DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JUN 15 1993

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Administrative Costs Claimed Under Part A of the Health Insurance for the Aged and Disabled Program - Independence Blue Cross (A-03-91-02000)

To
Bruce C. Vladeck
Administrator
Health Care Financing Administration

This is to alert you to the issuance on June 17, 1993, of our final report. A copy is attached.

During the period October 1, 1986 through September 30, 1989 Independence Blue Cross (IBC) claimed $35,442,862 for administering the Medicare Part A program. The audit showed that as much as $1.7 million of the costs claimed were unallowable.

The Health Care Financing Administration (HCFA) contracted with IBC to administer the Medicare Part A program. Under the provisions of the contract, IBC is required to receive, disburse, and account for Federal funds in making payments for services furnished to eligible Medicare beneficiaries. The IBC's responsibilities also include determinations as to coverage of services and the reasonableness of charges, furnishing timely information and reports to HCFA, and maintaining records to ensure the correctness and verification necessary for the administration of the contract. The IBC is entitled to reimbursement of all administrative costs claimed, provided that the provisions of the Medicare agreement have been met and that the costs were incurred in accordance with Federal regulations.

We determined that for the 3-year period IBC claimed $35,442,862, or $1,008,545 more than its HCFA approved budget of $34,434,317. The overrun, however, included two productivity investment (PI) projects totaling $59,973 mandated by HCFA. Since HCFA mandated these projects, we believe that IBC should not be held accountable for that portion of the overrun. We are questioning the remaining overrun of $948,572 which consists of:

- costs incurred and claimed of $406,224 which were associated with the processing of Medicare claims, and

- costs of $542,348 allocated to the Medicare program for nonapproved productivity investment projects and productivity investment projects that exceeded the approved budget.

We also determined that IBC could not support its method for computing the complementary credit (complementary credits to Medicare result from Medicare sharing claimant data with a complementary insurance program) and was not in compliance with revised Medicare guidelines. The IBC's formula for computing the complementary credit was developed in 1974 and was based on the Medicare claim form. Since 1974, the Medicare claim form, upon which the formula is based, has been changed. The IBC, however, did not change its formula for computing the complementary credit. In our opinion, there is no assurance that IBC's formula is resulting in an equitable allocation of costs to its complementary insurance program.

We recomputed the complementary credits using the revised Medicare guidelines. Following this methodology, we computed allowable Medicare complementary credits of $1,053,542 or $814,747 more than computed by IBC for Fiscal Years 1987 through 1989.

We are recommending that IBC make a financial adjustment of $948,572, the amount of the overrun for which it was responsible. We are also recommending that IBC provide HCFA with support for its complementary credits or coordinate with HCFA any recovery effort. As part of this coordination, HCFA should take into account the fact that IBC did not claim all costs incurred. The IBC made arbitrary adjustments to reduce costs claimed by $1.6 million in order to lower the cost per claim.

The IBC conceded that $416,841 of the questioned costs related to PI projects not approved by HCFA, but generally disagreed with the recommended adjustments. The operating division agreed in principle with the findings and recommendations contained in this report.

For further information, contact:

Thomas J. Robertson
Regional Inspector General
for Audit Services, Region III
(215) 596-6744

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

JUNE 1993 A-03-91-02000

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Our Reference: Common Identification Number A-03-91-02000

Mr. Robert A. McKeown
Vice President- Provider Services 38th floor
Independence Blue Cross
1901 Market Street
Philadelphia, Pennsylvania 19103-1480

Dear Mr. McKeown:

Enclosed for your information and use are two copies of an HHS/OIG Office of Audit Services final audit report titled **Review of Administrative Costs Claimed Under Part A Of The Health Insurance For The Aged And Disabled Program.** Your attention is invited to the audit findings and recommendations contained in the report.

Final determination as to the actions to be taken on all matters will be made by the HHS action 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 be bearing on the resolution of this audit may be presented at that time. Should you have any questions, please direct them to the HHS official named below.

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 subcontractors are made available, if requested to members of the press and general public to the extent information contained therein is not subject to the 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.)
A copy of this report is being sent to the Associate Regional Administrator for Medicare, Health Care Financing Administration for information and comments.

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

Sincerely yours,

Thomas J. Robertson
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to:

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

SUMMARY

The Independence Blue Cross (IBC) "booked" on its accounting records administrative costs of $37,068,838 for the processing of Medicare Part A claims from October 1, 1986 through September 30, 1989 (Fiscal Years [FYs] 1987, 1988 and 1989). The IBC claimed $35,442,862 of these costs on Final Administrative Cost Proposals. The difference between the "booked" costs and the claimed costs, $1,625,976, resulted from IBC's practice of placing an arbitrary "CAP" on claimed costs to lower the cost per claim. The Health Care Financing Administration (HCFA) approved Medicare budgets totaling $34,434,317 for the 3-year period.

We were unable to trace the "CAP" to either specific operations or specific cost centers. Therefore, we audited the "booked" costs of $37,068,838 and compared the claimed cost to IBC's budgets approved by HCFA.

We determined that the claimed costs of $35,442,862 exceeded HCFA's approved budget for the 3-year period by $1,008,545. Included in the budget overruns was $59,973 which resulted from Productivity Investment (PI) projects mandated by HCFA. The remaining budget overruns, which consists of $406,224 associated with the processing of Medicare claims, and $542,348 for PI projects that were neither approved nor mandated by HCFA or that exceeded the approved budget. The IBC did not seek advance approval to incur these costs from the Secretary of the Department of Health and Human Services. Therefore, the $948,572 is unallowable.

Aside from claiming more costs than authorized per the approved budgets, IBC understated its complementary credits (cost offsets) by $814,747. The understated complementary credits resulted from IBC using a cost allocation formula that was not supported.

The formula used to compute the complementary credits was developed by IBC in 1974 and was based primarily on: (1) the number of positions on a Medicare claims form; (2) the number of positions transferred to the complementary insurance program; and (3) the number of Medicare claims processed. The IBC was able to support the number of Medicare claims processed, but had no documentation supporting the other two factors. It is interesting to note that although IBC's formula was not changed since its inception in 1974, the Medicare claim forms, upon which the formula is based, has been changed.

Since there was no assurance that IBC's method of computing the complementary credits resulted in an equitable allocation of costs, we recomputed the credits using a method that had been developed by a large Medicare carrier in Pennsylvania. Using this method and the cost centers identified by IBC as

benefitting both Medicare and the complementary insurance, we determined that IBC had understated its complementary credits by $814,747.

We are making recommendations in this report for procedural improvements. Our recommendations for financial adjustments must take into account the allowable costs incurred but not claimed. If HCFA decides to limit reimbursement to the approved budget, no other financial adjustments are recommended. If HCFA decides to reimburse IBC based on the costs claimed in the FACPs, then our specific recommendations shown in this report should be implemented.

The IBC responded to our draft report by a letter dated May 28, 1992. The IBC generally disagreed with our findings and recommendations. The IBC's response has been incorporated in this report along with the auditors comments. We have included the response in its entirety as an appendix to this report.

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INTRODUCTION

BACKGROUND

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

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

The IBC is entitled to reimbursement for the allowable administrative costs incurred in carrying out its responsibilities under the Medicare sub-contract with BCA. From October 1, 1986 through September 30, 1989, IBC claimed administrative costs of $35,442,862 for processing Part A claims totaling more than $2.5 billion.

SCOPE OF AUDIT

Our audit was made in accordance with generally accepted government auditing standards. Initially our primary objective was to determine whether IBC's Medicare Part A Final Administrative Cost Proposals (FACPs) for Fiscal Years (FYs) 1987 through 1989 presented fairly the allowable costs of administration in conformity with reimbursement principles contained in Chapter 1, Part 31 of the Federal Acquisition Regulation (FAR), as interpreted and modified by the Medicare sub-contract and the Medicare Intermediary Manual published by HCFA.

We could not, however, trace the specific costs claimed on the FACPs to Medicare "booked" costs on the accounting records because IBC placed an arbitrary "cap" on costs charged to Medicare Part A. The purpose of the "cap" was to lower the cost per claim so that HCFA's annual contractor review would result in a favorable evaluation. As illustrated below, IBC's "booked" costs totaled $37,068,838 for FYs 1987 through 1989

and costs claimed for the same period totaled $35,442,862, or $1,625,976 less than the "booked" costs.

"BOOKED" COSTS VERSUS CLAIMED COSTS			
FY	"Booked" Costs	"CAP" Adjustments	Claimed Costs
1987	$10,989,551	$567,045	$10,422,506
1988	12,489,312	517,402	11,971,910
1989	13,589,975	541,529	13,048,446
Total	$37,068,838	$1,625,976	$35,442,862

As a result of IBC's practice of arbitrarily "capping" claimed costs, we were unable to trace the adjustments to either specific operations or specific cost centers. Therefore, we audited the allowability of the "booked" costs of $37,068,838 and not the claimed costs of $35,442,862. The IBC may offset allowable costs not claimed against costs which we questioned in this report, with one exception. We were able to determine that the adjustments were made from IBC's claims processing operation and not from productivity investment (PI) projects. Therefore, costs questioned relative to PI projects should not be offset by allowable costs which were not claimed.

As part of our audit, we reviewed the accuracy, reasonableness and allowability of Medicare complementary credits computed by IBC for FYs 1987 through 1989.

During the 3-year period of our review, IBC used a manual cost accounting system to allocate costs to all lines of business including Medicare. The allocation percentages used to allocate costs to the Medicare program were manually developed based on the functions performed in the cost center. There are approximately 250 cost centers in the cost accounting system, of which, about, 140 are allocated to Medicare. Our review of the cost accounting system was limited to reviewing Medicare's allocation percentages from several cost centers in FY 1989 to determine if the allocation percentages were reasonably developed and consistently applied to the Medicare program.

Other than the issues discussed in the FINDINGS AND RECOMMENDATIONS section of this report, we found no instances of noncompliance with applicable laws and regulations. With respect to those items not tested, nothing came to our attention to cause us to believe that the untested items were not in compliance with applicable laws and regulations.

Our audit dealt primarily with allowability of costs. We did not audit either the effectiveness or efficiency of IBC's operations. Our review was performed during the period October 1990 to March 1991 at IBC's corporate offices in Philadelphia, Pennsylvania.

FINDINGS AND RECOMMENDATIONS

COSTS CLAIMED IN EXCESS OF BUDGET

The HCFA approved Medicare budgets for IBC totaling $34,434,317 in administrative costs for FYs 1987 through 1989. During this period, IBC claimed on its FACPs $35,442,862 or $1,008,545 more than approved by HCFA.

The IBC did not obtain HHS approval for budget overruns of $948,572.

Two PI projects mandated by HCFA, but not included in the annual budgets, accounted for $59,973 of the budget overruns. Since these PI costs were incurred as a result of HCFA mandates, IBC cannot be held accountable for that portion of the budget overruns. We are, however, questioning budget overruns of $948,572 because IBC did not obtain HCFA's approval to incur the cost.

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

Our review showed that IBC did not comply with the requirements of paragraph H in any of the 3 years in which the budget was exceeded.

TOTAL IBC APPROVED BUDGETS			
FY	Approved Budget	Claimed	Overrun
1987	$9,798,900	$10,422,506	$623,606
1988	11,656,517	11,971,910	315,393
1989	12,978,900	13,048,446	69,546
Total	$34,434,317	$35,442,862	$1,008,545

The overrun of $1,008,545 included two FY 1989 PI projects, totaling $59,973, that were mandated by HCFA. These projects were:

- Pro Adjustments - $2,559,
- Durable Medical Equipment - $57,414.

Since HCFA mandated these projects, we believe that IBC should not be held accountable for that portion--$59,973--of the overrun attributable to the projects. We are questioning the remaining portion of the overrun or $948,572, because IBC did not obtain approval from HCFA to exceed the approved budgets. The overrun consists of $406,224 associated with the processing of Medicare claims, and $542,348 for PI projects that were not approved or mandated by HCFA or that exceeded the approved budget.

Productivity Investments

During our 3-year audit period, IBC allocated to Medicare over $1.8 million for PI projects. We believe that $542,348 of this amount is unallowable because two PI projects totaling $416,841 were neither approved nor mandated by HCFA, and three PI projects exceeded the approved budget by $125,507.

The IBC claimed $542,348 for two PI projects that HCFA had neither approved nor mandated and three PI projects that exceed the approved budget.

The HCFA authorizes intermediaries to perform special PI projects that are outside the realm of normal claims processing. These PI projects are reimbursed through the FACPs. Since PI projects are not included in the regular

budget process, the projects and their budgets must be approved by HCFA.

PI Projects Not Approved

Our review of IBC files and budgets approved by HCFA as well as discussions with HCFA staff showed that the following PI projects, totaling $416,841, were neither approved nor mandated by HCFA.

Outpatient Physical Therapy

Under the Outpatient Physical Therapy (OPPT) project, claims for outpatient physical therapy services were screened prior to payment to identify services which were neither skilled nor necessary. In FY 1986, HCFA directed IBC to implement the OPPT prepayment screens and indicated that the FY 1986 Notice of Budget Approval (NOBA) would be amended by $120,000 to include funding for the project. The HCFA instructed IBC that the PI project was to be completed and funds expended in FY 1986.

In FY 1986, IBC started the OPPT project. Due to complications and problems related to the original specification, the project was not completed during that year and continued into FY 1987. The IBC incurred $101,448 of costs in excess of the amount approved by HCFA due to the complications and problems.

In April of 1987, HCFA instructed IBC to absorb the excess amount of $101,448 for the OPPT project in its approved Medical Review & Utilization Review funding (which is line 4 of the FACP report). In September of 1987, HCFA informed IBC that the OPPT project would not be approved or funded in FY 1987. Nevertheless, IBC claimed the $101,448 on its FY 1987 FACP.

Management Data Communication Corporation

In FY 1988, IBC allocated to Medicare $315,393 for training and implementation costs associated with the Management Data Communication Corporation (MDCC) Medicare claims processing system. In a letter dated August 2, 1988, HCFA disallowed funding for the MDCC project because IBC did not follow the required procurement procedures prescribed in the Medicare agreement in obtaining the MDCC claims processing system. In the letter HCFA stated that the $367,000

cost of acquiring and installing the MDCC system could not be paid with Federal funds.

On February 17, 1989, HCFA reduced IBC's 1988 NOBA by $315,393 because its 1988 FACP included $315,393 for in-house training activities to implement the MDCC system. In a letter dated August 22, 1989, IBC questioned HCFA's denial of funding. The IBC agreed that in the August 2, 1988 letter HCFA denied funding for the acquisition and installation of the MDCC system, but disagreed that HCFA ever mentioned not being able to claim any in-house implementation costs related to the MDCC system. The IBC believed that the $315,393 for in-house training and testing costs of the MDCC Medicare claims processing system were internal costs related to Medicare activities and were allowable according to the Medicare agreement. The IBC letter explained that the claimed costs for FY 1988 included in-house training costs but excluded the MDCC acquisition and installation costs.

In a letter dated September 25, 1989, HCFA reaffirmed its position by stating that its August 2, 1988 letter intended to inform IBC that any costs related to the MDCC acquisition and installation would not be paid with Federal funds because IBC did not follow the appropriate competitive procurement procedures. The HCFA further stated that at no time in FY 1988 did HCFA issue a NOBA giving IBC approval to incur implementation costs related to the acquisition or installation of the MDCC system.

PI Projects Over Budget

During FY 1987, IBC exceeded the approved budget by $125,507 for three PI projects; $73,653 for the Electronic Media Claims; $51,137 for the OBRA Implementation, and $717 for the Unibill project. Since IBC did not obtain HCFA's approval to exceed the approved budget, we are questioning the $125,507.

Conclusions and Recommendations

The IBC claimed $1,008,545 more than the budgeted amounts approved by HCFA for FYs 1987 through 1989. A portion of this budget overrun, $59,973, was allowable as the costs were incurred on HCFA mandated PI projects. The remaining overruns totaling $948,572 were unallowable because IBC, contrary to provisions of the Medicare Agreement, did not obtain HCFA's approval to exceed the annual budget amounts.

We, therefore, recommend that IBC:

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

2. Reduce the FY 1987 FACP by $396,651 and the FY 1989 FACP by $9,573 for costs in excess of the approved budgets for the claims processing operation.

3. Reduce the FY 1987 FACP by $101,448 and the FY 1988 FACP by $315,393 for costs associated PI projects not approved by HCFA.

4. Reduce the FY 1987 FACP by $125,507 for costs associated with the three PI projects that exceeded the approved budget.

IBC's Response and OIG Comments

The IBC responded that of the $948,572 of cost overrun questioned in this report, it conceded to $416,841 related to PI projects not approved by HCFA, but stated that this concession cannot be considered a precedent for future transactions. The IBC requested reimbursement for the remaining overrun of $531,731. The IBC stated it did everything short of issuing a formal letter of abatement to notify HCFA it was in an underfunded position and would incur overruns. The IBC stated this is supported by several supplemental budget requests and other correspondence to HCFA.

The Medicare contract Article VI, paragraph C, specifically states that the contractor may not exceed the budget without the approval of HCFA. Our review found that IBC did not receive prior approval to exceed the authorized budget. As a result, the overrun of $948,572 is unallowable.

We recognize that the contract provides that if cost overruns were incurred in accordance with the Medicare costs principles and funds are available for the contractor administration, HCFA may reimburse the contractor for these costs upon final settlement of the FACP. This does not negate the fact, however, that IBC violated the provisions of paragraph C.

COMPLEMENTARY CREDITS

During FYs 1987 through 1989, IBC allocated $238,795 of costs to its complementary insurance program based on an allocation methodology that was developed in 1974. In our opinion, the methods used by IBC to compute the complementary credits for

FYs 1987 through 1989 was not adequately documented. Consequently, there was no assurance that the allocation of costs between Medicare and the complementary insurance program was either fair or reasonable.

Since IBC could not support its method of allocation, we reallocated the costs using an allocation method adopted by one of the larger Medicare carriers in Region III. Using this method and the cost centers identified by IBC as benefitting both Medicare and the complementary insurance program, we computed Medicare complementary credits of $1,053,542, or $814,747 higher than the amount computed by IBC. We are recommending that IBC provide adequate documentation to fully support its allocation method or reduce its FACPs by $814,747.

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

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

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

- The term allocation means to distribute all costs to Medicare and the complementary insurance program in such proportion as to reflect the benefits received by each program.
- When both programs derive mutual benefits from an activity, full cost sharing is required.

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

IBC Computation of Complementary Credits

The IBC implemented its totally integrated claims process in 1974. At that time, IBC implemented procedures to credit the Medicare program for the use of the Medicare claimant information. The procedures differed for indirect and direct costs. Indirect costs were allocated on the basis of the ratio of Medicare indirect costs to total indirect costs. Direct costs were allocated based on the number of positions on a Medicare claim form and the number of positions that were transferred to the complementary program, weighted by the number of claims processed. The following chart shows the numbers used by IBC in its formula for allocating direct costs.

DIRECT COST ALLOCATION

Type of Claim	Positions on Claim	
	Total	Transferred
Hospital In-Patient	483	56
Hospital Out-Patient	238	45

In FYs 1987 through 1989, IBC processed 1,142,747, 1,081,513 and 1,196,356 Medicare claims, respectively. During the same 3-year period, IBC reported that 170,173, 140,229 and 142,903 Medicare claims, respectively, were transferred to the complementary insurance program.

Using the claims statistics and the two formulas, IBC computed complementary credits of $238,795 ($72,623 for FY 1987, $90,047 for FY 1988 and $76,125 for FY 1989). We requested that IBC furnish us documentation supporting these credits. The IBC was able to support the number of claims processed and the number of claims transferred but could not provide any documentation to support the number of positions used in its formula.

The IBC officials could not identify the 483 positions on a Medicare in-patient claims form or the 238 positions on a Medicare outpatient claims form. It is to be noted that since developed in 1974, the formula has never been revised even though the Medicare claims form has been revised. The IBC officials also could not identify the 56 positions on an in-patient claims form and the 45 positions on an out-patient

claims form that were supposedly transferred to the complementary insurance program. The IBC officials that we discussed this issue with stated that, in their opinion, there was no set number of positions on either claims form that were transferred to the complementary insurance program.

The IBC could not provide any documentation showing that its method of computing complementary credits resulted in a fair and equitable allocation of costs between Medicare and the complementary insurance program. Therefore, there was no assurance that Medicare was paying only its fair share of the costs of providing claimant data to IBC's complementary insurance.

Revised Computation Methodolgy

Since IBC's allocation methodology was not supported by documentation, we substituted it with a methodology that had been used by one of the largest Medicare carriers in Region III. We had audited this carrier and found the methodology to be reasonable. The methodology, based on a weighted claims processed ratio, is as follows:

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

In the formula above, the number of Medicare claims transferred is included twice in the denominator, once in the total Medicare claims and also as a separate item. This, in effect, reduces the allocation percentage and ensures that Medicare pays its share of the costs associated with the transferred claims.

In implementing the above formula, we determined the total number of Medicare claims and the total number of Medicare claims transferred to the complementary insurance program for each of the 3 years reviewed. We then applied the formula shown above to arrive at the following allocation percentages.

RECOMPUTED ALLOCATION PERCENTAGES

FY	Medicare Claims		Allocation %
	Total	Transferred	
1987	1,142,747	170,173	12.96
1988	1,064,597	140,229	11.64
1989	1,196,357	142,913	10.67

Once we computed the allocation percentages, we applied them to the cost centers that IBC had identified as benefitting both Medicare and the complementary insurance programs for each fiscal year of our review. The IBC had identified 22 such cost centers in FY 1987, 18 cost centers in FY 1988 and 14 cost centers in FY 1989. We included all costs in these centers except for costs associated with PI projects (IBC had also removed these costs from its computations). Our results are summarized below.

RECOMPUTED COMPLEMENTARY CREDITS

FY	Cost Centers Number	Costs	Allocation %	Complementary Credit
1987	22	$2,568,296	12.96	$332,851
1988	18	3,322,080	11.64	386,691
1989	14	3,130,266	10.67	334,000
Total				$1,053,542

The complementary credits of $1,053,542 were $814,747 higher than the $238,795 computed by IBC as shown below.

COMPLEMENTARY CREDITS UNDERSTATED

FY	AUDIT	IBC	Difference
1987	$332,851	$72,623	$260,228
1988	386,691	90,047	296,644
1989	334,000	76,125	257,875
Total	$1,053,542	$238,795	$814,747

Conclusion and Recommendations

The IBC computed complementary credits of $238,795 for FYs 1987 through 1989 but was unable to support the method used in its calculation. Lacking such support, IBC could not ensure that its allocation of costs between Medicare and its complementary insurance program was fair and equitable. We recomputed the complementary credits using a formula developed by a large Medicare carrier in Region III and determined that the complementary credits computed by IBC were understated by $814,747.

We, therefore, recommend that IBC:

1. Ensure that its computation of complementary credits complies with the Medicare Intermediary Manual.

2. Either provide documentation fully supporting its method used to compute complementary credits for FYs 1987 through 1989, or coordinate with HCFA any effort to offset allowable costs not claimed on FACPs against the understated complementary credits of $814,747 ($260,228 for FY 1987; $296,644 for FY 1988 and $257,875 for FY 1989).

IBC's Response and OIG Comments

The IBC did not agree with our findings and recommendations regarding complementary credits. The IBC stated that written documentation was provided to the auditors that supports its method for computing the complementary credit. Also, IBC did not agree with our method of computing the complementary credit. IBC considers our method, which uses claims data, to be totally arbitrary.

The allocation methodology used by IBC to compute the complementary credit was developed in 1974 and was based on:(1) the number of positions on a Medicare claim form; (2) the number of positions transferred to the complementary insurance program; and (3) the number of Medicare claims processed. Since 1974, the Medicare claim form has been revised and the positions on the claim form are not standard. We agree that IBC provided us with documentation to support the number of Medicare claims processed, however, IBC did not provide us with documentation to support the positions on the revised Medicare claim form or the positions on the claim form that are transferred to the complementary insurance program.

Since IBC's allocation method was not supported, there was no assurance that IBC's method resulted in a fair and equitable allocation of costs between Medicare and the complementary insurance program which is required by the Medicare Intermediary manual.

We are making recommendations in this report for IBC to provide HCFA documentation to fully support its method to compute complementary credits for FYs 1987 through 1989 in the settlement process or coordinate with HCFA any efforts to offset allowable costs not claimed on the FACPs against the understated complementary credits of $814,747 identified in this report.

APPENDICES

Appendix A

Schedule of Questioned Costs
Independence Blue Cross

Audit Adjustment	1987	1988	1989	Total
FACP in Excess of NOBA	$396,651		$9,573	$406,224
PI Projects not Approved	101,448	315,393		416,841
PI Projects Exceed Approved Budget	125,507			125,507
Complementary Credit	260,228	296,644	257,875	814,747
Total Audit Adjustments	$883,834	$612,037	$267,448	$1,763,319

Appendix B

Schedule of Recommended Settlements
on
Final Administrative Cost Proposals
As submitted by
Independence Blue Cross

	1987	1988	1989	Total
FACP Totals	$10,422,506	$11,971,910	$13,048,446	$35,442,862
Total Audit Adjustments	883,834	612,037	267,448	1,763,319
Recommended Settlement Amount	$9,538,672	$11,359,873	$12,780,998	$33,679,543

Independence Blue Cross

1901 Market Street. Philadelphia. Pennsylvania 19103-1480

An Agent for Pennsylvania Blue Shield

May 28, 1992

Mr. G. A. Rafalko
Regional Inspector General for Audit Services
Health Care Financing Administration
P.O. Box 13716, Mail Stop 9
Philadelphia, PA 19101

Dear Mr. Rafalko:

This letter is intended to respond to the audit report issued by the Office of Inspector General April 1992, reference number A-03-91-02000.

While we disagree in principle, the unallowable PI projects amounting to $416,841 are conceded and we agree with these adjustments. The $315,393 for the MDCC project was reduced from the 1990 NOBA. The remaining $101,448 for the OPPT project will be reflected as deductions of the FACP of FY 1987. IBC acted in good faith on both of these projects under direction from HCFA on the OPPT project and to achieve enhanced operating ability under the MDCC project. The issue in both cases was the integrity of the program and enhancements to it. Each of these situations involved IBC expending its own funds to ensure a higher level of service to the program with little or no direct benefit to the company. We feel it is important that this position be made clear. This scenario cannot be considered a precedent for future transactions.

We find the issue raised regarding complementary credits totally inappropriate. The complementary credit currently being given is $.50 per claim. We have polled other Blue Cross Plans unofficially and have found the majority to be less than our current $.50. Only one Plan polled exceeded the $.50 and that Plan used $.52. The complementary credit was primarily designed to share the cost of tasks that benefited IBC's 65 Special line of business. This was evident when all claims required data entry. Today with electronic submission of claims, the cost and value of such activity is greatly reduced and the complementary credit loses its basis in actual allocation of cost. The current credit is more an arbitrary custom of past business practices than a tangible sharing of cost. IBC did not change its formula in the past years, as noted in the audit report. However, a change would more likely be a reduction not an increase as happened in reality. The original credit was $.25. The current is double this amount while the actual effort, cost and value have diminished.

The audit team questioned the value of the claim data to IBC under the theory that IBC had an interest in the treatment of the Medicare patient. IBC only covers a deductible in the Medicare claim. Underlying diagnostic data is valueless given the age group of the recipients. IBC recognizes this data would be of value but only to a company underwriting life coverage, not basic health policies.

We take issue with the auditor's contention that the method of calculation of the complementary credit could not be supported. The calculation was provided to the audit team in writing. They did not indicate that the documentation provided was not adequate for their purposes and we were under the assumption that the issue was closed at that point.

We find the auditor's proposed application of statistics based on the claim data as primary factors in allocating cost centers to be totally arbitrary. These cost centers cover a greater base of activities than the data contained in a 65 Special claim. Had this position been raised during the field work of the audit, our position would have been easily demonstrated. Every cost center at IBC is thoroughly reviewed prior to the cost allocation base being established. These allocations are reviewed on an ongoing basis after initial establishment to ensure continued appropriateness. We therefore find the proposed allocation method to have no merit.

Our final statement regarding complementary credit highlights the inequity of the proposed audit adjustment. Under the funding from HCFA for the bills payment function on line 1, IBC has seen a gradual erosion of reimbursement. Currently IBC is covering, at best, direct cost with little margin for corporate overhead. The rate we have received on average amounts to $1.98 per claim to process the entire Medicare claim through the adjudication process. Under the proposed audit adjustment the OIG auditors would have IBC give a credit of $2.32 ($1,053,542 / 453,315 claims (reference Page 17 of OIG audit report) per claim to HCFA for a minor part of this data and process, which benefits IBC's private line of business. This would amount to a profit of $.34 to HCFA.

The draft report suggests that IBC exceeded its approved budget by $948,572 without notifying the Secretary under the guidelines of the contract (Article VI paragraph H). Our position is that we did everything short of issuing a formal letter of abatement (which is not required) to notify HCFA (therefore the Secretary) that we were in an underfunded position and would have cost overruns. This is supported by several supplemental budget requests and other correspondence to HCFA.

Of the $948,572, we concede to $416,841 related to unallowable PI projects. Ignoring the allowability of the other booked costs, we request reimbursements for cost claimed in excess of NOBA equaling $531,731.

Please contact me so we can meet to discuss our position at your convenience.

Sincerely,

Robert A. McKeown
Senior Vice President
Medicare Operations &
Provider Services

RM/gb

cc:Robert Larson