DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

APR - 5 2004

TO: Wynethea Walker
Acting Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Dennis J. Duquette
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicare Part A Administrative Costs Claimed by Anthem Health Plans of Maine – October 1998 Through September 2001 (A-01-02-00525)

Attached is an advance copy of our final report on administrative costs claimed by Anthem Health Plans of Maine. We will issue this report to the Medicare contractor within 5 business days. A copy of the report is attached. This audit was performed at the request of the Centers for Medicare & Medicaid Services (CMS).

We suggest that you share this report with those CMS components involved with monitoring the Medicare fiscal intermediaries' (FI) financial operations, particularly the Office of Financial Management, the Centers for Medicare Management, and the Office of the Actuary.

The objectives of our review were to determine whether the FI established effective controls over the accounting and reporting of administrative costs, and the costs claimed on the proposal complied with applicable Federal regulations and contract provisions.

During fiscal years (FY) 1999 through 2001, the FI claimed $67.6 million in Medicare administrative costs. We found that the FI did not employ control procedures sufficient to ensure compliance with Federal cost principles and Medicare contract provisions. As a result, the FI claimed unallowable costs totaling $2,754,992, including:

- $1,878,501 in unallowable incentive and bonus payments because they were for goals that were too easily attainable and lacked prior CMS approval, were for work performed in a different period, were not documented, and were for excessive amounts;

- $555,579 in unallowable salaries in two departments because time records did not reflect the actual work performed for the period October 1998 through December 2000 ($456,870) and excessive executive office overhead was allocated to Medicare ($98,709);

- $260,546 in unallowable acquisition and lobbying costs during FYs 1999 and 2000; and

- $60,366 in unallowable legal fees improperly allocated to Medicare in FYs 1999 and 2000.

Internal control weaknesses also resulted in $634,724 in data processing costs being set aside for CMS review and $1.4 million of pension cost reporting errors being included in the FY 2001 proposal.

The above findings primarily relate to inadequate controls for supporting and allocating indirect costs to the Medicare program. We found that the FI had control weaknesses including failure to:

- create written procedures,
- comply with Federal regulations,
- maintain documents to support charges,
- follow existing procedures,
- treat like costs in a consistent manner,
- consistently charge unallowable costs to the appropriate accounts, and
- use correct rates to make adjustments.

RECOMMENDATIONS

We recommend that the FI:

- reduce its proposals by $2,754,992;

- work with CMS to remove all salaries, outside legal, consulting, professional services, and any other costs related to acquisition and lobbying activities; and to remove legal, consulting, and professional services directly related to its private lines of business to ensure that these costs are not claimed for Federal reimbursement and reduce its proposals accordingly;

- reduce its proposals by any part of the $634,724 in data processing costs that cannot be supported;

- work with CMS to ensure that the $1.4 million reporting error for pension costs is not included in future budget periods; and

- establish written procedures to ensure that proposals are current, accurate, and complete and submitted timely to CMS.

In its October 14, 2003 response to our draft report (Appendix D), the FI agreed with $60,366 of the recommended disallowances related to private-side legal fees allocated to Medicare. The FI generally concurred that unallowable in-house and outside professional services costs related to acquisition, financing, and lobbying efforts were included in its proposals to CMS. However, it believed that the amount of such unallowable costs was less than the OIG-computed amount of $260,546. The FI did not concur with our recommended adjustments of $1,878,501 in unallowable bonus and incentive payments and $555,579 in inappropriately allocated salaries

and wages. Finally, the FI did not agree with our findings on control weakness relating to unsupported data processing costs and reporting errors for pension costs. We believe that our recommended disallowances and identified internal control weaknesses accurately reflect the extent of the FI's failure to comply with applicable Federal regulations, Medicare program criteria, and internal policies and procedures. We continue to believe that these financial adjustments are warranted.

We summarized the FI's comments and responded to those comments after the Recommendations section of each finding and included the comments in their entirety as Appendix D to the report.

If you have any questions or comments about this report, please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689. Please refer to report number A-01-02-00525 in all correspondence.

Attachment

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

APR - 8 2004

Report Number: A-01-02-00525

Mr. Michael E. McCarron
President and Chief Operating Officer
AdminaStar Federal
8115 Knue Road
Indianapolis, Indiana 46250

Dear Mr. McCarron:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's (OIG) report entitled "Review of Medicare Part A Administrative Costs Claimed by Anthem Health Plans of Maine - October 1998 Through September 2001." A copy of this report will be forwarded to the action official named below for review and any action deemed necessary.

Final determinations as to actions to be taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are made available to the press and general public to the extent information contained therein is not subject to exemptions in the act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-01-02-00525 in all correspondence.

Sincerely,

Michael J Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services – Region I
Department of Health and Human Services
Room 2325, JFK Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PART A ADMINISTRATIVE COSTS CLAIMED BY ANTHEM HEALTH PLANS OF MAINE OCTOBER 1998 THROUGH SEPTEMBER 2001

APRIL 2004
A-01-02-00525

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) administers Part A and Part B of Part A of the Medicare program through contracts with private organizations, called fiscal intermediaries (FI), to process and pay claims. Part A of the Medicare program is the hospital insurance program and covers the costs of inpatient hospital care, posthospital extended care, and posthospital home health care. Part B of Part A covers outpatient costs. Contracts between CMS and FIs define the functions to be performed and provide for the reimbursement of allowable administrative costs incurred by the FI.

Following the close of each fiscal year (FY), each FI submits a proposal to CMS reporting the Medicare operating costs incurred during the year. The proposal and supporting data serve as the final settlement of allowable administrative costs.

For the first 20 months of our review, Associated Hospital Service was responsible for the receipt, review, and payment of Medicare Part A, Part B of A, and home health agency claims submitted by hospitals and other medical suppliers in Maine and Massachusetts. On June 5, 2000, Anthem Insurance Companies, Inc. (Anthem), acquired Associated Hospital Service and created Anthem Health Plans of Maine, Inc. The FI (meaning both Associated Hospital Service and Anthem Health Plans of Maine) claimed $67.6 million in administrative costs to process 16 million claims for the period October 1998 through September 2001.

OBJECTIVES

The objectives of our review were to determine whether the FI established effective controls over the accounting and reporting of administrative costs, and the costs claimed in the proposal complied with applicable Federal regulations and contract provisions.

SUMMARY OF FINDINGS

During FYs 1999 through 2001, the FI claimed $67.6 million in Medicare administrative costs. We found that the FI did not employ control procedures sufficient to ensure compliance with Federal cost principles and Medicare contract provisions. As a result, the FI claimed unallowable costs totaling $2,754,992, including:

- $1,878,501 in unallowable incentive and bonus payments because they were for goals that were too easily attainable and lacked prior CMS approval, were for work performed in a different period, were not documented, and were for excessive amounts;

- $555,579 in unallowable salaries in two departments because time records did not reflect the actual work performed for the period October 1998 through December

2000 ($456,870) and excessive executive office overhead was allocated to Medicare ($98,709);

- $260,546 in unallowable acquisition and lobbying costs during FYs 1999 and 2000; and

- $60,366 in unallowable legal fees improperly allocated to Medicare in FYs 1999 and 2000.

Internal control weaknesses also resulted in $634,724 in data processing costs being set aside for CMS review and $1.4 million of pension cost reporting errors being included in the FY 2001 proposal.

The above findings primarily relate to inadequate controls for supporting and allocating indirect costs to the Medicare program. We found that the FI had control weaknesses including failure to:

- create written procedures,
- comply with Federal regulations,
- maintain documents to support charges,
- follow existing procedures,
- treat like costs in a consistent manner,
- consistently charge unallowable costs to the appropriate accounts, and
- use correct rates to make adjustments.

RECOMMENDATIONS

We recommend that the FI:

- reduce its proposals by $2,754,992;

- work with CMS to remove all salaries, outside legal, consulting, professional services, and any other costs related to acquisition and lobbying activities; and to remove legal, consulting, and professional services directly related to its private lines of business to ensure that these costs are not claimed for Federal reimbursement and reduce its proposals accordingly;

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In its October 14, 2003 response to our draft report (Appendix D), the FI agreed with $60,366 of the recommended disallowances related to private-side legal fees allocated to Medicare. The FI generally concurred that unallowable in-house and outside professional services costs related to acquisition, financing, and lobbying efforts were included in its proposals to CMS. However, it believed that the amount of such unallowable costs was less than the OIG-computed amount of $260,546. The FI did not concur with our recommended adjustments of $1,878,501 in unallowable bonus and incentive payments and $555,579 in inappropriately allocated salaries and wages.

Finally, the FI did not agree with our findings on control weakness relating to unsupported data processing costs and reporting errors for pension costs. We believe that our recommended disallowances and identified internal control weaknesses accurately reflect the extent of the FI's failure to comply with applicable Federal regulations, Medicare program criteria, and internal policies and procedures. We continue to believe that these financial adjustments are warranted.

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INTRODUCTION

BACKGROUND

CMS administers Part A and Part B of Part A of the Medicare program through contracts with private organizations, or FIs, to process and pay claims. Part A of the Medicare program is the hospital insurance program, which covers the costs of inpatient hospital care, posthospital extended care, and posthospital home health care. Part B of Part A covers outpatient costs. Contracts between CMS and FIs define the functions to be performed and provide for the reimbursement of allowable administrative costs incurred by the FI.

Following the close of each fiscal year, the FI submits a proposal to CMS reporting the Medicare operating costs incurred during the year. The proposal and supporting data serve as the final settlement of allowable administrative costs.

For the first 20 months of our review, Associated Hospital Service was responsible for the receipt, review, and payment of Medicare Part A, Part B of A, and home health agency claims submitted by hospitals and other medical suppliers in Maine and Massachusetts. On June 5, 2000, Anthem Insurance Companies, Inc. (Anthem), acquired Associated Hospital Service and created Anthem Health Plans of Maine, Inc. The FI (meaning both Associated Hospital Service and Anthem Health Plans of Maine) claimed $67.6 million in administrative costs to process 16 million claims for the period October 1998 through September 2001.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our review were to determine whether the FI established effective controls over the accounting and reporting of administrative costs and the costs claimed on the proposal complied with applicable Federal regulations and contract provisions.

Scope

Our review covered the 3 FYs ending September 30, 2001. Because the FI used two different accounting systems to track and claim administrative costs for Federal reimbursement, we obtained an understanding of the internal controls in both systems, and analyzed the differences between them. As part of our review, we reconciled claimed costs with the FI's books and records.

Methodology

We used applicable Medicare contract provisions and instructions, Federal regulations, and FI company policies to ascertain whether the claimed costs met reimbursement

requirements. In addition, we obtained supporting expense reports, payroll journals, and personnel records to perform tests of various cost categories.

Our fieldwork was performed at the FI Medicare Home Office in South Portland, Maine, during the period September 2002 through June 2003. We met with FI officials during our fieldwork to advise them of our tentative findings. In addition, we held meetings with CMS officials in the Regional Office in Boston, Massachusetts. We issued our draft report on August 29, 2003 and received a draft response from the FI on October 14, 2003 (see Appendix D). Where appropriate, the report was revised in response to additional information provided by the FI.

Our review was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

During FYs 1999 through 2001, the FI claimed $67.6 million in Medicare administrative costs. We found that the FI did not employ control procedures sufficient to ensure compliance with Federal cost principles and Medicare contract provisions. As a result, the FI claimed unallowable costs totaling $2,754,992, including:

- $1,878,501 in unallowable incentive and bonus payments because they were for goals that were too easily attainable and lacked prior CMS approval, were for work performed in a different period, were not documented, and were for excessive amounts;

- $555,579 in unallowable salaries in two departments because time records did not reflect the actual work performed for the period October 1998 through December 2000 ($456,870) and excessive executive office overhead was allocated to Medicare ($98,709);

- $260,546 in unallowable acquisition and lobbying costs during FYs 1999 and 2000; and

- $60,366 in unallowable legal fees improperly allocated to Medicare in FYs 1999 and 2000.

Internal control weaknesses also resulted in $634,724 in data processing costs being set aside for CMS review and$1.4 million of pension cost reporting errors being included in the FY 2001 proposal.

These findings are discussed below in detail.

INCENTIVE/BONUS PAYMENTS

The FI claimed $1,878,501 in incentive and bonus payments in its proposals for FY 1999 through FY 2001. We found that these payments did not meet at least one of the four Federal requirements (summarized in Table 1 on page 4).

Federal Acquisition Regulation (FAR) 31.205-6(f)(1), "Bonuses and incentive compensation," requires that bonuses and incentive compensation be based on production, cost reduction, or efficient performance. The awards are to be paid or accrued under an agreement entered into in good faith between the contractor and the employees before the services are rendered, or pursuant to an established plan or policy followed by the contractor so consistently as to imply an agreement to make such payment, and the basis for the award is supported.

FAR 31.205-6(a)(4), "General," states that CMS should be notified of major revisions of existing compensation plans before they are implemented or within a reasonable period after, and provided an opportunity to review the changes.

FAR 31.205-6(a)(1), "General," states that "Compensation for personal services must be for work performed by the employee in the current year, and must not represent a retroactive adjustment of prior years' salaries or wages. . . ."

FAR 31.201-6(k)(1), "Deferred compensation other than pensions," states that deferred awards are allowable when they are based on current or future services. Awards made for services provided in prior periods are not allowable.

FAR 31.205-6(b), "Reasonableness," requires that compensation for personal services paid or accrued to each employee be reasonable for the work performed. Relevant factors include conformity with the compensation practices of other firms of the same size, the compensation practices of other firms in the same industry, and the compensation practices of firms in the same geographic area. Part 31.201-3(a) states that the burden of proof is on the contractor to establish reasonableness.

As shown in Table 1, the FI did not meet the criteria for establishing appropriate goals for all three fiscal years. While none of the bonuses and incentive payments were approved by CMS, the amounts paid out in 1999 and 2000 were indirectly approved when CMS signed the administrative cost budget. For 2001, $325,176 related to work performed in 2000 and $761,690 exceeded the market rate.

		Federal Criteria			
Fiscal Year	**Amount Claimed**	**1 Appropriate Goals**	**2 CMS Approved**	**3 Proper Period**	**4 Within Market**
1999	$ 192,400	N	Y	Y	Y
2000	208,200	N	Y	Y	Y
2001	325,176	N	N	N	Y
	761,690	N	N	Y	N
	391,035	N	N	Y	Y
	1,477,901				
Total	**$1,878,501**				

Table 1 - Compliance With Federal Regulations

1999 Bonus Payments

Our review disclosed that the FI claimed $192,400 in bonuses for 1999. While the bonuses averaged about 2 percent of salaries, we found no evidence that they were based on production, cost reduction, or efficient performance goals achieved under an agreement with employees before services were rendered or as part of an established plan or policy. FI officials stated that bonuses were not part of an established incentive plan, but were part of a longstanding policy and that they were included in the budget approved by CMS. However, the bonuses were awarded at the discretion of the Vice President of Government Programs and the FI could not generate any documentation that verified the reasons for the incentive payments. Therefore, we were unable to ascertain whether they were reasonable or even allocable to the contract.

2000 Bonus Payments

We found that incentive goals were in place for 2000 (though this was disputed by the FI). The goals sought increased profits, greater customer satisfaction, increased number of customers, and improved quality of services. All four goals had to be achieved for employees to receive an incentive payment. However, Associated Hospital Service paid employees $208,200 in incentives even though the goal of increased profits had not been met. As in 1999, this amount was indirectly approved when CMS signed the budget.

In 2001, the FI paid employees an additional $325,176 in bonuses for work performed in 2000. Unlike the bonuses paid by Associated Hospital Service, CMS did not directly or indirectly approve the bonus plan. Instead of using funds remaining from 2000 to pay for the second year's bonus, the FI used 2001 funds. Such payments are not allowable deferred compensation payments under FAR 31.205-6(f)(2) and FAR 31.205-6(a)(1), since they represent awards for work performed in a prior accounting period.

2001 Incentive/Bonus Payments

While the FI claimed $1,477,901 in incentive payments in its 2001 proposal ($325,176 for work performed in 2000 and $1,152,725 for 9 months' work performed in 2001), we found that:

- goals established for 2001 were not nearly as demanding as the goals for 2000,
- the FI did not obtain CMS approval for the 2001 incentive payment, and
- $761,690 exceeded the market rate acceptable to CMS.

These shortcomings are explained below.

Timeliness of Goals

The chronology of events disclosed that the FI did not begin the process of establishing performance expectations with its employees for 2001until 8 months of the fiscal year had elapsed. Under FAR 31.205-6(f)(1), the plan should have been established before the year started. The goals presented in the 2001 incentive plan were the following:

- Successful migration of New Hampshire's financial operation to the Maine facility. According to CMS, this involved a small number of staff.
- Maintenance of a high level of compliance awareness in Medicare Operations, as measured by 97% attendance for compliance training from June to December. The course provided approximately 2 hours of training.
- Completion of CMS Security Initiative requirements from CMS Program Memorandum Change Request 1439 for 2001.[1]

While the FI achieved these three goals, CMS concluded that they were not difficult to attain. Unlike the goals for 2000, they did not include increases in profits, customer satisfaction, number of customers, or quality of service.

To further assess the basis for incentive payments, we compared the trends for the number of claims processed, administrative costs, and incentives from 1999 to 2001. The number of claims processed remained relatively constant over the 3 years, while administrative costs increased by nearly 8 percent. However, payouts for incentives and bonuses

[1] The memorandum requires the FI to conduct a core security self-assessment, submit security program documentation to CMS, submit a security plan architecture report, submit information security funding requirements, conduct an annual compliance audit on security and a triennial risk assessment, update and test the contingency plan, and obtain annual security certification.

increased 499 percent overall or 177 percent from 1999 to 2000 and 116 percent from 2000 to 2001.

CMS Approval

CMS was first informed of the 2001 incentive plan and related payments in a meeting with the FI on August 8, 2001--55 days before the end of the fiscal year. The purpose of the meeting was to discuss the 2002 budget. The FI included the 2001 incentive payments in its 2002 budget. Accordingly, CMS requested a copy of the 2001 incentive plan, which it received on August 17, 2001. To date, the plan has not been approved by CMS.

Excessive Payouts

In addition to setting easily obtainable goals and not obtaining CMS' approval, the $761,690 claimed for incentive payments in 2001 exceeded the 5 percent rate CMS budgeted. Specifically, the FI claimed $1,152,725 in incentive payments for 2001, or an average of 12.2 percent of salaries. The CMS Region I Office, in response to the excessive incentive payment rate, requested the FI to provide information about the competitiveness of its incentive payments on September 25, 2001. On November 15, 2001, the FI provided two job descriptions disclosing a market incentive rate of about 5 percent of salaries. Specifically, the two job descriptions disclosed that the 2001 industry standards for incentive payments were 3.5 percent and 6.4 percent or an average rate of 4.95 percent of salaries. The FI allotted a 5 percent incentive payment to the same in-house job categories, showing that its compensation was competitive with the industry.

On July 19, 2002, the FI provided CMS with a benefit and salary analysis prepared by its Human Resources Department. Although the analysis concluded that the FI was competitive in terms of fringe benefits and overall total compensation, it did not specifically address industry standards for incentive payment rates. Federal criteria state that the burden of proof rests with the FI to show that its incentive payment rate is reasonable.

Of the 253 individuals who received incentive payments for work performed under Medicare in FY 2001, 75 percent were targeted at the 5 percent level. Management and professional staff, which accounted for the remaining 25 percent, receive bonuses as high as 30 to 60 percent of their salaries if established goals were exceeded.

CMS has not received adequate justification from the FI to support the 12.2 percent incentive rate the FI claimed for 2001 and is concerned that there is no sufficient evidence supporting any amount in excess of the budgeted rate of 5 percent.

Conclusions and Recommendations

We found that the FI did not employ control procedures sufficient to ensure compliance with Federal cost principles and Medicare contract provisions. As a result, the FI overcharged Medicare $1,878,501 for unallowable incentive and bonus payments.

We recommend that the FI take the following steps:

- It should establish procedures to ensure that incentive and bonus payments comply with Federal requirements and Medicare contract provisions.

- It should reduce its proposal by $1,878,501. This amount does not include costs for both employer-paid payroll taxes and related 401(k) contributions claimed under Medicare for its 2001 incentive payment plan, which should be identified by the FI for additional adjustment to CMS.

Auditee's Comments

The FI did not concur with our finding that $1,878,501 in bonus and incentive payments claimed did not comply with Federal requirements. The FI stated that bonus and incentive payments were made in good faith pursuant to an established plan followed by the FI and qualify as allowable expenses for each year, as described below.

1999 Bonus Payments

In 1999, bonuses awarded by the Vice President of Government Programs were not part of an overall incentive plan. Rather, spot bonuses of $192,400 were paid at fiscal year end (September 30) to recognize selected Medicare associates who made a significant contribution to the success of Medicare during that FY. Several claims from 1991 to 1998 have included these year-end performance bonuses. The FI asserted that, when HCFA (CMS) audited these claims, no exceptions were taken for the bonuses.

2000 Bonus Payments

The 1999 spot bonus program was still in place in 2000. Pursuant to that program, the FI paid its employees $208,200 for individual instances of exceptional performance in support of the Medicare program. According to the FI, the four incentive goals for 2000 of increased profits, customer satisfaction, number of customers and quality of service applied only to its private-side and not to Medicare. The goal of profitability was not applicable to Medicare since it did not materially affect profits or have any effect on private-side customers.

In mid-2000, the FI was acquired by Anthem. To reward employees for a smooth transition into the new organization, Anthem paid a company-wide bonus of which $325,176 was claimed under Medicare. While the $325,176 was not included in the CMS-approved 2001 budget, the FI asserts that this amount was included in the 2001 expenses as directed by CMS.

2001 Incentive Payments

The FI believes that it established clear and appropriate goals and awarded a competitive incentive payment when considered as part of an employee's overall total compensation.

OIG Response

The FI claimed $1,878,501 million in questionable bonus and incentive compensation under the Medicare program. Under its negotiated contract, CMS provided funding and reimbursements in good faith to the FI for the administration of the Medicare program. However, we found that the FI incurred expenses that did not comply with contract provisions and claimed reimbursements that did not meet the Federal requirements for allowability, allocability, and reasonableness. Our response by year is noted below.

1999 Bonus Payments

The $192,400 in bonuses awarded by the Vice President of Government Programs was not in compliance with applicable Federal regulations. Specifically, the FI's payments did not meet Federal requirements that bonuses be based either on an agreement between the contractor and employee before services are rendered, or pursuant to an established plan followed so consistently by contractor as to imply an agreement to make payment and support the basis of the bonus.

FI officials stated that no support is available to show how employees qualified for an award, why they received a certain amount, and what they accomplished. We also could not determine whether the bonuses were reasonable or even allocable to the contract. FAR 31.205-6(f)(1).

CMS in Region I was not aware that spot bonuses had been included in the proposal filings from 1991 to1998. Apparently, the proposals did not include a line item or comment distinguishing such costs. When CMS audited the proposals, nothing came to their attention to indicate that spot bonuses had been claimed. When reviewing proposals, CMS often performs a trend analysis of claimed costs and focuses on material line item costs such as salaries. Therefore, spot bonuses may not have been reviewed if included in an immaterial line item.

2000 Bonus Payments

The same principles discussed above for the 1999 spot bonuses apply to the $208,200 spot bonuses awarded in 2000.

When asked to define the 2000 goals for Medicare, the Executive Director, Medicare Operations stated that ". . . while the Medicare goals were never converted to an AIP (annual incentive plan) like format, meeting all of CMS timeliness and quality standards were the goals of all AHS Medicare areas." However, our review of the minutes of the Human Resources Committee noted that the Medicare program had been included in the

2000 AIP. Specifically, the Committee approved four incentive goals: increased profits, enhanced customer satisfaction, increased number of customers, and improved quality of service. To receive an incentive payment all four goals must be met. Funding for the incentive payments was to be provided by making available $.50 of each additional dollar earned over a base of $2.4 million in operating income, not to exceed 4 percent of salaries. The calculation of the bonus at 4 percent of salaries meant that the FI would need to earn $7.66 million in excess of base income to pay out $2.8 million to salaried employees and over $1 million to wage earners. Salaried employees included those in the FI's Medicare line of business, thus confirming that Medicare associates were included in the incentive plan and required to participate in meeting the established goals.

Even though the established goal of increased profits was not met, the FI claimed $325,176 as a special recognition bonus for the employees who became part of the newly acquired entity. The special recognition bonus was for effort expended in 2000. This bonus plan was formulated without accrual at the end of 2000 and paid in 2001. Among the reasons cited for the payment of this bonus were the efforts of Medicare associates in the successful merger and transition into the Anthem family. Nonetheless, these payments do not meet criteria for deferred compensation set forth in FAR 31.205-6(f)(2), 31.205-6(k), and 31.205-6(a)(1).

The FI attempted to recover the $325,176 in 2000 bonuses by including it in the $1.5 million incentive payments for the 2002 budget. The next section provides details on this matter.

2001 Incentive Payments

First, Federal regulations state that incentive compensation should be based on production, cost reduction, or efficient performance, and established by contract entered or policy in place before services are rendered. FAR 31.205-6(f). Also, costs related to major revisions of existing compensation plans or new plans are not allowable if the FI has not notified the contracting officer either before or shortly after of the changes. FAR 31.205-6(a)(4).

As stated above, the FI submitted a $1,477,901 incentive plan for 2001 only 55 days before the end of the fiscal year. The plan included $325,176 for bonuses paid in 2000. The actual goals for 2001 were disseminated to employees 8 months into the fiscal year, indicating that the plan went into effect after a substantial proportion of services had already been rendered by employees, in violation of FAR 31.205-6(f).

Compounding matters is the difference in opinions regarding the difficulty of the goals. Our assessment of the 2001 goals noted that they were not as demanding as the 2000 goals, which called for increased profits and quality of services. While the FI contends that the 2001 goals are equally as difficult, CMS has stated otherwise and to date the incentive plan has not been approved.

Second, Federal regulations state that compensation to employees must be reasonable and that the burden of proof for establishing reasonableness rests with the FI.

As stated above, the FI did not offer adequate information supporting its bonuses and incentive payments. The FI provided information including two job descriptions indicating that incentive payments for 2001 should have averaged 4.95 percent of salaries. This is in line with the 5 percent rate CMS included in the budget for the FI. However, payouts for 2001 averaged 12.2 percent. Other data provided by the FI addressed summary studies of its total compensation package instead of incentive payments as requested by CMS.

Federal regulations state that it is appropriate for the OIG to assess a single element of compensation. Specifically, FAR 31.205-6(b) states that compensation will be considered reasonable if each of the allowable elements making up the employee's compensation package is reasonable.

ALLOCATION OF SALARIES AND WAGES

Inadequate timekeeping controls caused two FI departments to improperly allocate $456,870 to Medicare, which also resulted in $98,709 of executive office overhead being improperly allocated to Medicare.

Inadequate Timekeeping Controls

OIG found that timesheets did not consistently reflect actual time spent on Medicare and non-Medicare activities because essential time reporting procedures were not followed or codes for recording time were not clear. This resulted in the improper allocation of $456,870 to Medicare.

The Medicare Administrative Manual, chapter 1, "Principles of Reimbursement For Administrative Costs," sections 1221 and 1222, outlines how to complete the cost classification report, Form 2580. The Manual requires contractors to certify that the proposal when submitted is accurate, current, and complete.

The FI's Code of Ethics and Business Conduct (January 4, 1999), section L.2., "Charging of Costs/Timecard/Timesheet Reporting," states that:

> Employees who file timecards/timesheets must do so in a complete, accurate and timely manner. Employees performing services under U.S. government contracts must ensure that hours worked and costs are applied to the account for which they were in fact incurred.
>
> An employee's signature on a timecard/timesheet is his/her representation that the timecard accurately reflects the number of hours worked on the specified project. The supervisor's signature is a representation that the timecard/timesheet has been

reviewed and that steps have been taken to verify the validity of the hours reported and correctness of the allocation of the hours.

Additionally, section L.3., "Contract Negotiation," states "In negotiating contracts, be accurate and complete in all representations. . . . In negotiating contracts with the U.S. government, the Company has an affirmative duty to disclose current, accurate, and complete cost or pricing where such data are required under appropriate law or regulations."

Noncompliant Employee Timesheets

The FI used exception reporting to record and allocate labor costs from October 1998 through December 2000. Specifically, employees were assigned a primary labor code that reflected their regular work activity (for example, direct Medicare or non-Medicare, indirect Medicare or non-Medicare). As required by the FI's Employee Handbook, any variations in the work schedule should have been manually written to a secondary code on the timesheet and used to update the payroll ledger for the given pay period.

We tested 148 timesheets representing 11 of 42 departments/cost centers that worked exclusively on Medicare activities or that allocated significant charges to Medicare and found that the FI did not comply with its written procedures. Our results disclosed that 26 timesheets with time adjustments were not posted to the payroll journal. The timesheets in question came from five departments servicing various lines of business.

The FI's timekeeping practices were also not consistent with its Code of Ethics and Business Conduct policy. These procedures require employees who file timesheets under Government contracts to do so in a complete, accurate, and timely manner. The timesheet should accurately report the number of hours worked by project and be validated by the supervisor.

Inadequate Time Reporting Instructions

We found that the FI was not in compliance with the Medicare Administrative Manual or its own policies. Interviews with management from the departments that allocated their costs to Medicare disclosed that they were unaware of existing timekeeping procedures, and that adjustments to timesheets were for informational purposes only. Labor charges allocated to Medicare were monitored only to compare timesheet charges to budget amounts. We found that:

- The relationship between actual job activities and time charge codes was not clear. Questions arose as to whether a primary code for Medicare or non-Medicare should be assigned to an employee charging time to both.

- Supervisory review and approval of timesheets for salaried employees was not consistent.

Overcharges for Salaries, Wages, and Fringe Benefits

Due to the lack of internal controls, noncompliance with Federal and FI policies, and an inconsistent understanding of timekeeping requirements by management and employees, we could not rely on the process used to charge salaries and wages to Medicare for two departments. Therefore, we used the FI's approach for allocating indirect costs to determine a reasonable amount to charge Medicare--that is, the ratio of Medicare operating salaries to total operating salaries.

	Fiscal Year		
	1999	**2000**	**2001**
Total Salaries	$ 1,525,741	$ 1,585,060	$ 396,967
Ratio of Medicare to Total Operating Salaries	22.46%	22.75%	21.90%
OIG Calculation	$ 342,681	$ 360,601	$ 86,936
Amount Claimed	466,132	554,582	149,776
Amount Overcharged	123,451	193,981	62,840
Related Fringe	24,381	39,165	13,052
Total w/Fringe	147,832	233,146	75,892
Total			**$ 456,870**

Table 2 - Calculation of Indirect Costs for Salaries

As shown in Table 2, we applied the FI's annual operating salary ratio (for example, 22.46% in FY 1999) to total department salaries ($1,525,741 in FY 1999) to calculate a reasonable amount to claim (for example, OIG calculated an amount of $342,681 in FY 1999). The OIG amount was compared to the amount actually claimed by the FI (for example, $466,132 in FY 1999). Any differences were considered overcharges. As a result, we found that the FI overcharged Medicare a net amount of $456,870 in salaries, wages, and fringe benefits for the two overhead departments we tested--External Contracts and General Accounting--from October 1998 through December 2000.

Executive Office Overhead Allocation

FAR 31.201-4, "Determining allocability," 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 . . . a cost is allocable to a Government contract if it (a) Is incurred specifically for the contract; (b) Benefits both the contract and other work, and can be distributed to them in reasonable proportion to the benefits received. . . .

A parent executive department (Government and Legal Affairs) improperly allocated its salaries and wages to Medicare. The department used the proportion of Medicare salaries and wages to total salaries and wages for the units it oversees to allocate its costs to Medicare. The overstated costs to Medicare for External Contracts discussed above resulted in an excessive charge of $98,709 to Medicare.

Conclusions and Recommendation

As a result of the need to adjust charges allocated to Medicare for External Contracts described earlier, the overhead amount used by the parent executive department to allocate to Medicare was overstated. Accordingly, the FI overcharged Medicare $98,709 in salaries, wages, and fringe benefits for the parent executive department from October 1998 through December 2000. We did not include the General Accounting Department since the related costs were not material.

We recommend that the FI reduce its proposal by $555,579 ($456,870 in salaries and $98,709 in excess overhead allocations).

Auditee's Comments

The FI did not agree with this finding. The FI pointed out that the departments at issue in this finding, External Contracts and Government and Legal Affairs, did not base their charges on timesheets, nor was such a methodology required. Specifically, the FI asserted the following:

(1) The allocation for External Contracts was based on estimates of work performed in prior years for three lines of business. The allocation basis was audited by CMS and no exceptions were taken.

(2) The allocation of Government and Legal Affairs was based on the salaries of the departments that reported to it. Salaries, headcount, and work volume are as valid bases as timesheets for allocating costs to government contracts.

OIG Response

Federal regulations state that a cost is allocable if it is assignable or chargeable and if it can be distributed in reasonable proportion to the benefits received. Our review of the allocation of costs for External Contracts noted that the basis for determining estimated work performed in prior years was the assigned primary labor code. As stated above, the primary code is assigned to employees based on regular activity. Any variation in work activity, direct or indirect, should be manually written to a secondary code on the time sheet, which is used to update personnel and payroll records. The requirements for completing time sheets by both exempt and non-exempt employees are contained in both the FI's Employee Handbook and the Code of Ethics and Business Conduct Manual.

These FI procedures state that timesheets are to be used for cost accounting purposes and must be accurate in reflecting the number of hours worked on the specified project.

If exceptions to the primary workload of employees are not accurately reported, the allocation method of estimating work performed in prior years is meaningless because costs may not be distributed in reasonable proportion to direct or indirect cost categories.

Failure to consider exceptions or adjustments in the employee workload for External Contracts would have a "trickle-down" effect in the salaries used as a basis for allocating costs incurred by Government and Legal Affairs. Because External Contracts reported to Government and Legal Affairs, the amount overstated in salaries increased the allocation percentage of Medicare salaries and wages to total salaries and wages.

ACQUISITION AND LOBBYING COSTS

During the period October 1998 through September 2000, the FI's proposals included at least $260,546 in unallowable costs related to acquisition and lobbying activities. These costs included $79,879 in outside professional services and $180,667 in in-house expenses.

Anthem acquired Associated Hospital Services on June 5, 2000. According to the FI's chief legal counsel, the decision to acquire Associated Hospital Services was made around May 1999. Approval for the acquisition was needed from the Maine Department of Insurance. As a condition for approval, a statutory change was needed to ensure that if the charitable nonprofit was acquired, the value of the company would be put in a charitable trust established to benefit the uninsured and underserved population in Maine. Getting this statute drafted, introduced and passed by the legislature required lobbying efforts. Legislative hearings on this matter were held in February 2000. The FI also made lobbying efforts after the acquisition when it filed to change its status to a for-profit entity.

Our review of minutes of the Board of Directors meetings, interviews with the FI's chief legal counsel, and review of related invoices disclosed that significant efforts were expended in exploring and executing Anthem's acquisition of Associated Hospital Service between October 1998 and June 5, 2000. The chief legal counsel estimated that during the acquisition period, half of his time was spent on related activities. (The other executives involved in the acquisition no longer work for the FI and the percentage of time their departments devoted to acquisition and lobbying activities for their departments could not be determined.)

Organization and Lobbying Costs Not Allowed

FAR 31.205-27, "Organization costs," stipulates that expenditures in connection with planning or executing the organization or re-organization of the corporate structure of a business, including mergers and acquisitions and raising capital are unallowable. Expenditures include but are not limited to incorporation fees and costs of attorneys, accountants, brokers, promoters, and organizers, management consultants and investment

counselors, whether or not employees of the contractor. Unallowable re-organization costs also include the cost of any change in the contractor's financial structure.

In addition, FAR 31.205-22(a), "Lobbying and political activity costs," requires that contractors to separately identify lobbying activity costs in their indirect cost rate proposal and treat them as unallowable costs. Lobbying and political activity costs include attempts to influence the introduction, enactment, or outcome of any state initiative or legislation. Unallowable activity also includes communication with state legislature, legislative liaison activities, and attendance at legislative sessions.

Outside Professional Services

The FI claimed $79,879 in outside professional services related to acquisition and lobbying activities for FYs 1999 and 2000. As explained below, employees did not always use the appropriate accounts when recording payments to vendors and also did not apply the appropriate allocation rate when making adjustments for one department.

Our review of 30 outside professional services payments in FYs 1999 and 2000 disclosed that 17 payments were related to unallowable acquisition and lobbying costs. We found that 7 of these 17 payments (41 percent) represented unallowable costs that were excluded by the FI from its proposals. However, the remaining 10 payments (59 percent), totaling $19,276, represented unallowable costs that were not removed by the FI and were included in its claim for Federal reimbursement. An additional $60,603 in unallowable professional services from one department (cost center 160) was inappropriately included for reimbursement.

We found that FI screening procedures were not adequate. While the FI established certain accounts for unallowable legal and lobbying expenses, we found that employees did not always charge these costs to the appropriate accounts. Our analysis of the 10 payments in question noted that unallowable legal, consulting, and lobbying costs were posted to an account that was reviewed only on a cursory basis. We found that this practice was not adequate and did not detect unallowable costs in over 30 percent (10 out of 30 payments) of items sampled. In addition, we found that adjustments in one department (cost center 160) did not eliminate all unallowable costs to Medicare due to use of different allocation rates.

As a result, the FI overcharged Medicare by $79,879 ($19,276 in unallowable charges + $60,603 in incorrect adjustments) in unallowable acquisition and lobbying costs charged by outside professional contractors.

In-House Expenses

The FI claimed $180,667 in unallowable salaries and wages related to acquisition and lobbying activities. This occurred because the FI did not eliminate unallowable activity.

In our review of timesheets for the six departments most involved in acquisition and lobbying efforts during Anthem's acquisition of Associated Hospital Service, we noted that employees did not distinguish salaries and other costs related to the acquisition as unallowable.[2] Instead, they recorded all costs to indirect cost accounts that were allocated to all lines of business, including Medicare. Consequently, the FI was not in compliance with both Federal regulations and its Code of Ethics and Business Conduct policy requiring employees to eliminate unallowable costs from Government programs.

Noting the percentage of time the chief legal counsel spent on lobbying and acquisition activities, we determined that 21 percent of his salary was unallowable in FY 1999 and 33 percent was unallowable in FY 2000. We used these percentages for all six departments and recalculated the Medicare share using the FI's allocation process.

Conclusion and Recommendations

We found that although the FI had a process in place to distinguish unallowable costs for outside professional services, it did not have a similar process for in-house expenses. As a result, Medicare was overcharged $180,667 in unallowable salaries, wages, and fringe benefits related to acquisition and lobbying activities in FYs 1999 and 2000. This amount does not include other departments involved in the acquisition (for example, Human Resources, Accounting, and Finance).

We recommend that the FI:

- reduce its proposal by $260,546 ($79,879 in outside professional services and $180,667 in in-house expenses; and

- remove all salaries, outside legal, consulting, and professional services accounts; remove any other related costs charged to Medicare to ensure that costs related to acquisition and lobbying activities are not claimed for Federal reimbursement; and reduce its proposals accordingly.

Auditee's Comments

The FI generally concurred with this finding. However, the FI questions whether time spent by the legal department on the acquisition should represent time spent by all of senior management. Further, the FI believes that some of the amounts questioned relate to "transitioning" into the FI's business practices and systems, and are not part of the acquisition.

[2] The six departments are the President's Office, the Office of the Chief Executive Officer, Government and Legal Affairs, Corporate Affairs, Treasurer's Office, and Business Development. Not included in our review were the Human Resources, Accounting, and Finance Departments.

OIG Response

Federal regulations disallow costs related to lobbying and political activity and to reorganizing the corporate structure.

Based on our review of Board of Directors' minutes, interviews with chief legal counsel, and review of invoices for legal and professional services, the amount of time expended by the legal department is representative of time spent by senior management. Senior management made extensive public relations and legislative lobbying efforts to obtain the statutory changes it needed to allow for a successful acquisition, including the establishment of an $80 million charitable trust.

Not only is the percentage of time we used to calculate acquisition costs reasonable, but our approach generated conservative results. Foremost, we provided the FI with the opportunity to remove its claim for acquisition, financing, and lobbying costs. Because the FI declined to do so, we tested six executive departments using the best available information. Other departments with unallowable in-house reorganization costs that we did not review include but are not limited to the Accounting, Finance, and Human Resources Departments. The FI argues that some of these acquisition costs were really "transitioning' costs to avoid the unallowable cost designation. However, without more specific information and documentation, such "transitioning" costs could well be costs associated with the reorganization which should be disallowed. FAR 31.205.27.

OUTSIDE LEGAL AND CONSULTING FEES

During the period October 1998 through September 2000, the FI allocated $60,366 in outside legal and consultant fees directly to Medicare for services related to its private lines of business. This occurred because it had no written procedures for ensuring the consistent treatment of similar costs.

The contract between the FI and CMS stipulates that the criteria for determining the allocation of costs to a product, contract, or cost objective should be the same for all similar cost objectives. Specifically, the FI's Medicare contract with CMS, Appendix B, "Principles of Reimbursement for Administrative Costs," section II, "Accounting Practices," part B, "Consistency in Allocating Costs for the Same Purpose" states:

> The contractor shall be required to provide assurance that each type of cost is allocated only once and only on one basis to the contract or other cost objective. The criteria for determining the allocation of costs to a product, contract or other cost objective should be the same for all similar cost objectives. Adherence to these cost accounting concepts is necessary to guard against the overcharging of some cost objectives and to prevent double counting. Double counting occurs most commonly when cost items are allocated directly to a cost objective without eliminating like cost items from indirect cost pools, which are allocated to that cost objective.

Standard practice would require that the Legal Department, which handles both government and private side cases to directly charge costs when they can be identified to a particular line of business and allocate costs that benefit the organization.

The FI did not consistently apply standard allocation practices. For example, at least $266,695 for 10 legal cases directly relating to the FI's private lines of business was included in the Legal Department's cost pool and allocated to all lines of business. Medicare received $60,366 in the allocation of these costs. Yet, in another instance, the FI directly charged or assigned Medicare all of the $271,113 in legal and consulting costs in FY 1999 for a Government investigation.

Conclusions and Recommendations

Based on our discussions with Legal and External Contracts officials, we found that the FI does not have written procedures to enforce compliance with Medicare contract requirements for the consistent treatment of legal or consulting fees, including which department(s) should absorb these costs under various circumstances. As a result, the FI overcharged Medicare $60,366 for legal fees.

We recommend that the FI:

- establish procedures to ensure that similar costs are treated in a consistent manner,
- reduce its proposal by $60,366, and
- remove all legal and consulting fees charged to Medicare to ensure that costs directly relating to its private lines of business were not claimed for Federal reimbursement and reduce its proposal accordingly.

Auditee's Comments

The FI concurred with this finding.

DATA PROCESSING COSTS

During the period October 1998 through December 2000, the FI allocated $634,724 in data processing costs to the Medicare program without maintaining detailed support for services rendered or the allocation method used.

FAR 31.201-2(d), "Determining allowability," states:

> A contractor is responsible for accounting for costs appropriately and for maintaining records, including supporting documentation, adequate to demonstrate that costs claimed have been incurred, are allocable to the contract, and comply with applicable cost principles in this subpart and agency supplements. The contracting officer may disallow all or part of a claimed cost which is inadequately supported.

FAR 31.201-4, "Determining allocability," 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. . . a cost is allocable to a Government contract if it (a) Is incurred specifically for the contract; (b) Benefits both the contract and other work, and can be distributed to them in reasonable proportion to the benefits received. . . .

The FI's data processing costs were allocated monthly to various lines of business, including Medicare, using a computer program that applied usage charges for different functions. The FI recorded the calculated amount to the general ledger each month. We could not determine whether the amount recorded was an actual cost or a standard allocation to be compared to actual costs at year-end. Furthermore, we could not ascertain the type of costs that were included in the monthly charges.

Conclusion and Recommendations

The FI did not maintain documentation to support its data processing charges as required by Federal criteria. Moreover, we found that documents demonstrating how the computer program works were not available, and individuals who were knowledgeable about the computerized allocation no longer worked for the FI. As a result, we could not determine whether the $634,724 in data processing costs was properly allocated to Medicare.

We recommend that the FI:

- provide documentation to CMS on how data processing costs are allocated to Medicare, and

- reduce its proposal by any part of the $634,724 that cannot be supported.

Auditee's Comments

The FI asserted that access to individuals who have knowledge of the allocation system is not necessary because the allocation methodology was reviewed and tested in previous OIG audits and no findings were noted. The FI referred to an audit of costs claimed for FYs 1985 through 1990 by a public accounting firm. Further, the FI asserted that the data processing costs claimed are reasonable because the actual costs over the 3-year period were reduced from 8 cents per unit to 3 cents per unit.

OIG Response

Federal regulations require that costs claimed be reasonable, allowable, and allocable. Accordingly, the FI is responsible for maintaining records to demonstrate that costs claimed have been incurred, are allocable, and comply with cost principles. The reference to an audit performed 8 years earlier is not a valid basis to support costs from October

1998 through December 2000, nor does it demonstrate how the $634,724 was allocated to Medicare.

REPORTING ERRORS

We found that the FI did not have written procedures to ensure compliance with Federal and FI policy for preparing and submitting accurate, complete, current, and timely proposals. The FI's practice primarily relied on the format used in prior years, resulting in a $1.4 million reporting error, as explained below.

The Medicare Administrative Manual requires FIs to certify that their proposals are accurate, current, and complete when submitted. The FI contract requires that a proposal be submitted as soon as possible but no later than 90 days after fiscal year end.

The FI's Code of Ethics and Business Conduct (January 4, 1999), section L.3., "Contract Negotiation," states that "In negotiating contracts, be accurate and complete in all representations . . . In negotiating contracts with the U.S. government, the Company has an affirmative duty to disclose current, accurate, and complete cost or pricing where such data are required under appropriate law or regulations."

After our audit fieldwork began, the FI submitted a revised FY 2001 proposal dated September 25, 2002--its fifth for fiscal year 2001, and submitted nearly a full year after the end of that fiscal year. It included an adjustment for overstated pension costs. Our review of the FI's reconciliation of the September proposal to supporting records noted nearly $1.4 million in pension costs that had been erroneously claimed in its prior FY 2001 proposals. The overstatement was not detected and corrected until almost a year after the end of the fiscal year. FI officials stated that the correction was necessary because pension contributions were not required for FY 2001.

This practice was not consistent with the FI's Code of Ethics and Business Conduct policy requiring employees to provide current, accurate, and complete cost or pricing data for Government contract negotiations. CMS used the FI's FY 2001 proposals to establish the FI's Medicare administrative cost budget for FY 2003. CMS indicated it was unaware that the September proposal included a significant correction for pension costs. Our discussions with CMS disclosed that, in establishing the FI's FY 2003 budget, CMS would have relied on an earlier version of the FY 2001 proposal that included the overstated pension costs.

Conclusion and Recommendations

We found that the FI was not in compliance with both applicable Federal requirements and its own policy to ensure that costs claimed in its proposals are current, accurate, and complete. As a result, the FI overstated its prior proposals by $1,386,930 (rounded to $1.4 million) in pension costs for FY 2001. The amounts in question included:

- $835,907 in duplicated pension contributions claimed in the prior FY, and

- $551,023 in inappropriate home office allocations for pension costs.

We recommend that the FI:

- establish written procedures to ensure that proposals are current, accurate, and complete and submitted timely to CMS; and

- work with CMS to ensure that the $1.4 million reporting error for pension costs is not included in future budget periods.

Auditee's Comments

The FI asserted that the FY 2001 proposal was adjusted timely based on information received by Associated Hospital Service regarding the pension evaluation. Budgets are normally due to CMS long before the proposal is completed. In addition, the FI pointed out that the proposal from prior periods is not utilized as a basis for determining the subsequent year budget.

OIG Response

Medicare contract provisions and internal policies require FIs to submit accurate, current, and complete financial information to CMS.

According to an FI official, the pension fund was to be fully funded as part of the acquisition. Based on an evaluation by the actuary, the FI fully funded its pension on October 9, 2000. The Medicare share was $835,907. The FI official explained that due to high returns on pension assets, a pension contribution for FY 2001 was not required. However, the FY 2001 proposals submitted by the FI included $1.4 million in duplicate pension costs ($835,907 Medicare share) and unallowable home office pension costs ($551,023 Medicare share). The $1.4 million overstatement was corrected about 9 months later in their September 25, 2002 proposal, after the FY 2003 budget was approved by CMS. According to a CMS official, prior year's proposals, year-to-date actuals, and proposed budgets are used to establish future funding.

A P P E N D I CES

Appendix A

ANTHEM HEALTH PLANS OF MAINE
FINAL ADMINISTRATIVE COST PROPOSALS
FOR THE FISCAL YEARS ENDED SEPTEMBER 30, 1999, 2000, AND 2001

Operation	COSTS CLAIMED BY FISCAL YEAR 1999	2000	2001	Total
Bills/Claims Payment	$ 4,727,232	$ 5,186,943	$ 5,254,881	$ 15,169,056
Appeals/Reviews	1,199,883	1,350,422	1,741,855	4,292,160
Inquiries	1,308,870	1,892,168	964,915	4,165,953
Provider Education and Training	447,094	516,484	490,147	1,453,725
Reimbursement	1,297,154	1,537,006	1,457,199	4,291,359
Productivity Investments	108,284	580,864	180,988	870,136
Provider Telephone Inquiries	-	-	676,810	676,810
Credits	(928,314)	(726,776)	(632,077)	(2,287,167)
Medical Review	4,811,630	4,840,813	4,665,595	14,318,038
Medicare Secondary Payer	1,697,853	1,584,627	1,876,174	5,158,654
Benefits Integrity	774,567	685,802	747,863	2,208,232
Provider Education and Training	59,571	78,656	184,839	323,066
Audit	5,516,040	5,373,974	6,068,064	16,958,078
Total	**$ 21,019,864**	**$ 22,900,983**	**$ 23,677,253**	**$ 67,598,100**

Appendix B

ANTHEM HEALTH PLANS OF MAINE
SUMMARY OF OAS RECOMMENDED ADJUSTMENTS
FOR THE FISCAL YEARS ENDED SEPTEMBER 30, 1999, 2000, AND 2001

Finding Category	1999	2000	2001	Total	Page
INCENTIVE PAYMENTS					3
(1) FY 1999 Bonus Payments	$ 192,400			$ 192,400	4
(1) FY 2000 Bonus Payments		$ 208,200		208,200	4
(3) FY 2001 Incentive/Bonus Payments			$ 1,477,901	1,477,901	5
ALLOCATION OF SALARIES AND WAGES					10
(1) Inadequacy Timekeeping Controls	147,832	233,146	75,892	456,870	10
(2) Executive Office Overhead Allocation	15,751	68,102	14,856	98,709	12
ACQUISITION AND LOBBYING COSTS					14
(1) Outside Professional Services	70,271	9,036	572	79,879	15
(2) In-House Expenses	64,613	116,054	-	180,667	15
OUTSIDE LEGAL AND CONSULTING FEES	33,047	27,319	-	60,366	17
Total	**$ 523,914**	**$ 661,857**	**$ 1,569,221**	**$ 2,754,992**	

Appendix C

ANTHEM HEALTH PLANS OF MAINE
SUMMARY OF (1) OAS RECOMMENDED COST SET ASIDES AND (2) REPORTING ERRORS
FOR THE FISCAL YEARS ENDED SEPTEMBER 30, 1999, 2000, AND 2001

Finding Category	1999	2000	2001	Total	Page
DATA PROCESSING COSTS	382,354	177,221	75,149	634,724	18
REPORTING ERRORS	-	-	1,386,930	1,386,930	20
Total	**$ 382,354**	**$ 177,221**	**$ 1,462,079**	**$ 2,021,654**	

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

October 14, 2003

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services
Region 1
John F. Kennedy Federal Building
Boston, MA 02203

Re: Report Number: A-01-02-00525

Dear Mr. Armstrong:

Enclosed is Associated Hospital Service's response to the Office of Inspector General draft report entitled "Review of Medicare Part A Administrative Costs Claimed by Anthem Health Plans of Maine – October 1998 through September 2001." The OIG report findings relate to the following areas:

- Incentive/Bonus Payments
- Allocation of Salaries and Wages
- Acquisitions and Lobbying Costs
- Outside Legal and Consulting Fees
- Costs Set Aside for CMS to Assess for Appropriateness
- Reporting Errors

AHS' response addresses each of these above areas in the order presented in your report. If you or your staff have any questions, please contact me at (317) 841-4510 or David C. Crowley, AHS Executive Director, Medicare Operations at (207) 822-8623.

Thank you.

Sincerely,

Michael E. McCarron
Medicare Operations Officer

cc: Pat Volk, CMS
Charlotte Yeh, CMS
Jim Bryant, CMS
Ava Chung, CMS
David Crowley, AHS

AHS

Associated Hospital Service

Response to OIG Report Number: A-01-02-00525

"Review of Medicare Part A Administrative Costs Claimed by Anthem Health Plans of Maine – October 1998 through September 2001"

A. BONUS AND INCENTIVE PAYMENTS TO EMPLOYEES

The OIG report challenges the incentive and bonus payments of Blue Cross Blue Shield of Maine and Anthem Health Plans of Maine (collectively "AHS") on the basis that the payments did not meet at least one of four "Federal requirements". AHS disagrees.

FAR Part 31.205 – 6(a) acknowledges that compensation to employees for personal services can include a variety of components, including bonuses and incentive plans. Pursuant to FAR 31-205 – 6(f), bonuses and incentive compensation based on production, cost reduction or efficient performance are allowable expenses if the awards are **either** (1) per an agreement between the contractor before the services are rendered, **or** (2) pursuant to an established plan or policy followed by the contractor so consistently as to imply, in effect, an agreement to make such payment and the basis for the award is supported.

The bonus and incentive payments made in good faith by AHS' to its employees were made pursuant to an established plan or policy followed by AHS and qualify as allowable expenses as described more particularly for each year, as follows:

(1) FY 1999 Bonus Payments

In 1999, bonuses awarded by the Government Programs Vice President were not part of an overall incentive plan. Rather, the bonuses paid, totaling $192,400, were spot bonuses paid at year-end (9/30) to recognize Medicare associates who had made a significant contribution to the success of the Government Programs (Medicare) unit during the fiscal year. Not all Medicare associates received the award - - only those who earned distinction in view of the Vice President, Government Programs. All amounts paid to associates at year-end were also approved by the President of Blue Cross and Blue Shield of Maine.

The practice of awarding year-end performance bonuses began in the early 1990's. Several FACP filings for years 1991 – 1998 have included these year-end performance bonuses. BCBSME's FACPs through 1998 have been audited by HCFA (CMS) and no findings or recommendations regarding the year-end performance award were noted. The spot bonus practice to reward outstanding performance was well established. The Report also recognizes that CMS approved those performance awards. If CMS now has concerns about the allowability of spot bonuses, AHS would invite discussions regarding future treatment of spot bonuses. However, with respect to bonuses already paid in good faith by AHS to its employees in recognition of outstanding service to the Medicare program, AHS firmly believes those payments are allowable.

(2) FY 2000 Bonus Payments

In FY 2000, the same spot bonus program was in place as for 1999. The FY bonus program was commensurate with the same prior practice as described above in connection with the 1999

bonus payments. Pursuant to that program, AHS paid its employees a total of $208,200 for individual instances of exceptional performance in support of the Medicare program. The Report's statement: "The incentive goals for FY2000 included increased (1) profits, (2) customer satisfaction, (3) number of customers, and (4) quality of services. All four goals had to be achieved for employees to receive an incentive payment" is a recitation of Blue Cross and Blue Shield of Maine's ("BCBSME") goals for its private business, and not descriptive of AHS' goals for Medicare work. Similarly, the Report's statement, "...AHS paid employees $208,000 in incentives even though the goal of increased profits had not been met", is based on that same incorrect premise. Again, the goal relating to profits was a BCBSME, not AHS, goal. AHS Medicare associates were unable to materially impact profits or have any affect on private BCBSME customers. As stated above - - the Medicare unit performance bonuses were not tied to BCBSME profitability but to Medicare unit successes. Also, we should recognize the presence of an overarching goal during this period of time, Y2K. This goal was, in fact, met by Medicare associates and entailed a huge amount of effort by all. Thus, for the reasons outlined above with respect to the FY 1999 Bonuses, we firmly believe these FY 2000 bonuses qualify as allowable expenses.

In mid-2000, Blue Cross and Blue Shield of Maine was acquired by Anthem Insurance Companies, Inc. ("Anthem"), and the Part A Fiscal Intermediary contract was novated to Anthem Health Plans of Maine, Inc. (Anthem Health Plans of Maine retained "Associate Hospital Service" as a d/b/a. Thus, we will continue to refer to the Medicare operations in Maine as "AHS".)

In February, FY2001, Anthem paid all BCBSME (Anthem Health Plan of Maine) associates a year-end 2000 bonus of which $325,176 was paid to AHS Medicare associates. This payment by Anthem was based on company-wide year-end 2000 performance and the all associate effort to smoothly transition into Anthem while maintaining high level of Medicare performance. A spot bonus was paid in recognition of this performance, however, it was not part of the formal Anthem Incentive (AIP) Program. The $325,176 paid in February 2001 was not included in the CMS approved FY2001 budget. However, based on discussions with the CMS Boston Regional Office, AHS was directed to charge the expense on a paid basis and thus include it in expenses for FY2001.

(3) FY2001 Incentive Payments

In FY 2001, AHS, a new company and member of the Anthem family of companies, followed Anthem's overall compensation program for its employees that included an Annual Incentive Program (AIP). The AIP program was an established Anthem program announced to Anthem associates early in the year. Documentation on this program was provided to OIG during the audit.

Medicare unit AIP goals were set early in calendar 2001, and addressed responsibilities of every associate in the Medicare unit. AIP payments were made in good faith by AHS, for meeting legitimate goals relating to the administration of the Medicare program. The OIG states "...goals established for FY2001 were not nearly as demanding as the goals for FY2000". However, as outlined above, the 2000 goals cited by the OIG were not goals that pertained to Medicare. Thus, a comparison to the 2001 AIP Medicare goals is not relevant. In any event, AHS believes its 2001 AIP Medicare goals were appropriate.

AIP Goal #1 related to the successful migration of the NH financial operations to the finance unit in AHS. This goal called for the transfer of all budget processes including development, ongoing monitoring, reporting, and communicating with CMS regarding budget issues. All members of NH Medicare management were included in this activity as well as the finance unit (External Contracts) of AHS. In addition, responsibilities for accounting and CFO reporting were

transferred to AHS as part of this goal. This activity included a significant level of coordination and involved more than just "migrating a small number of staff..." as the OIG states. This goal involved staff from several areas in Medicare including Audit & Reimbursement, MSP, and Medical Review. The net result of successfully achieving this goal was a significant improvement in the finance capability of NH - improved budgeting and reporting. Also, we achieved a much-improved CFO reporting process which impacts all Medicare associates, results which were consistent with previous CMS directives regarding the need for improved contractor financial reporting.

AIP Goal #2 related to maintenance of a high level of compliance. The area of compliance is, of course, very important to contractors and CMS, and is relevant to all aspects of the Medicare program. The goal measurement was attendance at a compliance training course - - but the overall objective was to heighten the awareness of the importance of compliance overall.

AIP Goal #3 related to the CMS Security Initiative as reflected in Change Request 1439. This goal included eight specific activities related to CR 1439 such as security self-assessment, submission of security plan, annual compliance audit on security, triennial risk assessment as well as performing all security related tasks within CMS approved budget. The audit report minimizes the effort required the CMS Security initiative because all contractors were required to do it. We find that logic flawed. A similar statement could be made regarding Y2K - - since every contractor was required to do it, becoming Y2K compliant was not difficult.
The Medicare unit AIP 2001 goals did not include increased profits, customer satisfaction, number of customers as these goals relate to private Anthem business goals. The Medicare goals were difficult and addressed areas of great importance to CMS and to AHS as a contractor. Areas such as finance, compliance, and security effect all Medicare associates and address the importance of maintaining our efforts to mitigate risk to the program. Reducing risk has great benefit to the program overall.

Finally, we note that on Page 6, the OIG states AHS claims processed remained constant during 1999-2001 period while administrative costs increased by nearly 8 percent, presumably inviting the reader to conclude that AHS has somehow failed to work effectively to contain costs. However, based on AHS review of FACP information for other contractors for this same period, AHS three-year increase was well below the average for all Part A contractors which was 14.47%.

Excessive Payouts

OIG states the $761,690 exceeded the 5 percent rate generally accepted by CMS. CMS has not shared information or guidelines with AHS showing its study or analysis supporting the 5 percent (or any other rate) as an acceptable rate. The OIG report also states "CMS believes that the market information for incentive payment rates averages about 5 percent for the industry." Again, there is no study or information substantiating this claim. AHS shared with CMS a comparison of total compensation levels in which it was shown that Anthem (and AHS) was in a competitive range with other national insurers and Medicare contractors. Surveys used by Anthem were conducted by William Mercer, Towers-Perrin, Watson Wyatt and others and Rhodeback and Associates focused report on Medicare and Medicaid contractors. Companies who participate in the surveys include Highmark, Care First, Empire, BCBS of Florida, BCBS of South Carolina, BCBS Alabama, BCBS Montana, BS of California, HUMANA, Independence BC, Primera BC, Providence Health Systems, the Regents Group and United Government Services.

OIG/CMS have focused on one component of compensation. They have not examined other elements of compensation such as medical benefits, retiree medical benefits, pension, etc. to determine if Anthem is comparable to other contractors. In fact, when Anthem/AHS examined

the total compensation package including all benefits, salary and wages, the data shows Anthem/AHS comparable to others and certainly not the highest. The Report's conclusion that a single component of compensation is more than what the OIG deems reasonable without comparing other elements of compensation costs - - has resulted in the OIG drawing an unsupported finding. We believe that companies must be free to design compensation programs that attract and retain a high quality workforce. Dictating what percentage of compensation must be base salary, what percentage must be bonuses, what percentage must be disability, what percentage must be health benefits appears to go beyond any contractual relationship that we have entered into.

B. ALLOCATION OF SALARIES AND WAGES - $555,579

The draft Report challenges a total of $555,579 in charges on the basis that time sheets do not consistently reflect actual time spent on Medicare and non-Medicare activities. The departments at issue in this finding are External Contracts and the Senior Vice President of External Affairs. These departments did not use time sheets as the basis for allocating their costs, nor is such a methodology required.

External Contracts was established in 1997 when AHS was awarded the Massachusetts Medicare Part A contract. External Contracts handled the finance for three distinct lines of business: Medicare, FEP, and Minnesota TPU. The allocation for External Contracts was determined by the required work related to each line of business. This allocation methodology (based on estimated work performed was used in prior audited years and no findings were reported.

The Senior Vice President of External Affairs, Edward Kane, managed the Medicare, FEP, and Minnesota Programs including all operations pertaining to the programs. The allocation for this department was based on the departments that reported to it, i.e. salaries of the departments. This allocation methodology was consistently used for all senior management at BCBSME. Copies of staff performance reviews and individual staff goals were reviewed and they confirmed the validity of the method as well as the reasonableness of percentages derived. The audit implies that the use of time sheets would be the only acceptable allocation method. However, percentage of work volume, salaries supervised and headcount are equally valid bases for allocation in government contracts.

C. ACQUISITION AND LOBBYING COSTS - $265,546

OIG had conversations with the Legal staff during the course of its audit which led the OIG to conclude that the time spent on acquisitions and lobbying by the legal staff, represented the work performed or time spent by all senior management. The legal department spent a large amount of time on the merger with Anthem, however, this percent should not be applied to all senior management.

The unallowable costs noted in the OIG report are being researched. Some of the invoices referenced pertain to transitioning to Anthem business practices and systems and are not part of the acquisition.

D. OUTSIDE LEGAL AND CONSULTING FEES - $60,366

In reviewing the list of expenses in this area provided by OIG, it appears that these costs should have been removed from the Final Cost Proposal. AHS is requesting copies of these invoices to ensure the disallowed portion of costs is properly stated.

E. COST SET ASIDE FOR CMS TO ASSESS FOR APPROPRIATENESS - $5,500,000

We did not render an opinion on the allocation of $5.5 million in salaries in our draft report. Based on our review of additional information provided by the FI, the allocated costs appear reasonable and related recommendations no longer apply.

F. DATA PROCESSING COSTS - $634,724

As OIG states, individuals who had knowledge of the computerized allocation system no longer work for the FI. Access to them should not be necessary. This allocation methodology was reviewed and tested in previous OIG audits and no findings were noted. In researching the reasonableness of the data processing costs, the actual costs over the three year period in question demonstrate AHS' cost containment efforts by reducing from $.08 per unit to $.03 per unit over the 1998 to 2000 period. This allocation methodology was no longer used once AHS used Anthem's general ledger.

G. PENSION

The FACP 2001 was adjusted timely based on the information received by AHS regarding the pension evaluation. Budgets are normally due to be submitted to CMS long before the FACP is completed. In addition, the FACP from prior periods is not utilized as a basis for determining the subsequent year budget.