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Report to Congressional Committees

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MEDICARE+CHOICE AUDITS

Lack of Audit Follow-up Limits Usefulness

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Accountability * Integrity * Reliability

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Congressional Committees

The Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, spent about $35 billion dollars in 2000 on Medicare+Choice, Medicare's managed care alternative to its fee-for-service program. During this time, almost 6.3 million Medicare beneficiaries were enrolled in health plans[1] offered by managed care organizations (MCO) that participate in the Medicare+Choice program. Annually, a MCO choosing to participate in the Medicare+Choice program must submit an Adjusted Community Rate Proposal (ACRP) for each plan that it intends to offer to CMS for its review and approval. The ACRP identifies the health services the MCO will provide to its Medicare members and the estimated cost of providing those services. It also shows the estimated payments that the MCO expects to receive for providing these services. According to CMS, the purpose of its review of the ACRPs is to ensure that the MCO benefit packages provide all Medicare covered benefits, and that any excess of estimated payments over the MCO plan's estimated costs of providing the Medicare benefits are used by (1) providing additional services, (2) reducing beneficiary premiums or copayments, (3) distributing the excess to a benefit stabilization fund,[2] or (4) using a combination of these.

[1]A "plan" is a package of specific covered benefits, beneficiary premiums/copayment, and terms of coverage available, offered by an MCO within a specific geographic area. A MCO may offer one or more plans.

[2]A benefit stabilization fund is a non-interest-bearing escrow account that may be used to finance benefits in future years. Typically, however, plans chose to provide additional benefits or to charge lower premiums and/or copayments to beneficiaries.

The Balanced Budget Act of 1997 (BBA)[3] enacted the Medicare+Choice program, which included several changes to the ACRP process. Among these, BBA required CMS to audit the ACRPs[4] and supporting financial records of at least one-third of the participating Medicare+Choice organizations annually and required that we monitor these audit activities.[5]

To fulfill our responsibility under the act, we (1) evaluated CMS' process for auditing the ACRPs to determine if it met BBA requirements and financial audit standards and (2) identified significant findings resulting from the audits and CMS' plans and efforts for resolving them. This report summarizes our work and provides recommendations to the CMS Administrator that we believe will improve the ACRP process.

Results in Brief

Overall, CMS' approach in the first year met BBA requirements, was carefully considered, and lays the foundation for future years audit process. However, the lack of follow-up on audit findings to date limits the usefulness of the audit results and minimizes the audits' effectiveness as a management tool. In 2000, CMS contracted with four organizations—the Department of Health and Human Services' Office of Inspector General (HHS OIG) and three CPA firms—to conduct these first year audits of the ACRPs submitted by 80 MCOs, which met the one-third requirement. The organizations conducted the audits in accordance with generally accepted auditing standards (GAAS) and generally followed CMS' audit program, including submission of audit reports detailing their findings.

[3]Public Law No. 105-33, Title IV, 111 Stat. 251, 270 (1997), amending Title XVIII of the Social Security Act, 42 U.S.C. Ch. 7, Subchapter XVIII, Part C.

[4]As discussed in more detail later in the report, the ACRP consists of two parts—the Benefit Information Form (BIF) and the Adjusted Community Rate (ACR). The BIF contains a detailed description of the benefits contained in a particular plan and the ACR contains a detailed description of the expected costs of providing these benefits. The emphasis of the ACRP audits, and thus of our report, is on evaluating the reasonableness of the ACR cost estimates.

[5]42 U.S.C.§1395w-27(d)(1).

Our review revealed that the audit reports were not always complete or consistently prepared. The audit reports differed in format, scope, and presentation primarily because of conflicting instructions between the audit contracts, which required a report with an opinion on the overall reasonableness of the ACRP, and the audit program, which required an attestation report.[6] Although the reports differed, our analysis of the work performed and reports issued reveal that the reports generally met the requirements of BBA and the CMS-provided audit program. Further, CMS has clarified the reporting format and standards for contract year 2001.

CMS has not yet developed a formal process to resolve the findings identified by the auditors. The auditors' findings ranged from minor errors to incorrect or unrecorded costs that could affect the level of services provided by MCOs and/or premiums/copayments paid by the beneficiaries. CMS has not calculated the overall net effect of the adjustments for all the audits, thereby limiting the usefulness of the audits. Computing the net effect of the errors is key to assessing the magnitude of the impact on beneficiaries and could aid in developing an appropriate follow-up protocol. CMS plans to require the calculation of the overall net effect in its 2001 audits.

CMS has now hired a contractor to re-evaluate certain contract year 2000 audit reports in which possible overcharges were identified. According to its agreement with CMS, after completing its work the contractor is required to prepare a written report summarizing its results. CMS officials responsible for managing the ACRP audits advised us that after receipt of the report, they plan to seek a decision from senior CMS management regarding its actions to address the audit findings. Without timely follow-up activities and clear communication to MCOs on specific corrective actions, the types of problems identified during this initial round of ACRP audits will likely continue, and the enrollee population may not receive the maximum benefits for the amounts paid. This report contains recommendations to the CMS Administrator about the actions needed to improve the ACRP audit process.

In its comments on a draft of this report, CMS generally agreed with our recommendations. However, there were a few areas where they disagreed or where they had a different understanding on a particular matter. Of

[6]Generally, these reports addressed only certain agreed-upon procedures and did not provide opinions on the ACRPs.

particular concern, CMS believed we unfairly concluded that CMS lacked a formal process for follow-up on the audit findings although they were developing such a process. We disagree. While we acknowledge, in the report that CMS had advised us they were considering various follow-up policies, our concern is that CMS has not implemented follow-up procedures over a year after the audits were initiated. Without follow-up policies and procedures in place, identified problems may remain unresolved, which undermines the utility of the audit process.

Background

Medicare is the national health insurance program for those aged 65 and older and certain disabled individuals. In 1982, the Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA)[7], which created a risk-contract program for Medicare, a predecessor to the current Medicare+Choice program. Under the risk-contract program, CMS contracted with a MCO to pay a fixed monthly amount for each Medicare enrollee in return for the MCO assuming the financial risk of providing all covered medical services that the enrollee uses. In 1997, BBA created the Medicare+Choice program in an effort to expand beneficiaries' managed care options. Under the Medicare+Choice program, CMS provides a fixed monthly amount to MCOs for each beneficiary they serve. Each MCO develops cost estimates for the contract year[8] for which the ACRP is being submitted using some of its own information and some CMS-supplied information. As discussed below, the MCO must make assumptions on which to base the estimates. Until the passage of BBA in 1997, which required the annual audits of at least one-third of the MCOs participating in the Medicare+Choice program and assumptions relating to Medicare utilization, costs, and computation of the adjusted community rate, there was limited oversight of this process or these assumptions by CMS. Prior to initiating the full one-third-audit requirement, CMS contracted with HHS OIG and a consulting firm to conduct pilot audits in late 1999 to test its audit program and to refine its methodology. Since CMS was implementing its new ACRP methodology[9] for the 2000 contract year, CMS decided that contract year 2000 would be the appropriate time to begin the audits.

Annually, each MCO that chooses to participate in the Medicare+Choice program must submit an ACRP for each plan that it intends to offer to CMS for its review and approval. A single MCO may have multiple plans because of differences in the combination of benefits, beneficiary fees, or

[7]Public Law No. 97-248, §114, 96 Stat. 324, 341 (1982).

[8]In general, contracts run on a calendar year basis and ACRPs were submitted approximately 6 months before the start of the contract year. For example, ACRPs for the 2000 contract year were submitted in July 1999. With CMS approval, plans could add coverage or lower fees during the contract year, but under no circumstances could plans change benefit packages to make them less generous for beneficiaries.

[9] CMS implemented a revised Adjusted Community Rate (ACR) process for contract year 2000. Significant changes reflected in the new ACR include: (1) new methods for developing relative cost ratios based on actual historical costs in order to estimate MCO plan costs, (2) consolidation of direct medical care costs, (3) changes to the administrative cost component, and (4) revised methods for calculating the average payment rate.

geographic areas. For example, according to CMS, PacifiCare of California submitted 48 ACRPs under four separate contracts in contract year 2000.

The ACRP consists of two parts—the Benefit Information Form (BIF)[10] and the Adjusted Community Rate (ACR). The BIF contains a detailed description of the benefits, including services covered, annual limits, copayments, premiums, and any benefit restrictions. The ACR contains a detailed description of the costs the MCO estimates it will incur in providing the plan's package of covered services (benefits) to an enrolled Medicare beneficiary.

Before the start of the contract year, each plan estimates its per person cost of providing Medicare-covered services. These costs are calculated based on how much a plan would charge a commercial customer to provide the same benefit package if its members had the same expected use of services as Medicare beneficiaries. This amount is known as the plan's ACR and includes the plan's normal profits. A plan cannot charge fees—in the form of monthly premiums or copayments—that are higher than beneficiaries would likely pay, on average, under traditional Medicare. Each year, the MCO's costs (stated on a per member per month basis in the ACR) are calculated to cover direct medical care, administration, and additional revenues.[11]

According to CMS, costs included in the ACR should be supported by the MCO's historical operating experiences related to utilization and expenses. CMS also requires that all assumptions used in developing the projected costs and other information used by MCOs in calculating the ACR should be consistent with the calculations it uses for its non-Medicare enrollees. Further, the chief executive officer, the chief financial officer, and the head marketing official of the MCO are required to certify that the ACRP

[10]Beginning in contract year 2001, MCOs participating in the Medicare+Choice program submit a Plan Benefit Package in lieu of the BIF. The Plan Benefit Package is an upgraded version of the BIF. Both the Plan Benefit Package and ACR are electronically linked and must be submitted in tandem.

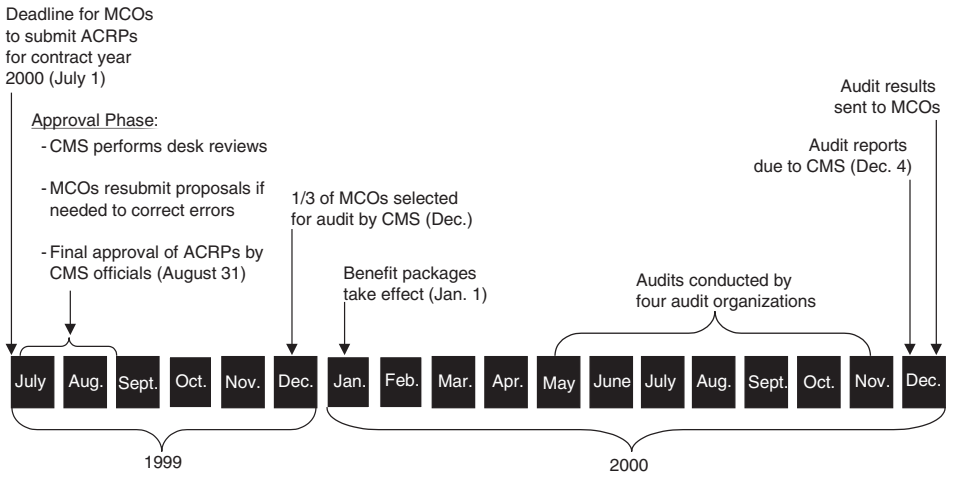
[11]According to CMS, additional revenues are revenues collected or expected to be collected from charges for benefit packages offered by a type of Medicare+Choice plan that exceeds costs incurred or to be incurred. Additional revenues include such things as revenues in excess of expenses directly related to a benefit package, profits, contributions to surplus, risk reserves, and any premium component not reflected in the direct medical care and administrative costs.

contains accurate information, which also serves as a management assertion.

In completing the ACRP for each plan, MCOs must also estimate expected per capita payments from Medicare, known as the plan's average payment rate (APR). These estimates are based on published Medicare+Choice payment rates and the characteristics of the plan's expected enrollees. If the estimated ACR costs (as computed on the ACRP) are greater than the estimated payment rate, and if the MCO still chooses to participate, it agrees to accept the CMS payment rate in accordance with the conditions outlined in the MCO's ACRP. However, if the estimated ACR costs are less than the estimated payment rate, the MCO must (1) provide additional services, (2) reduce beneficiary premiums or copayments, (3) distribute the excess to a benefit stabilization fund, or (4) use a combination of these.

CMS performs a multiphase review of the ACRPs to ensure that the MCO benefit packages provide at least the minimum services established by CMS. As shown in figure 1, CMS' approach to analyzing the ACRPs includes a desk review of the BIF and ACR, followed by an audit of the ACR worksheets included in the ACRPs of selected MCOs.

Figure 1: ACRP Desk Review and Audit Process for Contract Year 2000



Source: GAO analysis of CMS process.

The approval phase of ACRP includes both desk review and approval. For contract year 2000, this covered the period from the submission date of

July 1, 1999, through the end of August 1999, during which CMS reviewed and approved ACRPs. The desk review includes limited checking of each ACRP submission before CMS approves it. For example, this would include checks for mathematical consistency in the ACRPs and checks for consistency between the ACR worksheets and the BIF, including a comparison of the services covered, annual limits, premiums, copayments, and service areas. According to CMS, desk reviews are performed for all ACRPs. If errors are found or corrections are needed, MCOs are required to resubmit their ACRPs for final approval. CMS' approval of a plan's ACRP establishes the minimum benefits that the plan must offer during the contract year. After the approval phase, MCOs were selected for audit beginning in May 2000, after the contract year had started. The audits were completed by November 2000, and results were due to CMS in December 2000.

CMS required its auditors to perform auditing services in accordance with standards established by the American Institute of Certified Public Accountants (AICPA). The auditors generally used attestation standards as promulgated by the AICPA. The term attestation standards is generally used to refer to the professional standards that apply to the performance of an engagement, such as an examination, review, or agreed-upon procedures, that provide assurance on representations other than historical financial statements. Reports issued when work is limited to audit procedures are considered agreed-upon procedures reports, and they generally enumerate the findings resulting from the procedures and do not provide opinions.

Scope and Methodology

To evaluate CMS' process for conducting the contract year 2000 ACRP audits and to determine if it met BBA requirements and financial auditing standards, we interviewed key CMS officials[12] and appropriate personnel at each of the organizations[13] with which CMS had contracted to conduct the ACRP audits as well as other contractor personnel working for CMS on the ACRP audit effort. We reviewed BBA, AICPA auditing and attestation standards, ACRP submission policies and procedures, the Comptroller General's *Standards for Internal Control in the Federal Government*,[14] and relevant CMS and GAO reports.

We analyzed the planned and performed audit procedures to assess compliance with auditing standards and to determine the adequacy of the procedures in relation to the audit objectives. Specifically, we compared the work steps in the audit program to the requirements for MCOs submitting ACRPs and determined whether the program was adequate. We also analyzed the audit program used by the audit organizations to determine if it included steps to ensure that, if executed as planned, the work performed would comply with professional standards. In addition, we visited each audit organization to review the working papers for four audits (one per audit organization) and to assess the organizations' quality control procedures for the audits. During these visits, we determined whether (1) the audit program had been completed, (2) all the steps in the audit program were executed as planned, (3) all significant findings identified by the audit work were included in the report, and (4) the working papers included evidence of supervisory reviews. We attended some meetings between CMS and the organizations performing the ACRP audits, the MCOs, and a contractor assisting CMS in managing the ACRP program.

In order to identify significant findings resulting from the audits, we reviewed the 80 audit reports and their findings resulting from the ACRP audits for contract year 2000 and discussed the findings with the organizations performing the audits and CMS officials. We also reviewed a

[12]CMS officials interviewed include the Director and Deputy Director of the Division of Premiums and Financial Evaluation, Health Plan Purchasing and Administrative Group, and Centers for Health Plans and Providers.

[13]The organizations interviewed include Ernst & Young, HHS OIG, KPMG Consulting, and PriceWaterhouseCoopers.

[14] GAO/AIMD-00-21.3.1.

CMS contractor's analysis of the audit reports and its evaluation of the findings. To identify CMS' plans and efforts to resolve the findings, we interviewed CMS officials. We also reviewed draft model reports that CMS plans to use in the future. During each phase of our work, we obtained and analyzed appropriate documentation, such as legislative history, laws, regulations, procedures, reports, documents, and other information that we considered pertinent to our work.

We conducted our work from November 2000 through June 2001 at CMS headquarters in Baltimore, Maryland and contractor offices in the greater Washington, D.C., area in accordance with generally accepted government auditing standards. We provided the CMS Administrator a draft of this report for review and comment. The CMS Administrator's comments have been incorporated where appropriate and reprinted in appendix III.

Audit Process Addressed BBA Requirements and Financial Audit Standards

CMS has fulfilled its statutory responsibility to audit the ACRPs of at least one-third of the MCOs participating in the Medicare+Choice program. However, opportunities to improve the audit process exist. To its credit, CMS selected MCOs for the ACRP audits on a risk basis, developed a detailed audit program, contracted with audit organizations to perform the audits, held entrance and exit conferences with the MCOs, and conducted "lessons learned" conferences with both the MCOs and auditors.

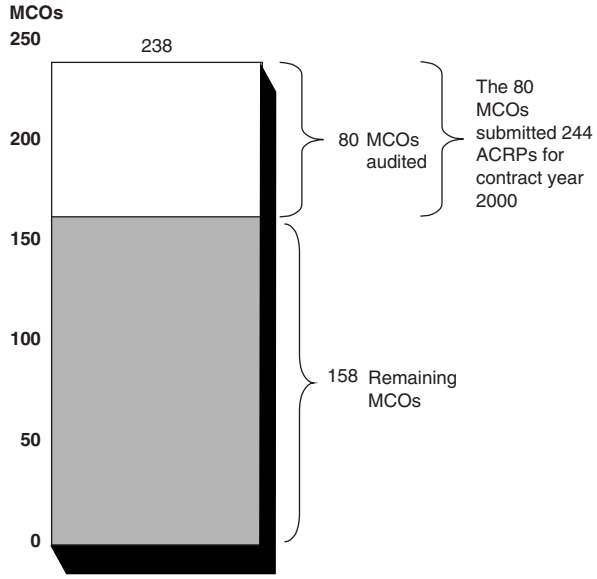
Although the audits were performed in conformity with GAAS, the auditors were not always able to completely fulfill the scope of work required in their contracts with CMS. In many cases, auditors faced difficulty in satisfying the scope of work envisioned by CMS because the MCOs did not maintain data that CMS requires. Also, due to a lack of clarity in the contracts with CMS, the auditors' reports varied in presentation and content. These issues limited the usefulness of the audit reports in assessing the ACRPs.

Contract Year 2000 ACRP Audit Process Met BBA Requirements

In order to fulfill the BBA requirement that at least one-third of the ACRPs of the participating MCOs be audited each year, CMS selected 80 of the 238 MCOs participating in the Medicare+Choice program for audit in contract year 2000. These 80 MCOs included about 2.5 million of the 6.3 million beneficiaries enrolled in the Medicare+Choice program in 2000—or about 40 percent of all beneficiaries enrolled in the Medicare+Choice plans. The

80 MCOs submitted a total of 244 ACRPs (each ACRP represents a different plan), as shown in figure 2.

Figure 2: Medicare+Choice Organizations Contract Year 2000



Source: CMS.

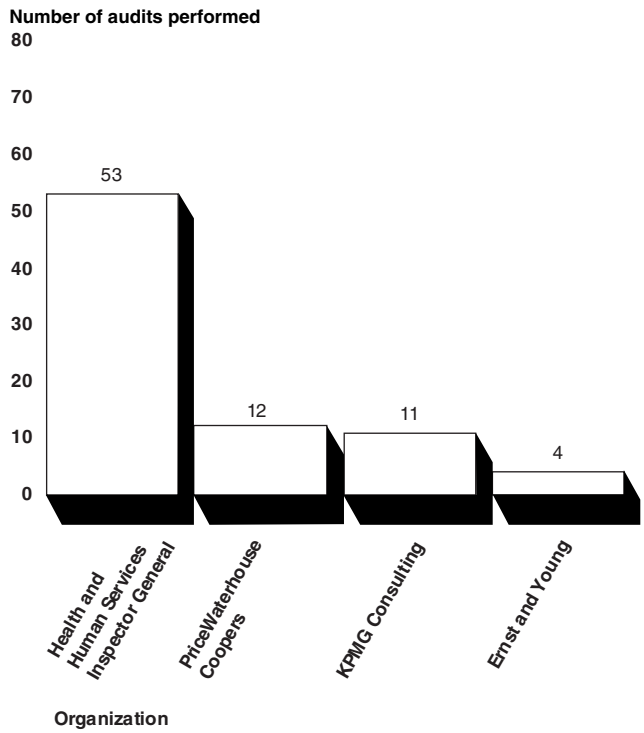
CMS' goal is to audit all the MCOs participating in the Medicare+Choice program over a 3-year period. According to CMS officials, they began by selecting every third MCO from those filing ACRPs for 2000. After the initial selection, CMS used a risk-based approach to eliminate or add MCOs based on the desk reviews and prior experience with particular MCOs. The selection method not only enabled CMS to meet the one-third-audit requirement, but allowed CMS to rank the audits based on risk. CMS plans to use this MCO selection approach in future years. See appendix I for a list of the MCOs selected for audit.

After selecting the MCOs for audit, CMS officials contracted with four organizations—Ernst and Young LLP, HHS OIG, KPMG Consulting, and PriceWaterhouseCoopers LLP—to conduct the ACRP audits for contract year 2000. These organizations were selected based on their prequalification as CMS contractors with auditing and accounting expertise and managed care experience. CMS assigned audits to the organizations based on the lowest bid received from the auditors and statements from the firms certifying that they had no conflict of interest with any of the MCOs that they were engaged to audit. This approach helped provide efficiency and effectiveness to the audit process. As shown in figure 3, the majority of the audits were awarded to the HHS OIG, in part due to its previous audit experience, lower per hour costs, and ability to enter into an interagency agreement[15] with CMS. The approximate cost of engaging the four organizations was $5.6 million. This does not include CMS staff costs or additional contractor oversight costs.[16]

[15]An interagency agreement allows agencies to have an "expedited" contract process, thus shortening the time from the beginning of the contract process through the actual start of work.

[16]CMS retained two oversight contractors to assist with the review and management of the ACRP process.

Figure 3: ACRP Audits Performed for Contract Year 2000



Source: CMS.

The audit program was made available to both the auditors and the MCOs prior to the start of the audits to ensure an understanding of the audit criteria and to expedite the auditors' work. CMS' guidance to MCOs for complying with the ACRP process, including requirements pertaining to the maintenance of necessary documentation, was provided in a number of ways. This guidance included CMS regulations, CMS *Operational Policy Letter* dated April 1999, and the *Instructions for Completing the ACRP*. CMS provided training to its auditors on the ACRP process, potential issues, and CMS requirements. The audit organizations stated that CMS provided helpful training, and they were generally pleased with the assistance provided. Additionally, the organizations indicated that when questions arose in the field during the course of the audit, CMS personnel were responsive.

The audit program required that the auditors analyze each of the six worksheets (appendix II provides a general description of the type of data

included in each worksheet) that were submitted to CMS as part of the ACRP and that they check the calculations and examine the support for each calculation. In addition, the auditors conducted on-site visits and interviews with MCO officials. The audits began in May 2000 and were concluded by November 2000. Audit organizations spent approximately 2 weeks on-site at each organization. As mentioned earlier, a single MCO can submit multiple plans, and each plan must have an ACRP. As shown in figure 2, the 80 audited MCOs had 244 plans and related ACRPs that needed to be audited. Each of the 244 ACRPs were audited, and the results were grouped by MCO and shown in 80 reports.

The audits concentrated on two aspects of the ACRPs—the actual costs incurred by the MCO for the base year,[17] and the factors used to project the base year costs to estimated costs for the contract year. The audit program called for the auditors to trace the actual cost information back to the organization's general ledger through the use of source documents and reconciliations to the financial statements. Differences between the general ledger and the financial statements were to be noted by the auditors in their reports. MCOs were to take the base year data (actual historical costs) and use them as a starting point to project expected costs in the contract year, based on numerous assumptions and trend analysis. This analysis included, but was not limited to, a review of the (1) impact of inflation on medical costs, (2) changes in technology, (3) revisions to underwriting guidelines, and (4) shifts in the plan's utilization patterns. Thus, in addition to tracing the actual cost data to the MCO's financial records, the auditors were asked to evaluate the support for the assumptions used in the projections, and to check the calculations employed by the MCO in arriving at the final amounts for the ACR. For example, auditors reviewed trend factors used to project direct medical care costs from base year 1998 to contract year 2000.

After the audits were performed, exit conferences were conducted with each MCO. Generally, both the audit organization personnel and CMS personnel (either in person or by telephone) participated in these meetings. At the exit meetings, in accordance with the contract between the audit organizations and CMS, the MCOs were informed of the findings and had

[17]The base year is the latest full year for which actual data are available. Since the plans/ACRPs are to be submitted by July 1 in the year preceding the contract year, the base year is 2 years prior to the contract year. For example, for contract year 2000, the plans were due in July 1999 using 1998 as the base year.

an opportunity to resolve outstanding issues. After completion of the audit reports, the audit organizations forwarded copies of their reports to CMS personnel. In turn, CMS sent copies of the reports to the audited MCOs. CMS also provided copies of the reports to the contractor that it hired to assist it in providing oversight of the ACRP audits. The contractor entered the reported findings into a database and evaluated the reports submitted to CMS.

As part of the first-year process, CMS conducted post audit sessions, which should enhance future audit efforts. After submission of the audit reports, CMS held two "lessons learned" conferences—one with the MCOs and one with the auditors. The MCOs participating in the audits provided feedback to CMS on length and timing of the audits, the need for a clear definition of materiality, documentation requirements, and exit conferences. Further, MCOs urged CMS to define its policies for follow-up action on understatements and overstatements of the ACR. The auditors' "lessons learned" conference provided CMS with information on areas that needed improvement, such as the need for clarification on several technical issues involved in the ACR calculations and the level of documentation required in certain areas. The auditors also acknowledged that some of the concerns raised by MCOs were attributable to the fact that this was a "first year" audit effort. Based on input received at the conferences, CMS plans to further refine its audit program, review its audit and documentation requirements, and reallocate the audit workload among the various audit organizations. Overall, CMS' approach in the first year met BBA requirements, was carefully considered, and lays the foundation for future years' audit process.

Audit Reports Did Not Always Meet CMS Format and Content Requirements

The audit reports, while in compliance with GAAS, differed in format, scope, and level of findings presented. CMS' contract required that the audit reports contain

- a detailed discussion of each audit finding containing the condition, criteria, cause, effect, and recommendation;
- a revised ACRP showing the estimated dollar effect each audit finding had in determining whether the costs to the Medicare program were justified; and
- a conclusion in the report concerning the reasonableness of the audited ACRP.

The auditors were required to follow CMS' audit program, which specified the work to be performed. The contract also required that the auditors conform to standards established by the AICPA for audits and attestation engagements. Some audit organizations issued reports with an audit opinion, while others issued agreed-upon procedures reports.[18] The differences in report format and scope were due to confusion over the interpretation of the scope of work. Based on the type of engagement, an agreed-upon procedures report format provides appropriate assurance for the ACRPs.

While the auditors followed the attestation standards in performing their work, not all the audit reports fully complied with CMS' reporting requirements stated above. Our review of the 80 reports showed that the reporting format, scope, and presentation of findings varied by audit organization. As discussed in detail later, CMS has changed its audit reporting requirements for contract year 2001 to address these reporting issues.

Even with varying formats and presentation styles, our analysis of the reports showed that 52 of the 80 audit reports included recommended adjustments—where warranted—to the ACRP, a detailed analysis of the findings, additional worksheets, and an explanation of the calculations. Twenty-eight of the 80 reports did not include a revised ACRP or did not address the reasonableness of the ACR. According to the auditors we interviewed, this was because they lacked some essential information to make these calculations—often either the information was not forthcoming from the MCOs or the MCOs did not maintain the information. Regardless of the varying report formats, the appropriate auditing standards were employed and the auditors fulfilled contract requirements except in instances in which information was not provided or unavailable.

Significant Findings Were Identified, But No Formal Resolution Process Is in Place

From an overall perspective, the ACRP audits contained several significant findings; however, CMS has not quantified the results or developed a plan for follow-up action. CMS hired a contractor to evaluate the audit results. CMS classified the audit results into three categories, based on the severity of the findings. To date, CMS has not determined the net effect of the

[18]An audit opinion states the auditor's overall conclusions based on the results of the audit. Agreed-upon procedures engagements are used when the auditor and a third-party user agree that the audit will be limited to certain specific audit procedures.

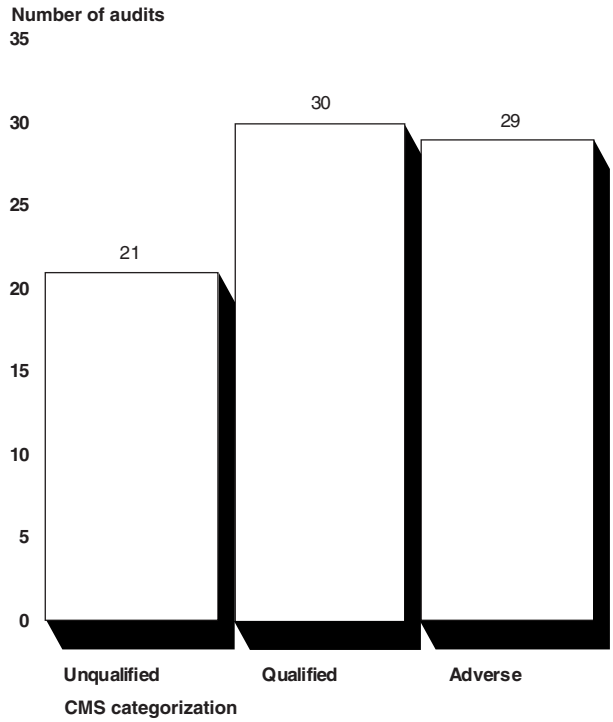
understatements or overstatements or developed a formal follow-up policy to resolve the findings. Further, CMS has hired another contractor to evaluate the audit findings in 23 of the 80 audit reports in which possible overcharges were found. Once the contractor's work is completed, CMS plans to develop a recommended follow-up policy for submission to its senior management.

Audits Reported Significant Findings, But Impact Has Not Been Quantified

To date, CMS has not evaluated the specific overstatements and understatements identified in the audit reports. As a result, CMS is currently unable to assess the materiality of ACRP errors identified in several of the audits or determine their potential impact. The findings from the audits vary in magnitude and in potential impact on the costs and level of services provided to beneficiaries. Although the auditors did not uniformly provide opinions, CMS attempted to gain consistency among the reports by categorizing them. CMS analyzed the audit reports and the findings and placed them into three internally devised categories—unqualified, qualified, and adverse. While these categories are similar to an auditor's opinion classification usually found in an audit report, they do not necessarily reflect the actual opinions of the auditors. The reports were placed in these categories based on CMS' analysis of the audit reports and other factors. CMS' definitions of the categories are shown below, and the category breakdown of the reports is depicted in figure 4.

- Unqualified: Management's assertions regarding the ACRP were fairly stated in all material respects.
- Qualified: Except for the specific issues of noncompliance raised, management's assertions regarding the ACRP were fairly stated in all material respects.
- Adverse: Due to the material noncompliance on specific issues, management's assertions regarding the ACRP were not fairly stated.

Figure 4: 2000 Audit Results as Classified by CMS



Note: The categories reflect the judgment of CMS staff and may or may not align with the conclusions of the performing auditor.

Source: CMS.

Several common findings existed among the 80 audited MCOs–ranging from minor clerical errors to incorrect costs and/or costs that were not included in the ACRPs. According to CMS' analysis of the audit reports, 21 of the audit reports showed no material findings. However, 59 of the reports showed that ACR amounts were both understated and overstated, or, in some cases, the MCO accounting records were so unreliable that auditors could not calculate a valid ACR.

As mentioned before, CMS also hired a contractor to help evaluate the auditors' findings. Based on its analysis of the 80 audit reports the contractor reported that the auditors found the following.

- In 68 audit reports, base year information was incorrect (for example, dollar amounts did not agree with those in the general ledger, or dollar

amounts were classified in the wrong health care component or statutory benefit category) or there was a lack of supporting documentation.

- In 58 audit reports, clerical errors were made when calculating per member/per month copayment amounts, copayments were not included in the ACRP but were included in a plan's BIF, and/or copayment amounts were unsupported.
- In 54 audit reports, the average payment rate was misstated. According to the contractor, in some of the cases the ACRPs did not include certain groups of individuals in the calculations or used the wrong risk adjuster. In other cases, the reports attributed the mistakes to clerical errors.
- In 50 audit reports, base period costs were not based upon generally accepted accounting principles.
- In 45 audit reports, expected variations were inadequately explained or supported.
- In 45 audit reports, administrative costs were not properly recorded.
- In 35 audit reports, Coordination of Benefits[19] was either unsupported or miscalculated.

In some instances the auditors were able to quantify the results in their reports to CMS. For example, based on our review of the audit reports, we identified seven audit reports that specifically quantified the net effects. We identified another 39 reports that showed an impact but did not identify it as "net effect." For example, in one of the seven reports where the results were quantified, the report for a MCO with three plans indicated that the combined result for the three plans was a net understatement of estimated revenues. The auditors estimated that the net effect of these errors was $0.61 per member per month for contract year 2000. This adjustment implies that the MCO should have proposed spending an additional $516,872[20] on extra benefits, lowered beneficiary premiums or copayments, or contributed the amount to a stabilization fund. This example illustrates that even seemingly minor adjustments to per member/per month charges can have a major impact when calculated at the MCO level.

[19]In the private insurance industry the term "coordination of benefits" is generally used when discussing the order of payment when a beneficiary has insurance with more than one company. Medicare is not always the beneficiary's primary insurer.

[20]The original revenue for three of the MCO plans was projected at $8,236,726. The auditor's findings increased the total estimated revenue to $8,753,607.

As discussed above, CMS has yet to follow up on these or other errors identified in the audit process. To address this and other reporting issues, in contract year 2001, CMS plans to require the auditors, where applicable, to quantify the net effects of the errors found in their audit reports. CMS provided the organizations hired to conduct the contract year 2001 audits with a standard report format and standard method of issuing the findings requiring statements of net effect. Further, for contract year 2001, CMS has clarified the expected scope of work and professional standards the auditors should follow when performing audits. This report format, if appropriately adopted by the auditors, should clarify the reporting responsibilities expected from the auditors and provide CMS with relevant information to use in administering the Medicare+Choice program.

CMS Has No Process for Resolving Findings

Although CMS has provided copies of the audit reports to MCOs, the agency has not developed a policy on the actions it will take to address the findings or communicated specifically with MCOs about actions needed to improve or correct future submissions. CMS officials are aware that BBA includes provisions for penalties and sanctions specifically for the Medicare+Choice program,[21] and they are considering this section as they contemplate appropriate follow-up action. Furthermore, the Comptroller General's *Standards for Internal Control in the Federal Government* states that monitoring of internal control activities should include an assessment of the quality of performance over time and ensure that the findings of audits and other reviews are promptly resolved. Monitoring activities include reviewing the results identified by audits and other reviews, determining the proper actions to take to resolve the problems identified, and completing those actions within an established time frame. Management actions on a finding or recommendation can be considered complete only after actions have been taken that correct the identified deficiencies, produce improvements, or demonstrate that the findings and recommendations did not warrant management action. Further, Office of Management and Budget (OMB) Circular A-50 emphasizes the need for agencies to assign a high priority to the resolution of audit recommendations and to implementing corrective actions.

During the course of our work, CMS personnel advised us of several occasions when they evaluated the actions they should take to address of

[21] 42 U.S.C. §1395w-27(g).

the contract year 2000 audit findings, but told us that the change in administration had delayed any final decisions. In a meeting in June 2001, they advised us that they had hired a contractor to further review the audit reports and working papers in order to evaluate the quality of the findings categorized as potential overcharges and to determine their net effect by MCO. They expect this work to be completed in the fall of 2001. Subsequently, CMS ACRP management officials expect to make recommendations to higher-level CMS management on what actions CMS should take regarding the contract year 2000 audits. The lack of a follow-up process on the findings for contract year 2000 is likely to result in the same types of errors in the ACRPs in contract year 2001 and future years.

Conclusions

CMS met the requirements to have the ACRPs submitted by one-third of the MCOs for contract year 2000 audited, and the audits were performed in accordance with professional auditing standards. Overall, CMS has developed a solid foundation for its future years' audit process. However, errors identified in the audits were generally not quantified to enable CMS to assess the magnitude of the problems and the extent to which the audited MCOs should have contracted to provide additional benefits, charge lower premiums/copayments, or contribute to a stabilization fund. In addition, CMS did not have a follow-up mechanism in place to resolve the specific problems identified in the audits. Therefore, the usefulness of the audit process was undermined for the first year, and the value of these audits is unlikely to be realized in 2001 and future contract years unless remedial action is taken.

Recommendations for Executive Action

To improve the utility of the audit reports and usefulness of their findings, we recommend that the CMS Administrator

- fully implement plans to calculate the net effect by plan and potential impact of ACRP audit findings and adjustments,
- develop and implement a follow-up mechanism to address the audit findings in a timely manner, and
- communicate to each MCO specific corrective actions needed for future ACRP submissions.

Agency Comments and Our Evaluation

In written comments (reprinted in their entirety in appendix III) on a draft of this report, CMS generally agreed with our recommendations. However, there were a few areas where they disagreed or where they had a different understanding on a particular matter. Of particular concern to CMS was their belief that the report did not fairly acknowledge the audit follow-up process that is under development.

CMS believed that we did not provide adequate recognition of the time and effort that were expended in the first year ACRP audit effort. Throughout the report, we discuss the various procedures that CMS has in place to analyze the ACRPs and the level of effort expended in the initial year of the ACRP audits. For example, we discuss the training provided by CMS to the auditors and the lessons-learned conferences held after the audits were completed. However, the emphasis of our report was on evaluating the overall audit process—and the attendant results, to include follow-up actions—and not the level of resources expended.

CMS expressed concern that the report unfairly concluded that there was an absolute lack of a process for follow-up on the findings although such a process is under development. We disagree. In the report, we discuss that a follow-up process is under development. However, our concern is based on the fact that well over a year after initiating the audits, follow-up policies and procedures have not been implemented. Not having such policies and procedures in place and carrying them out undermines the utility of the audit findings. For this reason, we still consider our conclusions and recommendations concerning the development and implementation of a formal follow-up process on the findings from the ACRP audits appropriate and we encourage CMS to expedite its plans to develop and implement such a process.

With regard to our recommendation to communicate to each MCO specific corrective actions needed for future ACRP submissions, CMS stated that it had provided the audited organizations with a copy of the final audit report, had instructed the organizations to institute remedial actions in subsequent ACR filings, and intended to follow-up on the audit findings during subsequent audits. In our report, we note that CMS has provided the audit reports to the MCOs that were audited and conducted lessons learned conferences. However, CMS may have misunderstood the intent of our recommendation to communicate to each MCO the specific corrective actions needed for future ACRP submissions. As we discuss in our report, a formal follow-up process is imperative to resolving the audit findings.

Also, as discussed in the report, communication to MCOs of specific remedial actions needed is critical so that misunderstandings do not occur on the actions MCOs are expected to take to resolve audit findings. Simply transmitting an audit report will not explicitly convey the actions CMS believes need to be taken. Further, CMS' position that it will follow up during subsequent audits would indicate that such follow-up could occur 3 years from the date of the initial audit because of the audit selection procedures used by CMS. This could allow identified problems to continue for a longer period than if an effective follow-up protocol were in place.

In its comments, CMS also discusses several other points made in the report, such as why the auditors encountered difficulties completing the scope of work, that the audit reports varied in presentation, and that the audits performed extended only to the ACR worksheets. These issues are discussed in the report, including that CMS has already provided the organizations hired to conduct the contract year 2001 audits with a standard report format. While the draft report clearly stated that the scope of the audits extended only to the ACR worksheets, because of CMS' request that this be further clarified, we have modified the report to ensure that there are no misunderstandings regarding our use of the term ACRP audit process.

CMS also provided technical comments that we incorporated as appropriate.

We are sending copies of this report to the Administrator of the Centers for Medicare and Medicaid Services and interested congressional committees. Copies will be made available to others upon request. This report is also available on GAO's home page at *http://www.gao.gov*. If you or your staffs have any questions regarding this report, please contact me at (202) 512-9508 or by e-mail at *calboml@gao.gov*, or Kay Daly, Assistant Director, at (202) 512-9312 or by e-mail at *dalyk@gao.gov*. Other key contributors to this assignment were Aditi Archer and Johnny Clark.

Linda M. Calbom
Director, Financial Management and Assurance

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House of Representatives

The Honorable Nancy Johnson
Chairwoman
The Honorable Fortney (Pete) Stark
Ranking Minority Member
Subcommittee on Health, Committee on House Ways and Means
House of Representatives

Managed Care Organizations Selected for Audit in Contract Year 2000

Aetna U.S. Healthcare, Inc.[a]
Aetna U.S. Healthcare, Inc.
Aetna U.S. Healthcare, Inc.
Aetna U.S. Healthcare, Inc.
Aetna U.S. Healthcare, Inc. of NJ
Americhoice
Amerihealth HMO
AV Med Health (Rev.)
AV Med Health (Rev.)
Blue Care Network of Michigan
Blue Cross Network – Eastern MI
Blue Cross Network – Southeast MI
Blue Cross of California
Blue Cross of Idaho
Bluelincs HMO
California Physicians' Services Corp
Cigna Healthcare of Arizona
Cigna Healthcare of Florida, Inc.
Cigna Healthcare of Georgia, Inc.
Cigna Healthcare of New Jersey, Inc.
Cigna Healthcare of Texas, Inc.
Empire Blue Cross Blue Shield
Florida Health Care Plan, Inc.
Foundation Health, Florida Health Plan
Group Health Coop of Puget Sound
Health Alliance Medical Plans
Health Care Plan, Inc.
Health First Health Plans, Inc.
Health Partners-Philadelphia
HealthAmerica Pennsylvania, Inc.
HealthAmerica Pennsylvania, Inc.
Healthcare Oklahoma
Healthcentral
Health Net, California
HealthNet

(Continued From Previous Page)

HealthPlus
Health Partners-Alabama
HMO Georgia
HMO Partners
Horizon-New Jersey
Humana
Humana Kansas City, Inc.
Independent Health Association
John Deere Health
Kaiser Foundation HP of KC, Inc.
Kaiser Foundation HP of the NW
Kaiser Foundation HP, Inc.
Kaiser Foundation HP, Inc.
Keystone East
Lovelace Health Plan, Inc.
Lovelace Health Plan, Inc.
Maricopa County Health
Maxicare California
Medspan Health
National Medical, Inc.
NY Care Plus Insurance Co., Inc.
NYLCare Health Plans of Maine
Oschner Health Plans
Oxford New York
Pacificare of Colorado, Inc.
Pacificare of Nevada, Inc.
Pacificare of Texas, Inc.
Paramount
Partners National Health
Penn State-Geising
Physicians Health-Connecticut
Presbyterian Health Plan
Primecare Health Plan, Inc.
Primetime Medical
Prudential Health Care Plan, Inc.
Prudential Health Care Plan, Inc.
Prudential Health Care Plan, Inc.

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Regence HMO Org.
Tenet Choices, Inc.
Texas Health
United Healthcare of Alabama, Inc.
United Healthcare of New York, Inc.
United Healthcare of Ohio, Inc.
United Healthcare of Florida, Inc.
WellPath Select

[a] Some MCOs are listed several times due to their organizational structure and location. However, they represent different plans and geographic areas.

Description of the ACRP Worksheets

Worksheet	Description
A	*Summary information for the contract period pertaining to the APR, the initial rate, and enrollment estimates.* The initial rate and APR for the year 2000 are used on worksheet E.
B	*Total Medicare and non-Medicare enrollee costs incurred for the base period (1998).* These costs are used for calculating relative cost ratio (ratio per member/per month) cost actually incurred for Medicare enrollees to the corresponding cost of non-Medicare enrollees) to be used on worksheet E.
B-1	Key financial information about the MCOs that is used to measure the organizations' performance and ability to bear a financial loss.
C	*Premiums and cost sharing that the MCO intends to charge per member/per month for the Medicare+Choice plan unique to this ACR.* These amounts are limited by the amounts calculated on worksheet E for Medicare enrollees.
D	*Expected variations in costs for health care components per member/per month.* Variation is an increase or decrease in the projected cost or revenue of a Medicare+Choice plan reflecting factors not captured in the relative cost ratio. Adjustments are made for these variations to make the ACR computation more closely approximate the costs that would be incurred for the Medicare population during the contract period.
E	*Calculation of the ACR for the Medicare+Choice plan being offered, comparing the ACR to the APR to determine any excess amount of the APR over the ACR.* Worksheet E then reports the excess amount that is contributed to the stabilization fund and/or applied to additional benefits. The ACR is determined by taking the initial rate times the relative cost ratio, then adjusting for expected variations.

Comments From the Centers for Medicare and Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: SEP 25 2001

TO: Linda M. Calbom
Director, Financial Management and Assurance

FROM: Ruben J. King-Shaw, Jr.
Chief Operating Officer and Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report, *MEDICARE+CHOICE AUDITS: Lack of Audit Follow-up Limits Usefulness* (GAO-01-1065)

We appreciate the opportunity to review and comment on the subject report. The Centers for Medicare & Medicaid Services (CMS) appreciates the fact that GAO recognizes that we have built a solid foundation for future year's audits and that we have taken steps to correct problems related to scope of work and audit report presentation. However, we are concerned that GAO criticized us for lacking formal processes for follow-up. This is an issue that we are working on as we complete this first audit cycle and we do not believe GAO adequately recognizes the effort we have expended in this area.

As with any effort, cooperation is needed among the various parties in order to make goals achievable. The first year included the involvement of CMS personnel with staff from 4 audit organizations, 2 consulting firms, and 80 audited managed care organizations. Many questions and issues were dealt with as the audit process began to evolve during the audit period. This progression of problem solving was critical to the audit process and the eventual establishment of a methodology for identifying and handling audit findings. The GAO does agree that the actions taken to date by CMS have laid the foundation for a stronger audit effort for future years, however; we believe the audit report fails to adequately recognize the effort that has been completed, and continues to be done to institutionalize the audit process.

The GAO unfairly concludes that CMS lacks a formal process for follow-up on the findings when such a process is under development. We are currently in the process of determining the beneficiary impact through the analysis of a number of completed audits. Once this task is completed, we will craft a strategy for audit follow-up and adjudication. We believe the audit report also fails to adequately address the time and effort expended to initiate the audit function and the procedures that have been developed during the first year of the audits. The report title especially appears to emphasize the lack of procedures

*The Health Care Financing Administration (HCFA) was renamed to the **Centers for Medicare & Medicaid Services (CMS).** We are exercising fiscal restraint by exhausting our stock of stationery.*

even though CMS is still actively developing these procedures through the use of the first year audits.

The CMS further disagrees that the current lack of formal follow-up procedures has limited the usefulness of the audit results. We have provided all audit organizations a copy of the final audit report and have instructed organizations to institute remedial actions in subsequent Adjusted Community Rate (ACR) filings. It is CMS's intent to follow-up on the audit findings during subsequent audits.

The audit report also indicates that "... the auditors were not always able to completely fulfill the scope of work required in their contract with CMS. In many cases auditors faced difficulty in satisfying the scope of work envisioned by CMS, because the managed care organizations (MCOs) did not maintain data that CMS requires." Again, CMS is aware of this issue which would have been expected during the first year of audits. Because this was the initial year of audit activity, CMS did not know how the MCOs tracked and maintained data supporting the entries on the ACR worksheets. Some of the findings support this position. CMS has taken steps to clarify audit instructions and to ensure consistent reports for future audits. This and other matters have been disclosed and addressed in a number of meetings with both the auditors and the auditees.

The GAO audit report further indicates that the auditors' reports varied in presentation and content, thus affecting the usefulness of the reports. Initially, it was CMS's position to have the auditor's issue an audit opinion based upon the results of their work. However, it was soon discovered that for CMS to obtain the audit opinion, each audit organization would have had to create its own audit program and not use the audit program which CMS had developed. Because of time restrictions, CMS decided to use its own audit program which would produce an agreed upon procedures report. Before the reviews began, however, one of the certified public accounting firms agreed to provide us with an audit opinion even though it would use the audit program produced by CMS. It is for this reason that some of the final reports do not follow the same format. The CMS was aware of the inconsistency, but felt it could make a comparison between the audit reports containing audit opinions and the agreed upon procedures reports containing unqualified, qualified, or adverse opinions. Since this was the initial year for the audits, it seemed appropriate to make the comparison. For contract year 2001, CMS has provided the audit firms with a model audit report to use for reporting the results of their reviews. This model report should provide CMS with an across-the-board consistency that was lacking during the first year of audit activity.

It should also be noted that the audit extended only to the ACR worksheets and did not include, nor was it required to include, the Plan Benefit Package (PBP). The PBP is the document that defines and describes the benefit details while the ACR is the pricing of the benefits. These two documents, the ACR and the PBP, are commonly referred to as the Adjusted Community Rate Proposal (ACRP). Although the GAO report consistently uses ACRP as the audit process, the Balanced Budget Act of 1997 audit requirements

extended only to the ACR. We recommend the GAO audit report should be revised to make this important distinction.

GAO recommended that CMS:

- fully implement plans to calculate the net effect by plan and the potential impact of ACRP audit findings and adjustments; and
- develop and implement a follow-up mechanism to address the audit findings in a timely manner.

CMS is addressing these issues.

GAO also recommended that CMS:

- communicate to each MCO specific corrective actions needed for future ACRP submissions.

The CMS has effectively implemented this recommendation through the distribution of audit reports to the audited organizations. These findings will be followed-up through subsequent audits.

In conclusion CMS does not believe it currently lacks a formal audit follow-up procedure. This process is ongoing and will be structured using the results of the methodology developed in concert with work currently under way.

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