Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PART B ADMINISTRATIVE COSTS

FISCAL YEARS 1995 – 1997

HIGHMARK, INC. CAMP HILL, PENNSYLVANIA

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INSPECTOR GENERAL

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Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

This report presents the results of an Office of Inspector General (OIG) review of administrative costs claimed by Highmark, Inc, d/b/a HGSAdministrators (HGSA) for the administration of the Medicare Part B program for Fiscal Years (FYs) 1995 through 1997 (October 1, 1994 - September 30, 1997). During the period under review, HGSA claimed a total of $299,169,893 in Medicare administrative costs.

The Medicare Part B program is administered by the Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (HCFA), with the assistance from public or private organizations known as Carriers. The Carriers are responsible for establishing safeguards against unnecessary payments, as well as the receipt, review, audit and payment of Medicare Part B claims in designated geographical areas. The HGSA is the Carrier responsible for processing Medicare Part B claims and executing the day-to-day operations of the Medicare program in Pennsylvania.

Program regulations governing the administrative costs reimbursed under the Medicare program are contained in Chapter 1, Part 31 of the Federal Acquisition Regulation (FAR), as interpreted and modified by Medicare contracts, and the Carrier Manual.

OBJECTIVE

The primary objective of our review was to determine whether cost claimed on the Final Administrative Cost Proposals (FACPs) for FYs 1995 through 1997 presented fairly the allowable costs of administration of the Part B program in conformity with reimbursement principles as outlined in Appendix B of the Medicare contract "Principles of the Reimbursement for Administrative Costs" and the provisions of Part 31 of the FAR.

SUMMARY OF FINDINGS

The HGSA claimed Medicare Part B administrative costs for FY 1995 through 1997 as follows:

Fiscal Year	Total
1995	$103,490,483
1996	98,439,877
1997	97,239,533
Total	**$299,169,893**

Our review showed that HGSA booked administrative cost totaling $341,347,731 or $42,177,838 in excess of claimed cost of $299,169,893. The majority of this difference is due to revenue (Complementary Credits) that HGSA received from supplemental

insurance companies who purchased Medicare claims data to use in processing supplemental claims. This revenue was applied against total booked expenses and served to reduce the expenses claimed (billed) on the Final Administrative Cost Proposals. Based on our review, we determined that HGSA could use only $1,048,349 of excess booked cost to offset any reported findings.

Of $299,169,893 in claimed administrative cost, HGSA allocated unallowable and unsupported cost totaling $1,864,916 to the Medicare Part B program. These cost consist of $1,224,793 in unallowable cost and $640,123 in unsupported or insufficiently supported cost.

The unallowable costs consisted of the following:

Category	**Amount**
Cost Overrun	$ 53,536
Complementary Credit	921,718
Executive Compensation	243,952
Fixed Assets	904
Productivity Investments	4,683
TOTAL	**$1,224,793**

There was also $640,123 in claimed cost for which supporting documentation was not provided or documentation was not sufficient to determine the allowability of the cost.

OTHER MATTERS

We are not rendering an opinion on FY 1995 reported Medigap credits totaling $478,418 because of the significant amount of unsupported Medigap billings. In addition, CMS and HGSA need to resolve the write-off of $58,034 in erroneous Complementary Credit transfers that HGSA adjusted in FY 1998 and 1999, which included $15,033 in FY 1997 credits.

RECOMMENDATIONS

We recommend that HGSA:

- coordinate with CMS to reduce the cost claimed for FY 1995 through 1997 FACPs by $1,224,793,

- provide adequate documentation for unsupported costs of $640,123 or make the appropriate adjustment to the FACPs,

- review its cost allocation system to ensure that unallowable costs, including the type identified in this report, are not allocated to the Medicare program,

- report all Complementary Credits on the accrual basis as prescribed by the Medicare Carriers Manual, and

- obtain approval from CMS to establish partial payment procedures for Complementary claims and the write-off of $58,034 in unpaid Complementary claim credits.

On January 25, 2002, HGSA responded to a draft of this report. While HGSA agreed that there were certain costs that were inappropriately charged to the Medicare program and other costs were not sufficiently supported, HGSA generally did not agree with the OIG's findings. The HGSA also provided additional clarifying information that we included in the final report.

We have reviewed HGSA's response and have not changed our position since HGSA has not provided any additional information that would cause us to change our findings, conclusions or recommendations. We have summarized HGSA's response after each finding area along with our comments and have included the HGSA 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.

The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA) with assistance from public or private organizations known as Carriers. The Highmark, Inc. d/b/a HGSAdministrators (HGSA) is the Carrier responsible for processing Medicare Part B claims and executing day-to-day operations of the Medicare program in Pennsylvania

The HGSA is reimbursed for its costs under the terms of the contracts with CMS under the principle of neither profit nor loss. The HGSA is entitled to reimbursement of all allowable costs claimed on the Final Administrative Cost Proposal (FACP), provided that the required provisions of the Medicare contract have been met. Appendix B of the contract and referenced Federal regulations, primarily Part 31 of the Federal Acquisition Regulation (FAR), identify allowable administrative costs that may be reimbursed.

The CMS and HGSA negotiate an annual budget for administrative costs. The CMS approves an annual budget by issuing a Notice of Budget Approval (NOBA). From October 1, 1994 to September 30, 1997 (Fiscal Years (FYs) 1995 through 1997), CMS approved NOBA's totaling $299,116,357 and HGSA claimed administrative costs of $299,169,893 for processing Medicare Part B claims in excess of $4.5 billion.

OBJECTIVE, SCOPE AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. The primary objective was to determine whether HGSA's Medicare Part B FACPs for FYs 1995 through 1997 presented fairly the allowable costs of administration in conformity with the reimbursement principles contained in Chapter 1, Part 31 of the FAR, as interpreted and modified by the Medicare contracts, and the Carrier Manual. We reconciled the FACPs to the accounting records, compared the Medicare and Corporate allocation rates, reviewed various types of documentation, including, but not limited to, payroll registers, subsidiary ledgers, vendor invoices, statistical data, lease agreements, and time and attendance records. All financial adjustments made in this report are based on cost allocation rates applied by HGSA's Cost Allocation department.

As part of our audit, we performed a limited review of HGSA's systems of internal control for the accounting and reporting of administrative costs incurred under the program, to the extent we considered necessary to evaluate the systems and determine compliance with contractual and administrative requirements.

We performed audit procedures necessary to achieve the objectives of the audit. We used judgmental sampling techniques to select a sample of administrative costs for review from 69 of 469 cost centers. Among the categories of costs selected for review were:

- Complementary Credits
- Executive Compensation
- Productivity Investments (PIs)
- Fixed Assets
- Leased Facilities/Occupancy Cost
- Cost Allocation
- Payroll
- Accounts Payable

In reviewing the allowability and allocability of selected costs, we considered whether the costs incurred were: (1) allowable; (2) reasonable; (3) approved; (4) adequately supported (5) beneficial to Medicare; and (6) deemed to be assignable to Medicare in view of the provisions contained in the FAR, Medicare contracts, and the Carrier Manual.

Our review was performed during the period of January 2001 to August 2001 at HGSA offices in Camp Hill, Pennsylvania.

RESULTS OF AUDIT

During FYs 1995 through 1997, HGSA claimed administrative costs totaling $299,169,893 or $42,177,838 less than booked costs of $341,347,731. The administrative costs claimed by HGSA included $1,224,793 in unallowable cost and $640,123 in unsupported costs for which the documentation supporting the expense was either not provided or proved inadequate to determine the nature, type, reasonableness, or necessity of the expense. Also, as described in the Other Matters section of this report, we are not rendering an opinion on reported Medigap credits totaling $478,418 in FY 1995 because of the significant amount of unsupported billings. In addition, CMS and HGSA need to resolve the write-off of $58,034 in erroneous Complementary Credit transfers that HGSA adjusted in FY 1998 and 1999 claimed Complementary Credits. This includes $15,033 written off for FY 1997. The questioned costs are summarized below.

Schedule of Total Questioned Cost

	FY 1995		FY 1996		FY 1997		TOTAL	
Reconciliation								
Excess Cost	(41,020)		(953,793)		(53,536)		**(1,048,349)**	
Audit Findings	**Unallowable**	**Unsupported**	**Unallowable**	**Unsupported**	**Unallowable**	**Unsupported**	**Unallowable**	**Unsupported**
Cost Over Run					$53,536		**$53,536**	
Comp Credit	1,125,053		346,242		(549,577)		**921,718**	
Executive Comp			75,112		168,840		**243,952**	
Fixed Assets	228	11,388		355	676		**904**	**11,743**
Productivity Investments	4,683	27,583		9,779			**4,683**	**37,362**
Accounts Payable		260,543		210,268		120,207		**591,018**
Total	**$1,129,964**	**$299,514**	**$421,354**	**$220,402**	**$(326,525)**	**$120,207**	**$1,224,793**	**$640,123**

RECONCILIATION OF BOOKED COSTS TO CLAIMED COSTS

As a result of our reconciliation of booked cost of $341,347,731 to claimed costs of $299,169,893 for FYs 1995 through 1997, we determined that HGSA recorded unclaimed costs of $42,177,838 on their accounting records. Although these costs were not claimed by HGSA, we found that the adjusted booked balance for unclaimed costs that can be used to offset reported questioned costs should be $1,048,349; not $42,177,838 as reported on HGSA accounting records. The majority of the difference between the accounting records and the FACPs is attributable to revenue (Complementary Credits) received from supplemental insurance companies who purchase Medicare claims data for use in processing supplemental claims. This revenue was applied against total booked expenses and served to reduce the costs claimed on the FACP. The following schedule illustrates the reconciliation of booked cost to claimed cost.

	FY 1995	FY 1996	FY 1997	TOTALS
Medicare Cost File "Booked Cost"	$119,788,901	$114,395,091	$107,163,739	$341,347,731*
Comp Credits/Other Credits	(14,874,872)	(16,162,899)	(17,943,769)	(48,981,540)
Year-End Adjustments	1,382,526)	1,738,672	(806,433)	(450,287)
Miscellaneous-PI Project Cost			8,825,996 [1]	8,825,996
"CAP" Allocable not Charged	(41,020)	(1,530,990)		(1,572,010)
Total Cost Claimed on FACPs	**$103,490,483**	**$98,439,874**	**$97,239,533**	**$299,169,890***

*** HGSA's total reported unclaimed cost $42,177,838 ($341,347,731 - $299,169,893)[2]**

[1] Included is MCS Project cost of $53,536 that caused a cost over-run in FY 1997 (See "Cost Claimed in Excess of Approved Budget" section of report). However, the $53,536 is allowable excess cost and can be used to offset questioned cost.

[2]The difference of $3.00 for the total FACP claimed cost is due to rounding.

During FY 1995 through 1997, HGSA recorded all Medicare financial activities to the Medicare cost history file, a distinct group of Medicare accounts within the Walker General Ledger (GL) Cost Allocation System (CAS) that comprise a Medicare operations ledger. Because the FY's reported FACP total costs must agree with the FY's approved NOBA total costs, HGSA must adjust out any excess costs from the Medicare cost history file to bring the file's total in agreement with the reported FACP's total.

To accomplish this, HGSA prepared a FY FACP detailed adjustment reconciliation schedule (crosswalk) by Medicare administrative cost center from the cost history file. The crosswalk included manual and out-of-system adjustments that adjusted final costs to report on the FACP as follows:

- **Allowable** charges were added to the cost file total.
- **Allowable** credits were subtracted from the cost file total.
- **Unallowable** charges were subtracted from the cost file total.
- **Allowable** remaining excess charges were subtracted from the cost file total.

According to our reconciliation review of the crosswalk and adjustment summary schedule, HGSA allowable unclaimed excess cost for FY 1995, 1996 and 1997 was only $1,048,349 of the total "CAP Allocable Not Charged" cost of $1,572,010 including $53,536 of the Miscellaneous – PI Project Costs shown in the above schedule. The following illustrates the allowable excess cost that can be used to offset questioned cost.

"CAP" Allocable not Charged

Allowable Excess	**FY 1995**	**FY 1996**	**FY 1997**	**TOTAL**
Compensation	$41,020			$41,020
Beneficiary Internet		$27,945		27,945
Beneficiary Outreach		325,040		325,040
Financial System Implementation		599,820		599,820
Flood Volunteer		988		988
MCS Miscellaneous PI Project			$53,536	53,536
Total Allowable Excess Cost	**$41,020**	**$953,793**	**$53,536**	**$1,048,349**

The allowable "CAP Allocable Not Charged" adjustments of $1,048,349 consisted mainly of special projects mandated by CMS. The CMS directs project initiatives that expect to result in savings in administrative cost or are those essential for maintenance of effective program operations.

QUESTIONED COST

Cost Claimed in Excess of Approved Budget - $53,536

According to the Federal Medicare contract, the Carrier is to submit a prospective initial budget request (IBR) of administrative costs to be incurred during the Federal FY to the CMS Regional Office (RO) for review and approval. In addition, the Carrier is to submit Supplemental Budget Requests (SBRs) when accrued expenditures are expected to exceed the originally approved prospective budget amounts.

Following the close of each Federal FY, the Carrier was to submit a FACP reporting the costs of performing Medicare functions incurred during the year. This cost proposal and supporting data serves as the basis for final settlement of allowable administrative costs. Total administrative costs reported on the FACP cannot exceed CMS's approved NOBA for the FY's budgeted Medicare operation costs. The approved budget became a ceiling that may not be exceeded without prior approval of the Secretary.

The CMS approved HGSA Medicare budgets for FY 1995 through 1997 totaling $299,116,357 while HGSA claimed $299,169,893 on its FACPs or $53,536 more than approved by CMS. The HGSA never received a NOBA from CMS approving the excess claimed cost. The following illustrates the excess cost claimed over budget for FYs 1995 through 1997.

	NOBA	FACP	EXCESS
FY 1995	$103,490,483	$103,490,483	$0
FY 1996	98,439,877	98,439,877	0
FY 1997	97,185,997	97,239,533	(53,536)
TOTALS	**$299,116,357**	**$299,169,893**	**$(53,536)**

HGSA Response

The HGSA agreed with OIG's position that costs were claimed over the NOBA. However, HGSA believed that the Secretary was notified that the approved budget amount was not sufficient and, therefore, the $53,536 should be reimbursed. The HGSA maintained that they were in close contact with the CMS Regional office budget staff both with written correspondence and verbal communication.

OIG Comment

Despite the HGSA claim that they maintained close contact with CMS and that CMS was fully apprised of HGSA's ongoing financial performance, HGSA nevertheless did not receive approval from CMS to exceed the budget.

Complementary Credits - $921,718

Our calculation of Complementary Credits accrued during FY 1995 through FY1997 as compared with HGSA's reported FACP Complementary Credits disclosed that Medicare income was understated. As a result, HGSA claimed and was reimbursed excess administrative Medicare Part B operating costs totaling $921,718. The following shows the difference in the calculation and reporting of Complementary Credits for each FY.

	Calculated Complementary Credit Total	FACP Complementary Credit Total	Difference
FY 1995	$15,644,386	$14,519,333	$1,125,053
FY 1996	16,410,425	16,064,183	346,242
FY 1997	17,368,987	17,918,564	(549,577)
Totals	**$49,423,798**	**$48,502,080**	**$921,718**

Regulations permit contractors to release Title XVIII claims information to complimentary insurers under specified conditions. A complimentary insurer must furnish the required authorizations for release of claims information and pay any necessary charges. The charges take the form of a Medicare complementary claim transfer rate established by CMS for each transferred claim.

The HGSA had a contract with Highmark as well as all other coordination of benefits (COB) supplemental insurers that were furnished complementary claims payment data. The beneficiary claim information was used by the insurers to process supplemental claims for services that were not normally covered by the Medicare Part B program. The HGSA was permitted to bill each insurer a designated fee per claim for this service. The COB payments received were income to the Medicare Program, and were reported on the FACP; line #9, "Other" as credits.

The CMS issued a directive dated January 1, 1995 that required all Part B Carriers to apply a standardized complementary rate of $.51 per claim for FY 1995. The standardized rates for FY 1996 and 1997 were established at $.51 and $.54 respectively. The directive allowed the Carrier to continue to apply a lower rate for the following reasons:

i. If less than 30 days have passed after notifying a complementary insurer of the change.

ii. If there is an existing contractual agreement with a complementary insurer, the new rates will be implemented upon expiration of the contract.

iii. If a specific term is not included in the agreement, the new rates will be implemented with an amendment to the contract, effective 30 days from the date of notification to the complementary insurer of the change.

In addition, for FY 1995, CMS and HGSA agreed to provide 3 COB insurers with Explanation of Medicare Benefits (EOMBs) for a total charge of $.76; comprised of the base rate of $0.45 per claim and an additional charge of $0.31 per claim which represents HGSA's cost of producing the EOMB. The procedure to report the additional Medicare income from the $0.31 charge was to include the amounts along with the complementary credits on line #9 of the FACP.

Our review showed that HGSA understated Complementary Credits by $921,718 because HGSA did not apply the correct rate to transferred claims and did not properly report estimated credits. The HGSA did not start applying the FY 1995 rate until April 1995. We only received documentation that identified 5 of 26 COB contractors for whom the new rate of $.51 did not apply until a later date, based on their contract dates. Therefore, the new rate for the remaining COB contractors was effective according to the January 1, 1995 CMS directive.

In addition, our comparison of the calculated Complementary Credit amount for each FY with that year's reported FACP Complementary Credit amount identified variances and disclosed that HGSA reported FY 1995 through 1997 Complementary Credits based on collections received (cash basis) rather than the billed claims transferred (accrual basis). The reporting requirements prescribed by CMS's Medicare Carriers Manual, Part I - Fiscal Administration, Chapter II - Budget Preparation, General - §4212.7) state that a carrier should report all estimated costs and credits on an accrual basis**.**

HGSA Response

The HGSA disagreed with OIG's position that Medicare income was understated because the correct Complementary Credit rate was not applied timely and HGSA did not properly report credits. The HGSA believed that their implementation of the new rate calculation in April of 1995 was reasonable since HGSA did not receive the CMS Transmittal until January 25, 1995 and requested clarification from CMS on several issues.

The HGSA agreed with the report's accuracy in asserting that HGSA was using the cash basis rather than the required accrual basis in reporting Complementary Credits. However, HGSA stated that the full amount of the finding related to this issue ($743,607) was subsequently credited in FY 1998.

OIG Comment

We believe that the CMS directive requiring revised Complementary Credit rates allowed sufficient time (at least 30 days) for HGSA to apply the new rates. Further, we did not review whether a credit was made in FY 1998 or the amount of the credit since the FY 1998 period was outside the scope of our review. If the credit was properly applied in FY 1998, this issue should be developed with CMS. However, for our audit period, the use of a cash basis for reporting credits instead of the accrual basis resulted in a significant understatement to the Medicare program.

Executive Compensation - $243,952

During our review period, the Medicare Part B program was allocated $243,952 in unallowable executive compensation charges. These unallowable charges represent unreasonable executive compensation increases that far exceeded the national average.

Regulations to which the contractors must adhere support the position that compensation charged to Medicare must be reasonable. Section 31.205-6(b) of the FAR, which has been incorporated by specific reference in the Medicare contract, states, in part:

> *"Based upon an initial review of the facts, contracting officers or their representatives may challenge the reasonableness of any individual element or the sum of the individual elements of compensation paid or accrued to particular employees or classes of employees. In such cases there is no presumption of reasonableness and, upon challenge, the contractor must demonstrate the reasonableness of the compensation item in question."*

The onus, therefore, is placed on the contractor to show that compensation is reasonable.

In reviewing the reasonableness of increases to executive compensation, we used the Employment Cost Index (ECI) corrected data news release, as issued by the U.S. Department of Labor's (DOL) Bureau of Labor Statistics and provided by HGSA. The news release contained corrected data for the December 1995 and March 1996 reference periods.

The ECI represents dozens of indices that are calculated for various occupational and industry groups to measure the rate of change in employee compensation. It is a fixed weight index at the occupational level and eliminates the effects of employment shifts among occupations. The ECI is distinguished from other surveys in that it covers all establishments and occupations in both the private non-farm and public sectors. We used the index for assessing the reasonableness of executive compensation allocated to Medicare because we considered it to be the most equitable and relevant measure.

The Federal regulation at 48 CFR 31.201-3(a) states that:

> *"a cost is reasonable if it does not exceed that which would be incurred by a prudent person in the conduct of a competitive business."*

For FY 1997, Section 809 of Public Law 104-201 increased the limit of executive compensation to $250,000 before any allocations are applied. This amount is the maximum allowable compensation of the 5 highest paid executives at the home office and at each segment of the organization. Therefore, for FY 1997, we determined the portion of unreasonable increase according to the ECI and the threshold limit of $250,000.

We selected for review 26 executives, vice presidents and above, whose total compensation exceeded $125,000 and was allocated to Medicare in FYs 1995, 1996 or 1997. Because of retirement and corporate reorganization, not all executives were in the comparison for the full 3-year period. Therefore, the compensation increases were calculated as follows:

- For FY 1995, 15 executives worked to the end of the FY. Their actual FY 1995 compensation package was used as the base to calculate the increase from FY 1995 to FY 1996.

- In FY 1996, 19 executives worked to the end of the FY. We selected 17 of the 19 executives and used their actual FY 1996 compensation package as the base to calculate the increase from FY 1996 to FY 1997.

- Based on the ECI new release, the ECI used for FY 1995 and FY 1996 was 2.8% and 3.2%, respectively.

- All appropriate credit adjustments were applied according to the sampled FY and executive's organization location as identified by HGSA.

From FY 1995 to FY 1996, HGSA claimed excess compensation for 15 executives in the amount of $334,910 of which $75,112 was allocated to Medicare. From FY 1996 to 1997, HGSA claimed $1,223,397 ($771,707 – ECI and $451,690 – threshold limit) in excess compensation for 17 executives. The total adjusted excess compensation allocated to Medicare was $168,840.

After adjusted credits, Medicare was allocated a total of $243,952 in unallowable executive compensation for FY 1995 through 1997.

HGSA Response

The HGSA disagreed with OIG's position that they claimed unallowable executive compensation charges that far exceeded the national average. Significant points of difference include differences in the individuals included in the calculations (i.e., who met the definition of "executive") and differences in the amounts used as salaries for some individuals in the calculations. The HGSA also believed that there were certain facts that were not properly considered by the OIG in the calculation of the questioned costs. For example, it appears that the OIG included relocation benefits as a component of compensation. The HGSA did not consider relocation benefits but considered relocation as a separate item in determining adjustments to the accounting records as the FACPs were prepared.

OIG Comment

The OIG carefully reviewed the assertions made by HGSA and found them to be unsubstantiated. The list of executives used by the OIG was provided by HGSA and confirmed

by HGSA at the time OIG began calculating compensation amounts. Also, the OIG did not include non-salary costs such as relocation benefits in computing executive compensation.

Fixed Assets - $12,647

During our audit period, HGSA claimed $12,647 in unallowable or unsupported fixed asset cost. Unallowable cost included $904 in incorrect depreciation calculation while unsupported cost included $11,743 for which no documentation was provided or the documentation provided proved inadequate. The following illustrates unallowable or unsupported cost by our audit period:

	FY 1995	FY 1996	FY 1997	TOTAL
Incorrect Depreciation Calculation	$228	$0	$676	$904
Unsupported by Documentation	11,388	355	0	11,743
Total	**$11,616**	**$355**	**$676**	**$12,647**

We judgmentally selected 100 cost center months for review. From the 100 cost centers months, we selected 207 fixed assets with depreciation totaling $610,782 and a Medicare share of $257,266. We reviewed support documentation such as capitalization polices, invoices and purchase orders to determine if the fixed asset depreciation cost was allowable, allocable, reasonable and properly supported.

Based on our review, HGSA allocated to Medicare $12,647 in unallowable or unsupported fixed asset cost for FYs 1995 through 1997. Of the 207 fixed asset invoices that were reviewed, 13 invoices had a difference in depreciation cost calculation totaling $904, and 10 invoices had unsupported or insufficiently supported cost totaling $11,743.

HGSA Response

HGSA will not object to this finding.

Productivity Investments - $42,045

During our 3-year audit period, HGSA allocated a total of $12,155,888 to Medicare Part B for 32 PI projects. In FY 1997, PI cost claimed exceeded the approved budget by $207,030[3]. Based on our review of selected PIs, we are questioning $42,045 which includes $4,683 in unallowable PI cost and $37,362 for lack of supporting documentation.

[3] Cost overrun is a result of overclaimed EMC PI. After transferring cost between under claimed FACP line items, the subsequent cost claimed over budget totaled only $53,536. As of the end of our fieldwork, CMS had not approved the $53,536 or the $207,030 cost overrun.

The CMS authorizes Carriers to perform projects that are outside the realm of normal processing of Medicare Part B claims. These costs are the direct result of initiatives either by the Carrier proposing cost savings or HCFA as a mandate. Each project has a specific budgeted amount, requires specific before the fact approval from CMS, is assigned a control number by CMS, and should be reported on FACP line #8, PIs.

Our review of project costs showed that HGSA did not use its automated CAS system for the allocation of most PI costs. Instead, PI costs were maintained manually and entered into HGSA's Medicare Financial Reporting System according to a designated operation code related to CMS' FACP line item. In addition, out-of-system adjustments were made by the Government Financial Reporting department at the verbal or written request of the division or cost center manager who maintained the supporting documentation for the transfer of costs.

We judgmentally selected the highest PI cost from each FY in our audit period for detail review. The following are the 3 PIs reviewed in detail:

FY	# PI	PI Name	PI Amount
1995	9511	EDI/STD Format Migration	$102,608
1996	9646	PBS System Conversion	2,220,122
1997	9766	EDS-MCS Other Conversion	3,492,727
TOTAL	**3**		**$5,815,457**

We are questioning $4,683 in unallowable PI cost from the FY 1995 EDI/STD Format Migration project. Based on the documentation provided by HGSA, the cost for Beneficiary Eligibility Printing in May 1995 was overstated by $4,683.

In addition, we are questioning a total of $ 37,362 of PI cost on this project for lack of supporting documentation. In FY 1995 and 1996, HGSA allocated $27,583 and $9,779, respectively, for which no documentation was provided or the documentation provided proved inadequate to determine the nature, type, reasonableness or necessity of the expense.

Article XX of the Medicare Part B contract states:

> *"The Plan shall maintain adequate accounting records covering the use of funds under this agreement. . . . These records shall be maintained for the time periods for particular records specified in Subpart 4.7 of the FAR. . . ."*

We determined that Medicare was allocated a total of $42,045 in unallowable or unsupported PI project cost.

HGSA Response

The HGSA agreed that $4,683 is unallowable and also agreed that there was insufficient documentation supporting the identification of the remaining $37,362 as PI costs. However, HGSA believes that these costs are appropriately charged to Medicare and included on the FACPs.

OIG Comment

Without sufficient documentation there is no way to verify that the costs are, in fact, chargeable to the Medicare program.

Unsupported Accounts Payable Cost - $591,018

The Accounts Payable (AP) system was used for processing administrative costs incurred by HGSA. The system reported cost transactions according to designated cost classification such as travel, supplies, and postage. Administrative costs by classification account were interfaced monthly into the GL-CAS for expenses paid in the current month, as well as for amortization of prepayments and the accrual of items received but not yet paid.

During our audit period, HGSA assigned administrative cost transactions totaling $144,866,119 to 52 accounts. Of the 52 accounts, 45 accounts totaling $99,276,467 represented AP transactions, and 7 accounts totaling $45,589,652 represented other transactions ("explosions"). The explosions stemmed from a reclassification system within the CAS or from manual journal entries in AP. An explosion occurred because a corporate expense was booked to one cost center when the payment occurred; however, the expense benefited many cost centers. As a result, the cost was "exploded" to user cost centers based on statistical data.

The HGSA provided magnetic tapes containing all AP and other expense transactions for FY 1995, 1996, and 1997. Using a random number generator, we randomly selected 600 account transactions totaling $13,145,771. We reviewed supporting documentation such as invoices, POs, contracts, and statistical data to determine if selected cost were allowable, allocable, reasonable and supported according to FARs and the Medicare contract agreement.

The HGSA provided no documentation or inadequate documentation to determine the nature, type, reasonableness or necessity for 56 selected AP transactions totaling $591,018. Unsupported AP transactions consisted of 22 transactions totaling $260,543 in FY 1995, 22 transactions totaling $210,268 in FY 1996, and 12 transactions totaling $120,207 in FY 1997.

According to Article XX of the Medicare Part B Contract,

> *"The plan shall maintain adequate accounting records covering the use of funds under this agreement.... These records shall be maintained for the time periods for particular records specified in Subpart 4.7 of the FAR. . ."*

Further, FAR Section 31.201-4 states:

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

We are questioning $591,018 for lack of adequate support. We did not, however, project the results of our sample.

HGSA Response

The HGSA claims to have provided supporting documentation for all but $17,815 of Accounts Payable cost questioned by the OIG and requested clarification as to the deficiency in the documentation that was provided.

OIG Comment

We provided ample opportunity for HGSA to provide sufficient supporting documentation and made numerous requests for the documentation. We questioned Accounts Payable cost primarily because HGSA was unable to provide information showing the nature of the cost or whether the cost was actually incurred. We would have accepted documents such as purchase orders, invoices, expense reports etc. However, in 8 of the 56 questioned cases, HGSA was unable to provide any documentation. In the remaining 48 cases, the documentation was not adequate for OIG to make a determination on the applicability of the expense to the Medicare program. The primary documents provided by HGSA for the questioned transactions were distribution sheets that showed where the cost was ultimately charged. However, this information did not disclose anything as to the nature of the cost or the relative benefit to Medicare.

OTHER MATTERS

Unsupported Medigap Credits - $478,418

We are not rendering an opinion on Medigap credits totaling $478,418 for FY 1995 because of unsupported Medigap billings.

Regulations permit contractors to release Title XVIII claims information to complementary insurers under specified conditions. Complementary insurers use the Medicare complementary claim information to process supplemental policy benefits they offer to their subscribers' Medicare insurance coverage. The Medicare supplemental insurance policies provide the benefit of paying the beneficiaries' deductibles and coinsurance not covered under the Medicare program. The HGSA was allowed by CMS to bill each contracted complementary insurer at a CMS established rate that was in effect at the time of the claim transfer.

The mandated user-fees collected during FYs 1995 through 1997 were identified on the respective FACPs. The supporting billing documentation to validate the credits was available for FYs 1996 and 1997, but complete FY 1995 supporting billing documentation was not available for our review. The HGSA did not provide complete FY 1995 Medigap billing information for the 9-month period from January through September 1995. Without the complete Medigap billing information for all of FY 1995, we were unable to audit to a control amount and were unable to review all credits billed under the Medigap program. As a result we are not rendering an opinion as to whether $478,418 in Medigap credits for FY 1995 were calculated accurately and paid in full.

HGSA Response

The HGSA agreed that they were unable to provide detailed supporting documentation showing how they developed the Medigap credit applied to the government for FY 1995. However, the credit was given and Part B expenses were reduced accordingly.

OIG Comment

While there is no dispute that the credit was given, the OIG was unable to determine whether the amount of the credit was correct without the required supporting documentation.

Complementary Credit Adjustment - $58,034

The HGSA circulated a memorandum on February 25, 2000 that approved the write-off of COB billings totaling $58,034.

FY1998 adjustment	$24,503
FY1999 adjustment	33,531
Total COB invoice adjustment	$58,034

The FY 1998 write-off included $15,033 in FY 1997 Complementary Credits, which is within our audit period.

The HGSA performed an internal review of Complementary Credit partial payments and concluded that $58,034 in claim invoices had outstanding balances that should be adjusted (written-off). The HGSA determined that COB insurers sometimes received claims that did not match the client's beneficiary files or claims that were duplicates. As a result HGSA adjusted down $58,034 in erroneous claim transfers. This adjustment covered partial payments from FY 1999 and prior years. There was $15,033 for FY 1997 that applied to our period.

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As of February 1, 2000, CMS was not aware of any specific policy for the write-off of uncollected Complementary billings and had issued no guidance. The CMS advised HGSA that

no adjustments should be made until the CMS Central Office was contacted for clarification on the issue. The issue, however, was never resolved.

Consequently, HGSA should obtain the approval of CMS to write-off erroneous billings of $58,034, including $15,033 that applied to FY 1997. Partial payment procedures, adjustments and write-offs represent a potential loss of Medicare Part B Complementary claims revenue and therefore require CMS approval.

HGSA Response

The HGSA contends that the write-offs are actually adjustments that were necessary to correct errors that occurred when the initial complementary credit receivables were recorded. The errors could have resulted from the same claims being billed twice to the supplemental insurance companies or from charges to a supplemental insurance company for claims for beneficiaries that were not covered by that supplemental insurance company. The HGSA does not believe that approval from CMS is required to correct this type of error that occurred in the normal course of business.

OIG Comment

The OIG did not perform an analysis of the nature of the claims that were written-off. Write-offs or adjustments require the approval of CMS since they affect Medicare claims revenue.

CONCLUSIONS AND RECOMMENDATIONS

Our review of booked costs for FY 1995 through 1997 showed that HGSA did not adequately identify and exclude excessive unallowable and unsupported costs from being allocated to the Medicare Part B program.

We recommend that HGSA:

- coordinate with CMS to reduce the cost claimed for FY 1995 through 1997 FACPs by $1,224,793,
- provide adequate documentation for unsupported costs of $640,123 or make the appropriate adjustment to the FACPs, and
- review its cost allocation system to ensure that unallowable costs, including the type identified in this report, are not allocated to the Medicare program,
- report all Complementary Credits on the accrual basis as prescribed by the Medicare Carriers Manual, and

- obtain approval from CMS to establish partial payment procedures for Complementary claims and the write-off of $58,034 in unpaid Complementary claim credits.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare
Part B

January 25, 2002

Mr. David M. Long
Regional Inspector General for Audit Services
DHHS, OIG
150 S. Independence Mall West
Suite 316
Philadelphia, PA 19106-3499

Re: Medicare Part B Audit of Highmark – FY1995 - FY1997; CIN: A-03-00-00003

Dear Mr. Long:

Attached is a response to your letter of December 27, 2001 requesting comments on your draft Report CIN A-03-00-00003 entitled "Review of Medicare Part B Administrative Costs Claimed by Highmark, Inc. for Fiscal Years 1995 through 1997."

We have spoken with Lee Scros about holding a conference call exit conference in the near future.

If you have any questions, please feel free to contact me at (717) 730-5891 or Stephen Bovino at (717) 763-3167.

Sincerely,

Patrick M. Kiley

Patrick M. Kiley
Vice President and Principal Officer
HGSAdministrators

PMK/taj

Attachment

HGSADMINISTRATORS
A CMS CONTRACTED CARRIER
Camp Hill, PA 17089
http://www.hgsa.com

Review of Medicare Part B Administrative Costs for Fiscal Years 1995 – 1997

HGSAdministrators

Comments to OIG Draft Report CIN: A-03-00-00003

Highmark Comments on the OIG Audit Report Dated December 2001

Executive Summary / Background (page i)
The following information is offered to clarify the legal structure of Highmark Inc. during the three (3) fiscal years covered by this audit. During fiscal years 1995 and 1996, Medical Services Association of Pennsylvania (MSA), d/b/a Pennsylvania Blue Shield (PBS), held the contract for the administration of the Medicare Part B Program. In December 1996, Highmark Inc. was formed through the consolidation of MSA and Veritus Inc. The Medicare Part B contract previously held by MSA was novated and assigned to Highmark. A business unit within MSA / Highmark (herein after referred to as "Highmark"), d/b/a Xact Medicare Services, was responsible for the daily administration of the contract. In May 2000, Xact Medicare Services changed its "fictitious" name to HGSAdministrators (HGSA).

Within the second paragraph of the background section, reference is made to the Blue Cross Blue Shield Association's (BCBSA) participation in the administration of the Medicare Part B Program. The BCBSA is not a party to the carrier agreement. CMS (formerly HCFA) contracts directly with Highmark.

Executive Summary / Summary of Findings (page ii)
Within this section, OIG identifies the reconciling difference between the Medicare Part B total booked administrative expenses for the FY1995 - FY1997 period ($341,347,731) and the total amount reported on the FACPs ($299,169,893) as unclaimed costs. The report states that Highmark deducted the difference ($42,177,838) from Medicare booked costs to avoid exceeding the NOBA CAP.

We disagree with that statement. The majority of this difference is due to revenue (Complementary Credits) Highmark received from supplemental insurance companies who purchased Medicare claims data to use in processing supplemental claims. This revenue was applied against total booked expenses as required by CMS and served to reduce the expenses claimed (billed) on the FACP. The reconciliation, shown on the bottom half of page three of the draft audit report, demonstrates the application of these revenue credits against Medicare Part B incurred costs.

Executive Summary / Other Matters (page ii)
Concerns related to these "Other Matters" are identified on page five of our response.

Recommendations (Page iii):

The report makes the following five recommendations:

- ❑ Coordinate with CMS to reduce the cost claimed for FY1995 through FY1997 FACPs by $1,224,793.

  Response

  Highmark agrees with $5,587 of this recommendation and will coordinate adjustment with CMS. Please see our responses below.

- Provide adequate documentation for unsupported costs of $640,123 or make the appropriate adjustment to the FACPs.

  Response

  Highmark agrees that adequate documentation has not been provided for costs totaling $29,558 and will coordinate adjustment with CMS. Please see our responses below.

- Review its cost allocation system to ensure that unallowable costs, including the type identified in this report, are not allocated to the Medicare Program.

  Response

  Highmark's accounting processes are constantly monitored to ensure only allowable, allocable, and reasonable costs are allocated to the Medicare Program.

- Report all Complementary Credits on the accrual basis as prescribed by the Medicare Carriers Manual.

  Response

  Effective with the implementation of the new CAFM II system by CMS in FY1998, Highmark began using the accrual basis of accounting for Complementary Credits.

- Obtain approval from CMS to establish partial payment procedures for Complementary claims and the write-off of $58,034 in unpaid Complementary Claim Credits.

  Response

  As described in our response below, the adjustments that are the subject of this recommendation are not write-offs, and approval from CMS is not needed to process these routine adjustments.

Introduction / Background (page 1)
As noted previously, the BCBSA is not a party to the carrier agreement. CMS contracts directly with Highmark.

Results of Audit
We do not agree with the results of the audit as documented on page two as described within this response.

Results of Audit / Reconciliation of Booked Costs to Claimed Costs (page 3-4)
In the first paragraph in this section, the report states "As a result of our reconciliation of booked cost .....we determined that the unclaimed excess costs on Highmark's accounting records were overstated by $41,129,489."

We do not agree that the unclaimed excess costs on Highmark's accounting records were overstated as indicated in the report. The majority of the difference between the accounting records and the filed FACPs is attributable to revenue (Complementary Credits) received from supplemental insurance companies who purchase Medicare claims data for use in processing supplemental claims. As required by CMS, this revenue was applied against total booked expenses, via memorandum records, and served to reduce the costs claimed on the FACP. Our starting point in reporting cost on the FACPs is total allowable expenses allocated to the Medicare Part B Program ($341,347,731). This amount is then offset by revenue credits, calculated in accordance with CMS' instructions, as separately listed on the FACPs, as well as other adjustments.

The second paragraph in this section provides a brief description of the process followed by Highmark to prepare the FACP beginning with the general ledger system. We believe the following clarification is warranted. During the fiscal years covered by this audit, the Walker General Ledger (GL) system was used to record financial activity related to all of Highmark's business. The expenses within the GL, categorized by account and cost center, were allocated to product (of which Medicare Part B is one product) using standard allocation methods and defined statistics. The resulting Medicare Part B allocated expense system file was known as the Part B Cost History and was the source data for reporting costs on the FACPs. Revenue credits (Complementary Credits) and other credits and needed adjustments were applied via memorandum records.

Questioned Cost / Costs Claimed in Excess of Approved Budget - $53,536 (page 4-5)
Highmark disagrees with this finding.

The report states "Total administrative costs reported on the FACP cannot exceed CMS's approved NOBA for the FY's budgeted Medicare operation costs. The approved budget became a ceiling that may not be exceeded without prior approval of the Secretary."

Article XVI (Cost of Administration) of the Medicare contract states "cumulative costs.....cannot exceed the annual amount on the Notice of Budget Approval without prior approval of the Secretary, or as subject to paragraph I."

Paragraph I states "If the amount of costs incurred by the Carrier which are determined to be allowable upon final settlement exceeds the budgeted amount, the Secretary shall pay such costs provided that the requirements of paragraph H have been met by the Carrier, and provided further that funds are available to the Secretary for intermediary and carrier administrative costs."

Paragraph H states "If at any time it appears to the Carrier that the approved budget amount(s) will not be sufficient....the Carrier shall so notify the Secretary, ..."

During FY1997, Highmark maintained close contact (both written and verbal) with the CMS Regional Office budget staff to ensure the Regional Office (Secretary) was fully apprised of Highmark's Medicare Part B ongoing financial performance. Written correspondence included quarterly variance analysis, Supplemental Budget Requests, and status reports. Verbal communications included telephone conference calls (at least daily with the Regional Office budget analyst – as characterized by the Regional Office budget analyst) and special project reviews (e.g., CMS' MCS bi-weekly conference calls).

In summary, while we agree that the claimed costs exceed the approved NOBA, we believe that the Secretary was notified that the approved budget amount was not sufficient and, therefore, the $53,536 should be reimbursed.

Questioned Costs / Complementary Credits - $921,718 (page 5-6)
Highmark disagrees with this finding.

The first issue identified by the OIG relates to the implementation of the fixed complementary rate ($.51). As identified by the OIG, Highmark was to implement this rate effective January 1, 1995, unless stated conditions existed, as summarized in the OIG report. Highmark received the CMS Transmittal AB-95-1 on January 25, 1995. After receiving and reviewing the CMS Transmittal, we requested clarification from CMS on several issues. CMS' clarification came several weeks after receipt of the letter. After receiving clarification from CMS, Highmark notified each supplemental insurance company of the rate increase and provided them with a 30 days advance notification as required in AB-95-1. Highmark began charging supplemental insurance companies at the CMS imposed rate beginning April 1 unless their contract contained specific terms requiring a longer lead time for rate increase notification. We began charging our Highmark Private Business supplemental insurance operation the increased rate effective January 1, 1995. Of the total finding , $187,111 relates to the lead time required to implement the rate increase to $.51. Given the sequence of events identified above, we believe our implementation time line was compliant and request this portion of the finding be eliminated.

The second issue identified by the OIG relates to the use of cash vs. accrual basis accounting for recognition of revenue related to Complementary Credits. The report accurately states that Highmark was using the cash basis. As further clarification, we would like to point out that Highmark had been working with the CMS Regional Office budget staff on this issue. CMS was fully aware that Highmark had employed the cash basis method to account for Complementary Credits, and that the revenue billed would be credited on the FACPs as it was collected from the supplemental insurance companies. With the implementation of the CAFM II system in FY1998, Highmark converted to the accrual method of accounting for this revenue and credited the government with $743,607 to reflect the final net timing difference between cash and accrual accounting at the time of the conversion. Because the full amount of this portion of the finding ($743,607) was credited to the government in FY1998, we request that this finding be eliminated.

Questioned Costs / Executive Compensation - $243,952 (page 7-8)
Highmark disagrees with this finding.

For each of the fiscal years under review, Highmark analyzed executive compensation using methods that are consistent with the then applicable government regulations and limited executive compensation costs claimed on the FACPs, accordingly.

We provided the OIG with a complete set of our work papers documenting how we developed our adjustments to costs per our accounting records in the preparation of the FACPs. We received work papers from the OIG supporting their calculation of the questioned costs. Our review of the documentation provided by the OIG disclosed a number of differences in the methodology and compensation used by Highmark to calculate adjustments to exclude compensation from the FACPs and the methodology and compensation amounts used by the OIG to calculate the allowable executive compensation. Significant points of difference include differences in the individuals included in the calculations (i.e., who met the definition of "executive") and differences in the amounts used as salaries for some individuals in the calculations. In addition, there were some facts that we believe were not properly considered in the calculation of the questioned costs. For example, it appears that the OIG included relocation benefits as compensation for purposes of determining the increase in salary for two individuals. Highmark's calculations did not consider relocation benefits as a component of compensation, but considered relocation as a separate item in determining adjustments to the accounting records as the FACPs were prepared.

In general, lacking any definitive guidance or regulation criteria, we believe we used a reasonable and sound methodology in performing an analysis of executive compensation and limiting costs charged to the Medicare Program.

We believe the inclusion of these costs in the FACPs was appropriate and request this finding be eliminated.

Questioned Costs / Fixed Assets - $12,647 (page 8)
Highmark will not object to this finding.

Questioned Costs / Productivity Investments - $42,045 (page 9)
Highmark agrees that $4,683 is unallowable.

With regard to the remaining $37,362, although we agree that there is insufficient documentation supporting the identification of these costs as PIs, we believe these costs are appropriately charged to the Medicare business and included on the FACPs.

For clarification purposes, PI expenses flow through the normal accounting/general ledger process like any other expense incurred by the Corporation. HGSA staff and management keep track of time spent on PIs and other costs incurred in support of PIs. HGSA reports this information to Government Financial Reporting for use in distributing costs to the PI line item on the FACP.

Questioned Costs / Unsupported Accounts Payable Cost - $591,018 (page 10)
Highmark does not agree with this finding.

Highmark has provided supporting documentation for all but $17,815 of the Accounts Payable (AP) transactions selected for testing. We request clarification from the OIG as to the deficiency in the documentation provided and request that the entire finding, net of the $17,815, be removed from the report.

Other Matters / Unsupported Complementary Credit Billings - $478,418 (page 11)
This finding relates to Medigap credits, not Complementary Credits. Highmark agrees that we were unable to provide detailed supporting documentation showing how we developed the Medigap credit applied to the government for FY1995. However, the Medicare Program was given credit for this amount, and Part B expenses were reduced accordingly.

Complementary Credit Adjustment - $58,034 (page 12)
Highmark disagrees with this finding.

The transactions that are being referred to as "write-offs" in the reports are more accurately described as "adjustments." The adjustments are necessary to correct errors that occurred when the initial complimentary credit receivables were recorded. The errors could have resulted from the same claims being billed twice to the supplemental insurance companies or from charges to a supplemental insurance company for claims for beneficiaries that were not covered by that supplemental insurance company. The invoices sent to the supplemental insurance companies and the related accounts receivable balances on Highmark's books (for each of the impacted supplemental insurance companies) had to be corrected, which was accomplished by adjustments to the amounts previously billed. We do not believe that approval of CMS is required to correct this type of error that occurred in the normal course of business.

Conclusions and Recommendations (page 13)

- Coordinate with CMS to reduce the cost claimed for FY1995 through 1997 FACPs by $1,224,793.

  Response

  Highmark agrees with $5,587 of this recommendation and will coordinate adjustment with CMS. Please see our responses above.

- Provide adequate documentation for unsupported costs of $640,123 or make the appropriate adjustment to the FACPs.

  Response

  Highmark agrees that adequate documentation has not been provided for costs totaling $25,558. Please see our responses above.

- Review its cost allocation system to ensure that unallowable costs, including the type identified in this report, are not allocated to the Medicare Program.

  Response

  Highmark's accounting processes are constantly monitored to ensure only allowable, allocable, and reasonable costs are allocated to the Medicare Program.

- Report all Complementary Credits on the accrual basis as prescribed by the Medicare Carriers Manual.

  Response

  Effective with the implementation of the new CAFM II system by CMS in FY1998, Highmark began using the accrual basis of accounting for Complementary Credits.

- Obtain approval from CMS to establish partial payment procedures for Complementary claims and the write-off of $58,034 in unpaid Complementary Claims Credits.

  Response

  As described in our response above, the adjustments that are the subject of this recommendation are not write-offs, and approval from CMS is not needed to process these routine adjustments.