carrier for the State of Louisiana. As the Intermediary/Carrier for the state of Arkansas, for the period October 1, 1986 through September 30, 1988, the Plan reported administrative costs of $6,706,232 and $14,216,931 respectively, on its Medicare Parts A and B Final Administrative Cost Proposals (FACPs). As the Carrier for the state of Louisiana, for the period January 1, 1985 through September 30, 1988, the Plan reported Part B administrative costs of $35,462,194. Our recommended audit adjustments reduce reported costs by $1,441,937 ($222,176 for Part A and $645,087 for Part B of Arkansas and $574,674 for Part B of Louisiana). The audit findings are summarized as follows:

* The Plan failed to calculate the cost of claims crossed over to private lines of business in accordance with its Intermediary/Carrier manuals. This resulted in an estimated $769,770 overstatement of costs.

* The Plan claimed $292,129 of costs in excess of its notices of budget approval.

* The Plan claimed $155,243 of automobile costs in excess of those allowed by federal guidelines.

* The Plan claimed $136,616 in unallowable pension costs not funded by the income tax return filing date.

* $24,456 in excessive annual report costs were allocated to the Medicare programs.

* The Plan claimed $20,689 in unallocable State Insurance Commissioner audit expenses.

* As a result of clerical errors, return on investment costs were overstated by $10,954.

* Travel costs in excess of federal guidelines and directly chargeable to private lines in the amount of $9,454 were charged to the Medicare programs.

* Cost center allocation errors caused the Plan to claim $8,417 in costs not associated with the Medicare program.

* The Plan claimed $7,568 in unallowable sales taxes which were the result of a state audit of periods before the inception of the Louisiana Part B contract.

* Less material findings related to non-allocable costs, professional fees, contributions, promotion and entertainment resulted in a $6,641 overcharge to the FACPs.

We evaluated the Plan's system of significant internal accounting and administrative controls, and compliance with laws and regulations that can materially affect the Plan's financial statements. Based on our evaluation, except as indicated in the above recommended adjustments, we believe control procedures were adequate for the Department of Health and Human Services' (HHS) purposes, and that the Contractor complied with the terms and provisions of laws and regulations for the transactions tested. Sheffield, Behan and Company, Ltd. reports on review of internal control and on compliance appear on pages 28 and 30 respectively.

We expressed an unqualified opinion on the FACP. Costs recommended for adjustment appear on pages 4 to 18. The opinion of Sheffield, Behan and Company, Ltd. appears on page 27 of this report. Prior HHS report findings were reviewed for applicability to the current report.

An exit conference was held February 4, 1992. The Plan's responses to our audit findings are paraphrased after each finding, along with our additional comments if appropriate. The Plan concurred with 12 of the 15 dollar findings. Their response in full text is located in the Appendix A.

INTRODUCTION

BACKGROUND

Health Insurance for the Aged and Disabled (Medicare), Title XVIII of the Social Security Act, provides a hospital insurance program for (a) eligible persons aged 65 and over; (b) disabled persons under 65 who are entitled to Social Security or Railroad Retirement disability benefits for at least 24 consecutive months; and (c) individuals under 65 with chronic kidney disease, who are currently insured by or entitled to Social Security benefits.

The Hospital Insurance Program, Part A, Hospital Insurance Benefits for the Aged and Disabled, provides protection against the costs of hospital in-patient care, post-hospital extended care, and post-hospital home health care.

The Medical Insurance Program, Part B, Supplementary Medical Insurance Benefits for the Aged and Disabled, is a voluntary program and provides protection against the cost of physicians' services, hospital out-patient services, home health care services, and other health services.

Title XVIII provides that public or private organizations, known as intermediaries (Part A) and carriers (Part B), may assist in administering the Medicare program, including the conditions and limitations on payment and the amounts for which the beneficiary is responsible.

Intermediaries and carriers are reimbursed for all reasonable and allowable costs incurred in administering the programs, except for specific limitations that may be agreed to in the individual Medicare contracts and subcontracts. The Plan serves as the Arkansas intermediary and carrier administering Medicare Parts A and B claims, respectively. The Plan also processes all Medicare Part B claims for the State of Louisiana.

During the audit period, October 1, 1986 through September 30, 1988, the Plan claimed $6,706,232 and $14,216,931 for administering Parts A and B of the Arkansas Medicare program. In addition, during the audit period, January 1, 1985 through September 30, 1988, the Plan also claimed $35,462,194 for administering Part B of the Louisiana Medicare program. The contractor paid benefits of $960,932,044; $442,663,427 and $1,205,641,456 for Arkansas Parts A and B and Louisiana Part B, respectively, during the same periods.

Costs incurred in connection with the Plan's activities are accumulated in cost centers and subsequently allocated to various lines of business, which includes lines of business for Arkansas Medicare Part A and Part B and for Louisiana Medicare Part B.

REGULATIONS RELATING TO COST REIMBURSEMENT

Article XIII of the Medicare agreements states that allowable costs under the agreements shall be determined in accordance with the provisions of Part 31 of the Federal Acquisition Regulations (FAR) as interpreted and modified by Appendix B to the agreements. Section 31.201-1 of the FAR provides that the total cost of a contract is the sum of the allowable direct and indirect costs allocable to a contract, incurred or to be incurred, less any applicable credits.

FAR Part 31 also provides that items of cost are allowable charges provided that the tests of reasonableness and allocability are met and that generally accepted accounting principles are followed. A reasonable cost is defined as one that would be incurred by an ordinarily prudent person in the conduct of competitive business. Further, a cost is allocable if it is assigned or chargeable to a particular cost objective in reasonable proportion to the benefits received.

Sections 31.202 and 31.203 of the FAR define direct and indirect costs as follows:

* Direct Costs: Any cost that can be identified specifically with a particular cost objective. Costs identified specifically with the contract are direct costs of the contract and are to be charged directly thereto. Costs identified specifically with other work of the Contractor are direct costs of that work and are not to be charged to the contract directly or indirectly.

* Indirect Costs: Any cost that, because of its incurrence for common or joint objectives, is not readily subject to treatment as a direct cost.

SCOPE OF AUDIT

Our examination was made in accordance with generally accepted auditing standards and with the Standards for Audit of Governmental Organizations, Programs, Activities and Functions (GAO, 1988), published by the Comptroller General of the United States. The primary purpose of the examination was to express an opinion as to whether the Plan's Final Administrative Cost Proposals present fairly the allowable costs of administration in conformity with the reimbursement principles contained in Part 31 of the FAR as interpreted and modified by the Medicare agreements. The examination included an evaluation of the accounting system and related internal controls, tests of the accounting records, and the application of the auditing procedures contained in Interim Audit Instruction, E-1 Revised, Part One, dated May 1981.

The period covered by the examination was October 1, 1986 through September 30, 1988 for Arkansas Parts A and B and January 1, 1985 through September 30, 1988 for Louisiana Part B. The audit fieldwork was conducted at Louisiana Health Service and Indemnity Company, Baton Rouge, Louisiana during the period July 1989 through August 1989 and at Arkansas Blue Cross and Blue Shield, Little Rock, Arkansas, during the period August 1989 through December 1989.

This report is intended solely for the purpose described above and should not be used for any other purpose.

FINDINGS AND RECOMMENDATIONS

The findings and recommendations resulting from the audit are described below:

COMPLEMENTARY INSURANCE CREDITS

Clerical errors in the amount of $2,296 and the failure of the Plan to properly document Complementary crossover rates caused the Plan to understate its complementary credits by $373,058 in Fiscal Year 1987 and by $396,712 in Fiscal Year 1988.

Complementary credits are the result of a Medicare Intermediary/Carrier charging a private insurance provider for the medical information contained in a Medicare claim. The information may be (crossed over) either internally through the Intermediary/Carrier's private lines of business or externally to another insurer. Prior to June 1, 1986, carriers and intermediaries were required to reimburse the Medicare program for the information extracted from a Medicare claim at either an agreed upon rate or at the standard rates designated in the carrier and intermediary manuals. The Plan used $.25 and $.29 for each Part A and Part B claims crossed over internally and $.30 for crossovers to outside entities. As of June 1, 1986, however the Plan's intermediary and carrier manuals required that the amount reimbursed for crossover claims be based on a cost allocation approach.

Section 1601(c) of the intermediary manual states:

> ...Charges to the complementary insurer are determined by cost allocation. As used in this section, the term allocation means to distribute all costs to Medicare and complementary insurance in such proportion as to reflect the benefits received by each program. In selecting the appropriate method of allocation consider the benefits derived from each function. Where mutual benefits are derived full cost sharing is required.... .

It further states:

> ...When allocating costs to complementary insurance,...observe the following principles:
>
> - o Charge all direct costs to the appropriate lines of business,
> - o Prorate indirect costs on an appropriate bases subject to audit....

During the audit period, the Plan reimbursed Medicare at its old rates for crossover claims. Apparently the Plan was not aware of the change in the intermediary and carrier manual's requirements; therefore, the Plan did not document or calculate what the crossover rate should be. We assumed that the Plan has a fully integrated complementary insurance claims processing system. Therefore, we calculated the proposed adjustment by adding the FACP bills payment costs to the complementary credits initially claimed to obtain the total bills payment costs. This total was divided by the total claims processed to obtain a cost per claim. The cost per claim was divided by two, assuming equal benefit for each program. The resultant total was then multiplied by the number of claims crossed during each fiscal year, to obtain the total credit per year from which the initially claimed credit amounts were subtracted to obtain the proposed adjustments.

Clerical errors and the failure of the Plan to properly document and calculate the costs related to crossover claims resulted in the following overstatements of the FACPs.

	1987	1988	Total
LA Part B	$ <10,583>	$ <16,641>	$ <27,224>
Part A	<93,871>	<83,529>	<177,400>
Part B	<268,604>	<296,542>	<565,146>
	$<373,058>	$<396,712>	$<769,770>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts. We further recommend the immediate development of a program to properly allocate claim costs between Medicare and Complementary crossovers.

Plan Response

We concur with the recommendation to reduce the appropriate FACPs for the proper allocation of claim costs between Medicare and complementary crossovers.

CLAIMED COSTS IN EXCESS OF APPROVED BUDGET

The Plan claimed $182,818 in Fiscal Year 1985 and $109,311 in Fiscal Year 1987, exceeding the approved Notice of Budget Approvals (NOBA's).

The Plan's Medicare Part B contract with HHS, Article XVI, paragraph C, states:

> ...On any individual quarterly basis, should the actual costs differ from the cumulative quarterly funding, such a difference shall be carried forward to subsequent quarters, but cannot exceed the annual amount on the Notice of Budget Approval without prior approval of the Secretary or as subject to paragraph I... .

The allocation of claimed costs in excess of the approved budget caused the following overstatements of the FACP's:

	1985	1987	Total
LA Part B	$<182,818>	$<109,311>	$<292,129>
Part A	-	-	-
Part B	-	-	-
	$<182,818>	$<109,311>	$ <292,129>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts. However, this finding should be reduced to the extent that the other findings result in sustained disallowances for the years indicated. In addition, we recommend that the Plan strengthen its procedures for monitoring budgeted versus actual expenditures.

Plan Response

There are two fiscal years at issue in this category of the audit; FY 1985 Louisiana Part B - $182,818 and FY 1987 Louisiana Part B - $109,311. These will be addressed separately below:

FY 1985

Arkansas Blue Cross and Blue Shield became the prime contractor for the Louisiana Part B program effective January 1, 1985. By Memorandum of Understanding in mid-1984, HCFA approved a unit cost for this major conversion for the first three years. We were, however, required to file all budget and cost reports for this program as well as those which had been ongoing for many years.

Well into FY 1985, it became evident that the workload which had been transferred from the previous carrier required much more handling than routine claims; i.e., the volume equated to approximately three times the "normal" volume requiring enormous amounts of temporary and overtime support. This had an equally adverse impact on Reviews and Hearings as well as Beneficiary and Physician Inquiries.

Many attempts were made to acquire additional funding for this workload, but with limited success. Additional claims were funded at a lower than normal unit cost, and upon final reporting, we were underfunded some $182,818.

It is our belief that ABCBS acted in good faith in advising HCFA on a timely basis and otherwise complying with all rules of work efficiency. We respectfully request reconsideration and settlement of this issue without the need for further action.

FY 1987

In regards to FY 1987 overrun, we submitted a letter which drew some discussion with the Regional Office budget staff about covering the shortfall in Louisiana with funds which were not expended in the other two Arkansas programs. We anticipate settlement of this issue.

Auditor's Additional Comments

We believe this is a matter to be decided upon by HCFA and we will leave this item for their adjudication.

PERSONAL USE OF PLAN-OWNED VEHICLES

The Plan claimed $155,243 of unallowable costs associated both with the personal use of company vehicles and costs in excess of the Federal Travel Regulations (FTR) maximum rate per business mile.

The Plan provides some of its employees with company owned vehicles. The employees are allowed personal usage of these vehicles at no charge. The Plan failed to remove these costs from its FACPs.

FAR Section 31.205-6(m)(2) states:

> ...That portion of the costs of company furnished automobiles that relates to personal use by employees (including transportation to and from work) is unallowable regardless of whether the cost is reported as taxable income to the employees...

The Plan also failed to remove costs in excess of the FTR maximum.

Section XII of Appendix B of the Medicare agreement states:

> ...Reimbursement for automobile travel costs will be as follows: The cost of automobiles includes the cost of depreciation, lease, maintenance, insurance, fuel, and other related costs. The reasonable cost of such automobiles which may be charged to this agreement/contract shall be the actual cost not to exceed the rate published in the Federal Travel Regulations, as issued by the General Services Administration during the term of this agreement/contract....

The allocation of the costs associated with the personal usage of company owned vehicles and the Plans failure to reduce costs to the FTR maximum caused the following overstatement of the the FACPs:

	1985	1986	1987	1988	Total
LA Part B	$<8,744>	$ <7,501>	$ <36,624>	$ <16,219>	$ <69,088>
Part A			<22,539>	<11,305>	<33,844>
Part B			<23,627>	<28,684>	<52,311>
	$<8,744>	$<7,501>	$<82,790>	<56,208>	$ <155,243>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts.
We further recommend that the Plan alter its accounting for personal usage of company owned vehicles and maximum cost per business mile to comply with the Federal Acquisition Regulations and the Federal Travel Regulations respectively.

Plan Response

We concur with the recommendations regarding the personal usage of company owned vehicles and maximum cost per business mile.

Additionally, procedures have been developed and are in place to recognize personal mileage and mileage rate adjustments for FY 1991 and for making adjustments necessary for FY 1989 and FY 1990, as yet unaudited.

PENSION EXPENSE

Apparently because of an oversight and because of a lack of understanding of the FAR, pension expense was overstated on the Louisiana FACP by $136,616 for the Fiscal Year ended September 30, 1988.

The pension expense overstatement consists of two parts. First, a year end financial statement adjustment was made to pension expense which resulted in a $62,496 allocation to the Medicare program in excess of the funding requirements of the pension plan. Secondly, the Plan recorded a standard journal entry to pension expense for the first nine months of calendar year 1988 which resulted in an overaccrual of expense and consequently an overallocation to the Medicare program of $74,120. The overaccrual was subsequently reversed during the ensuing Fiscal Year.

FAR section 31-205-6(j)(2)(i) states:

> ....To be allowable in the current year, pension costs must be funded by the time set for filing the Federal income tax return or extension thereof....

The recording of pension expense in excess of pension plan funding requirements resulted in the following overstatement of the FACPs for the year ended September 30, 1988.

		1988
LA	Part B	$<136,616>
	Part A	-
	Part B	-
		$<136,616>

Recommendation

We recommend that the Plan reduce its FACPs by $136,616.

Plan Response

We concur with the recommendation to reduce the FY 1988 Louisiana Part B FACP by $136,616 representing an overaccrual of pension expense ($74,120) and the overstatement of pension expense for CY 1987 ($62,496).

ANNUAL REPORTS

The Plan claimed $24,456 in excessive unallowable annual report costs.

Under normal circumstances, the costs relating to the preparation of a corporations annual report would be a general business expense and as such allocable to the various lines of business in accordance with the methodology used to allocate indirect costs. In other instances, however, the annual report may be professionally prepared in such a manner in that it becomes more of a marketing tool than a simple reporting mechanism. Such reports may be used to sell the company's products or to obtain investors neither of which benefit the Medicare programs. In fiscal 1988 for instance, the Plan spent in excess of $35,000 on the preparation and mailing of 3,106 reports at a cost of over $11 per report. The Medicare programs were allocated over $12,000 of these costs. If each Medicare program would have received one report and the cost allocation had been on the basis of benefits received, the allocation would have been approximately $35, not in excess of $12,000. We believe it to be obvious based on the number of reports issued and cost of each report that these costs represent a marketing effort, not a simple reporting mechanism. FAR Section 31.205-1(f)(5) states:

> ...Unallowable public relations and advertising costs include the following:...
>
> ...Costs of promotional material, motion pictures, videotapes, brochures, handouts, magazines, and other media that are designed to call favorable attention to the contractor and its activities...

The allocation of excessive annual report costs to the Medicare programs caused the following overstatement of the FACP's:

	1985	1986	1987	1988	Total
LA Part B	$<1,179>	$ <1,625>	$ <2,962>	$ <3,799>	$ < 9,565>
Part A			<2,145>	<2,974>	<5,119>
Part B			<4,137>	<5,635>	<9,772>
	$<1,179>	$<1,625>	$< 9,244>	<12,408>	$ <24,456>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts. We also suggest that in the future, annual report costs be allocated on the basis of benefits received.

Plan Response

We concur that this item be disallowed and an adjustment made in each year and to each program for which an amount was allocated.

STATE INSURANCE COMMISSIONERS EXPENSE

The Plan claimed $20,689 in unallowable State Insurance Commissioner audit expenses.

Apparently because the Plan believes the State Insurance Commissioners' audit expenses to be general business expenses, a portion of these costs were allocated to the Medicare programs. Although the preparation and submission of required regulatory agency reports is generally considered to be an allowable and allocable cost, we believe the State Insurance Commissioners' audit expenses to be a specialized area. The regulatory oversight in this instance is not directed at the corporation as a whole, but rather in the corporations ability to function as an insurer. If in this case the contractor were not an insurance company, there would not be any State Insurance Commissioners' expenses. It is apparent that this cost is related solely to the Plan's private lines and not to the Medicare program. In addition, it seems only equitable that these costs not be allocable as other insurers must absorb these costs as a cost of their product.

Section XV of Appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the Contractor's non-Medicare business and do not contribute to the Medicare agreement/contract... .

The allocation of the State Insurance commissioner's expense to the Medicare programs caused the following overstatement of the FACPs:

	1985	1986	1987	1988	Total
LA Part B	$< 45>	$ < 40>	$ <2,523>	$ <10,430>	$ <13,038>
Part A			<2,009>	< 700>	<2,709>
Part B			<3,630>	<1,312>	<4,942>
	$< 45>	$< 40>	$< 8,162>	<12,442>	$ <20,689>

Recommendation

We recommend that the Plan reduce its FACPs by $20,689.

Plan Response

A periodic audit by the state Insurance Department is, as stated in the draft report, a requirement to be an insurer in any state. It has always been our understanding and belief that in order to be a Medicare Contractor, an organization had to be so designated (as an insurer). We believe that section 421.110(c) of the Code of Federal Regulations effectively limits an intermediary to a health payor. Section 421.110(c) states:

> ...Before entering into or renewing an intermediary agreement, HCFA will -
> (c) Determine that the intermediary or prospective intermediary - (3) Has the overall resources and experience to administer its responsibilities under the Medicare program and has an existing operational, statistical, and recordkeeping capacity to carry out the additional program responsibilities it proposes to assume. HCFA will presume that an intermediary or prospective intermediary meets this requirement if it has at least 5 years experience in paying for or reimbursing the cost of health services...

Consequently, we feel that the cost of this audit is a fair and reasonable cost of doing business and is properly allocated to all company lines of business.

Additionally, as a general rule, Medicare audit teams request and are provided access to any and all audits of Contractor records. The audit of the State Insurance Department is one such document. This should be evidence that the cost of auditing the report should be an allowable expense.

Auditor's Additional Comments

We believe that the citation the Plan is basing its argument on does not state that the intermediary is required to be a health payor. It only states that HCFA will presume that an intermediary or prospective intermediary will meet one of the requirements necessary to be an intermediary if it has at least 5 years experience paying for or reimbursing the cost of health services. This by no means states that an intermediary or prospective intermediary needs to be a health payor. In addition, there have been intermediaries that were not insurance companies, thus they did not incur these costs.

RETURN ON INVESTMENT

The Plan claimed $10,954 in unallowable return on investment costs.

Our review of return on investment costs revealed that clerical errors resulted in the allocation of $10,954 in excess costs to the Medicare programs.

Clerical errors made in recording return on investment costs resulted in the following <over>under statements of the FACPs:

	1987	1988	Total
LA Part B	$ 838	$<9,459>	$ <8,621>
Part A	<559>	-0-	< 559>
Part B	<1,774>	-0-	<1,774>
	$<1,495>	$<9,459>	$<10,954>

Recommendation

We recommend that the Plan reduce its FACPs for the above amounts.

Plan Response

We concur with the recommendation regarding errors in recording Return on Investment both in Arkansas and Louisiana. The cumulative amount of $10,954 will be reflected as an adjustment to the appropriate FACPs.

TRAVEL COSTS

The Plan claimed $9,454 of unallowable travel costs. These costs are unallowable for the reasons discussed below.

Excessive Lodging Costs

The Plan claimed $9,058 of excessive lodging costs. While the Plan has established travel policies as a guide for the reimbursement of travel costs, the policies do not define the maximum amounts allowed by the Federal Travel Regulations. Overcharges will continue until the Plan amends its procedures.

FAR Section 31.205-46(a) states:

...Costs for lodging, meals, and incidental expenses may be based on per diem, actual expenses or a combination thereof provided the method used results in a reasonable charge...Cost incurred for lodging, meals, and incidental expenses shall be considered reasonable and allowable only to the extent that they do not exceed on a daily basis the maximum per diem rates in effect at the time of travel as set forth in the Federal Travel regulations...

Private Line Travel Costs

The Plan claimed $396 of unallowable costs because private line travel costs were allocated to the Medicare program.

Section XV of Appendix B states:

...The following items are unallowable: A. All direct and indirect costs which relate to the contractors' non-Medicare business and do not contribute to the Medicare agreement/contract...

The allocation of excessive lodging costs and private line travel costs caused the following overstatement of the FACPs:

	1985	1986	1987	1988	Total
LA Part B	$< 94>	$ <1,114>	$ <1,561>	$ <1,311>	$ < 4,080>
Part A			< 862>	< 961>	<1,823>
Part B			<1,517>	<2,034>	<3,551>
	$< 94>	$<1,114>	$< 3,940>	< 4,306>	$ < 9,454>

Recommendation:

We recommend that the Plan reduce its FACPs by $9,454. We further recommend, to prevent future overcharges, that the Plan revise its travel policies in accordance with Section 31.205-46(a) of the FAR.

Plan Response

We do not agree with the limitation based on the per diem rates prior to late 1987. This is the first notice we were given by HCFA that contractors were bound by these rates and not actual costs. The reference we have consistently utilized for this expense item is FAR 31.205-46 (a)(1)..."Costs for lodging, meals, and incidental expenses may be based on per diem, actual expenses, or a combination thereof, provided the method used results in a reasonable charge."

For FY 1988, we do concur with the $4,306 adjustment recommended.

Procedures are in place to review the Board of Directors travel expenses as well as those of a routine nature for allowable per diem rates as instructed.

Auditor's Additional Comments

We agree with the citation the Plan has chosen, however, the citation states that the method used must result in a reasonable charge. We do not believe that certain charges of two times the maximum per diem rate published in the Federal Travel Regulations are reasonable charges. We feel that the Federal Travel Regulation's maximum per diem rates are reasonable and anything above that should be absorbed by private lines of business that do not allocate to Medicare.

SALES TAX CHARGES

The Plan claimed $7,568 in out of period unallowable sales tax charges as the result of a state audit.

The state sales tax audit included periods prior to the inception of the Louisiana Part B contract. Apparently due to an oversight, Louisiana Medicare Part B was allocated $7,568 of these costs.

The erroneous allocation of sales tax costs from periods prior to the inception of Louisiana Part B contract resulted in the following overstatement of the FACPs:

		1987
LA	Part B	$< 7,568>
	Part A	-
	Part B	-
		$< 7,568>

Recommendation

We recommend the Plan reduce its FACP by $7,568.

Plan Response

We concur with the finding regarding the allocation of sales tax charges resulting from an audit of same in Louisiana ($7,568). The allocation to Part B was made in error as the audit was for a period prior to the inception of the Program.

COST CENTER ALLOCATIONS

The allocation of private-line and promotional cost centers, cost centers which have no basis for allocation to the Medicare program, and an input error which caused an overallocation to the Medicare program resulted in the Plan claiming $8,417 of excess costs on the FACPs. Private line cost centers 330, 760, and 764; Actuarial, ABS Management, and ABS Systems Support respectively and promotional cost center 106 - Sales Administration allocated $27 of the total excess costs. Cost center 910 - New Orleans Administration Services, which had no basis for allocating costs to the Louisiana Medicare Part B program, allocated an additional $912 of the total excess costs. An input error caused the over allocation of the final $7,478 from cost center 906-Retrieval Preparation and cost center 557-Supervisor Central Records.

FAR Section 31.201-4 states:

A cost is allocable if it is assignable or chargeable to one or more cost objectives on the basis of relative benefits received or other equitable relationship.

The allocation of various cost centers which were not allocable to Medicare and an input error caused the following overstatement of the FACPs:

	1986	1987	1988	Total
LA Part B	$ < 438>	$ < 368>	$ < 244>	$ < 1,050>
Part A		5		5
Part B		106	<7,478>	<7,372>
	$< 438>	$< 257>	< 7,722>	$ < 8,417>

Recommendation

We recommend that the Plan reduce its FACP by $8,417. In addition, we recommend the Plan strengthen its internal control procedures to prevent future misallocations to the Medicare programs.

Plan Response

We concur with the various findings identifying allocation and coding errors in both locations as noted. Additional internal audit review has been implemented to assist staff in reducing similar errors in the future. Further, review of cost detail prior to filing the FACP also supports this procedure.

ENTERTAINMENT COSTS

The Plan claimed $2,449 in unallowable social club dues and entertainment costs.

Apparently due to an oversight, the Plan allocated a minor amount of unallowable social club dues and the Travel-Out of State Entertainment account to the Medicare programs.

FAR Section 31.205-14 states:

> ...Costs of amusement, diversion, social activities, and any directly associated costs such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities are unallowable....

The allocation of social club dues and entertainment costs caused the following overstatement of the FACPs:

	1985	1986	1987	1988	Total
LA Part B	$< 198>	$ < 789>	$ < 523>	$ < 17>	$ < 1,527>
Part A			< 705>	< 13>	< 718>
Part B			< 178>	< 26>	< 204>
	$< 198>	$< 789>	$< 1,406>	< 56>	$ < 2,449>

Recommendation

We recommend the Plan reduce its FACPs by $2,449.

Plan Response

We concur with the recommendation regarding minor allocation and coding errors for social and entertainment costs. An adjustment will be made to appropriate FACP.

Additional internal audit review has been implemented to assist staff in reducing such errors. Further review of cost detail will also be made prior to the filing of the FACP each year.

PROFESSIONAL FEES

The Plan claimed $2,126 in non-allowable professional fees.

Apparently due to an oversight $1,501 of consulting fees related an HMO and $1,800 of legal fees related to a corporate reorganization were inadvertently allocated to the Medicare programs.

Section XV of appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the contractor's non-Medicare business and do not contribute to the Medicare agreement/contract....

In addition, FAR Section 31.205-27(a)(1) states:

> ...Expenditures in connection with planning or executing the organization or reorganization of the corporate structure of a business. including mergers and acquisitions...are unallowable....

The allocation of non-allowable professional fees caused the following overstatement of the FACPs:

	1985	1986	1988	Total
LA Part B	$<573>	$<1,227>	$ <326>	$ <2,126>
Part A	-	-	-	-
Part B	-	-	-	-
Total	$<573>	$<1,227>	$< 326>	$ <2,126>

Recommendation

We recommend that the Plan reduce its FACPs by $2,126.

Plan Response

We concur with the various findings identifying minor coding errors in both locations as noted.

Management review of all outside legal services and most other professional fees is made to reduce the incidence of this type error in the future.

RETIREMENT BENEFITS

The Plan allocated $1,023 in non-allowable retirement benefits to the FACP.

Apparently due to a clerical error the health insurance benefits for several individuals who were never related to the Medicare program were being coded to centers which allocated to the Medicare program.

Section XV of Appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the Contractors' non-Medicare business and do not contribute to the Medicare agreement/contract... .

The misallocation of retiree health benefits caused the following overstatement of the FACPs:

	1986	1987	1988	Total
LA Part B	$<66>	$< 337>	$ <620>	$ <1,023>
Part A	-	-	-	-
Part B	-	-	-	-
Total	$<66>	$< 337>	$< 620>	$ <1,023>

Recommendation

We recommend the Plan reduce its FACP by $1,023.

Plan Response

We concur with the recommendation regarding the minor coding error for retirement benefits ($1,023). An adjustment will be made to the appropriate FACP.

CONTRIBUTIONS

The Plan allocated Medicare $892 in unallowable contributions.

Apparently because the Plan believed support for programs to be different from direct giving, the cost of sandwiches provided March of Dimes workers and purchased Walk America T-shirts was allocated to Medicare.

Section 31.205-8 of the FAR states:

> ...Contributions or donations, including cash property and services, regardless of recipient are unallowable... .

The allocation of unallowable contributions to the Medicare programs resulted in the following overstatement of the FACPs:

	1985	1988	Total
LA Part B	$< 615>	$ <277>	$ < 892>
Part A	-	-	-
Part B	-	-	-
Total	$< 615>	$< 277>	$ < 892>

Recommendation

We recommend the Plan reduce its FACP by $892.

Plan Response

We concur with the recommendation regarding the minor coding error for contribution expense ($892). An adjustment will be made to the appropriate FACP.

PRIVATE LINE COSTS

Due to an apparent oversight the Plan inadvertently allocated $151 of costs related to an insurers conference registration and some promotional supplies to the Medicare programs.

Section XV of Appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the Contractors' non-Medicare business and do not contribute to the Medicare agreement/contract...

The misallocation of private lines costs caused the following overstatement of the FACPs.

	1987	1988	Total
LA Part B	$< 118>	$ < 9>	$ < 127>
Part A	-	< 9>	< 9>
Part B	-	<15>	< 15>
Total	$< 118>	$< 33>	$ < 151>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts.

Plan Response

We concur with the recommendation regarding the minor coding errors for conference expenses ($118) and for promotional expenses ($33). An adjustment will be made to the appropriate FACP.

SALARIES OF PROVIDER AUDITORS

Prior to our beginning the audit, HCFA expressed concern to us that the starting salary ($26,500) of the Plan's entry level provider auditors was too high in relation to its geographical location. HCFA requested that we review this matter.

During our fieldwork we contacted an employment recruiting firm and several Certified Public Accounting firms to ascertain an appropriate entry level salary range. The range given was $16,000 to $22,000 a year for corporations and $18,000 to $24,000 per year for Public Accounting firms. Our firm, located in the Chicago area, hired its most recent entry level staff personnel at $19,500 per year plus overtime. Based upon our research and our knowledge of the area, we concur with HCFA that the starting salary for entry level provider auditors is excessive. We have not proposed a dollar adjustment due to the nature of the finding.

Recommendation

We recommend the Plan review and reduce its entry level salaries for provider auditors.

Plan Response

Salary levels are continually reviewed by internal staff as well as by independent personnel consulting service organizations. The required travel as well as the necessity of working in an ever-changing environment contribute to the establishment of salary structure.

We appreciate your comments on this subject.

Auditor's Additional Comments

We believe this is a matter to be decided upon by HCFA and we will leave this item for their adjudication.

OTHER MATTERS

The Department of Health and Human Services and the Health Care Financing Administration requested that we specifically address several issues during our audit. These issues are discussed below.

Significant Increases (Decreases) In Costs Between Years

To assess significant variations in costs, we compared costs reported by operation on the Plan's final administrative cost proposals. Details of items which were investigated further because of large increases or decreases follow:

Fiscal Year 1986 Versus Fiscal Year 1987 - Part A Costs

Operation	% Increase (Decrease)	Description
Provider Reimbursement	(19.9)	The decrease partially resulted from the fact that EDP support of the PS&R was held at a minimum during 1987. Contributing also to the decrease was the fact that turnover in clerical positions was high and there were several professional staff vacancies which were maintained early in the fiscal year.
Other-Reconsiderations	Infinite	No costs were classified as Reconsiderations in FY 1986. The costs in FY 1987 relate to special funding for the processing of Reconsiderations. The receipt of Reconsiderations increased considerably as a result of denials of claims submitted by hospital based HHAs and SNFs which were previously paid under waiver.
Medicare Secondary Payer	62.5	A portion of the increase can be attributed to additional direct staffing and systems support costs incurred for requirements on disabled claims. Increased staffing levels were also needed to implement new MSP Provisions - subrogation, working aged and workers compensation.

Fiscal Year 1987 Versus Fiscal Year 1988 - Part A Costs

Operation	% Increase (Decrease)	Description
Provider Settlements	22.7	Increase is attributable to an increase in workload. Workload was 99 for FY 1987 and 373 for FY 1988. The increase in the workload was primarily the result of a lift of the malpractice freeze. This required that the Plan become current in settling these cost reports by the end of the fiscal year. In the case of most hospitals, this represented the processing of several years of cost reports.
Provider Reimbursement	55.2	A portion of the increase was the direct result of dedicated systems staff as well as the utilization of computer resources in the resolution of problems with the PS&R system. Cost in the reimbursement area was up also due to the hiring of a reimbursement specialist for the entire fiscal year 1988.
Reviews and Hearings	367.9	The increase results from an increase in the workload from FY 1987 to FY 1988. A total of 53 Reconsiderations and Hearings were completed in FY 1987 while a total of 251 were completed in FY 1988. Reconsiderations were pushed in an effort to reduce pending levels in anticipation of more stringent timeliness standards beginning October 1, 1988.
Medical Review/Utilization Review	22.4	Increased staffing levels were needed to help meet all requirements for the review of outpatient, SNF and HHA claims. Also, activities were performed during the year which did not contribute to the reported workload. This included training of providers on the new data element forms and a special postpayment review related to observation beds.
Peer Review Organizations	105.4	The increase can be attributed to the fact that in FY 1987 costs included only approximately 85% of one full time clerk. In FY 1988 costs included 100% of one full time clerk. Additional activities were also performed which did not contribute to the workload. This included an increase in the number of hardcopy requests, which resulted in more manual effort, increased time spent with programmers at PRO, problems with second PRO ID approval codes not working and additional time spent on referring current claims to PRO.

Fiscal Year 1986 Versus Fiscal Year 1987 -- Part B Costs

Operation	% Increase (Decrease)	Description
Medicare Secondary Payer	(53.6)	This decrease in costs was due to the fact that special funds were given in FY 1986 to prepare a regional survey of other insurance being carried by Medicare beneficiaries. This was around $300,000. This funding was not given in FY 1987.
Reviews and Hearings	115.7	Increase due to the transferring of the informal reviews work from the Bene/Inquiry section to this line. Previously only costs associated with the Hearings Officer were included on this line.
COBRA	(22.1)	The decrease is due to the fact that original funding for Physician Fee Freeze/COBRA was all to line 11 (Other). Any costs in excess of original funding were filed on line 7 per instructions from HCFA.

Fiscal Year 1987 Versus Fiscal Year 1988 -- Part B Costs

Operation	% Increase (Decrease)	Description
Reviews and Hearings	87.1	Increase is due to the fact that increased staffing was required to support the research and documentation requirements for use by the Administrative Law Judge (ALJ) process. Also, revised manual instructions issued in April, 1988 resulted in a reclassification of functions and expenses to line 2 which had previously been identified as line 3. These included requests for non-technical reopenings when a review or hearing has been performed, as well as requests for appeals of the most recent determination and inquiries reflecting dissatisfaction with the most recent determination.
Other	Infinite	The majority of the expense for FY 1988 ($40,600) relates to incentive payments given to Arkansas Blue Cross and Blue Shield by HCFA for increasing enrollment in the Participating Physician Program. Physicians enrolled in the program agree to accept assignment of Medicare claims. The remaining $2,500 relates to the cost to produce payment tapes as requested by the Office of Inspector General. Neither of these were applicable in FY 1987.
COBRA	(100%)	Decrease due to completion of COBRA project in 1987. No costs were incurred during 1988.
Physician Fee Freeze	101.7%	The increase resulted from increased printing and distribution costs of the Medpard in FY 1988. Also additional costs were incurred due to Maximum Allowable Actual Charge monitoring which ensures physicians do not exceed certain fee schedules. During the first quarter of FY 1988 all MAAC - A and MAAC - C data was computed twice due to the receipt of additional program instructions. This resulted in an extraordinary amount of staff analysis as well as EDP Support.

Fiscal Year 1985 Versus Fiscal Year 1986 -- LA Part B Costs

Operation	% Increase (Decrease)	Description
General Comments		FY 1985 for this program was January 1 through September 30, 1985; only nine (9) months. In comparing these costs to the full twelve-,month contract period of FY 1986, some distortion occurs. By annualizing the FY 1985 amounts, the Claims Payment and Reviews and Hearings Lines increase at a very reasonable rate; 6.0% and 16.6% respectively. Other variances are more significant and are explained below.
Printing Claims Forms	(100.0)	The decrease is due to the fact that FY 1986 claim forms became available from the government and HCFA discontinued funding of this cost.
Physician Fee Freeze (PFF)	(36.1)	The decrease was due to HCFA relaxing its big push for increased provider participation and monitoring was reduced to maintenance of the beneficiary WATS lines and distribution of the participating provider directory; monitoring was reduced to a minimal level.
COBRA		The increase is the result of implementing the COBRA project after no costs during 1985.
Medical Review/Utilization Review	149.0	The increase is a result of the PFF program receiving more funds for monitoring functions. Automation of utilization review screens has further enhanced the overall program. Two medical analysis employees (RNs) were added to work directly with the Medical Director. Along with the additional funding in this payment safeguard function, savings ratios were implemented.
Medical Secondary Payer	84.0	The increase is the result of a full year of the full year of the MSP activity with EDP support, and at the end of FY 1986, ABCBS was funded to prepare a regional survey of other insurance carried by Medicare beneficiaries. This was around $300,000.

Fiscal Year 1986 Versus Fiscal Year 1987 -- LA Part B Costs

Operation	% Increase (Decrease)	Description
Reviews and Hearings	139.6	Increase due to the transferring of the informal reviews work from the Bene Inquiry section to this line.
Other - Reviews and Hearings		Additional funding was given for requirements to meet reviews and hearings processing standards. This required an additional hearings officer as well as a hearings assistant.
Beneficiary Inquiries	81.0	Increase due to increase in workload from FY 1986 and FY 1987. Additional costs were incurred in order to maintain staffing levels necessary to respond accurately and timely to the increased number of beneficiary and physician/supplier inquiries.
Medicare Secondary Payer	48.4	EDP costs were much higher in 1987 which was due in part to the installation of South Carolina's MSPAY module as well as other programming support. Additional processing costs were also incurred which were related to disabled requirements.
COBRA	(66.6)	The decrease is due to the completion of the COBRA project in 1987. Any costs incurred which were in excess of original funding were filed on the PFF line per instructions from HCFA.
Physician Fee Freeze (PFF)	168.4	The increase is due to the fact that all COBRA costs which exceeded the original amount funded for COBRA were filed on this line per instructions from HCFA. There is a corresponding decrease in Line 11; the net is a 6.8% increase for this function.

Fiscal Year 1987 Versus Fiscal Year 1988 -- LA Part B Costs

Operation	% Increase (Decrease)	Description
Reviews and Hearings	103.2	Increase is due to the fact that increased staffing was required to support the research and documentation requirements for use by the Administrative Law Judge (ALJ) process as well as efforts to reduce the backlog of fair hearings. Also, revised manual instructions issued in April 1988 resulted in a reclassification of expenses to Line 2 which had previously been identified as Line 3. These include request for non-technical reopenings, when a review or hearing has been performed, as well as requests for appeals of the most recent determination and inquiries reflecting dissatisfaction with the most recent determination.
COBRA	(100.0)	The decrease is the result of the COBRA project being completed in 1987. No costs were incurred during 1988.
Medicare Secondary Payer	71.2	The increase is the result of staffing levels which were needed for all Medicare Secondary Payer functions in order to achieve maximum program savings. Additional costs were also incurred due to the Working Aged Recoupment project.
Other	(41.5)	In 1987 special funding was given to help meet requirements for reviews and hearings processing standards. No special funding was given in 1988. The majority of the expense in FY 1988 ($62,000) relates to incentive payments given to Arkansas Blue Cross and Blue Shield by HCFA for increasing our enrollment in the Participating Physician Program. Physicians enrolled in the program agree to accept assignment of Medicare Claims. The remaining $3,902 relates to the costs to produce payment tapes as requested by the Office of Inspector General. Neither of these were applicable in FY 1987.

Significant EDP Expenditures

There were no significant EDP costs incurred during our audit period for planning, development or modification of the Medicare claims processing system.

Interim Expenditure Reports

The Cumulative Interim Expenditure Reports for the period October 1, 1988 through May 31, 1989, were reviewed along with the methods and procedures for preparing these reports. Our limited review did not disclose any inaccuracies or weaknesses.

Areas of Audit Concern

HCFA expressed two areas of audit concern which are addressed in the findings entitled Claimed Costs In Excess of Approved Budget and Salaries of Provider Auditors in the Findings and Recommendations section of this report.

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INDEPENDENT AUDITOR'S REPORT

We have audited the Final Administrative Cost Proposals of Arkansas Blue Cross and Blue Shield, Inc. for the periods January 1, 1985 through September 30, 1988 for its Louisiana Part B contract and October 1, 1986 through September 30, 1988 for its Arkansas Parts A and B contracts. These Final Administrative Cost Proposals are the responsibility of the Company's management. Our responsibility is to express an opinion on these Final Administrative Cost Proposals based on our audit.

We conducted our audit in accordance with generally accepted auditing standards and Government Auditing Standards, 1988 revision, published by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the Final Administrative Cost Proposals are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts in the Final Administrative Cost Proposals. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall presentations of the Final Administrative Cost Proposals. We believe that our audit provides a reasonable basis for our opinion.

The accompanying Final Administrative Cost Proposals were prepared to present the cost of administration allowable and applicable to Parts A and B of the Health Insurance for the Aged and Disabled Program pursuant to the reimbursement principles of FAR Part 31, as interpreted and modified by the Medicare agreements. They are not intended to be a complete presentation of the company's assets, liabilities, revenue and expenses.

In our opinion, the accompanying Final Administrative Cost Proposals, as adjusted, present fairly, in all material respects, the cost of administration allowable and applicable to Parts A and B of the Health Insurance for the Aged and Disabled Program for the period January 1, 1985 through September 30, 1988, for the Louisiana contract and October 1, 1986 through September 30, 1988 for the Arkansas contracts, in accordance with the reimbursement principles of FAR Part 31, as interpreted and modified by the Medicare agreements.

Our examination was made for the purpose of forming an opinion on the Final Administrative Cost Proposals taken as a whole. The information on pages i-26 is presented for the purposes of background and analysis and is not a required part of the Final Administrative Cost Proposals. Such information has been subjected to the auditing procedures applied in our examination of the Final Administrative Cost Proposals and, in our opinion, is fairly stated in all material respects in relation to the Final Administrative Cost Proposals taken as a whole.

This report is intended solely for the use described above and should not be used for any other purpose.

Sheffield, Behan and Company, Ltd.

February 4, 1992

REPORT ON REVIEW OF INTERNAL CONTROL

As part of our examination, we reviewed and tested the Plan's system of internal accounting control to the extent we considered necessary to evaluate the system as required by generally accepted auditing standards and Government Auditing Standards, 1988 revision, published by the Comptroller General of the United States. The purpose of our evaluation was to determine the nature, timing and extent of the auditing procedures necessary for expressing an opinion on the Plan's final administrative cost proposals. Our study and evaluation was more limited than would be necessary to express an opinion on the Plan's system of internal accounting control taken as a whole.

The management of the Plan is responsible for establishing and maintaining a system of internal accounting control. The objective of internal accounting control is to provide reasonable, but not absolute, assurance that (1) assets are safeguarded against loss from unauthorized use or disposition, and (2) financial records are reliable for preparing financial statements and maintaining accountability for assets. The concept of reasonable assurance recognizes that the cost of a system of internal accounting controls should not exceed the benefits derived and also recognizes that the evaluation of these factors necessarily requires estimates and judgments by management.

Certain inherent limitations exist that should be recognized in considering the potential effectiveness of any system of internal accounting controls. In the performance of most control procedures, errors can result from misunderstanding of instructions, mistakes of judgment, carelessness, or other personal factors. The effectiveness of some control procedures depends upon segregation of duties; these procedures can be circumvented by collusion. Similarly, control procedures can be circumvented intentionally by management, either with respect to the execution and recording of transactions or with respect to the estimates and judgments required in the preparation of financial statements. Further, projection of any evaluation of internal accounting control to future periods is subject to the risks that the procedures may become inadequate because of changes in conditions and that the degree of compliance with the procedures may deteriorate.

The Plan has established significant internal accounting and administrative control procedures to provide:

* Accurate, current, and complete disclosure of the financial results of the Medicare program in accordance with Federal reporting requirements;

* Records that adequately identify the application of funds;

* Effective control over and accountability for all funds, property, and other assets.

* Comparison of actual with budgeted amounts for each period;

* Procedures for determining the allowability and allocability of costs in accordance with FAR Part 31, and Appendix B of the Medicare agreements;

* Accounting records that are supported by source documentation.

We evaluated all of these controls. Based on our evaluation, we believe that the Plan's procedures were adequate for HHS purposes except for the specific conditions described in the Findings and Recommendations section of this report on pages 4 through 18.

This report is intended solely for the purpose intended above and should not be used for any other purpose.

Deloitte Haskins and Sells

February 4, 1992

REPORT ON COMPLIANCE

We have audited the Final Administrative Cost Proposals of Arkansas Blue Cross and Blue Shield, Inc. for the periods January 1, 1985 through September 30, 1988 for its Louisiana Part B contract and October 1, 1986 through September 30, 1988 for its Arkansas Parts A and B contracts and have issued our report thereon dated February 4, 1992.

We conducted our audit in accordance with generally accepted auditing standards and Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the final Administrative Cost Proposals are free of material misstatement.

Compliance with laws and regulations applicable to the Plan is the responsibility of the Plan's management. As part of obtaining reasonable assurance about whether the Final Administrative Cost Proposals are free of material misstatement, we performed tests of the Plan's compliance with certain provisions of laws and regulations. However, our objective was not to provide an opinion on overall compliance with such provisions.

Material instances of noncompliance are failures to follow requirements, or violations of prohibitions, contained in statutes, and regulations that cause us to conclude that the aggregation of the misstatements resulting from those failures or violations is material to the Final Administrative Cost Proposals. The results of our tests of compliance disclosed the following material instances of noncompliance, the effects of which have been corrected in the Plan's Final Administrative Cost Proposals.

The Plan's procedures for determining the allowability and allocability of costs in accordance with the FAR Part 31 and Appendix B of the Medicare agreements were inadequate.

We considered these material instances of noncompliance in forming our opinion on whether the Plan's Final Administrative Cost Proposals are presented fairly, in all material respects, in conformity with generally accepted accounting principles, and this report does not affect our report dated February 4, 1992, on those Final Administrative Cost Proposals.

Except as described above, the results of our tests of compliance indicate that, with respect to the items tested, the Plan complied, in all material respects, with the provisions referred to in the third paragraph of this report, and with respect to items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

This report is intended for the information of the Department of Health and Human Services and the Plan management. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

Sheffield, Behan and Company, Ltd.

February 4, 1992

Exhibit 1

Arkansas Blue Cross and Blue Shield Inc.

Final Administrative Cost Proposal (LA Part B)

For the Period January 1, 1985 through September 30, 1985

Operation	Costs Claimed	(1) Increase <Decrease> Recommended Adjustments
Claims Payment	$ 4,471,671	
Reviews and Hearings	73,294	
Beneficiary/Physician Inquiry	732,268	
Printing Claims Forms	25,367	
Medical Review and Utilization Review	472,892	
Medicare Secondary Payer	115,800	
Physician Fee Freeze	160,192	
Productivity Investments	55,326	
Other	-0-	
Other	-0-	
Other	-0-	
Costs not associated with an operation		$<194,266>
Total	$ 6,106,810	$<194,266>

(1) See Findings and Recommendations section of this report. The opinion of Sheffield Behan and Company, Ltd. on this FACP appears on page 27.

Exhibit 2

Arkansas Blue Cross and Blue Shield Inc.

Final Administrative Cost Proposal (LA Part B)

For the Period October 1, 1985 through September 30, 1986

Operation	Costs Claimed	(1) Increase <Decrease> Recommended Adjustments
Claims Payment	$ 5,691,922	
Reviews and Hearings	113,993	
Beneficiary/Physician Inquiry	848,667	
Printing Claims Forms	-0-	
Medical Review and Utilization Review	1,177,493	
Medicare Secondary Payer	213,072	
Physician Fee Freeze	102,296	
Productivity Investments	203,754	
Other	-0-	
Other	-0-	
Other - COBRA	224,980	
Costs not associated with an operation		$< 12,800>
	$ 8,576,177	$< 12,800>

(1) See Findings and Recommendations section of this report. The opinion of Sheffield Behan and Company, Ltd. on this FACP appears on page 27.

Exhibit 3

Arkansas Blue Cross and Blue Shield Inc.

Final Administrative Cost Proposal (LA Part B)

For the Period October 1, 1986 through September 30, 1987

Operation	Costs Claimed	(1) Increase <Decrease> Recommended Adjustments
Claims Payment	$ 5,922,829	$<10,583>
Reviews and Hearings	273,176	
Beneficiary/Physician Inquiry	1,536,233	
Printing Claims Forms	-0-	
Medical Review and Utilization Review	1,146,853	
Medicare Secondary Payer	316,282	
Physician Fee Freeze	274,510	
Productivity Investments	283,629	
Other-	-0-	
Other-Reviews and Hearings	113,654	
Other - COBRA	75,095	
Costs not associated with an operation		$<161,057>
	$ 9,942,261	$<171,640>

(1) See Findings and Recommendations section of this report. The opinion of Sheffield Behan and Company, Ltd. on this FACP appears on page 27.

Exhibit 4

Arkansas Blue Cross and Blue Shield, Inc.

Final Administrative Cost Proposal (Part A)

For the Period October 1, 1986 through September 30, 1987

Operation	Costs Claimed	(1) Increase <Decrease> Recommended Adjustments
Bills Payment	$ 1,018,000	$ <93,871>
Reconsiderations and Hearings	6,389	
Medicare Secondary Payer	286,585	
Medical Review and Utilization Review	218,622	
Provider Desk Reviews	424,699	
Provider Field Audits	713,350	
Provider Settlements	170,918	
Provider Reimbursement	130,782	
Productivity Investments	201,032	
Other	-0-	
Other-PRO	22,367	
Other-RECONS	13,412	
Costs not associated with an operation		$< 28,814>
	$ 3,206,156	$<122,685>

(1) See Findings and Recommendations section of this report. The opinion of Sheffield Behan and Company, Ltd. on this FACP appears on page 27.

Exhibit 5

Arkansas Blue Cross and Blue Shield, Inc.

Final Administrative Cost Proposal (Part B)

For the Period October 1, 1986 through September 30, 1987

Operation	Costs Claimed	(1) Increase <Decrease> Recommended Adjustments
Claims Payment	$ 3,995,792	$<268,604>
Reviews and Hearings	147,660	
Beneficiary/Physician Inquiry	925,753	
Printing Claims Forms	-0-	
Medical Review and Utilization Review	907,707	
Medicare Secondary Payer	289,565	
Physician Fee Freeze	82,228	
Productivity Investments	332,163	
Other-		
Other-		
Other-COBRA	72,405	
Costs not associated with an operation		$< 34,757>
	$ 6,753,273	$<303,361>

(1) See Findings and Recommendations section of this report. The opinion of Sheffield Behan and Company, Ltd. on this FACP appears on page 27.

Exhibit 6

Arkansas Blue Cross and Blue Shield Inc.

Final Administrative Cost Proposal (LA Part B)

For the Period October 1, 1987 through September 30, 1988

Operation	Costs Claimed	(1) Increase <Decrease> Recommended Adjustments
Claims Payment	$ 6,380,516	$<16,641>
Reviews and Hearings	555,183	
Beneficiary/Physician Inquiry	1,676,968	
Printing Claims Forms	-0-	
Medical Review and Utilization Review	1,202,242	
Medicare Secondary Payer	541,569	
Physician Fee Freeze	247,376	
Productivity Investments	166,590	
Other	-0-	
Other-OIG Studies	66,502	
Other-	-0-	
Costs not associated with an operation		$<179,327>
	$10,836,946	$<195,968>

(1) See Findings and Recommendations section of this report. The opinion of Sheffield Behan and Company, Ltd. on this FACP appears on page 27.

Exhibit 7

Arkansas Blue Cross and Blue Shield, Inc.

Final Administrative Cost Proposal (Part A)

For the Period October 1, 1987 through September 30, 1988

Operation	Costs Claimed	(1) Increase <Decrease> Recommended Adjustments
Bills Payment	$ 1,021,814	$<83,529>
Reconsiderations and Hearings	29,893	
Medicare Secondary Payer	312,431	
Medical Review and Utilization Review	267,590	
Provider Desk Reviews	422,980	
Provider Field Audits	772,230	
Provider Settlements	209,717	
Provider Reimbursement	202,960	
Productivity Investments	214,516	
Other	-0-	
Other-PRO	45,945	
Other-	-0-	
Costs not associated with an operation		$< 15,962>
	$ 3,500,076	$< 99,491>

(1) See Findings and Recommendations section of this report. The opinion of Sheffield Behan and Company, Ltd. on this FACP appears on page 27.

Exhibit 8

Arkansas Blue Cross and Blue Shield, Inc.

Final Administrative Cost Proposal (Part B)

For the Period October 1, 1987 through September 30, 1988

Operation	Costs Claimed	(1) Increase <Decrease> Recommended Adjustments
Claims Payment	$ 4,501,417	$<296,542>
Reviews and Hearings	276,211	
Beneficiary/Physician Inquiry	919,577	
Printing Claims Forms	-0-	
Medical Review and Utilization Review	956,334	
Medicare Secondary Payer	339,136	
Physician Fee Freeze	165,824	
Productivity Investments	262,059	
Other-	-0-	
Other-OIG Studies	43,100	
Other-	-0-	
Costs not associated with an operation		$< 45,184>
	$ 7,463,658	$<341,726>

(1) See Findings and Recommendations section of this report. The opinion of Sheffield Behan and Company, Ltd. on this FACP appears on page 27.

COMPLEMENTARY INSURANCE CREDITS

Clerical errors in the amount of $2,296 and the failure of the Plan to properly document Complementary crossover rates caused the Plan to understate its complementary credits by $373,058 in Fiscal Year 1987 and by $396,712 in Fiscal Year 1988.

Complementary credits are the result of a Medicare Intermediary/Carrier charging a private insurance provider for the medical information contained in a Medicare claim. The information may be (crossed over) either internally through the Intermediary/Carrier's private lines of business or externally to another insurer. Prior to June 1, 1986, carriers and intermediaries were required to reimburse the Medicare program for the information extracted from a Medicare claim at either an agreed upon rate or at the standard rates designated in the carrier and intermediary manuals. The Plan used $.25 and $.29 for each Part A and Part B claims crossed over internally and $.30 for crossovers to outside entities. As of June 1, 1986, however the Plan's intermediary and carrier manuals required that the amount reimbursed for crossover claims be based on a cost allocation approach.

Section 1601(c) of the intermediary manual states:

> ...Charges to the complementary insurer are determined by cost allocation. As used in this section, the term allocation means to distribute all costs to Medicare and complementary insurance in such proportion as to reflect the benefits received by each program. In selecting the appropriate method of allocation consider the benefits derived from each function. Where mutual benefits are derived full cost sharing is required....

It further states:

> ...When allocating costs to complementary insurance,...observe the following principles:
>
> - o Charge all direct costs to the appropriate lines of business,
> - o Prorate indirect costs on an appropriate bases subject to audit...

During the audit period, the Plan reimbursed Medicare at its old rates for crossover claims. Apparently the Plan was not aware of the change in the intermediary and carrier manual's requirements; therefore, the Plan did not document or calculate what the crossover rate should be. We assumed that the Plan has a fully integrated complementary insurance claims processing system. Therefore, we calculated the proposed adjustment by adding the FACP bills payment costs to the complementary credits initially claimed to obtain the total bills payment costs. This total was divided by the total claims processed to obtain a cost per claim. The cost per claim was divided by two, assuming equal benefit for each program. The resultant total was then multiplied by the number of claims crossed during each fiscal year, to obtain the total credit per year from which the initially claimed credit amounts were subtracted to obtain the proposed adjustments.

Clerical errors and the failure of the Plan to properly document and calculate the costs related to crossover claims resulted in the following overstatements of the FACPs:

	1987	1988	Total
LA Part B	$ <10,583>	$ <16,641>	$ < 27,224>
Part A	<93,871>	<83,529>	< 177,400>
Part B	<268,604>	<296,542>	< 565,146>
	$<373,058>	$<396,712>	$ < 769,770>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts. We further recommend the immediate development of a program to properly allocate claim costs between Medicare and Complementary crossovers.

Contractor Response: Complementary Coverage Credits - April, 1992

We acknowledge that rates were not updated on a timely basis for all complementary crossover claims; however, we do not agree with the amounts originally calculated by this audit team. Subsequent to the initial draft report, we recalculated the rates and have reached an agreement on both the methodology and amounts to be adjusted.

We have followed the instructions outlined in Section 1601 of the Intermediary Fiscal Administration Manual and Sections 4601 and 4602 of the Carrier Fiscal Administration Manual.

For Arkansas Part A, we have a "totally integrated" systems and release claims to our own complementary claims operation only; there is no outside release of claims information.

On the Arkansas Part B side, we have a varying set of conditions: 1) Arkansas B - for release of claims to our own complementary claims operation, we are a B.3 - "totally integrated" operation. Additionally, we release information to outside organizations as well as providing Medicare information to a state agency. Each of these latter instances require a variation in pricing per our interpretation of the instructions.

Arkansas further transfers hardcopy claims to the Missouri Welfare Division. The rate billed per claim is $ 0.30 based on 4602.1 - "If, however, the State or its fiscal agent has the capacity to process data generated on magnetic tape, but requests the information on hardcopy, charge the State $.30 per claim for the information furnished." We have been furnishing the State of Missouri this data in hardcopy for many years, presumably, at the onset they were unable to utilize the magnetic media. We have recently discussed internally the need to solicit their use of magnetic media information and thus eliminating this credit. There have been no adjustments made for 1987 or 1988 for this portion of the Crossover Credits.

For the Louisiana B program, all claims are released to an outside organization. The difference in our calculation of the shared processing costs is the addition of actual transfer costs to the outside insurer.

Other amounts identified as clerical errors have been taken into account in developing the Contractor's adjustments.

Attachment I reflects by fiscal year and program the "shared processing costs", resulting unit cost for the complementary claim data, and the amount which should be applied as an adjustment to the appropriated FACP. There are minor dollar differences in the attachments and the above amounts due to rounding. Since the amounts are so minor, the Contractor accepts the auditor's adjustment recommendation.

CLAIMED COSTS IN EXCESS OF APPROVED BUDGET

The Plan claimed $182,818 in Fiscal Year 1985 and $109,311 in Fiscal Year 1987, exceeding the approved Notice of Budget Approvals (NOBA's).

The Plan's Medicare Part B contract with HHS, Article XVI, paragraph C, states:

> ...On any individual quarterly basis, should the actual costs differ from the cumulative quarterly funding, such a difference shall be carried forward to subsequent quarters, but cannot exceed the annual amount on the Notice of Budget Approval without prior approval of the Secretary or as subject to paragraph I....

The allocation of claimed costs in excess of the approved budget caused the following overstatements of the FACP's:

	1985	1987	Total
LA Part B	$<182,818>	$<109,311>	$<292,129>
Part A	-	-	-
Part B	-	-	-
	$<182,818>	$<109,311>	$<292,129>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts. However, this finding should be reduced to the extent that the other findings result in sustained disallowances for the years indicated. In addition, we recommend that the Plan strengthen its procedures for monitoring budgeted versus actual expenditures.

Contractor Response: Claimed Costs in Excess of Approved Budget

There are two fiscal years at issue in this category of the audit; FY 1985 Louisiana Part B - $182,818 and FY 1987 Louisiana Part B - $109,311. These will be addressed separately below:

FY 1985

Arkansas Blue Cross and Blue Shield became the prime contractor for the Louisiana Part B program effective January 1, 1985. By Memorandum of Understanding in mid-1984, HCFA approved a unit cost for this major conversion for the first three years. We were, however, required to file all budget and cost reports for this program as well as those which had been ongoing for many years.

Well into FY 1985, it became evident that the workload which had been transferred from the previous carrier required much more handling than routine claims; i.e., the volume equated to approximately three times the "normal" volume requiring enormous amounts of temporary and overtime support. This had an equally adverse impact on Reviews and Hearings as well as Beneficiary and Physician Inquiries.

Many attempts were made to acquire additional funding for this workload, but with limited success. Additional claims were funded at a lower than normal unit cost, and upon final reporting, we were underfunded some $182,818.

Attachment III includes many documents related to this issue. It is our belief that ABCBS acted in good faith in advising HCFA on a timely basis and otherwise complying with all rules of work efficiency. We respectfully request reconsideration and settlement of this issue without the need for further action.

FY 1987

In regards to FY 1987 overrun, the attached letter (Attachment IV) refers to an idea which drew some discussion with the Regional Office budget staff about covering the shortfall in Louisiana with funds which were not expended in the other two Arkansas programs. We anticipate settlement of this issue.

PERSONAL USE OF PLAN-OWNED VEHICLES

The Plan claimed $155,243 of unallowable costs associated both with the personal use of company vehicles and costs in excess of the Federal Travel Regulations (FTR) maximum rate per business mile.

The Plan provides some of its employees with company owned vehicles. The employees are allowed personal usage of these vehicles at no charge. The Plan failed to remove these costs from its FACPs.

FAR Section 31.205-6(m)(2) states:

> ...That portion of the costs of company furnished automobiles that relates to personal use by employees (including transportation to and from work) is unallowable regardless of whether the cost is reported as taxable income to the employees...

The Plan also failed to remove costs in excess of the FTR maximum.

Section XII of Appendix B of the Medicare agreement states:

> ...Reimbursement for automobile travel costs will be as follows: The cost of automobiles includes the cost of depreciation, lease, maintenance, insurance, fuel, and other related costs. The reasonable cost of such automobiles which may be charged to this agreement/contract shall be the actual cost not to exceed the rate published in the Federal Travel Regulations, as issued by the General Services Administration during the term of this agreement/contract...

The allocation of the costs associated with the personal usage of company owned vehicles and the Plans failure to reduce costs to the FTR maximum caused the following overstatement of the FACPs:

	1985	1986	1987	1988	Total
LA Part B	$<8,744>	$< 7,501>	$ <36,624>	$ <16,219>	$< 69,088>
Part A	-	-	<22,539>	<11,305>	< 33,844>
Part B	-	-	<23,627>	<28,684>	< 52,311>
	$<8,744>	$< 7,501>	$< 82,790>	$< 56,208>	$<155,243>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts. We further recommend that the Plan alter its accounting for personal usage of company owned vehicles and maximum cost per business mile to comply with the Federal Acquisition Regulations and the Federal Travel Regulations respectively.

Contractor Response: Personal Use of Plan-Owned Vehicles - April, 1992

The failure to reduce Medicare expenses for the portion of automobile costs associated with personal mileage was an oversight on the part of the Contractor. In previous years and through December 31, 1985, Arkansas Blue Cross and Blue Shield was reimbursed six or seven cents per personal mile by company drivers. This was discontinued when personal mileage became a taxable wage and no replacement deduction for Medicare was implemented.

We have calculated the amount which we believe should be adjusted for personal mileage utilizing information which we have available by driver - personal miles, total miles, Medicare auto expenses by cost center (representing a single driver in most cases), fixed expenses not specifically identified by account and the applicable Medicare percentage for each cost center/driver.

Additionally, we have computed the equivalent Medicare miles by applying the Medicare percentage by cost center to the total miles. To determine the cost per mile to be used in applying the allowable limits, we divided total Medicare auto expenses less the TOTAL gain on disposal of the automobile by these equivalent Medicare miles. The difference in this amount and the LIMIT for the fiscal year was then multiplied by the total Medicare miles for the adjustment amount.

The methodology used by the Contractor to determine the amounts to be adjusted as noted in the response to the original draft has been modified only slightly - in the basis for calculating the applicable miles. We are in agreement with the final recommendation as noted above.

Procedures have been developed and are in place to recognize personal mileage and mileage rate adjustments for FY 1991 and for making adjustments necessary for FY 1989 and FY 1990, as yet unaudited. They were, in fact, used as a basis for the adjustments provided herein and, although we utilized the actual Medicare "variable" and depreciation amounts for this calculation, generate the same end results.

Summary of Personal Mileage and Mileage Rate Adjustment

	FY 1985	FY 1986	FY 1987	FY 1988
AR A				
-Personal			$ 9,561	$ 9,934
-Mileage Rate			12,978	1,371
AR B				
-Personal			19,531	25,940
-Mileage Rate			4,096	2,744
LA B				
-Personal	$4,223	$7,501	16,205	15,919
-Mileage Rate	4,521	-0-	20,419	300
TOTAL	$8,744	$7,501	$82,790	$56,208
				$155,243

PENSION EXPENSE

Apparently because of an oversight and because of a lack of understanding of the FAR, pension expense was overstated on the Louisiana FACP by $136,616 for the Fiscal Year ended September 30, 1988.

The pension expense overstatement consists of two parts. First, a year end financial statement adjustment was made to pension expense which resulted in a $62,496 allocation to the Medicare program in excess of the funding requirements of the pension plan Secondly, the Plan recorded a standard journal entry to pension expense for the first nine months of calendar year 1988 which resulted in an overaccrual of expense and consequently an overallocation to the Medicare program of $74,120. The overaccrual was subsequently reversed during the ensuing Fiscal Year.

FAR section 31.205-6(j)(2)(i) states:

> ...To be allowable in the current year, pension costs must be funded by the time set for filing the Federal income tax return or extension thereof....

The recording of pension expense in excess of pension plan funding requirements resulted in the following overstatement of the FACPs for the year ended September 30, 1988.

	1988
LA Part B	$<136,616>
Part A	-
Part B	-
	$<136,616>

Recommendation

We recommend that the Plan reduce its FACPs by $136,616.

Contractor Response: Pension Expense

We concur with the recommendation to reduce the FY 1988 Louisiana Part B FACP by $136,616 representing an overaccrual of pension expense ($74,120) and the overstatement of pension expense for CY 1987 ($62,496).

ANNUAL REPORTS

The Plan claimed $24,456 in excessive unallowable annual report costs.

Under normal circumstances, the costs relating to the preparation of a corporations annual report would be a general business expense and as such allocable to the various lines of business in accordance with the methodology used to allocate indirect costs. In other instances, however, the annual report may be professionally prepared in such a manner in that it becomes more of a marketing tool than a simple reporting mechanism. Such reports may be used to sell the company's products or to obtain investors neither of which benefit the Medicare programs. In fiscal 1988 for instance, the Plan spent in excess of $35,000 on the preparation and mailing of 3,106 reports at a cost of over $11 per report. The Medicare programs were allocated over $12,000 of these costs. If each Medicare program would have received one report and the cost allocation had been on the basis of benefits received, the allocation would have been approximately $35, not in excess of $12,000. We believe it to be obvious based on the number of reports issued and cost of each report that these costs represent a marketing effort, not a simple reporting mechanism. FAR Section 31.205-1(f)(5) states:

> ...Unallowable public relations and advertising costs include the following:...
>
> ...Costs of promotional material, motion pictures, videotapes, brochures, handouts, magazines, and other media that are designed to call favorable attention to the contractor and its activities...

The allocation of excessive annual report costs to the Medicare programs caused the following overstatement of the FACP's:

	1985	1986	1987	1988	Total
LA Part B	$<1,179>	$<1,625>	$<2,962>	$ <3,799>	$ <9,565>
Part A	-	-	<2,145>	<2,974>	<5,119>
Part B	-	-	<4,137>	<5,635>	<9,772>
	$<1,179>	$<1,625>	$<9,244>	$<12,408>	$<24,456>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts. We also suggest that in the future, annual report costs be allocated on the basis of benefits received.

Contractor Response: Annual Report Expense

While the audit cited the FAR 31.205-1(f)(5) in recommending an adjustment for the cost of publishing the Annual Report, the Contractor feels that this expense is better classified as 31.205-1((e)(2)(ii) and (iii) - ..."Communicating with the public, press, stockholders, creditors and customers; and Conducting public relations with news media and Government public relations officers, to the extent that such activities are limited to communication and liaison necessary to keep the public informed on matters of public concern such as notice of contract awards, plant closings or openings, employee layoffs or rehires, financial information, etc."

Clearly, our annual report provides this public communication and, specifically, it provides appropriate financial information to the beneficiary and provider community. This population does not see the Medicare program as a part of the government, rather it sees Medicare as Arkansas Blue Cross and Blue Shield or Louisiana Blue Cross and Blue Shield.

The Contractor performed an additional review of all invoices related to this expenditure for the years in question. While the approximate 2,500 reports distributed each year very likely included the provider community as well as group decision-makers and others, this could not be adequately verified. Consequently, the Contractor is in agreement that the amounts listed above be disallowed.

STATE INSURANCE COMMISSIONERS EXPENSE

The Plan claimed $20,689 in unallowable State Insurance Commissioner audit expenses.

Apparently because the Plan believes the State Insurance Commissioners' audit expenses to be general business expenses, a portion of these costs were allocated to the Medicare programs. Although the preparation and submission of required regulatory agency reports is generally considered to be an allowable and allocable cost, we believe the State Insurance Commissioners' audit expenses to be a specialized area. The regulatory oversight in this instance is not directed at the corporation as a whole, but rather in the corporations ability to function as an insurer. If in this case the contractor were not an insurance company, there would not be any State Insurance Commissioners' expenses. It is apparent that this cost is related solely to the Plan's private lines and not to the Medicare program. In addition, it seems only equitable that these costs not be allocable as other insurers must absorb these costs as a cost of their product.

Section XV of Appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the Contractor's non-Medicare business and do not contribute to the Medicare agreement/contract...

	1985	1986	1987	1988	Total
LA Part B	$<45>	$<40>	$<2,523>	$<10,430>	$<13,038>
Part A	-	-	<2,009>	<700>	<2,709>
Part B	-	-	<3,630>	<1,312>	<4,942>
	$<45>	$<40>	$<8,162>	$<12,442>	$<20,689>

Recommendation

We recommend that the Plan reduce its FACPs by $20,689.

Contractor Response: Insurance Department Audit - April, 1992

A periodic audit by the State Insurance Department is, as stated in the draft report, a requirement to be an insurer in any state. It has always been our understanding and belief that in order to be a Medicare Contractor, an organization had to be so designated (as an insurer). Consequently, we feel that the cost of this audit is a fair and reasonable cost of doing business and is properly allocated to all company lines of business.

Additionally, as a general rule, Medicare audit teams request and are provided access to any and all audits of Contractor records. The audit of the State Insurance Department is one such document. This should be evidence that the cost of auditing the report should be an allowable expense.

The Contractor has provided additional documentation requiring that a fiscal intermediary be a licensed insurance company. This being the case, we believe that all Medicare programs should share in the cost of the audit as a routine and required expense of doing business.

RETURN ON INVESTMENT

The Plan claimed $10,954 in unallowable return on investment costs.

Our review of return on investment costs revealed that clerical errors resulted in the allocation of $10,954 in excess costs to the Medicare programs.

Clerical errors made in recording return on investment costs resulted in the following <over>under statements of the FACPs:

	1987	1988	Total
LA Part B	$ 838	$<9,459>	$ <8,621>
Part A	<559>	-	<559>
Part B	<1,774>	-	<1,774>
	$<1,495>	$<9,459>	$<10,954>

Recommendation

We recommend that the Plan reduce its FACPs for the above amounts.

Contractor Response: Return on Investment

We concur with the recommendation regarding errors in recording Return on Investment both in Arkansas and Louisiana. The cumulative amount of $10,954 will be reflected as an adjustment to the appropriate FACPs.

TRAVEL COSTS

The Plan claimed $9,454 of unallowable travel costs. These costs are unallowable for the reasons discussed below.

Excessive Lodging Costs

The Plan claimed $9,058 of excessive lodging costs. While the Plan has established travel policies as a guide for the reimbursement of travel costs, the policies do not define the maximum amounts allowed by the Federal Travel Regulations. Overcharges will continue until the Plan amends its procedures.

FAR Section 31.205-46(a) states:

> ...Costs for lodging, meals, and incidental expenses may be based on per diem, actual expenses or a combination thereof provided the method used result in a reasonable charge...Cost incurred for lodging, meals, and incidental expenses shall be considered reasonable and allowable only to the extent that they do not exceed on a daily basis the maximum per diem rates in effect at the time of travel as set forth in the Federal Travel Regulations..

Private Line Travel Costs

The Plan claimed $396 of unallowable costs because private line travel costs were allocated to the Medicare program.

Section XV of Appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the contractors' non-Medicare business and do not contribute to the Medicare agreement/contract...

The allocation of excessive lodging costs and private line travel costs caused the following overstatement of the FACPs:

	1985	1986	1987	1988	Total
LA Part B	$<94>	$<1,114>	$<1,561>	$<1,311>	$<4,080>
Part A	-	-	< 862>	< 961>	<1,823>
Part B	-	-	<1,517>	<2,034>	<3,551>
	$<94>	$<1,114>	$<3,940>	$<4,306>	$<9,454>

Recommendation:

We recommend that the Plan reduce its FACPs by $9,454. We further recommend, to prevent future overcharges, that the Plan revise its travel policies in accordance with Section 31.205-46(a) of the FAR.

Contractor Response: Travel Costs

We do not agree with the limitation based on the per diem rates prior to late 1987. That is the first notice we were given by HCFA that contractors were bound by these rates and not actual costs. The reference we have consistently utilized for this expense item is FAR 31.205-46 (a)(1)..."Costs for lodging, meals, and incidental expenses may be based on per diem, actual expenses, or a combination thereof, provided the method used results in a reasonable charge."

For FY 1988, we do concur with the $4,306 adjustment recommended.

Procedures are in place to review the Board of Directors travel expenses as well as those of a routine nature for allowable per diem rates as instructed.

SALES TAX CHARGES

The Plan claimed $7,568 in out of period unallowable sales tax charges as the result of a state audit.

The state sales tax audit included periods prior to the inception of the Louisiana Part B contract. Apparently due to an oversight, Louisiana Medicare Part B was allocated $7,568 of these costs.

The erroneous allocation of sales tax costs from periods prior to the inception of Louisiana Part B contract resulted in the following overstatement of the FACPs:

	1987
LA Part B	$<7,568>
Part A	-
Part B	-
	$<7,568>

Recommendation

We recommend the Plan reduce its FACP by $7,568.

Contractor Response: Sales Tax Charges

We concur with the finding regarding the allocation of sales tax charges resulting from an audit of same in Louisiana ($7,568). The allocation to Part B was made in error as the audit was for a period prior to the inception of the Program.

COST CENTER ALLOCATIONS

The allocation of private-line and promotional cost centers, cost centers which have no basis for allocation to the Medicare program, and an input error which caused an overallocation to the Medicare program resulted in the Plan claiming $8,417 of excess costs on the FACPs. Private line cost centers 330, 760, and 764; Actuarial, ABS Management, and ABS Systems Support respectively and promotional cost center 106 - Sales Administration allocated $27 of the total excess costs. Cost center 910 - New Orleans Administration Services, which had no basis for allocating costs to the Louisiana Medicare Part B program, allocated an additional $912 of the total excess costs. An input error caused the over allocation of the final $7,478 from cost center 906-Retrieval Preparation and cost center 557-Supervisor Central Records.

FAR Section 31.201-4 states:

> A cost is allocable if it is assignable or chargeable to one or more cost objectives on the basis of relative benefits received or other equitable relationship.

The allocation of various cost centers which were not allocable to Medicare and an input error caused the following overstatement of the FACPs:

	1986	1987	1988	Total
LA Part B	$<438>	$<368>	$ <244>	$<1,050>
Part A	-	5	-	5
Part B	-	106	<7,478>	<7,372>
	$<438>	$<257>	$<7,722>	$<8,417>

Recommendation

We recommend that the Plan reduce its FACP by $8,417. In addition, we recommend the Plan strengthen its internal control procedures to prevent future misallocations to the Medicare programs.

Contractor Response: Cost Center Allocations

We concur with the various findings identifying allocation and coding errors in both locations as noted. Additional internal audit review has been implemented to assist staff in reducing similar errors in the future. Further, review of cost detail prior to filing the FACP also supports this procedure.

ENTERTAINMENT COSTS

The Plan claimed $2,449 in unallowable social club dues and entertainment costs.

Apparently due to an oversight, the Plan allocated a manor amount of unallowable social club dues and the Travel-Out of State Entertainment account to the Medicare programs.

FAR Section 31.205-14 states:

> ...Costs of amusement, diversion, social activities, and any directly associated costs such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities are unallowable....

The allocation of social club dues and entertainment costs caused the following overstatement of the FACPs:

	1985	1986	1987	1988	Total
LA Part B	$<198>	$<789>	$ <523>	$<17>	$<1,527>
Part A	-	-	<705>	<13>	<718>
Part B	-	-	<178>	<26>	<204>
	$<198>	$<789>	$<1,406>	$<56>	$<2,449>

Recommendation

We recommend the Plan reduce its FACPs by $2,449.

Contractor Response: Entertainment Costs

We concur with the recommendation regarding minor allocation and coding errors for social and entertainment costs. An adjustment will be made to the appropriate FACP.

Additional internal audit review has been implemented to assist staff in reducing such errors. Further review of cost detail will also be made prior to the filing of the FACP each year.

PROFESSIONAL FEES

The Plan claimed $2,126 in non-allowable professional fees.

Apparently due to an oversight $1,501 of consulting fees related to HMO and $1,800 of legal fees related to a corporate reorganization were inadvertently allocated to the Medicare programs.

Section XV of appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the contractor's non-Medicare business and do not contribute to the Medicare agreement/contract....

In addition,
FAR Section 31.205-27(a)(1) states:

> ...Expenditures in connection with planning or executing the organization or reorganization of the corporate structure of a business, including mergers and acquisitions...are unallowable....

The allocation of non-allowable professional fees caused the following overstatement of the FACPs:

	1985	1986	1988	Total
LA Part B	$<573>	$<1,227>	$<326>	$<2,126>
Part A	-	-	-	-
Part B	-	-	-	-
	$<573>	$<1,227>	$<326>	$<2,126>

Recommendation

We recommend that the Plan reduce its FACPs by $2,126.

Contractor Response: Professional Fees

We concur with the various findings identifying minor coding errors in both locations as noted.

Management review of all outside legal services and most other professional fees is made to reduce the incidence of this type error in the future.

RETIREMENT BENEFITS

The Plan allocated $1,023 in non-allowable retirement benefits to the FACP.

Apparently due to a clerical error the health insurance benefits for several individuals who were never related to the Medicare program were being coded to centers which allocated to the Medicare program.

Section XV of Appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the Contractors' non-Medicare business and do not contribute to the Medicare agreement/contract..

The misallocation of retiree health benefits caused the following overstatement of the FACPs:

	1986	1987	1988	Total
LA Part B	$<66>	$<337>	$<620>	$<1,023>
Part A	-	-	-	-
Part B	-	-	-	-
	$<66>	$<337>	$<620>	$<1,023>

Recommendation

We recommend the Plan reduce its FACP by $1,023.

Contractor Response: Retirement Benefits

We concur with the recommendation regarding the minor coding error for retirement benefits ($1,023). An adjustment will be made to the appropriate FACP.

CONTRIBUTIONS

The Plan allocated Medicare $892 in unallowable contributions.

Apparently because the Plan believed support for programs to be different from direct giving, the cost of sandwiches provided March of Dimes workers and purchased Wall: America T-shirts was allocated to Medicare.

Section 31.205-8 of the FAR states:

> ...Contributions or donations, including cash property and services, regardless of recipient are unallowable...

The allocation of unallowable contributions to the Medicare programs resulted in the following overstatement of the FACPs:

	1985	1988	Total
LA Part B	$<615>	$<277>	$<892>
Part A	-	-	-
Part B	-	-	-
	$<615>	$<217>	$<892>

Recommendation

We recommend the Plan reduce its FACP by $892.

Contractor Response: Contributions

We concur with the recommendation regarding the minor coding error for contribution expense ($892). An adjustment will be made to the appropriate FACP.

PRIVATE LINE COSTS

Due to an apparent oversight the Plan inadvertently allocated $151 of costs related to an insurers conference registration and some promotional supplies to the Medicare programs.

Section XV of Appendix B states:

> ...The following items are unallowable: A. All direct and indirect costs which relate to the Contractors' non-Medicare business and do not contribute to the Medicare agreement/contract...

The misallocation of private lines costs caused the following overstatement of the FACPs.

	1987	1988	Total
LA Part B	$<118>	$ <9>	$<127>
Part A	-	<9>	<9>
Part B	-	<15>	<15>
	$<118>	$<33>	$<151>

Recommendation

We recommend the Plan reduce its FACPs by the above amounts.

Contractor Response: Private Line Costs

We concur with the recommendation regarding the minor coding errors for conference expenses ($118) and for promotional expenses ($33). An adjustment will be made to the appropriate FACP.

SALARIES OF PROVIDER AUDITORS

Prior to our beginning the audit, HCFA expressed concern to us that the starting salary ($26,500) of the Plan's entry level provider auditors was too high in relation to its geographical location. HCFA requested that we review this matter.

During our fieldwork we contacted an employment recruiting farm and several Certified Public Accounting farms to ascertain an appropriate entry level salary range. The range given was $16,000 to $22,000 a year for corporations and $18,000 to $24,000 per year for Public Accounting firms. Our firm, located in the Chicago area, hired its most recent entry level staff personnel at $19,500 per year plus overtime. Based upon our research and our knowledge of the area, we concur with HCFA that the starting salary for entry level provider auditors is excessive. We have not proposed a dollar adjustment due to the nature of the finding.

Recommendation

We recommend the Plan review and reduce its entry level salaries for provider auditors.

Contractor Response: Salaries of Provider Auditors

Salary levels are continually reviewed by internal staff as well as by independent personnel consulting service organizations. The required travel as well as the necessity of working in an ever-changing environment contribute to the establishment of salary structure.

We appreciate your comments on this subject.