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Medicaid Insurance Contracts--Problems in Procuring, Administering, and Monitoring. HRD-77-106; B-164031(3). January 23, 1978. 92 pp. + 5 appendices (15 pp.).

Report to Sen. Herman E. Talmadge, Chairman, Senate Committee on Finance: Health Subcommittee; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs: Compliance With Financing Laws and Regulations (1207); Federal Procurement of Goods and Services: Reasonableness of Prices Under Negotiated Contracts and Subcontracts (1904).
Contact: Human Resources Div.
Budget Function: Health: General Health Financing Assistance (555).
Organization Concerned: Department of Health, Education, and Welfare.
Congressional Relevance: Senate Committee on Finance: Health Subcommittee. Sen. Herman E. Talmadge.
Authority: Social Security Act, title XIX (42 U.S.C. 1396). Kerr-Mills Act (P.L. 86-778). Social Security Amendments of 1950 (P.L. 81-734). H.R. 1300 (81st Cong). 45 C.F.R. 249. 45 C.F.R. 74.

States have the primary responsibility for creating and operating their medicaid programs, and the Federal Government pays 50% to 78% of costs for providing services for programs which conform to legislative provisions. Some States, trying to have better control over medicaid costs, used insurance contracts for administering their medicaid programs. Findings/Conclusions: Many private firms declined to participate in medicaid programs under insurance contracts because of lack of accurate data on program costs and the belief that ventures were too risky. The Department of Health, Education, and Welfare (HEW) reviewed and approved contracts for Federal financial participation, but inadequate review resulted in its approval of one contract that violated regulations, one that was ineligible for Federal sharing, and Federal sharing at incorrect rates under two contracts. States generally did not follow Federal medicaid standards for procurement on insurance contracts. They did not follow competitive practices, evaluate proposals adequately, maintain contract negotiation records, nor evaluate alternatives. There was little Federal contract monitoring and no contractor financial assessments because HEW got involved only if States requested it, and the States generally did not have sufficient staff to adequately perform these functions. Information used by States for assessing contractor performance and determining shares of contract savings often contained inaccurate and unreliable data. Recommendations: HEW should: improve its assistance to States procuring medicaid insurance contracts, improve its contract approval and monitoring

functions, and revise its medicaid contracting regulations. The subcommittee should develop legislation to amend the law to prevent Federal sharing in the cost of medicaid contracts when State laws have restricted competition. (HTW)

5110

REPORT TO THE SUBCOMMITTEE ON HEALTH SENATE COMMITTEE ON FINANCE

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Medicaid Insurance Contracts--Problems In Procuring, Administering, And Monitoring

Medicaid insurance contracts do not always solve increasing Medicaid costs. Faced with the possibility of contract termination because of financial difficulties, some States renegotiated contracts. This reduced or eliminated contractor risk--a principal benefit of insurance contracts.

This review (1) determines the extent of HEW's involvement in developing and awarding contracts for Medicaid insurance contracts, (2) evaluates HEW's capability to monitor the contracts and (3) evaluates States' policies and procedures for obtaining and monitoring them and for reviewing contractors' financial performance.

HEW agreed with GAO's findings and is taking action to improve the procurement of Medicaid insurance contracts.

HRD-77-106

JANUARY 23, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

The Honorable Herman E. Talmadge
Chairman, Subcommittee on Health
Committee on Finance
United States Senate

Dear Mr. Chairman:

Your letter of May 22, 1975, requested us to review the award by the State of North Carolina of a 2-year insurance contract with Health Applications Systems, Inc., to administer most aspects of the State's Medicaid program. You also requested that we review the other Medicaid insurance contracts in effect at that time. We reported to the Subcommittee our findings on the North Carolina contract on July 1, 1976, (HRD-76-139).

This report concerns our broader review and discusses weaknesses in procuring, administering, and monitoring Medicaid insurance contracts by both the States and the Department of Health, Education, and Welfare. Included are recommendations for correcting the problems discussed.

Your office requested that we provide copies of the report to the Chairman, Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, but make no further distribution of the report until a decision is made as to whether to hold hearings on the matters discussed in the report.

In compliance with this request, we will make no further distribution of the report at this time. Unless you notify us that you plan to hold hearings and request that other arrangements be made for the report's distribution, we will make the report available to other interested congressional committees and the public 30 days after the date on the cover of the report.

Sincerely yours,

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE
SUBCOMMITTEE ON HEALTH
SENATE COMMITTEE ON FINANCE

MEDICAID INSURANCE CONTRACTS--PROBLEMS IN PROCURING, ADMINISTERING, AND MONITORING

D I G E S T

Some States, trying to have better control over Medicaid costs, used insurance contracts for administering their Medicaid programs.

However, the insurance contracts have not solved States' Medicaid funding and budgeting problems.

Many private firms have declined to participate in Medicaid programs under insurance contracts due to the lack of accurate, reliable program cost and utilization data, and the inability to predict recipient eligibility. This makes the venture too risky. (See pp. 37 and 38.)

Several firms that did enter into insurance contracts experienced severe financial difficulties. They charged that inaccurate, unreliable, and incomplete Medicaid program data caused them to underbid. These firms then terminated their agreements, refused to extend them, or pressured the State to renegotiate the contract in the contractor's favor so that they could avoid losses and reduce their underwriting risk. (See pp. 45 to 56.)

The Department of Health, Education, and Welfare (HEW) reviewed and approved contracts for Federal financial participation; however, weaknesses in the review resulted in its approving

--one contract that contained a loss recoupment provision in violation of existing Federal regulations,

--one contract that included estimated costs of $3.7 million ineligible for Federal sharing, and

--Federal sharing at incorrect rates on costs of about $181,000 under two approved contracts.

HEW also failed to make certain that a State complied with conditions placed on approval of a contract. (See pp. 10 to 25.)

In the procurement actions, States generally did not follow Federal Medicaid standards when obtaining their insurance contracts.

Open and free competitive practices were not followed, contractors' proposals were not adequately evaluated, and contract negotiation records were not maintained. In addition, they did not evaluate various alternatives, such as State administration, fiscal agent arrangements, or insurance contracts. (See pp. 27 to 41.)

There had been little Federal contract monitoring and no contractor financial assessments because HEW regional officials responsible for administering Medicaid programs believed that these functions were State responsibilities. HEW got involved only if the States requested it.

Most States, however, had not assigned sufficient staff to adequately perform these functions. They were relying on unverified financial and program data provided by contractors for use in assessing contractor performance, renegotiating contracts, and determining the State and Federal Governments' share of contract savings.

This information contained inaccurate and unreliable data. In some instances it did not fully disclose overall contract results because some contract revenues and costs were excluded. (See pp. 66 to 82.)

GAO reviewed the financial performance of one nonprofit contractor who had six Medicaid insuring agreements. Its affiliated, for-profit subcontractor realized an average profit of 32 percent of costs. Five of the

six contracts included provisions whereby the State would share in contractor profits. However, since almost all profits accrued to the affiliated subcontractor, the States could not share them.

RECOMMENDATIONS TO HEW

HEW should

--improve its assistance to States procuring Medicaid insurance contracts,

--improve its contract approval and monitoring functions, and

--revise its Medicaid contracting regulations.

RECOMMENDATIONS TO THE SUBCOMMITTEE

GAO identified a number of State laws which restricted competition for Medicaid insurance contracts or gave a competitive advantage to some potential contractors. The Subcommittee should

--develop legislation to amend the law to prevent Federal sharing in the cost of Medicaid contracts when State laws have restricted competition or provided competitors with a competitive advantage. (See p. 44.)

HEW, STATE, CONTRACTOR, AND SUBCONTRACTOR COMMENTS

HEW agreed with GAO's findings. It said that the report should be useful to HEW and the States in improving Medicaid contracts and contracting procedures. It concurred in all of GAO's recommendations and said it was taking actions to implement them. (See app. IV.)

Some States and contractors disagree with some of the information in this report. However, the data GAO gathered supports the information.

Contents

ABBREVIATIONS

EDS	Electronic Data Systems Corporation
EDSF	Electronic Data Systems Federal Corporation
GAO	General Accounting Office
HAS	Health Application Systems, Inc.
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
PAID	Paid Prescriptions, Inc.
SRS	Social and Rehabilitation Service

CHAPTER 1

INTRODUCTION

Medicaid is a Federal/State program for financing the health care of public assistance recipients and other low-income individuals and families. States have the primary responsibility for creating and operating their Medicaid programs. At the Federal level, Medicaid was administered until March 1977 by the Social and Rehabilitation Service (SRS) of the Department of Health, Education, and Welfare (HEW). On March 8, 1977, the Secretary of HEW announced a reorganization which abolished SRS and transferred Federal Medicaid administration to the newly established Health Care Financing Administration (HCFA). Our fieldwork for this report took place before March 1977, therefore, this report refers to SRS as the Federal administrative agency for Medicaid.

Normally, States have either administered their Medicaid programs directly or contracted with firms to administer the Medicaid claims payment process, paying such firms on a cost reimbursement or fixed-price-per-claim-processed basis. Firms with these claims processing agreements are called fiscal agents. However, some States have decided to administer all or part of their Medicaid programs by contracting with private firms for insurance coverage for Medicaid eligibles. Under insuring agreements, the contractor is responsible for paying all valid claims for covered services received by eligible persons in exchange for a predetermined per capita premium. The contractor is at risk because, if the costs of paying claims exceed premium payments, the contractor could suffer a loss.

Texas has had a Medicaid insuring agreement covering several types of medical services (primarily inpatient hospital and physician services) since 1967. Since 1972 Arkansas, California, Louisiana, Florida, Maine, North Carolina, and Pennsylvania have used insuring agreements for administering their Medicaid drug programs. California also entered into an insuring agreement in 1974 for dental services under its Medicaid program; and, in April 1975, North Carolina entered into an insuring agreement that covered all aspects of its Medicaid program, except for determining program policy and recipient eligibility, inspecting and certifying medical providers, and processing

and paying drug claims (which were already administered under a separate insuring agreement). All these contracts were included in our study.

By letter dated May 22, 1975 (see app. I), the Chairman, Subcommittee on Health, Senate Committee on Finance, requested that we review North Carolina's multiservice insurance contract as the first stage of a broader review of HEW's and various State's policies and procedures for awarding insurance-type contracts.

The Chairman expressed concern about

--the extent of HEW's involvement in the North Carolina contract award and

--HEW's capability to monitor such contracts and to assess contractors' performance.

The results of our North Carolina review are contained in our report of July 1, 1976, to the Chairman, Subcommittee on Health, Senate Committee on Finance. 1/ The report pointed out that

--competition for the contract was limited because of a number of conditions surrounding the procurement;

--the contractor's proposed price received limited evaluation;

--the State directed its negotiations at obtaining advantages which, in fact, were already in the contractor's proposal;

--most benefits claimed for the contract would either not materialize or were not related to the contract's insurance feature;

--HEW had limited involvement in preselection activities but more involvement in contract negotiations; and

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1/"North Carolina's Medicaid Insurance Agreement: Contracting Procedures Need Improvement" (HRD-76-139).

--the contractor was having financial difficulties under the contract and notified the State that it was contemplating termination.

In August 1976 the contract's insurance aspect was terminated effective July 1, 1976. The State agreed to pay the contractor an additional $16 million and the State hired the contractor to act as the State's fiscal agent.

The results of our broader review of HEW and State policies and procedures for awarding insurance-type contracts are discussed in this report. The scope of review is discussed in chapter 7. The contracts, contractors, and subcontractors included in the review are listed in appendix II.

THE MEDICAID PROGRAM AND ITS ADMINISTRATION

Title XIX of the Social Security Act (42 U.S.C. 1396) authorizes Federal financial participation in State medical assistance (Medicaid) programs which conform to the provisions of the act. The Federal Government pays 50 to 78 percent (depending on the State's per capita income) of the costs for providing Medicaid medical services.

Medicaid recipients include persons or families receiving or entitled to receive cash assistance payments under the Supplemental Security Income or Aid to Families with Dependent Children programs. These recipients are referred to as the categorically needy. In addition, States may pay for medical care to medically needy persons and their families (individuals whose income exceeds the State's standard under the appropriate cash assistance plan, but is insufficient to meet their medical costs). As of January 1977, 49 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands had operational Medicaid programs, and 32 of these jurisdictions had elected to pay for care to the medically needy.

The Social Security Act requires that a State desiring Federal sharing in the costs of its Medicaid program submit to the Secretary of HEW a plan for medical assistance which meets the conditions specified in the act, and that the Secretary approve any State plan which meets those conditions. The approved State plan is the basis on which the Federal Government shares in the costs of a State's Medicaid program.

Until March 1977 the Secretary of HEW had delegated the responsibility for Federal Medicaid administration to the Administrator of the Social and Rehabilitation Service. Authority to approve State Medicaid plans had been delegated to the SRS regional commissioners, who administered the program's field activities through HEW's 10 regional offices. The commissioners were to determine whether State programs comply with Federal requirements and approve State plans.

For a State to get Federal approval for its Medicaid plan, the State must provide inpatient and outpatient hospital care, physician services, X-ray and laboratory services, skilled nursing facility services, home health services, family planning services, and early and periodic screening, diagnosis, and treatment services for eligible recipients under 21 years of age. States can, at their option, cover virtually any other medical or remedial care under the Medicaid plans.

LEGAL AND REGULATORY BASIS FOR MEDICAID INSURANCE AGREEMENTS

The Social Security Act specifies, in section 1902 (a)(4)(A) (which deals with the requirements for State Medicaid plans), that the plan must provide for "* * * such methods of administration * * * as are found by the Secretary to be necessary for the proper and efficient operation of the plan." The act also states, in section 1903(a)(1)(B) (which deals with Federal sharing of Medicaid costs), that funds are available for sharing the costs of "* * * insurance premiums for medical or any other type of remedial care or the cost thereof." Based on these two provisions, the Secretary has determined that insurance agreements are an acceptable method for administering all or part of a State Medicaid program.

To determine the congressional intent in allowing Federal participation in the costs of Medicaid insurance agreements, we researched the provision's legislative history. We found that the sharing provision was a carryover from the Kerr-Mills Act (Public Law 86-778, Sept. 13, 1960), which preceded Medicaid and provided medical assistance to the aged. The provision in the Kerr-Mills Act was, in turn, a carryover from the medical assistance provisions contained in the preceding cash assistance programs for the aged, blind, disabled, and dependent children. The sharing provison was added to the Social Security Act by the 1956 Amendments (Public Law 85-239,

Aug. 30, 1957), but the congressional legislative committee reports relating to those amendments did not say why the provision was included. We found, however, that H.R. 81-1300 on the Social Security Amendments of 1950, (Public Law 81-734, Aug. 28, 1950), which first provided medical assistance to the aged stated:

> "Some [State] assistance agencies consider it preferable to pay the medical practioner or institution that supplies the medical care directly. Some State agencies have wanted to insure their clients' needs for medical care with organizations for group care such as Blue Cross."

Thus, it appears that the provision providing for Federal participation in Medicaid insurance agreements was included because some States desired this method for administration as long ago as 1949.

HEW regulations governing Medicaid insurance agreements

HEW Medicaid regulations (45 C.F.R. 249.82) provide for Federal financial participation in costs paid by a State to health insurance organizations, fiscal agents, or private nonmedical institutions under contracts for administration of a State's program.

When the contracts included in our review were initially proposed, negotiated, and awarded, regulations did not require HEW's prior insurance contract approval. The regulations were amended effective August 9, 1975, to require prior approval of all contracts costing more than $100,000.

States are also required to follow the procurement standards listed in 45 C.F.R. 74.150 through 74.159 when they procure Medicaid insuring agreements. These procurement standards prohibit conflict of interest in procurement actions, require free and open competition, establish procedural requirements and criteria for the types of procurements that can be negotiated, require the inclusion of certain clauses in contracts, and require States to have adequate contract administration systems. States are not required to follow the Federal Procurement Regulations, but instead can use their own procurement policies as long as they meet the standards contained in 45 C.F.R 74.150, et seq.

Regulations governing contracts with health-insuring organizations are discussed in greater detail later in this report.

CONTRACTORS AND SUBCONTRACTORS INVOLVED IN MEDICAID INSURING CONTRACTS

Between 1967 and 1976, seven different companies entered into insurance-type contracts with one or more States to administer some benefits of the State Medicaid programs. We reviewed States contracts with six of these companies. 1/ A discussion of the contract arrangements with the States, and the organizational relationships and business involvements of these six contractors and their major subcontractors follows.

Group Hospital Service, Inc. (Blue Cross of Texas)

Blue Cross of Texas, a not-for-profit health insurance corporation, through its fiscal agent organization, Group Hospital Service, Inc., have had an insurance-type contract 2/ with Texas since 1962 for several types of medical services provided under the State's medical assistance programs. In 1967 when Texas consolidated its previous medical assistance programs into a Medicaid program, it unsuccessfully attempted to solicit bids from additional firms--Group Hospital Service thus retained the program with the original contracts. The State resolicited the contract in 1976 and received three proposals. (See p. 24.)

Paid Prescriptions, Inc.

Paid Prescriptions, Inc. (PAID), is a California not-for-profit corporation which either currently has, or until recently had, insurance-type contracts with Arkansas,

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1/Prudential Insurance Company had Medicaid insurance agreements with two States in the late 1960s. Since these contracts were not in force at the time of our review, they were not included.

2/Actually there were three essentially identical agreements covering different categories of eligible recipients. In this report we will consider the three contracts as one.

California, Florida, Maine, North Carolina, and Pennsylvania to administer these States' Medicaid drug programs on a prepaid capitation basis. In addition to its Medicaid drug contracts, PAID has numerous drug contracts with insurance firms and private organizations.

PAID had an agreement with Health Application Systems, Inc. (HAS), under which PAID was obligated to subcontract with HAS for computer and marketing services for all PAID's contracts. HAS had exercised control over PAID since 1969 through a series of such agreements. For a more detailed discussion of the HAS/PAID relationship see page 67.

Developments in February and March 1977 affected the relationship between PAID and HAS. These changes are discussed in the next section.

HAS

HAS was a for-profit corporation which offered systems consulting, design, and implementation, and computer processing services in the health care area. HAS was a wholly owned subsidiary of the Bergen-Brunswig Corporation, a manufacturer of health products and a leading distributor of pharmaceutical products.

In addition to its relationship with PAID, HAS contracted directly with North Carolina to undertake all aspects of the State's Medicaid program except for determining program policy and recipient eligibility, inspecting and certifying providers, and processing and paying drug claims. The agreement, which covered all benefits except drugs, was executed on April 28, 1975, and called for HAS to function as a fiscal agent during May and June 1975 and as an insurer from July 1, 1975, through June 30, 1977. However, HAS exercised its option under the contract to cancel on 120-days notice and the State and HAS agreed to terminate the agreement effective June 30, 1976, 1 year before the scheduled expiration date. (See p. 46.)

On February 26, 1977, PAID, HAS, and Bergen-Brunswig entered into an agreement which would grant PAID many of HAS' assets and most of HAS's contractual requirements. Bergen-Brunswig had decided to divest itself of data processing activities performed by HAS because of financial difficulties HAS was having. HAS's Medicaid insuring

agreement with North Carolina had been terminated, effective June 30, 1976, but HAS continued to administer the program as a fiscal agent. HAS lost this fiscal agent arrangement in January 1977.

The Department of Defense notified HAS in August 1976 that it would not exercise the Department's option to extend HAS's fiscal agent contract for the Departments's health insurance program for dependents of active duty and retired military personnel. HAS then asked for and was granted early termination of the contract.

Also, in March 1977, PAID was considering converting itself (including the acquired portion of HAS) into a for-profit corporation called Professional Health Services, Inc., which had been incorporated in Delaware on February 16, 1977.

The relationship between PAID and HAS discussed in this report relates to the relationship which existed between the two entities prior to February 1977.

Lincoln National Life Insurance Company

Lincoln National Life, a for-profit corporation, entered into a 9-month contract, renewable for an additional year and effective October 1, 1975, with Louisiana to administer that State's Medicaid drug program. Lincoln, with corporate offices in Indiana, is the Nation's tenth largest life insurance company.

Under the contract's terms Lincoln assumed risk under the contract and subcontracted for a percentage of contract premiums with Pharmaceutical Card Systems, Inc., to perform all the program's administrative functions. Lincoln and Pharmaceutical Card have been involved as insurers and administrators on other drug programs, but no corporate relationship exists between the two companies.

Pharmaceutical Card Systems, Inc.

Pharmaceutical Card is a for-profit company which develops prescription drug claim administration systems and processes drug claims. It is a wholly owned subsidiary of Foremost-McKesson Incorporated, which is the parent company of McKesson and Robbins Drug Company, the world's largest drug wholesaler.

Pharmaceutical Card's Louisiana operation was incorporated as a wholly owned subsidiary solely to administer the Louisiana drug program. The Louisiana drug contract is Pharmaceutical Card's first experience with a Medicaid drug program; however, it administers prescription drug plans covering individuals in employee groups of all kinds throughout the United States and has bid on several Medicaid drug contracts.

Electronic Data Systems Federal Corporation (EDSF)

EDSF is a wholly owned subsidiary of Electronic Data Systems (EDS) Corporation. Formed in 1962, EDS designs, programs, installs, operates, and maintains management information systems under long-term fixed-price contracts with corporate customers and Government agencies. EDSF, incorporated in 1969 under the Texas Business Corporate Act, provides claims processing services mostly as a fiscal agent or as subcontractor for a fiscal agent for various government health care programs, including Medicaid in several States. Effective August 1, 1976, North Carolina awarded EDSF a prepaid insurance-type contract for that State's Medicaid drug program, the first prepaid Medicaid contract received by EDSF. EDSF also bid on the 1976 solicitation for Texas' Medicaid insurance agreement and was awarded that contract, effective January 1, 1977.

California Dental Service, Inc.

California Dental Service, Inc., is a not-for-profit health services organization administering prepaid dental programs in California. It was formed by the California Dental Association and incorporated in 1955, designated as the California Dental Association Service. The California Dental Service entered into its first dental service contract in 1957. Effective January 1, 1974, the California Dental Service was awarded a 4-year prepaid dental service contract for California's Medicaid recipients.

CHAPTER 2

HEW'S ROLE IN STATE PROCUREMENT OF MEDICAID INSURANCE-TYPE CONTRACTS WAS MINIMAL

HEW's role in developing and awarding Medicaid insurance-type contracts, executed before August 9, 1975, was minimal because Federal regulations in effect before that date did not require HEW's prior approval of such contracts and most States did not seek HEW advice or assistance in Medicaid contract procurement matters. Federal regulations were revised, effective August 9, 1975, to require written prior approval by HEW of all Medicaid contracts expected to involve expenditures greater than $100,000. However, the revised regulations do not require that HEW become actively involved in contract development and award. For that reason, HEW has continued to participate in State procurement activities only when and to the extent requested by the States. Because HEW written approval is now required, some States have increased their requests for HEW participation and HEW has intensified its contract review for compliance with Federal regulations.

HEW reviews all Medicaid insurance contracts to determine whether contract costs are eligible for Federal financial participation. However, contracts entered into before the regulations were revised usually were not reviewed by HEW until after they were awarded.

Although HEW did not disapprove any contracts for participation, one contract was amended at HEW's suggestion to bring it into compliance with Federal requirements. Also, one contract was conditionally approved by HEW, but HEW did not follow up to see whether the State complied with the conditions of approval. One contract approved for Federal participation by HEW included costs we estimated at $3.7 million not eligible for Federal sharing; two States claimed, and HEW allowed, Federal participation at an incorrect rate on costs of about $181,000.

HEW WAS NOT INVOLVED IN CONTRACT DEVELOPMENT AND AWARD

SRS regional officials said that before regulations were revised in August 1975, SRS had no authority to require

that States submit requests for proposals, contractors' proposals, proposed contracts, etc., for HEW review and comment or to otherwise become directly involved in States' procurement activities. Consequently, HEW had little involvement in the development and award of 8 of the 10 Medicaid insurance-type contracts awarded before August 9, 1975. HEW did participate, on a limited basis and at the State's request, in the development and award of the Medicaid drug and the Medicaid multiservice contracts awarded by North Carolina.

HEW and North Carolina officials said that although the State did not seek HEW's assistance in preparing the request for contract proposals, it asked an SRS regional medical services representative to suggest firms to which the request for a Medicaid multiservice contract might be sent. The State agency also sent a copy of the contractor's proposal to the SRS Regional Commissioner, whose staff made a limited review. In addition, numerous meetings occurred between SRS regional staff and State personnel during contract negotiations and contract document preparation. After several questions raised by HEW were satisfactorily resolved, the SRS Regional Commissioner approved the contract for Federal sharing.

Correspondence with the State agency showed that, before North Carolina executed its initial drug contract effective December 1, 1972, State officials asked HEW central office officials whether other firms were offering the prepaid drug service offered by PAID. An HEW official responded "* * * to our knowledge there is no organization which offers a similar pre-paid prescription program." The State agency then provided the SRS Regional Commissioner with copies of PAID's proposal and the proposed drug contract. Several questions raised by SRS were apparently resolved and the Regional Commissioner approved the contract for Federal participation in October 1972.

Louisiana submitted a copy of the request for proposals for the State's drug contract, effective October 1, 1975, to the Associate SRS Regional Commissioner for Medical Services. Several SRS officials reviewed the request and expressed, within the regional office, the following concerns:

--The prerequisite for prior experience in prepaid pharmaceutical insurance programs could restrict competition and inhibit new contractors with ideas or innovations.

--Prospective contractors might need more detailed data to make a reasonable bid on the required services.

--More current and projected costs on Louisiana's drug program would be necessary to effectively evaluate the pricing aspects of the proposals.

--A feasibility study had not been made to determine the reasonableness of contracting for the drug program's administration.

These concerns were not communicated to the State agency, however, because the State agency issued the request for proposals before SRS officials completed their review.

A copy of the proposed Louisiana drug contract was submitted to the SRS Associate Regional Commissioner for Medical Services for his review. Records at the SRS regional office indicated that the proposed contract was reviewed by an SRS representative, who observed that it did not contain all Federal "boiler plate" clauses. There was no evidence, however, that this matter was discussed with State officials. SRS regional officials cited a lack of authority as the reason for not becoming more involved in Louisiana's contracting process.

In addition to a lack of authority, other reasons cited by SRS regional officials for noninvolvement in developing and awarding Medicaid insurance-type contracts were

--the States did not seek HEW involvement,

--the contracts were for pilot projects and the normal procurement process was not applicable, and

--HEW lacked adequate staff resources and contracting expertise.

HEW APPROVES CONTRACTS FOR FEDERAL FINANCIAL PARTICIPATION

HEW reviewed executed contracts to determine whether contract costs would be eligible for Federal financial participation. However, before regulations were revised on August 9, 1975, HEW's review may not have taken place until after the contract was awarded because contracting for administration of a State's Medicaid program was generally considered to be only a change to a State's Medicaid plan.

A State, therefore, may not have informed the appropriate SRS regional commissioner of the change in the program administration method until it claimed Federal participation under the revised State plan.

Certain minimum Federal requirements must be met for costs incurred under a Medicaid insuring agreement to be eligible for Federal participation. Before August 9, 1975, regulations required that, as a minimum, insurance contracts must:

--Identify the amount of the premium to be paid, when it is to be paid, and the coverage group and contract period.

--Specify the amount, duration, and scope of medical care and services to be provided, and the fee schedule or other basis on which the contractor will pay providers.

--Provide that the premium payment would constitute full discharge of the State's responsibility for costs of covered services received by eligible recipients during the contract period.

--Require that the contractor maintain and provide records necessary for the State to meet requirements for reporting placed on the State by the Federal agency, and that the contractor furnish other reports as required by the State or local agency.

--Specify the time the contract would be in effect, with provisions for termination.

HEW did not disapprove Federal sharing for any Medicaid insurance contracts awarded under these regulations. However, as a result of HEW's review, the California dental contract was amended after it was awarded and HAS's North Carolina multiservice contract was revised before it was finalized.

The California dental contract became effective January 1, 1974. It was amended in November 1974 after HEW's review disclosed that it contained a loss-sharing provision that violated the regulatory requirement that premium payments constitute full discharge of the State's contract financial responsibility. To correct this situation, the contractor agreed to eliminate the loss-sharing provision in exchange for an increase in the contractor's premium to offset the additional underwriting risk assumed by the contractor.

HEW officials raised several questions during their review of the North Carolina Medicaid multiservice contract. Probably the most important question raised concerned whether a contract which made the State responsible for yearend cost settlements with institutional providers violated the regulation requiring that the premium payment constitute full discharge of all State responsibility for costs of covered medical care and services. The HEW General Counsel's office took the position that the contract did not meet the minimum requirements whereas SRS regional officials took the opposing position.

However, because changes to the applicable regulations allowed responsibilities to be apportioned between the States and the contractor (published in the "Federal Register" on May 9, 1975, and effective August 9, 1975), the point became moot and the HEW General Counsel's office dropped its objection. After other less important questions were resolved, the SRS Regional Commissioner told the State agency that HEW had determined that the contract for the period beginning July 1, 1975, met Federal regulations for a health-insuring arrangement. This effectively approved the contract for Federal sharing.

Need to strengthen HEW's procedures for review and approval

Although we did not determine whether all contracts approved by HEW for Federal sharing met all minimum Federal requirements or whether all costs claimed by the States were eligible for Federal sharing, we noted that HEW:

--Allowed sharing under two contracts even though they contained a provision which could have resulted in contractors recouping their losses.

--Approved one contract contingent upon several conditions but did not follow up to determine whether the conditions were met.

--Approved one contract which included an estimated $3.7 million in costs that were not eligible for Federal sharing.

--Allowed sharing at the incorrect rate on about $180,000 of costs claimed under two contracts.

Approved contract contained loss recoupment provision

The Pennsylvania drug contract, which became effective November 6, 1974, with the insuring feature effective February 1975, contained a loss recoupment provision similar to the provision that HEW required California to eliminate from its dental contract to bring that contract into compliance with regulations. The Pennsylvania contract provided that the contract could be continued from fiscal year to fiscal year at the same premium rates and terms. The contract also provided that, if the contractor suffered a loss in one year, it could offset the loss with profits from subsequent years. Thus, it was possible that payments made in one year could be used to offset losses incurred in a previous year. The provision was mitigated somewhat in the Pennsylvania contract because it could only be extended at the same premium rates. However, we believe this type of provision tends to reduce the risk assumed by the contractor. HEW regulations in force at the time the Pennsylvania contract was awarded specified that premium payments must fully discharge the States from responsibility for costs of covered medical care provided during the contract period to covered recipients. The revised HEW regulations effective in August 1975 expanded on, and clarified, this provision by stating that premiums could not include payments for recoupment of losses incurred by the contractor under the same or any prior contract. The Texas contract with Group Hospital Services also included a recoupment provision which is discussed on page 57.

Pennsylvania's follow-on contract with PAID, effective July 1, 1976, did not include this recoupment provision.

Conditions for contingent approval were not met

The SRS Regional Commissioner, in a letter dated July 17, 1974, advised Florida that SRS had conditionally approved the State's drug contract. Some of the more important conditions of approval were that

--SRS be notified at least 60 days before the contract was amended or terminated,

--the State had followed Medicaid procurement regulations (SRS had not determined so before the conditional approval), and

--the State monitor the contractor to make sure that Medicaid eligibles received quality services.

SRS did not follow up, however, to assure State compliance with these conditions and some key SRS officials responsible for Federal administration of the Florida Medicaid program did not know that the contract had only been conditionally approved. One SRS regional official said that he knew the State did not comply with Medicaid procurement standards.

We found that none of the conditions of approval listed above were fully met by the State. For example, without advance notice to HEW, the State negotiated contract changes which increased premiums and reduced recipient benefits. These changes were made in a contract amendment effective May 16, 1975, but SRS regional officials were not informed about the amendment until May 19, 1975. Upon notification that the contract had been amended, the Associate Regional Commissioner for Medical Services advised the State to send the amendments through the regular procedure for processing a change to the State plan " * * * sometime during the quarter."

Florida's procurement procedures for drug contracts did not meet Federal requirements because the State did not seek competition, justify sole-source negotiations, or document negotiations. Also, State officials acknowledged that the contract had not been monitored adequately because the contract-monitoring staff position had been vacant since August 1974.

In commenting on this section of our draft report, Florida stated that the State had "strived hard to meet all known requirements and to take all precautionary measures" in the initiating of its drug insuring agreement. The State said its failure to inform HEW about the May 1975 contract amendment until after it was signed was because the amendment resulted from an acute emergency situation. As discussed on pages 49 to 56, the State did negotiate this change after the contractor notified the State it would terminate the contract unless it was amended.

Florida also commented that at the time of its 1974 contract award, there was no Federal requirement for solicitation. As we have stated, 45 C.F.R. 74.153, which was in effect at that time, required States to conduct procurement actions so as to provide maximum open and free competition.

Costs not eligible for Federal participation were allowed

North Carolina had claimed $926,725 in Federal sharing for ineligible costs for the period July 1975 to March 1976 under its multiservice contract, and HEW had paid the State $317,238 of this amount. The overpayment occurred because the contract required that the contractor pay a monthly premium to the Social Security Administration to enroll certain individuals under part B of the Medicare program. Some of the enrolled individuals were not eligible for cash welfare payments and, according to Federal law, Medicare buy-in premiums paid by States on behalf of such individuals are not eligible for Federal cost sharing under Medicaid. In June 1976, after we brought this matter to the attention of SRS regional officials, the SRS Regional Commissioner notified the State that HEW was recouping the $317,238, that the remainder of the claimed Federal sharing ($609,487) was being denied, and that all further claims for Federal sharing in the cost of premiums paid to Medicare for individuals not eligible for cash assistance would be denied.

We estimate that buy-in premiums for individuals not eligible for Federal sharing would have totaled $3.7 million--a $2.5 million Federal share--had not the 2-year risk contract been terminated before its scheduled expiration date.

Federal cost sharing at incorrect rate

Arkansas and Maine had been overpaid $31,882 because they claimed, and the respective SRS regional offices allowed, Federal sharing on family planning drug costs at the 90-percent rate rather than at the two States' approved medical assistance rates. 1/

The Social Security Act establishes specific rates for Federal sharing in certain allowable Medicaid costs; for example, 50 percent for administrative costs, 75 percent for training costs, and 90 percent for family planning services. HEW regulations state, however, that sharing will be allowed at the State's medical assistance rate for total premiums paid to a health-insuring organization for carrying out all the provisions of the contract, including administration,

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1/A State's medical assistance rate is determined by comparing the State's per capita income with per capita income nationwide.

training, and family planning. Furthermore, the Commissioner, Medical Services Administration, SRS, issued a policy interpretation on July 3, 1975, concerning this matter. The Commissioner's interpretation stated that

> "Some states have arrangements with insuring agencies to furnish a package of Medicaid services for one inclusive premium rate per recipient. Where such arrangements include activities relating to * * * family planning services, the State may wish to take advantage of the increased Federal matching for these services * * *. To do so, the State agency must segregate the costs of these services * * * from the insurance arrangements (changing the premium accordingly) and reimburse the administration costs of such services * * * under a standard fiscal agent arrangement."

Both Arkansas and Maine required the contractor to identify costs incurred for family planning services, but the two States did not separate the costs of these services from the insurance arrangement and handle them on a fiscal agent basis. Instead, the cost of services which were covered by the insurance premiums were identified so that Arkansas and Maine could claim the difference between sharing at the medical assistance percentage in the premiums paid to the contractors and the 90-percent sharing which would have been allowed had the services been covered by a fiscal agent arrangement.

Between September 1, 1973, and June 30, 1975, Arkansas claimed and HEW allowed 90-percent Federal participation on $68,344 of family planning drug costs. Arkansas' medical assistance rate was 76.37 percent during this period. Therefore, Arkansas was overpaid about $9,367. We did not compute the amount of drug costs claimed by Arkansas at the 90-percent rate after June 30, 1975.

During Maine's 11-month drug contract, the State claimed and HEW allowed 90-percent Federal participation on $112,744 of family planning drug costs. Thus, Maine was overpaid about $22,515 because that State's medical assistance rate was 70.03 percent during the contract period.

SRS officials in both regions agreed to review the claims submitted by States for sharing in family planning costs at the 90-percent rate and to act to recover funds inappropriately claimed and prevent further payment of such claims. Subsequently, these funds were recovered from Maine.

HEW INVOLVEMENT IN DEVELOPMENT AND AWARD OF CONTRACTS EXECUTED UNDER REVISED REGULATIONS

The revised Federal regulations, effective August 9, 1975, generally strengthened HEW's role in review and approval of Medicaid insurance-type contracts. The revised regulations do not, however, require that HEW participate actively in contract pre-award activities. Thus, the extent of HEW's role in such activities is still essentially advising and assisting the States at the States' request.

Revised regulations

Probably the most important provision of the revised regulations is the requirement for HEW prior written approval of expenditures under contracts expected to exceed $100,000. The revised regulations also require, among other things, that a contract with a health insuring organization:

--Have reasonable premium rates.

--Prohibit payment for recouping any losses incurred under the same or prior insurance agreements.

--Specify the actuarial basis for computation of the premium rates.

HEW implementation of revised regulations

After the regulations were revised, but before our field work was completed in August 1976, four prepaid Medicaid contracts included in our review were resolicited. Florida, North Carolina, and Pennsylvania resolicited their drug contracts and Texas resolicited its Medicaid multiservice contract. We reviewed implementation of the revised regulations by two SRS regions (Atlanta and Dallas) in which three of the four contracts were resolicited.

Compared to involvement in procurement of the three prior contracts, which did not require prior written HEW approval, HEW participation in States' procurement activities during the contract renewal process remained unchanged unless the States sought more advice and assistance from HEW. However, HEW intensified its review of the completed contract documents and supporting data for compliance with Federal regulations.

One problem we noted was the lack of guidelines from SRS headquarters to the regional offices on how to make sure that the regulatory requirements for insurance agreements are met. This is particularly true with respect to making sure that the premium rates are fair and reasonable. SRS regional officials stated that they did not have qualified personnel to determine if premium rates are fair and reasonable. In two reports on the Medicaid prepaid health plan program 1/ we discussed the lack of guidelines for establishing premium rates, and have recommended that such guidance be provided to the HEW regions and the States. As of October 1977, such guidance had not been forthcoming, although HEW had awarded a grant to California to develop such guidance. We believe it is difficult for the HEW regions to assure compliance with Federal requirements for pricing insurance agreements because guidance from SRS headquarters and qualified personnel in the HEW regions are lacking.

The following sections discuss how HEW's Atlanta and Dallas regional offices implemented the August 1975 regulations.

Atlanta region

The SRS Regional Commissioner, Atlanta, in a memorandum to State Medicaid agencies dated September 26, 1975, emphasized the new Federal regulations and advised States that the revised regulations required that HEW take a more active role in preliminary contract activities; encouraged States to make full use of HEW regional staff, particularly in the planning phase and in interpreting and implementing Federal regulations; and requested that for each planned contract the State submit for review by SRS regional staff

--the request for proposals;

--documentation supporting final contractor selection;

--documentation supporting the contract price;

--proposed contract documents; and

1/"Better Controls Needed for Health Maintenance Organizations Under Medicaid in California," B-164031(3), Sept. 10, 1974, and "Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program" MWD-76-15, Aug. 29, 1975.

--a work plan showing State and contractor responsibilities, major tasks, and contract milestone schedules.

The Regional Commissioner also advised the States that SRS would need 30 days minimum to review the documents and decide whether the contract should be approved.

SRS's actual involvement in Florida's and North Carolina's procurement activities when their drug contracts were renewed under the revised regulations essentially consisted of providing technical assistance as requested by the States, reviewing the contract procurement and supporting documents for compliance with Federal regulations (45 C.F.R. 249.82 and 45 C.F.R. 74 subpart P), and approving the final contract for Federal sharing. SRS did not participate in developing and issuing a request for proposal, contractor selection, contract negotiations, or contract development and did not determine the reasonableness of contract prices. SRS concluded, however, that neither of the two contracts--as formally agreed to and executed by the contracting parties--fully complied with applicable Federal regulations. The States subsequently modified the contracts to overcome HEW's objections, as discussed below.

Florida submitted the final contract document to SRS on June 24, 1976, 2 days after the State and the contractor had signed it, and then requested that SRS approve the contract by July 1, 1976, its scheduled effective date--SRS had advised the States that it would need a minimum 30 days for its review. Although SRS expedited its review, several regulatory compliance questions were raised and the review was not completed until July 9, 1976. Among other things, SRS raised questions regarding whether:

--It could retroactively approve the contract to July 1, 1976.

--The software developed under the contract should be State property rather than contractor property as provided in the contract.

--The State and SRS could be assured reasonable premium rates for the last 2 years of the 3-year contract--since the rates would be renegotiated without the benefit of competition.

--The contractor should be required to maintain cost records in Florida rather than in California, so the State and SRS could determine if profits are accurately reported in accordance with the contract's terms.

--The State should be provided the right to terminate the contract for cause since the contractor had been provided such a right.

--The provision that the contractor could obtain reinsurance for 90 percent of any losses it might incur and, thereby, only retain 10 percent of the risk constituted a significant risk of loss to the contractor as required by the definition of underwriting risk.

After the State and the contractor resolved, or agreed to resolve these questions, SRS approved the contract effective July 9, 1976. Later correspondence showed that HEW would not participate in costs incurred before the effective date. The State agency advised SRS on July 19, 1976, however, that the contractor would not agree to make July 9, 1976, the effective contract date. The State agency claimed that the State and the contractor had intended that the new negotiated premium rates become effective July 1, 1976. However, SRS refused to retroactively approve the contract.

State agency officials said that to resolve the situation the effective date of the revised premium rates would be July 1, 1976, but that the claim for Federal sharing for the period July 1 to 9, 1976, would be limited to the amount that would have been claimed had the old rates under the old contract remained in effect until July 9.

At the State's request, SRS regional officials reviewed and commented on North Carolina's draft request for proposals for the resolicitation of its drug insuring agreement. The comments included the following:

--The option for contract renewal outlined in the request for proposals was unacceptable.

--The contract termination clause included in the request was not acceptable.

--The request did not stipulate that the contract would require the contractor to furnish within 10 days, on demand by the Federal or State government, supporting data for the required summary reports.

SRS's comments on the draft request for proposals were not incorporated into the document before it was released on February 16, 1976. The SRS Regional Commissioner advised the State, however, that the substance of her comments about deficiencies in the request for proposals would have to be

rectified in the final contract before SRS would approve it for Federal financial participation.

North Carolina received two proposals in response to this request. One proposal was submitted by PAID and one by EDSF. Following receipt of the proposals, the State required that each firm furnish additional data which, together with data furnished in the two proposals, were evaluated by the State's purchasing and contracting office with the assistance of other concerned State offices. On May 4, 1976, the purchasing and contracting office advised EDSF that it had been selected to receive the contract. However, during contract negotiations, the State and EDSF could not reach agreement on the dollar amount that EDSF should receive for retroactive eligibles 1/, so the State ended negotiations with EDSF.

In a May 17, 1976, letter, the State told PAID that if PAID agreed to certain contractual conditions it could receive the contract. However, the North Carolina Advisory Budget Commission, which had final contract approval authority, would not approve PAID as the contractor at its June 18, 1976, meeting and the purchasing and contracting office reopened negotiations with EDSF.

On July 2, 1976, a prepaid contract for Medicaid drug program administration from August 1, 1976, through June 30, 1977, was executed between the State and EDSF. A copy of the contract was delivered to the SRS Regional Commissioner on July 9, 1976, for review. In a letter dated July 23, 1976, the Regional Commissioner outlined several conditions that would have to be met for the contract to be eligible for Federal participation. One condition was that the State's

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1/Retroactive eligibles are those individuals whose date of Medicaid eligibility is established at a date prior to the day the State determines that a person is eligible. Almost everyone who becomes eligible for Medicaid has a retroactive eligibility period because the latest eligibility date a person receives is the date the person applied for eligibility. Eligibility determinations often take several months to complete after application. Also, the eligibility date can be established up to 3 months before application if the person was eligible during this period. Thus, a person can receive a number of months of retroactive eligibility. For example, if a person applies in July and is determined eligible in September he or she could be certified as eligible beginning in April. In other words, he or she would receive 5 months of retroactive eligibility.

contract award procedures be reviewed by the State Attorney General for compliance with State laws. This condition of approval was established because PAID had filed a protest with the State alleging irregularities in the handling of the award, including an allegation that the State had turned over PAID's bid and supporting data to EDSF.

After the State Attorney General concluded that there were no apparent violations of North Carolina contracting laws and a contract amendment was executed incorporating SRS-suggested changes into the contract, SRS approved the contract for Federal financial participation.

Dallas region

SRS regional officials in Dallas said that they had not issued any supplementary instructions regarding the revised regulations. However, we noted increased SRS participation in the procurement activities relative to readvertising and awarding the Texas multiservice contract in 1976.

Records at the regional office showed that SRS reviewed and commented on various aspects of the contract solicitation, and that a medical services specialist and a computer specialist from the regional office participated as advisors in the bid evaluation process. Increased SRS involvement is further illustrated by

--an attendance report by an SRS medical services specialist at a State agency policy committee meeting on the request for proposals and

--five letters from the SRS Regional Commissioner to the State agency (1) answering questions about the request for proposals, (2) commenting on an exposure draft for the request for proposals, (3) relaying an HEW regional attorney's opinion on State agency audit rights under the contract, (4) commenting on a sample contract document, and (5) relaying an HEW regional attorney's opinion on the legality of alternative proposals submitted by certain bidders.

We did not evaluate SRS participation in the procurement process because negotiations between the State agency and two of three initial bidders were still ongoing at the conclusion of our fieldwork in Texas in September 1976. Subsequently, Texas awarded the contract to EDSF effective January 1, 1977.

We noted that Texas had taken many steps to overcome deficiencies we identified in its earlier solicitation and solicitations by other States. These steps included widely publicizing its intentions to contract, providing extensive program data in the request for proposals, and extensive negotiations with offerors.

CONCLUSIONS

As a general rule, HEW was not actively involved in the procurement of Medicaid insurance-type contracts awarded before the Medicaid insuring agreement regulations were revised August 9, 1975. In those instances where HEW did participate in the procurement process, participation was in an advisory role and at the specific request of a State agency.

Our review of HEW's involvement in procurement activities of three contracts resolicited under the revised regulations showed that HEW's active participation in preaward activities increased slightly, but that it was still contingent upon requests from the State agencies.

HEW reviewed and approved Medicaid contracts for Federal financial participation. However, the review process needed to be strengthened because HEW had

--approved two contracts that contained a provision which could have resulted in contractors recouping their losses and thereby violate existing regulations,

--paid three States nearly $350,000 for costs either not eligible for Federal sharing or eligible for sharing at less than the rate paid, and

--failed to follow up to determine whether the State complied with the conditions of HEW's approval for one contract.

After the regulations were revised to require prior HEW approval of insurance-type contracts, the SRS regional offices intensified their review of final contract documents. However, because of a lack of guidance and a lack of qualified, experienced staff, the HEW regional offices' review of the contracts were hampered.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator of HCFA to:

--Issue to its regional offices guidance concerning their role in assisting States in (1) contracting for Medicaid insurance-type contracts and (2) the procedures and methods to be used in evaluating whether States have complied with Federal regulations for contracting under grants and obtaining Medicaid insurance contracts.

--Notify the States of assistance available from HEW during procurement of Medicaid contracts and to encourage States to utilize HEW's assistance.

HEW COMMENTS

HEW agreed with these recommendations and stated that it was in the process of revising the Medicaid contracting regulations (see p. 123). HEW also said it was preparing plans to allocate more headquarters and regional staff to contracting matters and to provide its Medicaid staff and State's Medicaid staff with training on procurement matters. HEW said it has determined that States also need more guidance and technical assistance in other types of Medicaid contracting, such as use of fiscal agents, health maintenance organizations, and data processing firms, and that HEW would increase its attention and activities in all these areas. In previous reports, we have pointed out Medicaid contracting problems with prepaid health plans and health maintenance organizations.

CHAPTER 3

STATES' PROCUREMENT PRACTICES DID NOT FOSTER COMPETITION OR MEET FEDERAL STANDARDS

HEW regulations applicable to contracting under grants (45 C.F.R. 74.151) allow States to use their own procurement policies for Medicaid procurement actions, provided their policies adhere to established Medicaid procurement standards. Procurement policies followed by States in obtaining Medicaid insuring agreements, however, generally did not adhere to Federal standards.

For most procurement actions initiated before 1976, most States did not (1) analyze the various alternatives for administering their Medicaid programs to determine whether insuring agreements were more economical and effective than other administration methods; 1/ (2) foster open and free competitive procurement practices; (3) adequately evaluate proposed contract prices; or (4) document contract negotiations.

For the most part contractors' proposed prices were accepted because they were less than the amount budgeted by the State for administering the program either by the State agency or through a fiscal intermediary. In our opinion, States' budget projections generally cannot be relied on to provide a sound basis for evaluating the reasonableness of proposed contract prices. Such projections frequently are not adequately supported and may be influenced by legislative actions and political considerations.

DECISIONS TO OBTAIN INSURING AGREEMENTS WERE OFTEN MADE WITHOUT ADEQUATE ANALYSIS OF ALTERNATIVES

The States' decisions to contract for the administration of various aspects of their Medicaid programs were not

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1/While such analysis is not required by Medicaid standards, we believe States should make them when considering obtaining insuring agreements because of the large value involved (usually millions of dollars). The Medicaid standards require that "Proposed procurement actions shall be reviewed by appropriate grantee officials to avoid purchasing unnecessary or duplicative items, * * *" and we believe such an analysis would help State officials meet this requirement.

supported by studies of the advantages and disadvantages of alternative means of administration. 1/ In some instances the decisions seemed to have been significantly influenced by unvalidated claims by prospective contractors.

Before executing contracts, State officials generally discussed the anticipated benefits of an insuring agreement with prospective contractors, often at the request of the prospective contractor. Contractors often promised States program cost savings, better and more comprehensive program data, improved utilization review, and more effective program management. States did little, however, to evaluate these claims. In retrospect, many of these claims were exaggerated or overstated.

Of the 10 contracts we reviewed, 4 were noncompetitively negotiated with one firm based on proposals from one prospective contractor. In at least two of the six other procurements, prospective contractors approached State officials about obtaining insurance agreements before the requests for proposals were issued. In fact, PAID, the successful bidder in Maine and Pennsylvania, assisted officials in those States in preparing the request for proposals or an earlier version thereof and in soliciting the proposals (see pp. 34 and 35). Also, the president of HAS, in a letter of September 16, 1974, to the Secretary, Department of Human Resources, State of North Carolina, encouraged the State to allow HAS to administer that State's Medicaid program on a prepaid basis. On October 23, 1974, North Carolina issued its request for proposals for its Medicaid multiservice contract. In outlining HAS' qualifications for administering the program, the president stated

> "We believe that our experience in dealing with providers, our automated utilization review procedures, our peer review concepts and our total program administration capabilities could result in significant savings. * * * in no case would payments exceed your current budgets * * *."

1/North Carolina did contract with a consulting firm to study the options available to the State for administering its Medicaid program. However, the contract was signed in November 1974 after the request for proposals for the insurance agreement was issued in October 1974 and after the decision to enter into an insuring agreement had been made.

With regard to the amount of savings, the letter contained computations based on the State's budgeted figures which showed that, under a prepaid arrangement with HAS, the State could save $668,000 during the remainder of fiscal year 1975 and nearly $4 million during fiscal year 1976. There was no evidence that the State conducted an independent study to validate these claims or to determine the advisability of contracting for the administration of its entire Medicaid program prior to its request for proposals in October 1974.

States usually held discussions with officials in other States which had entered into insuring agreements about the advantages of insuring agreements. Also, prospective contractors' proposed program costs and operation methods were compared with the States' existing program operations and projected program costs. The results of these discussions and comparisons, however, generally were not documented.

Some SRS regional officials apparently recognized the need for States to justify using insuring agreements for administering their Medicaid programs because, as discussed in chapter 2 (see p. 12), one SRS official reviewing the request for proposals for the Louisiana drug contract, stated that he would require "* * * a technical, operational and economic feasibility study before approving the contract." Also, the Acting Director, Division of State Systems Management, HEW, in the letter approving Federal financial participation in the North Carolina drug contract stated

> "After considerable discussion with State, the Region [HEW Region IV] and MSA [Medical Services Administration, SRS Central Office] I am still concerned as to the State's justification for taking an apparently adequate in-house operating system and contracting it out with an outside source."

Although in those two cases SRS officials had questioned whether the States had adequate justification for using a contractor to administer the programs, contracts were awarded by the States and approved for Federal participation without further justification.

We believe that it is neither economically nor programmatically sound for a State to contract for administration of its Medicaid program on the basis of claims made and data presented by prospective contractors without first making an independent study to determine the advantages and disadvantages of such action.

MAXIMUM COMPETITION WAS NOT ENCOURAGED

The procurement standards applicable to HEW grantees, including State and local governments (45 C.F.R. 74.150 et seq.) provide that all procurement transactions, negotiated or advertised, without regard to dollar value, shall be conducted to provide maximum open and free competition. For the procurement actions we reviewed, our analysis showed that requirement was not met. Basically, the failure to maximize competition for the various insuring agreements can be attributed to (1) States' insufficiently publicizing the intent to contract; (2) inadequate program information; (3) restrictive State contract requirements; and (4) the lack of accurate, reliable program data and the inability to accurately predict recipient eligibility and utilization trends resulted in many firms concluding that Medicaid insuring agreements were too risky.

Contract solicitations were not sufficiently publicized

Federal regulations governing Medicaid procurement actions permit States to negotiate procurements if formal advertising is not practicable or feasible. The regulations further state that, notwithstanding circumstances justifying negotiation, competition shall be maximized to the extent practicable.

Four of the 10 Medicaid contracts we reviewed were awarded by negotiations with only one prospective contractor. Thus, they were awarded without benefit of any competition. Although the other six contracts resulted from solicitations, the States did not do an adequate job of identifying firms that were capable of performing the desired services.

The North Carolina and Florida drug contracts were negotiated as sole-source procurements after PAID submitted proposals and advised the States that it was the only company capable of administering a prepaid Medicaid drug program. An HEW central office official also advised the North Carolina State agency that HEW knew of no other firms that could perform these services. However, at the time of the proposal to North Carolina, no State had a Medicaid drug insuring agreement, so no firm had experience in the Medicaid drug insuring field. We believe that any of the health insurance companies that covered drugs under their commercial policies may also be qualified to contract for a Medicaid drug insuring agreement. The States, however, made no attempt to identify other firms that might have been capable of performing the services.

In commenting on our report, North Carolina said that the State has solicited proposals from all known health insurance companies that the State believed might be qualified to contract for a Medicaid drug insuring agreement and that none of these companies submitted a proposal. We noted that in its 1976 solicitation for a drug insuring agreement, the State sent RFPs to 3 insurance companies, none of which responded. However, over 300 firms are licensed by the State's Insurance Commissioner to sell health insurance in the State.

Florida made a similar comment regarding its 1976 solicitation for a drug insuring agreement. The State also said it only received proposals from the incumbant contractor and one additional firm.

PAID commented that it never implied to the States that it was the only company capable of administering Medicaid drug programs on an insuring basis. However, in a letter dated August 21, 1972, PAID's president responded to North Carolina's request for a list of other companies who would be in a position to bid on North Carolina's drug program on an insuring basis by stating:

> "* * * Other than PAID Prescriptions we know of no company who have ever administered a prescription drug program on an underwritten basis for Title XIX recipients. There are no program comparable to PAID today in the Title XIX area which involve the risk factor."

California also negotiated its Medicaid drug and dental contracts based on unsolicited proposals from prospective contractors. California, however, designated the two contracts as pilot projects and Federal procurement regulations allow States to negotiate contracts which are "* * * for experimental, development or research work * * *."

Although requests for proposals were issued for the other six contracts, North Carolina and Louisiana did not publicize their intentions in the media. North Carolina issued 33 requests for proposals for its multiservice contract to selected firms, some of which appear to have been questionable, but only HAS submitted a proposal. The 33 firms included 6 certified public accounting firms, an automatic data processing equipment manufacturer, several management consulting firms, and a small local bank in the State of Georgia, but only two insurance companies.

Louisiana officials said that they solicited proposals from "all known companies" involved in "third party drug programs" and from other companies known to be interested in the request for proposals and two proposals were received. State purchasing officials advised us that the informal procedures used to solicit proposals were justified because the contract did not have to be awarded competitively since it was for professional services. In our opinion, insurance contracts which provide for processing Medicaid claims, collecting program data, implementing utilization controls, etc., are not exclusively contracts for professional services.

Three States (Arkansas, Maine, and Pennsylvania) formally publicized their procurement actions, but Maine did so only in the local papers. Maine officials identified four interested companies judged capable of performing the required services, mailed a request for proposal to each, and received two formal proposals. Both respondents had furnished the State with proposals before the request for proposals was issued.

Pennsylvania publicized its intent to contract for drug insurance in the "State Bulletin." Requests for proposals were issued to 26 firms, some of which appear to have been questionably selected; for example, 5 of the firms were public accounting firms. Only two firms submitted proposals.

Arkansas publicized its intention to obtain a prepaid insurance contract for drugs in the "Wall Street Journal" and in local newspapers. We were told by State officials that while six or seven firms expressed interest in the contract, only Arkansas Blue Cross-Blue Shield and PAID were mailed requests for proposals. 1/ Both companies responded with proposals. State officials said they could not recall the names of the other four or five interested firms, but they said that requests for proposals were not sent to them because they lacked experience in administering Medicaid programs.

1/In commenting on our report, Arkansas said that its State Purchasing Office has assured the State Medicaid agency that all firms which made formal requests for copies of the request for proposals were sent copies. As stated above, however, an official involved during the entire procurement action told us that four or five firms which expressed interest in the contracts were not furnished requests for proposals.

The Texas State agency solicited proposals from 14 firms and received one proposal before that contract was initially awarded in 1967. We could not determine the process used by the State to identify the 14 firms to which requests for proposals were sent or the extent to which the contract was advertised. The contract had been extended several times since 1967 through contract negotiations without the benefit of competition.

Procurement requirements and procedures restricted competition

Certain requirements, for some contracts that were awarded competitively, favored certain prospective contractors while placing others at a competitive disadvantage.

Five of the six requests for proposals stated that prior experience in administering prepaid programs was a primary factor that would be considered in selecting a contractor. Language in the request for proposals for the North Carolina multiservice contract specifically stated: "Experience in administering pre-paid Medicaid programs * * *" would be one evaluative factor. Language in the requests for proposals for the Arkansas and Maine contracts specifically identified prior experience as previous underwriting activities in title XIX (Medicaid) drug programs which, at that time, only PAID and HAS had. As stated above, however, we were told that Arkansas did not send requests for proposals to four or five firms because they lacked experience in administering Medicaid programs.

The request for proposals for the Louisiana drug contract contained essentially the same language as that for the Arkansas and Maine contracts except the statement was expanded to include "* * * and/or Third Party pharmaceutical programs." The addition of this phrase made Louisiana's criteria less restrictive because the criteria could probably be met by insurance companies which covered outpatient drugs under their commercial insurance contracts. The Pennsylvania request for proposals was also less restrictive than other States in that it only stated that the contractor's experience in "previous underwriting activity in drug programs" would be an evaluative factor.

The requests for proposals for these five contracts did not specify the weight to be given to prior experience in the evaluation process, but to the extent that prior experience in administering prepaid Medicaid programs might have determined the successful bidder the evaluation criteria may have

favored PAID and HAS. At the time these contracts were awarded, PAID was administering three prepaid Medicaid drug contracts in North Carolina, California, and Florida and HAS was a subcontractor under all three contracts. All three were negotiated contracts awarded without benefit of competition.

North Carolina, in commenting on our report, stated that it believes that experience is one of the most valid prerequisites upon which to base a contract. We agree that prior experience in performing the responsibilities listed in requests for proposals is a valid criteria for assessing the capability of a prospective contractor to perform contract duties. However, overly restrictive phrasing of the experience criteria can reduce competition especially when the weight given to the criteria is not set forth in the request for proposals. North Carolina's request stated that experience in administering prepaid Medicaid programs would be an evaluative factor and did not give a weight to this factor. Since in addition to HAS/PAID, only Texas Blue Cross, and Prudential Insurance Company had such experience, we believe the criteria could have restricted competition. If the criteria would have been experience in administering prepaid health programs, any health insurance company could have met the criteria.

The requests for proposals issued by Arkansas, Maine, and Pennsylvania were restrictive because they allowed for contracts with only not-for-profit organizations. 1/ The laws enacted by Arkansas and Pennsylvania, cited as authority for prepaid drug programs, authorized the respective State agencies to contract with not-for-profit corporations. State agency officials concluded that only not-for-profit corporations could receive the contract award.

The drug program coordinator in Maine said that it was an oversight on his part that the request for proposals excluded for-profit organizations. However, the coordinator said that the request for proposals and the newspaper advertisement for the request for proposals were drafted by PAID, a not-for-profit organization. In fact, the PAID proposal was received by Maine in October 1973, about 4 months before the request for proposals was publicized. The coordinator said that he sought assistance and information and accepted a proposal from PAID before the request for proposals was advertised because he did not know what prepaid drug services a contractor had to offer or how to prepare a request for proposals.

1/Pennsylvania amended its law in July 1976 to allow profit making firms to compete for Medicaid insuring agreements.

In commenting on our report, Maine and PAID acknowledged that PAID had assisted the State in preparing the request for proposals. Maine said that, in view of the fact that PAID eventually incurred a loss on the contract, "It is evident * * * that other States should have used a contractor's expertise for a much more economical contract rate."

Maine also said that it had sought assistance from HEW but very little was forthcoming. As discussed in chapter 2, we believe HEW should provide more assistance to the States when they procure insuring agreements.

Pennsylvania's request for proposals was prepared with assistance from HAS, and PAID was eventually awarded the contract with HAS as its subcontractor. In commenting on our report, Pennsylvania, PAID, and HAS all took exception to the statement that PAID/HAS had assisted the State in preparing the request for proposals. Each said that the July 1974 request for proposals on which PAID's contract with the State was based was not prepared with any assistance from PAID/HAS. PAID acknowledged that assistance had been rendered on an earlier April 1973 request for proposals which did not result in a contract. The State Medicaid agency had selected PAID for the contract award based on the April 1973 request for proposals, but the State Attorney General did not allow the contract award because PAID did not meet all the requirements of applicable State insurance laws.

We analyzed the April 1973 and July 1974 requests for proposals and found that they were virtually identical. The main difference was that the April 1973 request for proposals required the contractor to assist the State in developing an improved eligibility verification system for pharmaceutical benefits while the July 1974 request did not. In particular, PAID commented that it had assisted the State in preparing the drug utilization review requirements section of the April 1973 request for proposals. We noted that the July 1974 request included the same section, virtually word for word. Because the two requests for proposals were virtually identical, we concluded that, in effect, PAID/HAS by assisting the State in preparing the April 1973 request also contributed to the development of the July 1974 request which resulted in a contract.

When North Carolina's request for proposals was issued on October 23, 1974, for its multiservice contract, the State law permitted paying medical assistance funds only to providers of medical services--a provision which precluded contracting for an insuring agreement. The deadline for submission of proposals was extended from November 25, 1974, to

early January 1975 to give the North Carolina attorney general time to determine the effect of this provision on the State's intention to contract for an insuring agreement under the Medicaid program.

After the State attorney general concluded that the proposed contract would violate State law, the State legislature amended the law in April 1975, about 3 months after the deadline for submitting proposals, to permit payment of medical assistance funds to prepaid health service contractors.

Considering the substantial cost which would have been incurred in developing a response to the request for proposals for administering North Carolina's entire Medicaid program, it seems reasonable to expect that the uncertainty with respect to the legality of the proposed contract could have deterred some firms from submitting a proposal. By letter dated December 24, 1974, Blue Cross-Blue Shield advised the State that it would not submit a proposal in light of the attorney general's opinion.

In addition to this uncertainty, another problem existed which may have limited competition for the North Carolina multiservice contract. North Carolina insurance laws required that a hospital, medical, or dental service corporation, maintain a contingency reserve in excess of three times its average monthly payments for hospital, medical, and dental claims. 1/ Representatives of North Carolina Blue Cross/Blue Shield and of the Prudential Insurance Company said that this reserve requirement was another reason their firms did not submit proposals.

An assistant State attorney general in North Carolina said that, if any insurance company had obtained the prepaid Medicaid contract, the reserve requirement probably would have been applicable because other subscribers or policyholders with the company would have been adversely affected if the contract proved unsuccessful. However, the State attorney general issued an advisory opinion on April 4, 1975, which concluded that since HAS was not an insurance company it was not required to maintain a contingency reserve.

1/Based on the fiscal year 1976 monthly premiums for the contract, the contingency reserve would have had to have been about $44 million as compared with requirements for $6 million performance bond and $6 million in reinsurance included in the contract.

When requesting contract proposals, the States should exercise great care not to provide a competitive advantage to any prospective contractor. Favoritism or preselection, real or imagined, restricts competition.

Insufficient program data limited competition

Several States failed to provide sufficient financial and eligibility data in their requests for proposals--information which was necessary for prospective offerors to develop responsible contract proposals.

The request for proposals for the Louisiana drug contract provided no program cost information and provided only limited participant eligibility data. State officials believed that historical cost information could have unnecessarily influenced contractor bids and advised that, because of program changes, only 1 month of representative eligibility statistics were available when the request for proposals was issued. The State did provide some data after issuing the request for proposals when it was requested by a prospective bidder. The actuary for the successful bidder said, however, that the data furnished to him by the State was partially responsible for the development of inappropriate premium rates and as a result his company underpriced the Louisiana contract by 25 to 30 percent. Specifically, the Louisiana State agency furnished several months eligibility, utilization, and cost data which the actuary used to develop what he felt to be a representative month's experience. The actuary said he later discovered that the data were not representative because the State paid drug bills until monthly funds were exhausted, at which time payment of bills was discontinued until the next month.

Our review of the Louisiana drug contract procurement also disclosed that three companies requested and received from the State agency Medicaid eligibility and drug recipient data that were not in the request for proposals. In fact, these data were obtained by the companies before the request for proposals was issued.

Unavailability of data led some firms that received the request for proposals for the North Carolina Medicaid multiservice contract to believe that the venture was too risky. For example, the request for proposals required that prospective contractors quote a monthly per capita premium rate for each aid category (for example, aid to the blind and aid to the disabled). Development of valid premium rates on this

basis would require accurate data on the number of persons in each category (eligibles), the number of persons in each aid category who actually received medical care (users), and the cost of providing such medical care--all over a period long enough to permit identification and projection of trends. The request for proposals showed the number of eligibles in each aid category as of September 1974 and projected numbers of eligibles by aid category for fiscal years 1975-77, but no information on the number of users or related costs by aid category.

One insurance company to which North Carolina's request for proposals was sent requested the State to furnish data on the amount and number of claims paid and the number of eligibles by aid category for each month beginning with January 1973. This data was requested so that the company's actuary could compute reliable premium rates. The State agency supplied the requested information, but only for 5 months--July through November 1974.

North Carolina commented that it recognized the inadequacy of the data in the request for proposals and that one of the reasons the request for proposals was issued was to obtain a more efficient management information system. Of course, it is not necessary to obtain an insuring agreement to obtain better program data.

Insufficient time to respond limited competition

The time allowed by some States for potential bidders to respond to the requests for proposals appears to have been inadequate. The request for proposals issued by Maine, for example, was publicized in local newspapers for 6 days beginning on March 14, 1974, with a deadline for submission of proposals to the State agency by April 1, 1974. One potential bidder requested and received an extension to April 22, 1974. However, the potential bidder, in a letter dated April 17, 1974, stated that the extension would not allow time to study, research, prepare, and submit a proposal in the form requested. As discussed on page 34, the successful bidder had submitted a proposal before the request for proposals was publicized.

The requests for proposals for the Arkansas and Louisiana contracts provided prospective contractors a maximum of 28 days and 36 days, respectively, to submit proposals. Furthermore, Louisiana did not mail all the requests for proposals on the same date, resulting in five potential contractors having 26 days or less (one firm had only 8 days) to meet the proposal deadline.

The request for proposals for the North Carolina Medicaid multiservice contract was issued on October 23, 1974, calling for submission of proposals by November 25, 1974. On November 6, North Carolina Blue Cross-Blue Shield wrote to the State agency stating that it could not submit "a thoughtfully prepared and fiscally responsible bid" and still meet the November 25 deadline, and asked for a 2-month extension. In an addendum dated November 12, 1974, the State agency notified prospective offerors that the proposal submission deadline would be extended to an "early date in January 1975." In the last addendum, dated December 16, 1974, the State agency notified prospective contractors that the deadline for submission of proposals was January 14, 1975.

EVALUATION OF CONTRACT PRICES WAS MINIMAL

The States generally did not request, receive, or analyze detailed support for contractors' proposed prices. Essentially the price evaluation for negotiated contracts consisted of comparing the contractors' proposed prices with the States' anticipated program cost as shown in the States' budget. In those instances where more than one proposal was received, the State accepted the lowest price provided the State's budget was sufficient to finance that price.

The six requests for proposals required only that bids contain a capitation rate for each aid category which would include payments to providers for the required health service (drug, dental, etc.); contractor administrative costs, including subcontract costs; and allowances for reserves, profits, inflation, etc. There was no requirement for a breakout of the premium by each cost component or for an explanation of how the premium was derived. 1/

A statement made by the pharmaceutical consultant in Louisiana is typical of the responses offered by Medicaid program officials to our questions concerning the evaluations of contractors' proposed prices. The consultant said that because the lowest proposed price was less than the State's anticipated cost for a State-administered program, the premium would have been accepted regardless of the percentage of administrative cost contained therein. Furthermore, he stated that a breakout of the premium by its several components

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1/The Texas 1967 request for proposals did not require such data; however, beginning in 1970, Texas did obtain this type of information for purposes of renegotiating the premium rates.

would not be very meaningful because the State did not have the necessary experience or ability to properly analyze the cost elements.

Several States and contractors commented that they believed comparison of the contractor's proposed price with the State budget is a valid method for evaluating contract prices. In our opinion, the proposed price to State budget comparison should only be one element in evaluating prices. States should also obtain and analyze detailed price support data for a number of reasons including the following:

--Preparing Medicaid budgets has proved to be difficult and both State and Federal Medicaid budgets have been grossly misstated over the years. Also, budgets are initially prepared months before the start of the applicable budget period and more current data should be used for contract pricing.

--Insuring agreements are necessarily priced on a date of service basis whereas Medicaid budgets are based on date of payment. There can be significant differences between the amounts arrived at using these two bases and it is very difficult to convert date of payment data into date of service data.

CONTRACT NEGOTIATIONS WERE NOT DOCUMENTED

Even though Federal regulations (45 C.F.R. 74.157) require States to maintain records of negotiations that show, among other things, "the basis for the cost or price negotiated," the States generally did not document their contract negotiations. Therefore, we were unable to evaluate the effectiveness of the negotiations.

Four of the 10 contracts were negotiated as sole-source procurements, and 3 of the 4 contracts were extended beyond the initial contract period through renegotiations. Also, 2 of the other 6 contracts were extended through renegotiations and 7 of the 10 contracts had been amended through negotiations. However, formal records showing the date, location, changes resulting from negotiations; the identity of negotiators; and the basis for agreements reached were not maintained by any State agencies.

Several States provided us with a substantial amount of information, including memorandums, correspondence, and cost data. However, because much of the information lacked analytical clarity and did not provide a clear audit trail, we were

unable to determine changes resulting from contract negotiations. Information available to us indicated, however, that most States gained very little, especially during initial contract negotiations because the final contract prices and conditions were, in most cases, the same prices and conditions proposed by the contractors.

One contractor, PAID, successfully negotiated--before contract award--an increase of about $1.6 million above its proposed price. While the State agency did not document contract negotiations, apparently Arkansas asked PAID to revise its proposed premium billing and reporting procedures for the drug contract to separate noncash grant Medicaid recipients in nursing homes from other program eligibles. Although these nursing home patients were included in the total estimated number of eligibles shown in the request for proposal, PAID maintained that its proposal, which was about $2.3 million less than the second lowest proposal, did not consider the nursing home eligibles who supposedly use more drugs than other program eligibles.

We question the reasonableness of the State's granting an increase to PAID before the contract award, after the contractor was competitively selected, based on its bid in response to a request for proposals which included nursing home eligibles.

In the case of the North Carolina multiservice contract, the State's contract negotiations were aimed at adding to HAS' responsibilities or increasing the State's participation in any profits realized by HAS under the contract. Although no records of negotiations were maintained, the State subsequently valued negotiated benefits at $22.3 million. However, we determined that HAS' original proposals included 96 percent of the value of the items the State said it negotiated.

CALIFORNIA COMMENTS

In commenting on this chapter of our report, California stated:

> "Before proceeding to specific responsive comments, we would like to first observe generally that the report--at least in so far as it pertains to California--apparently fails to recognize the essential nature of the contracts involved as being a part of a pilot program in the State of California. It is essential to the nature of pilot contracts that they are part of an inquiry

and research into unknown areas. For this reason, those customs and rules which pertain to normal contracting and procurement programs cannot be applied with the same force and detail to innovative programs; rather, the nature of the development of pilot contracts must be tailored to the openended characteristic of pilot enterprises, so that the information sought after can be obtained without undue constriction."

California stated that its failure to publicize its intention to contract, seek competition for the contract, adequately evaluate proposed prices, and document contract negotiations were justified because of the research nature of the drug and dental insuring agreements.

In regard to the dental services insuring agreement, we question whether it was in fact a pilot project. The State did not request that HEW consider it a pilot project under any of the provisions of the Social Security Act authorizing such projects. The State did classify it as a pilot project under a State law allowing such projects; however, at the time of the contract award, under State law, the contract had to be classified as a pilot project because the State agency did not have the authority to enter insuring agreements. We also noted that at that time it was State policy to enter into insuring-type agreements, particularly with prepaid health plans, to the maximum extent possible. The primary reason we question whether the dental services contract was a pilot project is because of the scope and duration of it--the contract covered all Medicaid recipients in the State (about 2 million persons), had an expected first year value of about $62 million, and had a duration of 4 years. The prescription drug contract appeared to be more of a pilot project in nature--it covered Medicaid recipients in only four counties (about 300,000 persons), had an expected first year cost of about $15 million, and had a duration of 2 years.

As we pointed out on page 31, Federal regulations applicable to Medicaid allow States to negotiate pilot project contracts. However, we do not believe that, merely because a contract contains research-type aspects, a prudent contracting agency should forego the benefits obtainable from competition and/or meaningful price negotiations. Federal agencies contract extensively for research and development activities and the Federal procurement regulations (contained in 41 C.F.R.1) require them to seek competition and/or conduct meaningful price negotiations.

Federal agencies are allowed to obtain experimental, developmental, or research contracts through negotiations rather than the normally required formal advertising procedures (41 C.F.R. 1-3.211). However, 41 C.F.R. 1-3.101 requires Federal agencies negotiating research contracts to solicit proposals from the maximum number of qualified sources possible and ensure that procurements are on the basis of maximum competition to the extent practical. Federal agencies are required to publicize their intention to procure research contracts in the "Commerce Business Daily". If a Federal agency determines, either before or after publicizing its intention to procure and its solicitation of proposals, that only one source is qualified to perform the requirements of the contract, the agency must still conduct meaningful price negotiations with this sole source under the procedures set forth in 41 C.F.R. 1-3.8.

For contracts with values exceeding $100,000, 41 C.F.R. 1-3.807.3 requires the prospective contractor to submit written cost or pricing data and certify that the data is accurate, complete, and currrent. Accurate, complete, and current cost or pricing data is also normally required from major subcontractors. Federal agencies are required to use this data in negotiating the contracts. Finally, Federal agencies are required to thoroughly document negotiations for research contracts.

In view of the requirements placed on Federal agencies when they procure research-type contracts, we believe that California's view that, because its two Medicaid insuring agreements were classified as pilot projects of a research nature, normal procurement procedures were neither necessary nor desirable, is not consistent with Federal procurement regulations.

CONCLUSIONS

State procurement practices for obtaining insuring agreements did not assure fair and reasonable contract prices or foster maximum open and free competition because States generally did an inadequate job in (1) determining the feasibility of contracting their Medicaid programs; (2) identifying potential contractors with the ability to administer a prepaid Medicaid program; (3) providing potential contractors with reliable, accurate data on which to base a contract price; (4) evaluating contractors' proposals; and (5) documenting contract negotiations.

We believe that before States enter into insuring agreements for administration of all or part of their Medicaid programs, the States should determine whether this method of program administration is more economical and effective than other available methods. Should a State determine that administration of its Medicaid program would be less costly and more effective under an insuring agreement, the State should be certain that the procurement practices employed in obtaining the agreement comply with Federal procurement standards and produce fair and reasonable contract prices.

RECOMMENDATION TO THE SECRETARY, HEW

We recommend that the Secretary, HEW, instruct the Administrator, HCFA, to require States that desire to administer their Medicaid programs under insurance-type contracts to document their rationale for determining that this method is a proper and efficient method of program administration.

Our recommendation on page 26 to provide guidance to the HEW regional offices for procedures and methods for evaluating whether States comply with Federal regulations when procuring Medicaid insuring agreements should also help assure that States follow adequate procurement policies.

HEW COMMENTS

HEW agreed with our recommendation and said it would take action to implement it through guidelines to the States which are being prepared (see p. 105). HEW said the guidelines will also cover other types of program administration, such as fiscal agent and health maintenance organizations.

RECOMMENDATION TO THE SUBCOMMITTEE

During our review we identified a number of State laws which restricted competition for Medicaid insurance-type contracts or which gave a competitive advantage to some class of potential contractors. In some cases, State laws required Medicaid insuring agreements to be awarded to nonprofit firms. Some State laws also required insurance companies, but not other types of companies, to maintain contingency reserves. We recommend that the Subcommittee develop legislation to amend the Medicaid law to preclude Federal sharing in the cost of Medicaid contracts where State laws have restricted competition or provided potential contractors with a competitive advantage.

CHAPTER 4

RISK FEATURES MINIMIZED IN INSURING AGREEMENTS

Federal regulations require that, for a contract to qualify as an insuring agreement, the contractor must assume an underwriting risk. Specifically, the contractual arrangement must stipulate that premium payments to the contractor fully discharge the State's financial responsibility for the covered medical services provided to covered eligible recipients during the contract period. Proponents of the insuring agreement approach to administering Medicaid cite the risk feature as one of the principal benefits of the approach. They say that the risk feature provides the State with an element of control over program costs and a predetermined ceiling on costs per eligible. Nevertheless, we believe that these basic insuring agreement principles, as outlined in Federal regulations, were not included in several Medicaid contractual arrangements.

Medicaid insurance contracts normally include provisions to allow renegotiations of premium amounts when Federal or State laws and regulations or State Medicaid plans are changed and produce increased or decreased costs for the services covered by the contract. Such clauses are necessary because the contractor has no control over these changes and it would be inequitable to increase risk because of such a change. However, several States have negotiated contracts which included provisions which had reduced or eliminated contractor risk. Some Medicaid insurance contracts also lacked provisions which provide for risk or included unclear language which permitted contractors to eliminate or substantially reduce their underwriting risk.

To reduce anticipated contractor losses, two contracts were terminated by the contractors before their scheduled expiration dates. One was renegotiated to the advantage of the contractor as an alternative to early termination. In addition, two contracts contained language used by the contractor to negotiate contract amendments or to claim the right to negotiate amendments which favored contractors and reduced their financial liability under the contracts. Also, one contractor was allowed to accumulate large Medicaid reserve funds which had the effect of eliminating or reducing its underwriting risk.

CONTRACTORS TERMINATED, OR RAISED POSSIBILITY OF TERMINATION, TO AVOID LOSSES

The North Carolina Medicaid multiservice contract and the California drug contract both were terminated prematurely by the contractors to avoid or to reduce their anticipated losses under the contracts. Also, faced with the possibility of contract termination by the contractor, the Florida State agency agreed to certain contract changes which benefited the contractor by an estimated $12 million.

North Carolina multiservice contract was terminated

The North Carolina multiservice contract covered May 1, 1975, through June 30, 1977. During May and June 1975, the contractor (HAS) functioned as the State's fiscal agent. 1/ For the remainder of the contract period, HAS was to function as a health-insuring organization.

Under the terms of the risk portion of the contract, the State agreed to pay HAS a prepaid monthly premium of $14.66 million for the first year and $16.66 million for the second year. 2/ In return for these payments, HAS agreed to process and pay all valid claims for covered services received during the contract period. The only claims-related aspect of the program which the State remained directly responsible for was yearend cost settlements with institutional providers that were paid during the year on an interim-rate basis.

1/ HAS was also required to pay, as a fiscal agent, claims received after July 1, 1975, for services provided before that date. Under the contract the State was not liable to reimburse HAS for these payments until after contract expiration. However, the contract was modified in August 1976 to eliminate the risk feature, and the State agreed to reimburse HAS for these claims.

2/ Technically, the State was supposed to pay HAS monthly per capita premiums of $54.30 and $61.70 for the 2 years, respectively, limited to $14.66 million and $16.66 million monthly maximum premiums. However, HAS was virtually assured of receiving the monthly maximum because the per capita premiums were computed using an artificially low number of eligibles instead of the number of eligibles expected to be covered under the contract.

On May 12, 1976, however, HAS notified the State that it was considering terminating the contract on September 30, 1976, because of what HAS said was an unexpected increase in eligibles, difficulties in obtaining timely and accurate eligibility information from the State, and changes in recipient utilization patterns. These alledged conditions could have been expected to result in financial losses for HAS. Following receipt of the termination notification letter, the State and HAS conducted extensive negotiations.

HAS contended that it was entitled to terminate the contract for cause because the number of eligibles cited in the request for proposals (312,000) 1/ was a material misrepresentation by the State. Although the State did not agree with this contention, it agreed to terminate the risk portion of the contract effective June 30, 1976, 1 year before the scheduled expiration date. The obvious effect of this decision was to reduce the contractor's expected losses under the contract, and to shift the financial risk assumed by the contractor back to the Federal and State governments.

The contract between the State and HAS included provisions concerning a State takeover of the program in the event of contract termination. The provisions provided that the contractor turn over its claims processing system to the State and for a period of 120 days pay claims for medical services provided before termination and train State

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1/ The estimate of 312,000 was expressed in terms of the average number of certified eligibles. During the first year of the contract, this estimate was very close to the actual number of certified eligibles. The contractor contends that it believed this estimate represented eligible months rather than certified eligibles. Eligible months reached about 340,000 during the first year of the contract. Eligible months are different from certified eligibles because persons certified as eligible for Medicaid can be covered up to 3 months before they submit applications to participate in the program. The request for proposals stated that the 312,000 estimate was in terms of certified eligibles. Also, HAS had available to it, from its work as data processing subcontractor on the State's drug insuring agreement with PAID, data on the number of eligible months going back to February 1973. Documentation available to us showed that HAS had used the eligible month data from the drug program in preparing its proposal for the multiservice contract.

personnel in the use of the claims processing system. The State and HAS both believe that these provisions constituted an adequate contingency plan for termination. However, in our opinion, because of the relatively short time frame provided for the State to hire personnel and assume operations, combined with the need to prevent disruptions in the Medicaid program, the option of the State taking over administration of the program was not viable. In fact, the State modified its contract with HAS to remove the risk feature and provided for HAS to administer the Medicaid program until January 1, 1977, as a fiscal agent.

North Carolina solicited proposals for another insuring agreement and also for a fiscal agent arrangement. Although three companies submitted proposals to administer the program under a fiscal agent arrangement, only one of the three offered to administer the program under an insuring agreement and, under this proposal, the contractor's liability would have been limited. The State, therefore, evaluated only the proposals for administering the program under a fiscal agent arrangement. EDSF was selected as the recipient of a fixed price per claim fiscal agent contract which became effective January 3, 1977.

California drug contract was terminated

A provision in the California four-county drug contract allowed the contractor (PAID) to terminate the contract for cause, but the contract did not specifically state what would constitute cause. Thus, PAID was able to terminate the contract on grounds that negotiated premium rates were not adequate. The contract termination clause stated, in part, that:

> "Either party may terminate this contract for cause at any time by giving written notice to the other party to that effect. The termination shall become effective on the last day of second calendar month following the month in which notice of termination was given." (Underscoring supplied for emphasis.)

The contract became effective December 1, 1972, and covered 24 months; but it was extended and premium rates were increased several times as additional program cost data were accumulated and as program changes were made. The last extension and corresponding premium increases before the contract was terminated covered the 6-month period between

July 1 and December 31, 1975. However, in a letter dated August 29, 1975, to the State agency, PAID stated that it continued to incur increasingly large monthly program losses and that additional rate increases were necessary. As alternatives to rate increases, PAID proposed that it either administer the program on a fiscal agent basis or cancel the contract effective midnight, September 30, 1975.

On September 15, 1975, in response to PAID's letter, the State agency advised PAID that the State had reviewed its basis for developing the contract premiums and that to increase them would result in higher costs than would be incurred under the State's regular fee-for-service program administered by the State's fiscal agent in the remaining counties. Therefore, the State accepted PAID's termination notice and the four-county drug contract was officially terminated on September 30, 1975. The State's fiscal agent began processing the drug claims under the fee-for-service arrangement which covered all other counties in the State.

In commenting on our report, California said that the termination clause was justified because it was a pilot project. The State believes it is necessary to provide pilot project contractors with latitude in terminating the contract in order to induce firms to enter pilot projects. Allowing termination for cause because a contractor loses money definitely provides such latitude.

PAID said that the reason it agreed to the last contract extension at rates it felt were inadequate was that it believed it could negotiate more favorable rates for another extension. When the State notified PAID that the contract rates could not be raised to the level PAID felt were necessary for another extension because the PAID contract would become more costly than the fee-for-service program, PAID terminated the contract.

Florida drug contract was renegotiated

Due to anticipated contract losses, the contractor (PAID) raised the possibility of termination of Florida's drug contract unless the State agreed to certain amendments. Therefore, the State agreed to amendments which we estimate benefited PAID and its subcontractor (HAS) by about $12 million.

When Florida and PAID were negotiating the drug contract, PAID offered to remove, effective January 1, 1975, the $20 monthly maximum for drug benefits that the State imposed on each program eligible. State officials said that this aspect

of PAID's proposal was the primary reason that the State contracted with PAID for the program's administration.

A clause in the initial Florida drug contract, effective July 1, 1974, allowed either PAID or the State agency to terminate should they be unable to agree on modifications to the contract. Specifically the clause stated that:

> "* * * if the parties should be unable to agree upon such modifying amendments hereto as might be needed to enable substantial continuation of the program established hereby, then both parties shall be discharged from further obligation hereunder except for equitable settlement of their interests accrued to the date of such termination."

In a letter dated April 21, 1975, PAID claimed it was losing about $400,000 a month under the contract. PAID offered the State agency several alternatives for improving PAID's and HAS' financial positions. One alternative was to terminate the contract. Other alternatives proposed by PAID included reinstating the monthly limit of $20 in drug costs which had applied to each eligible or establishing a $25 monthly limit. PAID stated that it also expected the State to increase its premiums for the second year of the 2-year contract should the State accept either the $20 or $25 monthly limit. Other proposals offered by PAID for the State's consideration were to

- --implement a drug copayment program in which each program recipient would pay a portion of the cost of each prescription,
- --implement a program of maximum allowable costs for prescriptions coupled with an "equitable" professional fee for the pharmacists, and
- --establish a prior authorization drug list for selected therapeutic categories.

With regard to these alternatives and proposals, PAID stated that unless the State accepted some of the proposed program changes and rate increases it "* * * would have no alternative but to consider termination of the present contract with the State."

As an alternative to terminating the contract, the State, on May 16, 1975, agreed to reinstate the $20 limit on drugs; eliminate program coverage of all nonlegend antacids, multivitamins, and ferrous sulfate drugs; limit prescriptions to no more than a 34-day supply; and reduce the amount of the required contingency reserve. Also, the State agreed to separate the premium rates for those persons eligible for Medicaid because of the Cuban refugee program and to increase the premiums paid to the contractor for the Cuban eligibles retroactively to January 1, 1975. The State also agreed to reimburse PAID for all losses incurred--about $575,000--before January 1, 1975, for the Cuban eligibles. Drug costs for Cuban eligibles are 100-percent federally funded and thus the State incurred no cost for the increased charges relating to them. Because of the insufficiency of State funds, the State would not agree to increases in contractor premiums for the non-Cuban program eligibles.

The State did not document its contract negotiations with PAID and did not record the information that the State provided to PAID for use in developing its original premium rates. State officials said that PAID had been provided with all the information it requested. However, the information that we could determine was provided to PAID did not include data on the federally funded Cuban Refugee program. We were unable to conclusively establish whether or not PAID had included the costs of the Cuban refugees in its proposed premium rates.

The contract amendment eliminated PAID's underwriting risk for the Cuban program during the first 6 months of the 2-year contract. Also, the increases in premiums paid for Cuban eligibles for the remaining 18 months substantially decreased PAID's underwriting risk on this portion of the drug program.

The reimbursement of PAID's losses on the Cuban program and retroactive increases in premiums paid for Cuban eligibles specifically violated Federal regulations which state in part that the State agency shall not pay for any loss incurred by the contractor from claims exceeding premiums paid or from increases in administrative costs of the contractor during the covered period.

The State Auditor General, in a report issued in September 1976 on his review of the Florida drug contract, also questioned the propriety of the contract amendment. The report stated that:

"Based on information made available to me or the lack of it, in my opinion HRS [Florida Department of Health and Rehabilitative Services] should not have agreed to the retroactive adjustments * * *. These in effect provided for recoupment of losses incurred by the contractor for which he had assumed the risk under the provisions set forth in the contract prior to the amendment."

Overall the amendment increased Federal program costs by an estimated $5 million and State program costs by about $185,000, and reduced or eliminated an estimated $7 million in recipient benefits. PAID, therefore, reduced its costs by more than $12 million as a result of the contract amendment.

PAID, in commenting on our draft report concerning removal of the $20 limit, stated that the understanding reached between PAID and Florida officials during contract discussions was that the concept would be tried and then a determination made as to its feasibility. However, none of the correspondence between PAID and the State concerning removing or reimposing the $20 limit refers to such an understanding. Furthermore, the contract contains no language to suggest that removal of the $20 limit was anything but permanent. Also, several State officials including the former Director and Deputy Director of the State's Division of Family Services, both of whom were involved in contract negotiations, told us that PAID's offer to remove the $20 limit was the key to the State's decision to enter into the agreement and that without this concession by PAID, the State probably would not have entered into the agreement.

Florida in commenting on our report stated:

"The Cuban program is a Federal program and all policies, including the contract adjustments, were and are made by a Federal agency, not by the State. Therefore, the State did not agree as stated to reimburse PAID for all losses incurred. Although the State provided cost data to the Federal agency and was fully aware of the plan, the decision was completely that of the Federal agency".

Medical assistance provided to persons qualifying for the Cuban Refuge Program is 100 percent federally funded. However, this assistance is provided through the regular State-administered Medicaid program. The basic difference is that

a different Federal sharing percentage applies to services provided to Cuban refugees. The other Federal requirements for Medicaid services provided to Cuban refugees are identical.

The circumstances surrounding the contract modification as it affected the Cuban Program is as follows. The earliest document we could locate concerning the contract amendment was a memorandum discussing an April 1, 1975, meeting between PAID and State officials. The meeting revolved around financial problems PAID was having as a result of removal of the $20 per month prescription limit. One of the possible solutions to restore PAID's financial condition outlined by PAID was to remove the Cubans from the Medicaid recipients covered by the contract and charge the Federal Government for drugs provided to them on a fiscal agent/fee-for-service basis. The memorandum shows that the State officials thought this solution should be acted upon quickly. Another meeting was held on April 11, 1975, and again the Cuban solution was raised. The memorandum on the meeting indicates the State had begun to talk to HEW about the possibility of taking the action suggested by PAID.

On April 18, 1975, the State transmitted to HEW PAID's proposed changes to the premiums for Cuban refugees and its calculation of payments needed to recoup the losses it had experienced providing drugs to Cuban refugees. The transmittal letter requested approval of the premium changes and retroactive payments.

On May 16, 1975, the State signed the contract amendment which separated Cuban refugees from other program eligibles and increased the premiums for the Cuban refugees. The amendment resulted in PAID recouping all of its losses for Cuban refugees. On May 21, 1975, the Acting Director, Cuban Refugee Program, approved the changes in the premium rates for Cuban refugees with the apparent understanding that PAID was not to make a profit on the Cuban refugee portion of the contract. Thus, the State signed the contract modification before receiving HEW approval.

Based on the previous, we believe that the State did in fact negotiate the contract amendment affecting the Cuban refugees and signed the amendment before receiving HEW approval.

Also, the State agency failed to comply with all the provisions of a Florida law concerning procedures for notifying program participants about program policy changes

such as those precipitated by the contract amendment. Because of this, the State authorized PAID to make payments for drugs in excess of the dollar limit and quantities provided for by the amendment. The State agreed to reimburse PAID for all claims paid in excess of net premiums received for September 1975 claims, plus an 8-percent administrative fee for those claims in excess of premiums. Under this agreement the State paid $185,000 to PAID during September 1975. Thus, PAID assumed no underwriting risk for that month.

Another situation arose which, depending on its final disposition, could considerably improve PAID's financial position under the Florida contract. This related to the method of payment for retroactive eligibility which is the period of time during which an individual is eligible for Medicaid benefits before being certified by the State as eligible. There are two periods of retroactive eligibility.

1. The period between the time the individual applies for Medicaid eligibility and the time the State determines that the individual is in fact eligible. During this period, the State is verifying the information that the individual supplied to insure that the person's income and resources are below the maximums allowed for Medicaid eligibility. This verification process can take from several weeks to several months. We shall call eligibility during this period post-application retroactive eligibility.

2. Applicants for Medicaid eligibility can be certified for a period up to 90 days before the date of application if they also met the eligibility criteria during this pre-application period. We shall call eligibility during this period pre-application retroactive eligibility.

Regarding State payments to PAID for retroactive eligibility periods, the contract stated that:

> "Certain eligible persons may be certified by State Agency to Contractor with an eligible status predating such certification for a period up to ninety (90) days prior to such certification. Such individuals will have not been issued temporary identification cards, but may have incurred expenses for covered benefits during such ninety (90) day period. In such event, State Agency shall assume the obligation of reimbursing the eligible providers for all covered benefits furnished to such eligible persons during said period."

There never was any disagreement between the State and PAID regarding drug claims for services during the pre-application retroactive eligibility period--the State reimbursed PAID for the cost of the prescription plus a claim processing fee. However, a point of contention arose regarding the post-application retroactive eligibility period. During the first 9 months of the contract (July 1974-March 1975), the State paid premiums to PAID for each person for each month of this period. However, beginning in November 1974 discussions were held between State and contractor personnel regarding changing this practice to reimburse PAID only for recipients who actually received drugs. The State began paying PAID on this basis in April 1975.

On May 29, 1975, a vice president of PAID wrote the State about the change. The letter states that PAID believed the retroactive premiums would cease to be paid at a date later than that the State used. On July 14, 1975, the State responded that its position was that the retroactive premium should never have been paid.

In December 1975, in response to the State's refusal to renegotiate certain terms and conditions of the contract--notwithstanding the May 16 1975, amendment which signif-antly improved PAID's financial position under the contract-- D demanded premium payments for all post-application retroactive eligibles.

The issue had not been resolved as of October 1977, but it had been brought before the courts. If the court favors PAID's position, it could increase the Florida contract cost by more than $8 million.

Even though the contracts provide for amendments upon written agreement between the State and contractor and for termination under certain conditions, we believe that for a contractor to introduce the probability of contract termination merely because it is experiencing financial difficulty defeats the concept of, and nullifies one of the principal advantages of, an insuring agreement. Contracts, therefore, should contain provisions which specifically preclude amendment or termination of the contract solely to reduce or eliminate anticipated contractor losses.

BUILDUP OF MEDICAID RESERVE FUNDS REDUCED CONTRACTORS' UNDERWRITING RISK

Although Texas contends that its past and current Medicaid contractual relationships with Group Hospital Service, Inc. (Blue Cross of Texas) have been of the nature of an insuring arrangement, HEW in 1969 found that the relationships did not fully satisfy the requirements of an insuring agreement. Although the contracts have been amended several times since 1969 we found that they still do not satisfy all the requirements of a health insuring agreement.

Effective September 1, 1967, the State agency and Group Hospital Service, Inc. entered into three separate contracts covering three different categories of Medicaid eligibles--the contracts were essentially the same, differing only in the categories of eligibles covered. On March 28, 1969, the HEW Audit Agency issued a report covering the period from September 1967 to July 1968 which included the HEW Regional Counsel's opinion that, although intended as insuring arrangements, the contracts were in fact fiscal agent arrangements because a provision in the contracts provided that the premiums paid should at all times be sufficient to cover incurred costs. Because this provision had the effect of eliminating the contractor's risk, the Audit Agency took exception to and recommended recovery of the differences in Federal sharing in administrative costs that were actually claimed and paid under the contracts as insuring agreements and the lesser amounts that would have been allowed under fiscal agent contracts. The difference for the 10-month period covered by the audit was about $890,000. After nearly 2 years of State/HEW controversy over the validity of the HEW exception, the SRS administrator ruled that HEW would allow Federal sharing in administrative costs at the insuring agreement rate.

After the controversy arose, however, the contracts were amended effective September 1, 1969, to delete the questionable provision.

The State agency negotiated three new contracts with Group Hospital Service, Inc., effective September 1, 1970. These contracts had been amended 24 times as of May 1, 1976, for such things as premium increases, benefit changes, and technical amendments.

Based on our review and analysis of the three contracts, we concluded that a health insuring relation may have been intended, but the contracts still do not fully satisfy the requirements of either a health insuring or a fiscal agent arrangement.

One provision of the contracts provides that if, at the end of a contract year, the prepaid charges for that year did not cover the cost to implement the contract then any existing deficit could be charged against the Medicaid Reserve Account which was a continual year account. Thus, unless the contract was terminated and, at the time of such termination, the Medicaid Reserve was insufficient to pay outstanding contractor liabilities, Group Hospital Service, Inc., bore no risk of financial loss. Because any losses at the end of 1 year could be covered by surpluses accumulated in succeeding years, the payments under the contract did not necessarily discharge Texas from all liability for costs of covered services provided in a particular contract year. In effect, payments received by the contractor in one year could be used by it to pay for costs incurred in a previous contract year.

Because of continued negotiation of premium rates that exceeded the contractor's costs, a substantial reserve had been built up over the years. It was, therefore, unlikely that Group Hospital Service, Inc., would have sustained a loss due to insufficient reserve funds.

SRS officials discussed the reserve buildup with State agency officials and in May 1974 Group Hospital Service voluntarily refunded to the State agency more than $21 million of reserve funds. But the State returned $12 million to the contractor when the remaining reserve funds began to decrease.

In December 1974, SRS asked the State agency to establish safeguards to prevent further buildup of reserve funds. No such controls were ever established although limitations on reserves were supposed to be included in the new contract proposed under the 1976 solicitation discussed on p. 24.

We believe that the buildup of Medicaid reserves which are carried forward year after year violates insuring agreement principles because it tends to eliminate contractor risk--the large reserves from prior years can offset losses that occur in current periods.

In commenting on our report, Texas and Group Hospital Services, Inc., disagreed with our conclusion that the Texas contracts did not fully satisfy the requirements of an insuring agreement and that there was minimal risk to the contractor. Texas said that it believed it had met all Federal requirements for an insuring agreement and cited as evidence HEW's approval of Federal sharing in contract costs.

For the reasons previously stated in the report, we believe our conclusions about the Texas contracts prior to the 1977 contract are valid; that is, while it may have been the intent of Texas and Group Hospital Services, Inc., to have a health insurance agreement, the agreement nevertheless contained provisions that allowed it to operate as both a health insurance and fiscal agent contract.

UNCLEAR, AMBIGUOUS CONTRACT CLAUSES REDUCED CONTRACTOR'S UNDERWRITING RISK

The North Carolina multiservice contract contained unclear, ambiguous language concerning the extent of liability of the State agency and the contractor. The contract was amended twice under such language increasing the total contract price by an estimated $23.5 million over the 2-year contract period.

The contract contained two clauses under which the contract could be renegotiated. However, one contract clause provided for renegotiation under a certain set of circumstances while another clause appeared to preclude renegotiation under those circumstances.

The contract was renegotiated and amended effective July 1, 1975, to provide the contractor with additional income estimated at $6.7 million. This action was taken after the North Carolina General Assembly amended the State law to increase the maximum allowable daily payment to skilled nursing homes from $25 to $28. The act granting this increase cited the reason for the increase as being the "* * * pressure created by an inflationary economy."

In addition, during renegotiations over the contractor's plans for contract cancelation conducted from June to August 1976, the contractor (HAS) contended that the action by the State legislature to increase the maximum daily payment to skilled nursing homes to $28 created an extra incentive for providers to add additional beds in existing homes and to construct new intermediate care facilities 1/ between July 1975 and June 1976. HAS said that during this period, the State certified for participation in Medicaid 1,718 additional intermediate care facility beds and 1,372 additional skilled nursing facility beds. HAS said the increased number

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1/Payment rates to intermediate care facilities are dependent on payment rates to skilled nursing facilities.

of certified beds increased its costs for nursing home care under the contract. State officials agreed with HAS's contention during termination negotiations although the officials made no studies to determine whether other factors such as facilities under construction before the maximum payment was increased may have accounted for at least part of the increase in the number of beds.

The contract was amended a second time, increasing the contract price by an additional $16.8 million.

These two contract amendments were negotiated under article V, section 2, item 16, of the contract which states:

> "It is understood that the monthly capitation rates and the limitations on total monthly payments stipulated in Article VI hereof are based on the [Social Security] Act, [Federal] Regulations, North Carolina law and the State Plan, all as effective January 14, 1975. If there should be a proposed change in any of the foregoing which is likely to increase or decrease the cost of this program, either party shall have the right to renegotiate the capitation rates and limitations on total monthly payments subject to the change becoming effective."

The intent of this contract clause appeared to be to allow renegotiation of the contract price for any change affecting program costs in title XIX. Another contract clause dealing with renegotiations (article V, section 2, item 19) appeared to limit price renegotiations to cases where changes were made in the amount, duration, or scope of services under Medicaid or where additional administrative services were added to the contract. This clause states:

> "Increases in the capitation rates and limitations on total monthly payments provided for in Article VI, during the contract period shall only be to cover increased cost resulting from increases in amount, duration, scope of services or administrative services added to the Contract and not heretofore covered."
>
> (Underlining added.)

Inasmuch as the change in legislation did not affect the amount, duration, or scope of services 1/ provided under the contract this clause would seem to have precluded renegotiation based on increased costs resulting from the pressures of an inflationary economy.

CONCLUSIONS

Several of the contracts included in our review violated requirements of Federal regulations for insuring agreements that premium payments to contractors must fully discharge a State's liability. Contracts which permit either unilateral termination by the contractor or renegotiation of premium rates on the basis that the contract has not proven to be a profitable venture for the contractor do not achieve the objectives of an insuring arrangement and could cause serious disruption of the Medicaid program. We recognize that a contract which is priced unreasonably low is not advantageous to either party, but we believe that contractors that solicit Medicaid business on the premise that through better business methods and better program management they can hold program costs down should be given every opportunity and incentive to do so.

RECOMMENDATIONS

We recommend that before approving Federal participation in a contract intended as an insuring agreement, the Secretary, HEW

--ascertain whether the contract fully complies with Federal regulations for insuring agreements, and

--ascertain that the contract does not permit the contractor to terminate or to change the insuring arrangement for the purpose of reducing or eliminating the underwriting risk assumed by the contractor.

1/The amount, duration, and scope of services means the types of services provided to recipients along with any limitations placed on the recipient's use of the services. Since increasing the upper limits on payment rates for nursing homes did not either add or delete a covered service or change a recipient limitation placed on a covered service, this change did not effect the amount, duration, or scope of services.

Furthermore, we recommend that HEW require prior approval of changes to an insurance-type contract and that HEW officials not approve changes which would have the effect of eliminating or reducing the underwriting risk assumed by the contractor under the terms of the initial contract approved by HEW.

HEW COMMENTS

HEW agreed with these recommendations and said it believed the Medicaid insuring agreement regulations presently in force gave it the authority to implement our recommendations.

CHAPTER 5

HEW DID LITTLE TO MONITOR CONTRACTS

At the Federal level, SRS regional offices were to monitor State Medicaid programs. However, none of the five regional offices included in our review had developed specific plans for monitoring insurance-type contracts or for assessing the financial aspects of contractors' performance under the contracts. HEW regional offices had not developed the staff resources or expertise needed to adequately monitor insurance-type contracts or contractor financial performance because HEW regional offices viewed these functions as responsibilities of the States and of the HEW Audit Agency. HEW had not assessed State capability to perform these functions and since 1972, only one SRS region had requested the HEW Audit Agency to make a financial review.

SRS DOES NOT VIEW CONTRACT MONITORING AS ITS FUNCTION

Prior to the disestablishment of SRS and the formation of HCFA, the SRS Regional Commissioners in the 10 Federal regions had overall responsibility for monitoring Medicaid programs. While each SRS regional office had its own organizational structure and staffing pattern, each office had a staff responsible for assuring that Federal Medicaid policies were followed and a staff that was responsible for program financial management. Program policy specialists

--provided States with requested technical assistance,

--assisted States in preparing their Medicaid plans and recommended whether the State plans should be approved, and

--conducted periodic reviews to determine if the States were following Federal policies and the approved State plan.

Financial management specialists

--provided requested technical assistance to States;

--assisted States in preparing quarterly expenditure reports, quarterly and annual costs estimates, and cost allocation plans;

--recommended whether to approve Federal participation in State Medicaid expenditures; and

--conducted periodic review of States' program financial management.

Except for minimal involvement by an SRS regional financial specialist who assisted a State agency representative in reviewing contractor and subcontractor administrative costs charged under the North Carolina Medicaid drug contract, we found no evidence of direct SRS regional involvement in monitoring contracts and assessing contractors' financial performance. Most regional officials interviewed said that they viewed these as functions of the State and of the HEW Audit Agency. They did not foresee any significant changes in their methods of operation as a result of States' entering into insuring agreements. They said that they had neither the staff resources nor the staff expertise to adequately monitor Medicaid insurance contracts and to review or assess the financial performance of contractors. Although some officials indicated a desire to increase their staff and to expand their abilities for monitoring contracts and assessing contractors' performance, none had any specific plans for doing so.

HEW regional offices did not assess, as part of its Federal financial participation review and approval process, the States' capabilities to monitor insuring agreements or to evaluate contractors' financial performance. Also, HEW was not monitoring the States' activities under the contracts to determine whether they were adequately monitoring contracts or evaluating contractors' financial performance.

HEW AUDIT AGENCY HAD NOT REVIEWED ANY CONTRACTS

None of the 10 insuring agreements included in our review had been audited or were scheduled for audit by regional auditors at the time of our fieldwork. They had reviewed administrative aspects of the Medicaid programs, including some fiscal agent arrangements, and their audit plans called for additional reviews in the Medicaid area. However, none of the staff time budgeted for Medicaid reviews had been allocated specifically for reviewing insuring agreements. An official of the HEW Audit Agency in Atlanta stated, however, that the North Carolina Medicaid multiservice contract probably would be reviewed during fiscal year 1977.

The SRS regional office in Boston requested and the regional HEW Audit Agency agreed to review Maine's drug contract in 1975. The contract expired in June 1975 and the planned review was canceled. None of the other four HEW regional offices included in our review had requested an HEW audit.

PRIVATE CONSULTANTS AS CONTRACT MONITORS

HEW headquarters solicited proposals from private consultants to evaluate the efficiency and effectiveness of the North Carolina multiservice contract. However, HEW did not award an evaluation contract before the insuring agreement was terminated, effective June 30, 1976.

Arkansas and the contractor for that State's drug program agreed to a 38-percent increase in the contractor's premiums, effective July 1, 1975. To determine whether the increased premiums were justified, the SRS regional office in Dallas contracted with a private consultant after the new rates became effective to review the State's decision and supporting documentation. The consultant concluded in a December 1975 report that the State agency accepted the rates proposed by the contractor without analyzing them to determine whether they were reasonable; however, the consultant concluded that the new rates appeared reasonable.

CONCLUSIONS

HEW generally has not monitored the States' administration of contracts and has not assessed the contractors' financial performance. It also has not developed procedures to assure that the States are adequately monitoring the contractors' performance.

We believe that to protect the Federal Government's interest and to assure compliance with Federal legislation, regulations, and guidelines, HEW should require (1) States to establish effective contract monitoring and (2) HEW regional offices to implement the necessary procedures and controls to assure that contracts and contractors' performances are adequately monitored.

HEW regional offices view contract monitoring and evaluation of contractors' financial performance as State functions; therefore, HEW has not obtained the staff nor developed the expertise to perform these duties. We believe that it is important that States have effective contract

monitoring and evaluation programs to make sure that contract decisions are based on accurate, reliable, and complete data.

RECOMMENDATION

We recommend that the Secretary of HEW direct the Administrator of HCFA to develop procedures which delinate the role and responsibilities of HEW regional offices in monitoring Medicaid insuring agreements so that the Federal interest is protected.

HEW COMMENTS

HEW agreed with our recommendation and said that, under the organization of HCFA, attention is being directed at means to deal with contracting matters including increasing the technical competence of its staff in the procurement area.

CHAPTER 6

LIMITED MONITORING BY STATES

We found that States were not adequately monitoring their insuring agreements. We noted that:

--Income and costs associated with the contracts were sometimes inaccurately reported or not reported at all.

--Financial experience was not always used to renegotiate contracts.

--Payments to subcontractors were in some cases excessive.

The profits of one subcontractor that was affiliated with the contractor averaged 32 percent of cost on 6 contracts, and these profits were not considered in the profit-sharing arrangements with the States.

Conditions which hampered the States' efforts to monitor the insuring agreements were: (1) inadequate staff, (2) inaccurate and unreliable contractor reports, and (3) contractors often maintained their records and documentation supporting costs outside the State. When State officials did identify problems or questionable areas, these matters were often left unresolved.

FINANCIAL PERFORMANCE UNDER SOME CONTRACTS HAD NOT BEEN VERIFIED BY STATES

All insuring contracts except Arkansas' 1/ provided that the State would receive all or part of any contract savings as represented by the balance in the reserve account which reflects the difference between contract revenues and costs. Also, five States (Arkansas, California, Florida, North Carolina, and Texas) had renegotiated their contracts, including increasing contractors' premiums. Of these five States, only North Carolina and California had reviewed the contractors' and subcontractors' financial performance to determine the validity of the contractors' claims about financial experience and to validate the amount of the reserve balance. North Carolina's review was quite limited and very informal.

1/The Arkansas contract in effect from September 1973 to July 1975 did not include a provision for State sharing in savings. Effective July 1, 1975, the contract was amended to provide for State sharing in savings.

The results of our review of contractors' financial performance showed that the method for determining and reporting contract financial experience by one contractor (PAID) did not consider all revenue and cost items. PAID's financial data, for example, did not include interest income from prepaid premiums and contract reserve fund balances, revenues and costs associated with processing special claims, or the results of HAS' financial performance under subcontractor arrangements. HAS was closely affiliated with PAID. PAID's contracts with the States generally did not require it to include these items when reporting its financial experience to the States. However, when we included the items, it materially changed the financial experience under the contract. Because the States usually had profit-sharing agreements included in their contracts with PAID, significant differences in sharing amounts would have occurred if the contracts had included the items.

We did not review the financial performance of the other contractors for a variety of reasons. In the Texas case, the contractor had denied even the State access to its administrative cost records. For the Louisiana contract, insufficient time had elapsed under the contract to enable meaningful analysis when we performed our fieldwork. For the California dental contract, the State was evaluating the contractor.

HAS exercised control over PAID

PAID had an agreement with HAS under which PAID was obligated to subcontract with HAS for computer and marketing services for all of PAID's contracts. HAS had exercised control over PAID since 1969 through a series of such agreements.

PAID's management was aware of this control. An August 1975 report prepared at the request of the president of PAID by a member of PAID's board included the following statements:

> "The PAID/HAS relationship is the dominant and controlling factor in virtually every aspect of PAID's own existence. PAID is not a separate, self-sufficient entity unto itself, but depends upon the enabling capabilities of HAS to perform its role in society.
>
> "* * *PAID was a defacto subsidiary of HAS, used by HAS as needed, but not exerting influence or direction on HAS."

At the time of our fieldwork, the agreement between PAID and HAS covered the period from September 1, 1974, to December 31, 1993, and was renewable for two additional 10-year periods at HAS' option. Under this agreement, HAS had exclusive rights to promote, market, and use PAID's data service programs. All PAID contracts had to be approved by a joint committee consisting of three members designated by PAID, three by HAS, and a committee chairman. 1/

This agreement between PAID and HAS also details the subcontract formats under which HAS could assume some of PAID's contractual obligations. Under two agreements that affected PAID's Medicaid insuring agreements, HAS

--assumed and performed all administration and claims processing obligations imposed on PAID under the original third-party contract in return for an administration fee (usually a percentage of PAID's premium revenues, see p. 77) and

--reinsured PAID against incurred pharmacy claims in excess of adjusted premiums received by PAID (see p. 80).

The agreement stated that, upon its expiration, all third-party prescription data processing programs were to become HAS property, and PAID was to be granted a license to use any computer programs then used by HAS to service the company's contracts. Because of the control HAS exercised, we considered HAS and PAID to be related organizations. Under the related organization principle used by Medicare, an organization related to a provider as a result of common control is treated as if it were part of the provider. We applied this principle to PAID's contracts when we evaluated its financial performance by including HAS in the analysis, using its costs and profits instead of the subcontract prices.

1/The chairman could cast tie breaking votes. Effective April 2, 1976, the president of PAID was designated chairman of the committee. Before then the president of HAS served as committee chairman. Thus, HAS controlled the committee's actions. Notwithstanding the appointment of the PAID president as committee chairman, HAS still had veto power over contracts between PAID and third-party organizations because contract approval required a majority vote, including at least two HAS votes.

In commenting on our report, both PAID and HAS strenuously objected to our conclusion that HAS had at any time exercised control over PAID. Both firms maintained that they were, in law and in fact, separate legal entities. As pointed out previously, because of the administrative agreement between HAS and PAID and because of the ability of HAS to veto PAID contracts, we believe that HAS had effective control over PAID. Also, it should be pointed out that HAS, along with its parent corporation, and PAID had interlocking boards of directors.

In view of the importance of this issue to HAS and PAID we are including their comments regarding this matter as appendix III to this report.

Interest income earned on prepaid premiums and reserve balances was excluded

Federal Medicaid insuring agreement regulations do not address the disposition of interest earned by contractors on premium income and accumulated reserves.

Prepaid premiums and reserve balances under PAID's Medicaid drug contracts generated substantial interest income; however, only one contract (Pennsylvania) addressed interest income earned on these items. 1/ Pennsylvania's contract stipulated that interest income had to be used for contract expenses or credited to the reserve account and shared with the State. Because PAID was not required to report interest income under its other contracts, PAID, HAS, and Bergen-Brunswig received income or equivalent benefits we conservatively estimate at about $1 million which was not reflected in PAID's financial performance data reported to the States. The interest income was available to PAID for nonprogram use except in Pennsylvania, where the contract included a provision that prohibited the use of interest income for nonprogram purposes.

The administrative agreement between PAID and HAS provided that HAS could use funds received by PAID from the States until they were needed by PAID for paying provider claims and for operating expenses. The funds transferred to

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1/Arkansas' contract was amended, effective July 1, 1976, to include interest income earned after that data in the funds available for paying program costs and for profit sharing. The contract had been in effect since September 1973.

and used by HAS from the several contracts were comingled in a Bergen-Brunswig account and not maintained in separate accounts. Also, PAID and HAS did not account separately for interest income earned on the contract premiums. We estimated that through June 30, 1975, the cash flow generated under five drug contracts provided PAID and HAS with benefits worth at least $1 million in interest income or the free use of the cash flow.

For example, from December 1, 1972, to June 30, 1975, payments to PAID under the North Carolina drug contract allowed HAS and PAID to maintain a cash balance of from $1.1 million to $3.6 million. This balance on the North Carolina drug contract allowed PAID and HAS to receive more than $414,000 in interest income or equivalent cash flow benefits during the 31-month period.

The following table shows our estimate of interest income or equivalent dollar benefits which had accrued to PAID and HAS through June 30, 1975:

Estimated interest earnings or cash flow benefits accrued to HAS and PAID from inception of contract through June 30, 1975 (note a)

	California four-county	North Carolina	Arkansas	Maine	Florida	Total
HAS	$ 92,140	$247,560	$122,230	$ 630	-	$460,560
PAID	74,590	169,320	125,870	11,160	100,190	481,130
Total HAS and PAID	$166,730	$414,880	$248,100	$11,790	$100,190	$941,690

a/Interest earned before September 1974 on the California four-county, North Carolina, Arkansas, and Maine contracts accrued to HAS. Interest earned after September 1, 1974, accrued to PAID. Under the Florida agreement, interest earned from the program's inception accrued to PAID. A 6-percent interest rate was used for the period before July 1, 1974, and the applicable Treasury bill rates were used beginning July 1 to compute the estimated interest earned.

In commenting on our report, both PAID and HAS said our estimate of interest earned was overstated. HAS said that its interest income was only $256,000. In calculating our estimate, we used the rate of return on Federal long-term notes. This interest rate is generally the lowest one available in the country. Thus, our estimate probably understates the actual benefits received by PAID and HAS. Also, when we prepared our estimate, it was reviewed by HAS and PAID and both agreed it was fair. The reason we had to make the estimate was because neither HAS or PAID had any records relating to the equivalent benefits derived from having the cash balances from the drug contracts available for use in the Bergen-Brunswig account.

Financial experience from special claims was excluded

Five of the six drug contracts with PAID (Arkansas, California, Florida, North Carolina, and Pennsylvania) provided for processing special claims. 1/ PAID's internal administrative costs were reflected in financial data reported to States. However, PAID excluded from its contract financial data the revenues received from States for special claims and amounts paid to HAS to process them. Exclusion of these items understated PAID's financial experience under the contracts because, while some costs were included, other costs and all revenues relating to special claims were omitted. For example, the net income reported by PAID for the first 8 months of the Pennsylvania drug contract was understated by about $64,000 because $320,000 in revenues from special claims, and $256,000 in claims processing costs were excluded from the financial data. 2/ PAID's income under the other four contracts was not affected as much as it was under Pennsylvania's contract because revenues and costs for special claims were more equal.

1/Special claims are defined as claims submitted for recipients whose names do not appear in the eligibility files and for which the contractor did not receive a premium. The contractor was reimbursed the amount paid the provider plus an administrative fee for processing each special claim.

2/Pennsylvania informed us in its comments that it has subsequently conducted a detailed audit to determine PAID's status at the end of June 1976. The audit report concluded that PAID had incurred a loss of about $300,000 during the November 1974 - June 1976 period.

Subcontractors' financial experience was excluded

Five States (Arkansas, California, Florida, Maine, and Pennsylvania) allowed PAID to charge their drug contracts with the full amount of subcontractor payments even though the subcontracts were not awarded competitively and the subcontractor (HAS) may have realized substantial profits under them. In fact, PAID by administrative agreement was obligated to subcontract with HAS, who in turn had veto power over PAID contracts with third parties. Consequently, there were no arms-length negotiations for the subcontracts but the subcontract awards apparently were based on terms most favorable to HAS. This is substantiated by the fact that, based on HAS' unaudited records, HAS realized a profit of at least 32 percent of its costs on four substantially completed contracts.

HAS' profit may have exceeded 32 percent because, based on a limited review of charges to the drug contracts by HAS, many of the costs were questionable and probably would not have been allowed had Federal procurement principles been applicable to the subcontracts. (See p. 78.) Nevertheless, the subcontractor's financial performance was not included in the contractor's financial data reported to the States.

PAID's and HAS' financial experience under the six drug contracts is shown in the table on the following page.

In commenting on this section of our report, HAS said we had vastly overstated its net income under the subcontracts. HAS said that its income for the 6 subcontracts was 10 percent of revenues and ranged from 1 percent to 20 percent. For the four substantially completed contracts we said HAS had an average profit of 32 percent of costs; HAS said it had an average profit of 11 percent of revenues. HAS provided a schedule showing how it derived its figures for income under the subcontracts.

We analyzed the schedule provided by HAS and determined that most of the figures used were the same as those provided to us by HAS when we conducted our fieldwork. However, HAS had not made the adjustments to the data (expect for including interest income and reinsurance income and expenses) that we had felt appropriate when we had previously analyzed the data during the course of our onsite audit. The major adjustments we had made related to income taxes. HAS figures were for after-tax profits. Since income taxes are not an operating cost and are also not an allowable cost on government

State	Period	PAID's experience					HAS' experience		
		Contract revenue	Re-insurance recovery	Cost	Profit (loss) amount	Percentage based on cost	Contract revenue	Profit (loss) amount	Percentage based on cost
		(000 omitted)					(000 omitted)		
North Carolina	12/72-6/75	$53,020	170	$53,003	a/$187	.004	$6,395	$1,887	42
California	12/72-6/75	42,355	0	42,718	(363)	(.008)	5,727	606	12
Arkansas	9/73-6/75	24,499	491	24,990	0	0	4,453	1,680	61
Florida	7/74-9/75	29,7[illegible]	1,723	31,975	(471)	(1)	3,229	560	21
Maine	8/74-6/75	4,543	290	4,940	(107)	(2)	549	8	1
Pennsylvania	2/75-9/75	31,310	0	29,832	a/1,478	4	2,619	224	9

a/PAID records showed that North Carolina was due $192,000 and Pennsylvania was due $730,000 under the State/contractor sharing arrangements. However, at the conclusion of our fieldwork in August 1976, the only funds returned to the States by PAID was $89,000 to North Carolina.

contracts, we used before tax profits. Also, income taxes would not have been considered under any profit sharing arrangement with the States. This resulted in an increase of about $1.4 million in profits. We also made a number of other adjustments to revenues and expenses. The net result of all our adjustments was that we show HAS profits as being about $750,000 higher than HAS says they were. This difference arises primarily from different estimates of (1) interest earned or equivalent benefits received (about $200,000) and (2) costs to process claims for services provided during the contract period for which the claim is submitted after the period (about $475,000). Since we spent a substantial amount of effort verifying the information HAS provided during our fieldwork and since the data HAS provided in its comments is virtually identical to that data, we believe our adjustments would still be appropriate.

In the final analysis, if before tax profits as a percentage of costs are used, the figures provided by HAS in its comments show that HAS had an average profit of 32 percent on the 4 substantially completed contracts, which is essentially what is shown in this report.

HAS also said it was unfair and irrelevant to isolate certain contracts or pieces of HAS' business and look at their profitability in a restricted time frame. PAID made a similar comment. Because every Government contract is separate, distinct, and accountable in itself, and because the Medicaid drug insuring contracts in question were to be accounted for and settled for separately, we believe it is appropriate to look at each contract on a case-by-case basis. Furthermore, the issue we are raising is whether total experience under a contract, including subcontractor experience, should be evaluated in determining the outcome of a contract, not the overall financial well being of a particular firm.

PAID also said that its profitability figures included in the table were incorrect since they did not take into account incurred and unreported claims. We included in our data estimates of incurred and unreported claims for each contract. In fact, the estimates we used were prepared by PAID 3 to 6 months after contract expiration and verified as reasonable by us.

PAID pointed out that it had not yet received a reinsurance recovery on the Florida contract. The estimated reinsurance recovery included in the table was prepared by PAID and verified as reasonable by us.

Payments to subcontractor based on percentage of premiums

PAID and HAS agreed that a percentage of the premium income received from each State contract would go to HAS as payment for processing and paying the drug claims. The following table shows, for each of PAID's six drug contracts, the percentage of premium income that HAS was supposed to receive:

State	Percent of premium income for administrative services
Arkansas	10.0
California (four-county)	10.0
Florida	9.5
Maine	10.0
North Carolina	a/10.0
Pennsylvania	7.8

a/Reduced to a monthly fixed amount of $135,000 after the State agency conducted a limited review of HAS' charges to the North Carolina account.

Because PAID was required to contract with HAS, the fees were not established competitively. HAS contends that they were negotiated based on HAS' historical cost experience. HAS could not validate that this was the case. The fees varied among the contracts depending upon (1) specific responsibilities assumed by the subcontractor, (2) the number of program eligibles, (3) benefits provided under the program, (4) the condition of State eligibility files, and (5) the complexity of data required under the contract.

Lincoln National Life and Pharmaceutical Card System have a similar arrangement. Under their arrangement the minimum administrative fee to be paid Pharmaceutical was 5.5 percent of the premium income received by Lincoln. The arrangement also included a program cost reduction incentive whereby Pharmaceutical could receive a maximum administrative fee of 7.1 percent of premium income. Neither the contractor nor the subcontractor, however, had documentary support for the subcontract negotiations or for the historical cost

experience on which the percentages were based. 1/ We did not review Pharmaceutical Card Systems' financial experience.

Our review of HAS' financial experience indicated that the subcontractor fees may have been excessive. HAS had realized an overall 32-percent profit margin through September 1975 on four substantially completed contracts--individual contract profit margins ranged from 1 to 61 percent.

We believe that paying a percentage of total premium revenue to a subcontractor for claims processing services does not represent resonable subcontract pricing because much of the claims processing cost is fixed. For example, the subcontractor must have a facility, a computer, and a minimum number of personnel regardless of the volume of claims to be processed. These then represent relatively fixed costs. If the number of claims to be processed is proportionate to the number of people covered under the insuring contract, the addition of a beneficiary normally would not affect these fixed costs. Therefore, the subcontractor's cost increase per additional beneficiary is minimal, whereas the revenue increases by the applicable percentage of the beneficiary's premium. Much of the subcontractor's costs are not directly related to the number of contract beneficiaries and therefore a pricing mechanism, which provides the subcontractor a percentage of contractor premium revenues, is not directly related to subcontractor costs.

Costs charged to subcontracts not allowable under Federal procurement regulations

Some of the subcontractor costs charged to the six drug contracts awarded to PAID would not have been allowed had the subcontractor been required to comply with Federal procurement regulations. Although we did not attempt to determine the dollar amount or identify costs of items that would have been disallowed under Federal regulations, some questionable charges included advertising, bad debt, marketing expenses, amortization of goodwill, consultants' fees,

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1/ Lincoln National Life in commenting on our report stated that it had reviewed detailed cost data furnished by Pharmaceutical Card System which justified the percentage of premiums arrangement. During our fieldwork, we had asked for such data but neither firm could provide it.

donations to charitable organizations, and first-class travel accommodations. Federal regulations state that bad debts and contributions and donations are not allowable expenses; that advertising and management studies are allowable expenses only if specifically provided for under the contract; and that first-class travel accommodations are allowable only if less than first-class accommodations are not available.

Also, about $489,000 of the $2,[illegible]4,600 in costs charged to the North Carolina drug contract between December 1972 and May 1974 were questioned by representatives of the SRS regional office and the North Carolina State agency during their May 1974 review of the subcontractor's contract charges. The representatives said the amount questioned would not have been allowed under Federal regulations. According to the State agency representative, PAID credited the contract reserve account with $489,000. PAID commented that it has never agreed with the amount the State said was unallowable.

We observed that many cost items identical or similar to those questioned by the SRS and State representatives were charged to the other five drug contracts. Therefore, we believe it is reasonable to assume that these items likewise would have been disallowed had the State agencies required the contractor and subcontractor to adhere to Federal cost principles and to document and support their claims for administrative costs.

Based on our recommendation, PAID established a travel policy effective February 20, 1976, which generally prohibits first-class travel.

HAS in commenting on our report said that while it did not concede that these costs were unallowable, inasmuch as only 1.7 percent of its total operating costs during the period September 1972 to August 1975 represented advertising, bad debt, goodwill, donations, consulting services and marketing service accounts, our observations regarding the allowability of expenses under Federal procurement regulations were disproportionate.

We believe that if 1.7 percent of administrative expenses under Medicaid contracts and subcontracts could be avoided merely by making them subject to Federal cost principles, such an effort would be worthwhile.

Payments to subcontractor for reinsurance were excessive

As a matter of policy, PAID obtains reinsurance to protect itself against possible losses under its Medicaid drug contracts. PAID obtained the reinsurance directly from private insurance companies until September 1, 1974, generally covering 90 percent of its risks.

However, between September 1, 1974, and June 30, 1975, PAID purchased reinsurance for 100 percent of its losses from HAS for 1-3/4 percent of the monthly premiums it received under its drug contracts. HAS assumed a portion of the risk but arranged to obtain from private insurance companies reinsurance contracts which generally covered 90 percent of HAS' risk.

HAS received $1,523,000 from PAID for reinsurance of the six drug contracts during the 10 months that the PAID/HAS reinsurance agreement was in effect. During the same period, however, HAS' payments to private companies for the coverage totaled only $304,000. HAS estimated, however, that it may be required to reimburse PAID as much as $705,000 for losses relative to the risk it assumed directly under the agreement. Nevertheless, HAS will realize a profit of at least $514,000 for providing PAID with reinsurance, 90 percent of the value of which HAS arranged to obtain directly from private insurance companies for much less. HAS' reinsurance income and estimated liability for each of the six drug contracts under the reinsurance agreement are shown in the following table:

		Reinsurance revenues from PAID	Premium payments to private companies	HAS' estimated liability for PAID for assumed risk	Expected profit (note a)
9/74-6/75	North Carolina	$ 334,000	$ 81,000	$152,000	$101,000
9/74-6/75	California Four-County	234,000	44,000	1,000	189,000
9/74-6/75	Arkansas	201,000	24,000	309,000	(132,000)
9/74-6/75	Maine	72,000	17,000	53,000	2,000
7/74-6/75	Florida	416,000	84,000	190,000	142,000
2/75-6/75	Pennsylvania (note b)	266,000	54,000	-	212,000
Total		$1,523,000	$304,000	$705,000	$514,000

a/Expected profit was calculated by subtracting premiums paid to private companies and estimated payments to PAID from reinsurance revenues received. Interest income or equivalent benefits to HAS on these payments are not included.

b/Pennsylvania informed PAID in March 1976 that the State does not consider the payments to HAS for reinsurance to be an allowable cost under the contract.

HAS in commenting on our report said that if it had derived a profit on the reinsurance, it would not have been unreasonable in light of the unlimited risk HAS assured. PAID made a similar comment.

HAS did not assure an unlimited risk. In fact, as we stated, HAS assumed a risk for about 10 percent of any losses PAID might have suffered. HAS arranged for reinsurance from private insurance companies for the remaining 90 percent of the risk. Therefore, HAS bought insurance for 90 percent of the risk for $304,000 and retained $1,219,000 to cover the remaining 10 percent of the risk.

Revenues and costs were not separated by contract period

PAID's fund accounting system recognized cost and revenues by State rather than by contract period. The system, therefore, does not meet the needs of the States since, to assure an equitable contract settlement, the States must account for cost by contract period.

The problems resulting from PAID's accounting system are demonstrated by its application to the North Carolina drug contract. The initial contract was extended for two additional periods but the contract provisions concerning State and contractor sharing in contract savings were different for the three periods. The following table summarizes the provisions for each period:

Contract period	Contract provision concerning State and contractor sharing in contract savings
12/1/72 - 6/30/74	Not addressed in the contract document. (note a)
7/1/74 - 6/30/75	State and contractor will share equally in contract savings.
7/1/75 - 6/30/76	State and contractor will share 75/25 respectively, in contract savings.

a/State agency officials claimed that the State and contractor had orally agreed to share equally in contract savings. However, the contract stated that oral agreements were not binding.

The State agency did not make a final accounting at the end of each contract period to determine the contract savings applicable to that period. State agency officials said that a final audit would be conducted after June 30, 1976, for the period from December 1, 1972, to June 30, 1976. Because the sharing ratios are different for the three contract periods and at the time of our fieldwork PAID's accounting system did not recognize revenues and costs by contract period, it will be difficult for North Carolina to determine actual contract results by contract period.

STATE MONITORING ACTIVITIES WERE LIMITED

Although most States had not attempted to evaluate their insuring agreement contractors' financial performance, the States generally had recognized the need for, and assigned responsibilities for, contract monitoring. However, State monitoring activities were limited and heavily dependent upon management reports provided by contractors. However, some management reports were inaccurate, incomplete, and unreliable, and thus of little value to States.

Some States were not adequately staffed to monitor their contracts effectively. In addition, contractor and subcontractor records for six drug contracts were located at the contractor's and subcontractor's home offices in California, thus further restricting State monitoring efforts.

In Texas the contractor maintained that the State did not have authority to audit its administrative costs records because the contract lacked an access-to-records clause. The State never audited these records.

Management reports were not always reliable

Monitoring of both programmatic and fiscal aspects of contracts depends on reports and information provided by the contractor. Although these reports were generally adequate, and often provided States with data not previously available, in some instances they were untimely, inaccurate, inconsistent, and incomplete. Also, some States had not verified the reports' accuracy and reliability.

Contracts required that the contractor furnish the States reports on program providers, recipients, and financial activities under the contract. Generally, State agencies and contractors were using the reports as the basis for

--making payments under the contracts,

--conducting cost analyses and comparing costs to premiums,

--renegotiating contract prices, and

--responding to questions from providers and recipients.

Although California, Pennsylvania, and Louisiana commented favorably on the quality of the contractor management reports, the accuracy and reliability of some reports had not been verified by the States. Pennsylvania, for example, received monthly Medicaid reserve status report from the contractor, which supposedly showed the contractor's surplus (deficit) of revenues over expenses. The September 30, 1975, report, which had not been verified by the State, showed a negative balance of $174,534 in the reserve account. Our analysis of the September 30, 1975, reserve balance for the Pennsylvania contract, based on unaudited financial data provided by PAID, showed a positive balance of about $1.4 million. One major difference was that PAID's report to the State failed to include its revenues for certain claims processed on a cost reimbursement-plus claim processing fee basis, but did include the corresponding costs.

The North Carolina Medicaid multiservice contract required that the contractor furnish nearly 90 reports to the State. State agency employees assigned to review and analyze the reports said that the reports had been of little value because they were inaccurate, inconsistent, and incomplete, and had not been submitted on time. The officials said that their efforts (including delaying payment of contract premiums) to get the contractor to improve the quality and timeliness of the reports had not been successful. For example, in a letter of November 10, 1975, to HAS the Chief, Medical Services State of North Carolina stated that

> " * * the State of North Carolina is required to withhold your September premium payment in the amount of $14,660,000 until we receive the mandated monthly reports summarizing the business conducted during the month of August."

According to the provisions of the contract, monthly payments to the contractor were subject to the receipt of a series of reports by the State agency on or before the 8th of each month.

Also, a memorandum of September 10, 1975, between two North Carolina State agency officials stated that

> "* * * The non-MMIS [Medicaid Management Information System] reports received September 8, were the Financial Participation Report (FPR) and County Recipient registers. The FPR total of dollars expended does not agree with the statistical report NCSS-120 which was received yesterday and is still being analyzed. The FPR total is $5,259,333.95 and the NCSS-120 total is $5,549,198.28 and neither report includes the Buy-In Premium of $503,510.10. There is a difference of $289,864.33. Recipient counts by type of service are found in the NCSS-120 report but due to the difference in amounts paid I would question whether the recipient data is accurate. The MR-0-24 which is the only report which includes paid claim data has not been received from Health Application System."

In addition, the memorandum showed the results of the Medical Assistance Accounting Branch's "very brief analysis" of eight August 1975 reports received from HAS. This analysis reported a total of 39 errors, ommissions, etc., in the eight reports.

Another example of the magnitude of the reports problems under one of PAID's drug contracts is illustrated by a February 14, 1975, memorandum between two Florida Medicaid officials. The memorandum stated that the State had never been provided by PAID with reports on (1) program status including recipients, providers, and claims processed; (2) drug expenditure analysis by recipient aid category; (3) claims processing performance; (4) drug usage by recipient aid category; and (5) drug usage frequency analysis. The contract required PAID to provide the first three reports each month and the other two reports semiannually. Although the contract had been in effect for 7-1/2 months, the State said none of these reports had been furnished.

Staffing was not adequate

Four States (Arkansas, Florida, Louisiana, and Pennsylvania) acknowledged that they were not adequately staffed or that their staff did not have the necessary expertise to monitor their contracts and to evaluate their contractors' performance effectively.

A Florida employee was assigned to monitor the contract and the contractor's activities under the insuring agreement. However, the employee, after getting approval from the State, was hired by HAS about 2 months after PAID took over the drug program. The State agency had not filled the vacant contract-monitoring position as of June 30, 1976, because of a hiring freeze imposed by the State. Consequently, the State agency had not established a routine contract-monitoring program, and little effort had been spent on reviewing and analyzing management reports or performing other contract monitoring activities.

The Arkansas State agency had one pharmacist assigned to monitor its drug contract. A State agency official acknowledged, however, that one person could not effectively monitor the contract. Furthermore, the official stated that neither the pharmacist nor members of the State support staff had the actuarial training required to determine the soundness of premium rates proposed by the contractor.

North Carolina and Maine each had one person assigned to monitor their drug contract and Louisiana had two. Other support employees also participated in various monitoring activities in these three States, but none were actuaries. The director of the Louisiana program said that a staff increase was needed to monitor the contract effectively.

Both California and Pennsylvania had comparatively large staffs assigned to monitor their drug program contracts. But the director of the three pharmacists assigned to monitor the Pennsylvania contract had requested that the number of pharmacists be increased to 10 to enable monitoring of the numerous reports submitted by PAID.

Records were not readily accessible

Some contractor and subcontractor records for the Arkansas, California, Florida, Maine, North Carolina, and Pennsylvania Medicaid drug contracts were located at PAID's and HAS' home offices in Burlingame, California, or at Bergen-Brunswig headquarters in Los Angeles. Those States other than California, therefore, did not have ready access to the records and to some key contractor and subcontractor personnel. We believe that the States' effectiveness in monitoring the contracts and evaluating the contractors' financial performance is seriouly hampered when the records are not readily accessible for review.

HAS told us that about 85 percent of the records associated with each contract were maintained in the applicable State. HAS said the remaining records were maintained in California because HAS used Bergen-Brunswig's centralized corporate services. HAS said the services provided in California included those relating to accounts payable, general ledger, cash management, and administrative services. HAS believes the use of Bergen-Brunswig's centralized services lowered PAID's costs and consequently the State's contract costs. While using the centralized services may have resulted in lower costs, it also resulted in (1) making it difficult for States to audit the contracts and (2) some loss of identity of State funds since they were commingled with other States' funds. Since the contracts included profit sharing provisions, it was necessary for the States to be able to audit records so as to assure the proper amount of any profits were returned to them.

In Florida, for example, the State Auditor General's staff attempted to determine the reasonableness of premium rates and experienced difficulty in verifying contract charges to source documents located at the contractor's home office. Representatives of the Auditor General's office requested, on at least three separate occasions, documentary evidence to support certain charges to the drug contract, but according to the representatives, some costs charged to the contract were never fully supported by the contractor. In reference to one of the Auditor General's requests for records, the contractor stated:

> "* * * to provide the auditors, by mail, with all data supporting administrative costs as they have requested would be a substantially time consuming and costly project. All of these records and documents are available in Burlingame and we would welcome an on-site examination by the Florida auditors."

An official of the Auditor General's office said that conducting onsite reviews at the contractor's home office would be much less effective than having the records available for review at the contractor's place of business in Florida.

The staff assigned as fiscal monitors of the North Carolina Medicaid multiservce contract also were unable to complete a detailed evaluation of certain general and administrative expenses charged to that contract because the cash disbursement journals, canceled checks, and supporting and related records were located at HAS' parent organization

(Bergen Brunswing Corporation) in Los Angeles, California. Determining the allowability of these expenses is important because of the impact they can have on the profit-sharing provision of the contract. After the fiscal monitors raised the issue that location of records was hampering their contract monitoring efforts, HAS agreed to absorb the costs of sending the contract monitors to the parent organization's home office to conduct an onsite review of the company's records.

Access to the contractor's (Group Hospital Service, Inc.) records that show administrative costs charged to the Texas Medicaid contract has been a matter of controversy between the contractor and the State agency for several years. Even though a provision in the contract states that the contractor shall maintain such records and afford such access thereto as the State agency finds necessary, the contractor, on July 1974, denied State auditors access to administrative cost records claiming that the provision related only to records of payments to the providers of Medicaid services.

In an attempt to resolve this controversy, the State agency in January 1976 agreed to a contract amendment which granted the State agency full access to all administrative cost records for up to 1 month during a continual year of the contract. The amendment specified, however, that this audit right would be the only audit right provided for review of administrative costs, except those claimed on a cost-reimbursement basis, incurred by the contractor under the contract.

Determining the reasonableness and allowability of contractor administrative charges to the insuring agreement was important because under the contract the contractor was allowed to keep all payments made for administrative costs. Without access to the administrative records, the State could not be sure it was paying a proper amount for these services. Also, the State would have had no basis on which to renegotiate the administrative payments.

Because of the limited access to the contractor's records and the complexity of the contractor's accounting system, State auditors were still experiencing problems with reviewing and establishing the reasonableness of the contractor's administrative costs. Also, because of the nature of this problem, we did not attempt to gain access to the contractor's administrative cost records during our review.

FINDINGS OF STATE CONTRACT MONITORS AND AUDITORS HAD NOT BEEN RESOLVED

California appeared to have adequate staff to monitor and audit its Medicaid drug and dental contracts, and North Carolina appeared to have adequate staff to perform these functions for its Medicaid multiservice contract. However, many findings developed and issues raised by the persons responsible for these functions had not been resolved.

California dental contract

California's contract monitors and auditors disclosed two issues which could have significant effect on the dental contract and its costs to the State and to the Federal Government.

Inadequate program controls

Based on audits of the dental services contract which were conducted before November 1975, the State's contract manager concluded that the contractor (California Dental Society) had not exercised adequate controls over program utilization. Specifically, a November 1975 memorandum prepared by the manager stated:

> "Studies conducted * * * prior to awarding the CDS [California Dental Service] contract indicates significant savings could be realized if a larger percentage of the claims received by CDS were reviewed * * * on the basis of standards established by the State on what is reasonable and necessary. When this information * * * is projected to the 813,585 users of the present CDS dental program, an estimated savings of $8,460,119 could be realized."

The results of the State's audits were discussed during the 1976 contract negotiations between the State and the dental contractor. However, the contractor would not agree to reduce its proposed capitation rate to reflect the savings supposedly available by implementing the program controls because the contractor did not believe that the State's audit sample was statistically valid and because the State used its own "reasonable and necessary" criteria instead of the contractor's. The contract manager said that he planned to substantiate the State's claim that the contractor is not exercising adequate program controls.

California, in commenting on our report, agreed that the contract needed closer management control in this area and stated that this is one of the lessons it learned from the contract. Conversely, CDS said that it continued to question the validity of the State's conclusions and that, in its opinion, the State had not yet been able to substantiate them.

Alledged overpayments to the contractor

In 1974, the California Dental Service reported to the State that it received and paid 74,094 dental claims involving persons who had not been reported as program eligibles. The contractor was reimbursed $3,429,609 for claims payment plus 6.16 percent of the claims amount for administrative expenses. However, a State review of claims for payments for supposedly unreported eligibles revealed that, due to administrative errors in the contractor's claims processing system, more than half the claims should not have been categorized as claims from eligibles whose certification was received after the claims. The State concluded it had paid premiums for these eligibles and, thus, the contractor was overpaid nearly $2 million which, at the time of our fieldwork, had not been recouped by the State. State officials said that they would recoup the funds and require the contractor to establish appropriate controls to prevent these errors in the future.

California commented that it has taken steps to improve the eligibility reporting system to help eliminate this problem in the future.

North Carolina Medicaid contract

The North Carolina Medicaid staff monitoring the fiscal aspects of the contract had, at the time of our review, devoted most of its monitoring efforts to reviewing and analyzing general and administrative expenses claimed by the contractor for the 2-month period in which the contractor functioned as a fiscal agent and to evaluating and determining interim reimbursement rates to institutional providers.

Administrative expenses not supported

In November 1975, the State completed a detailed evaluation of HAS' general and administrative expenses which were reimbursed on a reasonable cost basis and were charged through August 1975 to the fiscal agent period of the contract. The

evaluation did not include a test of cash because the checks, cash disbursement journals, and related records were in California. The State questioned more than $420,000 of the $1.3 million claimed by HAS and recommended that these expenses be disallowed. In addition, the State found that HAS was not complying with the contractual requirement that HAS maintain commercially acceptable accounting records at its North Carolina office, but as discussed on page 85 this issue was resolved. The staff questioned the adequacy of HAS' North Carolina accounting system because

--the accounting records for the Medicaid program were maintained in a set of books with other HAS-administered programs,

--HAS provided the State only photocopies of California-originated invoices, and

--the records were not sufficient to permit adequate evaluation of the allocation of some general and administrative expenses.

Providers underpaid

For the period August 19, 1975, to October 15, 1975, the staff found that HAS had underpaid 58 intermediate care facility providers by $168,207. The underpayments resulted primarily from the contractor's failure or inability to update its reimbursement records in a timely manner. If the contractor was allowed to pay providers less than established interim rates, the State's Medicaid cost would have been increased to the extent of such underpayments because the contract required the State to make final cost settlements at yearend.

CONCLUSIONS

Most States were not adequately monitoring the financial performance of Medicaid insuring agreement contractors. Our review of the financial performance of one contractor (PAID), which along with its affiliated data processing subcontractor (HAS) had six contracts, revealed that HAS was making profits of 32 percent of costs which were not considered in the cost-sharing arrangement with the States. Also, since the States did not generally have information on HAS's financial experience under the six contracts, the actual cost experience could not be considered in renegotiating PAID's premium rates.

PAID was not always accurately reporting its revenues and expenses to the States. Most contracts did not address interest earned by the contractor, and PAID and HAS (and its parent corporation, Bergen-Brunswig) accrued interest income or equivalent benefits of almost $1 million during the period December 1972 through June 1975. We believe that Medicaid insuring agreements should include provisions which address the use of funds available to the contractor but not immediately needed to pay costs under the contract. The benefits derived by the contractor from such funds should be considered in establishing premium rates or in negotiating profit-sharing arrangements.

In addition, through a reinsurance agreement between PAID and HAS, HAS increased its profits by about $500,000 during a 10-month period.

PAID paid HAS a percent of its premium revenues (ranging from 10 percent to 7.8 percent) under the subcontracts. Lincoln National Life and Pharmaceutical Card System had a similar arrangement in Louisiana. We believe that paying a percentage of total premium revenue to a subcontractor for claims processing is not reasonable because this basis is not necessarily related to the costs of performing this function.

State efforts to monitor contract activities were not adequate and hampered by a number of factors. States relied upon unverified contractor-generated data for making decisions about program changes, contract premiums, and other contract matters. Information developed during our review showed, however, that some of this reported data were inaccurate, unreliable, and incomplete, and did not fully disclose contractors' financial experience for several contracts. Also, contractors' financial data were misleading because some contract revenues were excluded and some contract costs were questionable because they appeared to be excessive or would not have been allowable under Federal procurement regulations.

RECOMMENDATIONS

We recommend that, as a condition of contract approval for Federal financial participation, the Secretary of HEW require States to:

--Develop and submit to the appropriate HEW contract-approving authority an acceptable plan for monitoring Medicaid insurance contracts and evaluating contractors' financial performance under the contracts.

--Include language in Medicaid insurance contracts which would make the contractor and all subcontractors subject to Federal procurement standards (45 C.F.R. 74.150 et seq.) and Federal cost principles (45 C.F.R. 74.170 et seq.).

The Secretary should also:

--Issue regulations prohibiting the use of percentage-of-revenue agreements between Medicaid contractors and their subcontractors.

--Issue regulations requiring that all subcontracts assigning substantial portions of the contractor's responsiblities to a subcontractor be submitted along with the contract at the time of request for contract approval.

--Revise Medicaid regulations to require (1) State insuring agreements to address interest earned or equivalent benefits to be accured by contractors on premium payments and accumulated reserves and (2) the consideration of such interest and benefits in establishing premium rates and profit-sharing arrangements.

HEW COMMENTS

HEW agreed with these recommendations and said the Medicaid regulations would be modified to make specific reference to State monitoring systems. HEW said it was studying the value of requiring States to address interest or equivalent benefits accrued by contractors, and prohibiting percentage of revenue subcontracts. We believe that our report has already demonstrated the need for such provisions and that HEW should implement our recommendations without further study.

HEW also said that present regulations were being interpreted to require submission of subcontracts with the contract when States request contract approval. We believe the regulations should be made explicit in this regard.

HEW said that the current Medicaid insuring agreement regulations require, by reference, State Medicaid contracts to adhere to Federal procurement standards and Federal cost principles. While Medicaid regulations do incorporate by reference, "the appropriate requirements" of HEW regulations regarding contracting by grantees, which is what States

are under the Medicaid program, the cost principles included in those regulations state that they are applicable to "cost-type contracts." The specific guides included in the regulations state that they apply to "cost reimbursement type contracts." Because Medicaid insuring agreements are neither cost nor cost reimbursement type contracts, we do not believe current regulations require the application of Federal cost principles to Medicaid insuring agreements. We believe the Medicaid regulations should be revised to require the use of Federal cost principles in Medicaid insuring agreements.

CHAPTER 7

SCOPE OF REVIEW

We directed our review toward (1) ascertaining the extent of HEW's involvement in developing and awarding contracts for Medicaid insuring agreements, (2) evaluating HEW's capability to monitor insuring agreements, (3) evaluating States' policies and procedures for obtaining and monitoring insuring agreements, and for reviewing contractors' financial performance under insuring agreements.

Our review was conducted at HEW headquarters in Washington, D.C., and at the HEW regional offices in Atlanta, Georgia; Boston, Massachusetts; Dallas, Texas; Philadelphia, Pennsylvania; and San Francisco, California. Also, work was performed at State agencies in Arkansas, California, Florida, Louisiana, Maine, North Carolina, Pennsylvania, and Texas. The State agencies are responsible for administering and monitoring State Medicaid activities and developing and awarding State contracts. In addition, work was performed at the facilities of the contractors and subcontractors involved in administering State Medicaid programs under insurance-type contracts, except for Group Hospital Service, Inc.

We reviewed Federal and State legislation, regulations, guidelines, policies, and procedures pertaining to Medicaid activities and to the use of private industry and insurance-type contracts for administering Medicaid programs. Our work also included reviews and analyses of reports, records, and other data pertaining to State contract procurement and monitoring activities and to HEW's involvement in these activities. At the contractors' and subcontractors' facilities, we reviewed financial records, various reports required by the contracts, data used by contractors to develop contract proposals, and proposals for rate adjustments under existing contracts.

We also visited or telephoned several firms that either received a request for proposals or expressed interest in being awarded a Medicaid insurance-type contract. This was done to obtain their views concerning the use of insuring agreements to administer State Medicaid programs, and the effectiveness of State practices and procedures relative to awarding Medicaid insurance-type contracts.

A list of contracts included in our review is shown in appendix II.

APPENDIX I

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, D.C. 20510

B-164031(3)

May 22, 1975

The Honorable Elmer B. Staats
Comptroller General of
The United States
Washington, D. C.

Dear Mr. Staats:

I understand that the State of North Carolina awarded a twenty-sixth month, $405 million insurance-type contract to the Bergin Brunswig Corporation to underwrite and operate the State's Medicaid program. It is my understanding that there was only minimal involvement by the Department of Health, Education and Welfare (HEW) in the award of this contract. Since the Federal Government will be committed to paying 70 percent of the contract costs, I am concerned about the lack of HEW participation in the contract award.

Accordingly, I would like the General Accounting Office (GAO) to make a two-part review. First, to review and report on HEW's policies and procedures relating to Medicaid insurance contract awards and the extent of HEW's involvement in the award of this particular contract.

Second, to undertake a broader review of HEW and State policies and procedures for awarding insurance-type contracts. This would include the capability of HEW to monitor these contracts and assess the contractor's performance. States with Medicaid insurance-type contracts for all or part of their Medicaid program include Arkansas, California, Florida, Massachusetts, Pennsylvania, and Texas.

Other States may decide to enter into insurance-type contracts for all or a portion of their Medicaid program. I am concerned that HEW may not have the appropriate controls and capabilities to either provide the States with necessary guidance or to protect the Federal Government's interest. Most importantly, this attempt by a State to totally contract with a private firm for Medicaid underwriting and administration is wholly inconsistent with the legislative history of title XIX as a Federal-State program. Seemingly, a policy

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change of this magnitude and significance should be embodied in specific statutory authorization rather than handled as a matter of administrative discretion.

Sincerely,

Herman E. Talmadge

Herman E. Talmadge
Chairman,
Subcommittee on Health

APPENDIX II

MEDICAID INSURANCE-TYPE CONTRACTS INCLUDED IN OUR REVIEW

State	Name of contractor/ subcontractor	Medical services covered by the contract	Actual contract period (note a)
Arkansas	PAID/HAS	drugs	9/1/73- 6/30/76
California	PAID/HAS	drugs	12/1/72- 9/30/75
	b/CDS/none	dental	1/1/74-12/31/77
Florida	PAID/HAS	drugs	7/1/74- 6/30/76
Louisiana	c/d/LNL/PCS	drugs	10/1/75- 6/30/76
Maine	PAID/HAS	drugs	8/1/74- 6/30/75
North Carolina	PAID/HAS	drugs	12/1/72- 6/30/76
	HAS/none	multiservice	5/1/75- 6/30/76
Pennsylvania	PAID/HAS	drugs	2/1/75- 6/30/76
Texas	e/GHSI/none	multiservice	9/1/67-12/31/76

a/Includes contract renegotiations and extensions effected without competition through June 30, 1976.

b/California Dental Service.

c/Lincoln National Life.

d/Pharmacutical Card Systems.

e/Group Hospital Services.

APPENDIX III

EXCERPTS FROM HEALTH APPLICATION SYSTEMS, INC., COMMENTS RELATING TO THE RELATIONSHIP BETWEEN IT AND PAID PRESCRIPTIONS, INC.

Bergen Brunswig Corporation Park 80 Plaza East / Saddle Brook, New Jersey 07662

June 24, 1977

Mr. Robert E. Iffert, Jr.
Assistant Director
U. S. General Accounting Office
330 C Street, S.W., Room 1126
Washington, D.C. 20548

Reference No. B 164031 (3)

Dear Mr. Iffert:

Our response to the draft report of the General Accounting Office which you sent to Mr. Emil P. Martini, Jr., President of Bergen Brunswig Corporation, on May 16, 1977 is as follows. Reference in each case is to the page number in the draft report.

A. Pages 8 & 9. On pages 8 and 9, the draft states that HAS had control over PAID since 1969 through a series of agreements. This statement is untrue. This misconception permeates your report and may be very prejudicial in pending litigation. Please reexamine your conclusions in light of the following detailed history of the relationship between PAID and HAS:

PAID Prescriptions, Inc. was organized in 1964 as a California non-profit health care service contractor. It was originally sponsored by the California Pharmaceutical Association which loaned PAID $20,000 to design a drug delivery system embodying the prepaid concept and operated by and for retail pharmacists. 2,300 California pharmacies each contributed $100 for membership in the PAID network. PAID was among the first companies to underwrite prescription drug claims on a prepaid basis. It was also a pioneer in the application of data processing to drug claim payment and drug utilization review. Unfortunately, PAID had inadequate capital at the time and got into financial difficulty the first time it guessed wrong on a capitation rate. By September 1969, PAID owed providers approximately $275,000 and had no foreseeable way of paying the claims. Bankruptcy was at hand along with serious personal exposure for the PAID board of trustees. If PAID had failed, the credibility and salability of prepaid prescription drug programs could have been destroyed or at least damaged and the result would have been a delay in the acceptability of the prepaid concept.

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PAID turned to Bergen Brunswig Corporation for help. Because of Bergen's close ties with pharmacy as a wholesaler, because its president Emil P. Martini, Jr. is a registered pharmacist and therefore clearly understood the significance to pharmacy of a PAID collapse, and because Bergen's data processing subsidiary had developed expertise in the application of computer technology to the efficient operations of a drug delivery system, Bergen decided to rescue PAID. It did so by organizing Computer Clearing Services, Inc., a New Jersey corporation, to provide administrative services in connection with the processing of prescription drug claims and other third party claims. CCSI started with a capitalization of $1,000,000 of which Bergen subscribed $890,000. CCSI loaned PAID $300,000 and agreed to pay PAID $25,000 per month plus a royalty on each claim processed. PAID used the loan proceeds immediately to pay past due provider claims. At the same time, PAID and CCSI entered into a long term administrative agency agreement under which CCSI received an exclusive license to market the PAID program and to do its data processing.

Notwithstanding the financial rescue and the long term contract, PAID and CCSI were separate entities. Robert Abrams was president of PAID and zealous of its independence. Jerome Edwards was then the chief executive of CCSI and was equally zealous of its prerogatives. CCSI had facilities in Arizona, California, the District of Columbia and Illinois while PAID had its own facilities in California and New Jersey. PAID pursued the creation of a national pharmacy network, monitoring audit reports and peer review while CCSI pursued the sales effort and the development of a sophisticated data processing system.

The PAID concept was right but the market was not ready to accept the service so that the amount spent on marketing greatly exceeded the results. By August 31, 1970, Bergen's investment in CCSI had increased from $890,000 to $1,700,000. During the next fiscal year ending August 31, 1971, Bergen's earnings were adversely affected to the extent of $1,800,000 as a result of CCSI losses. Bergen stock had fallen from the high $30's in late 1969 to about $8 in 1971 -- not solely because of CCSI losses but they were clearly a major factor. The problem was compounded in fiscal 1971 when the State of California determined that PAID did not comply with the net equity requirements of a licensed health care service contractor because it owed CCSI $300,000. CCSI responded by forgiving

the debt but insisted upon a drastic reorganization to cut the losses.

By December 1970, a joint decision was made to combine facilities, executive, sales and clerical staffs, and to shut down the Arizona operation. Although PAID and CCSI continued in fact and in law as separate legal entities and the PAID board of trustees remained intact and continued to function, the PAID marketing effort was shifted entirely to CCSI. Robert Abrams was selected to run the combined operation and became an employee of CCSI. In an effort to save money, a new administrative agency agreement between PAID and CCSI was executed. It reduced the monthly commitment to PAID from $25,000 to $2,000, hardly enough to support a separate staff, but survival was the order of the day in 1971. Anyway, PAID's need for staff was low at that time because CCSI had assumed the marketing responsibility, the pharmacy network had already been established, claim volume was relatively low and the need for peer review, utilization review and disciplinary procedures were minimal.

In 1971, Bergen's data processing subsidiary and CCSI merged under the name of Bergen Brunswig Dataservice Co. with the operations formerly conducted by CCSI continuing as a separate division known as Health Application Systems. The merger had no effect on PAID or the relationship between PAID and Bergen or its subsidiary.

With the reduction in expenses and increased sales largely to the public sector, 1972 saw a turnaround. By 1973, Health Applications Systems had succeeded in its marketing efforts but that created a need for a substantial increase in the PAID staff to handle contract negotiations, peer and utilization review, provider review and discipline. PAID again needed more money than was available under the agreement with HAS which was then in force. As a result, extensive, vigorous and prolonged negotiations began in 1973 and ended in September 1974 with a third administrative agency agreement. These negotiations took place at arms length between Ed Baker, the then president of PAID, and Robert Abrams the then president of HAS. Both sides were represented by separate counsel. Despite the several changes in their relationship between 1969 and 1977, PAID and HAS were always separate and distinct in fact and in law.

Under the 1974 administrative agency agreement between HAS and PAID, HAS was merely a marketing agent and data processing subcontractor for PAID. On all contracts to which PAID was a

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party, it received the gross revenue and paid HAS a fee for administration. The risk and the favorable claim experience belonged to PAID not HAS. PAID had responsibility for and carried out contract administration, peer review, utilization review, education and discipline. Because the clerical and data processing facilities involved in a drug program require a lot more people than peer and utilization review, education, and discipline, most of the personnel working on a PAID project subcontracted to HAS were HAS employees, rather than PAID employees. However, PAID retained overall contract responsibility, and remained the sole owner of the contract and all rights accruing thereunder.

By the fall of 1976, PAID management had taken a series of actions in violation of the terms of the 1974 administrative agency agreement and in violation of the mandates of its own Board of Trustees. These actions created a new financial problem for PAID which once again turned to Bergen for economic aid. Bergen refused assistance and PAID then commenced a series of hostile actions including repudiation of the 1974 administrative agency agreement, unilateral and retroactive reduction of processing fees payable to HAS, withholding monies due HAS, physical seizure of HAS property, and a widespread campaign among State social service administrators falsely blaming HAS for all of PAID's difficulties and generally defaming HAS. The purpose of all these activities was clear enough; PAID wanted to enlist the assistance of State agencies to force HAS to renegotiate administrative fees and to provide PAID with substantial economic aid. Threats, counterthreats and endless negotiations continued until February 1977 when HAS sold out to PAID and incurred a $5,000,000 loss. HAS and Bergen concluded that they had no alternative primarily because all of the commercial and government drug contracts were contracts between PAID and third parties. Since PAID was unwilling to assign those contracts to HAS, PAID effectively controlled the situation, for without contracts and their revenue, HAS would have no choice but to shut down its large and costly data processing operations as quickly as possible at a loss which HAS management calculated to be well in excess of $5,000,000. HAS sold out to PAID and accepted the smaller loss.

GAO note: Page references refer to pages of draft report and not this report.

APPENDIX IV

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

NOV 21 1977

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Problems in Procuring, Administering, and Monitoring Medicaid Insuring Agreements." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

APPENDIX IV

Comments of the Department of Health, Education, and Welfare on the General Accounting Office Draft Report Entitled, "Problems in Procuring, Administering, and Monitoring Medicaid Insuring Agreements"

General Comments

We are in general agreement with the numerous findings in the GAO report on the States' Medicaid policies and procedures for procuring and managing insurance-type contracts. The review started in calendar 1975, focused on ten such contracts and was completed in 1976. During this period the Department issued a new contract regulation (45 CFR 249.82), which became effective on August 9, 1975. As a result, some of the deficiencies identified in the GAO report were corrected by implementation of the new requirements. Because the GAO review covered periods before and after the implementation of the regulation 249.82, the report tends to understate the current level of involvement by Regional staff in contract matters. The report does state, however, that because HEW's written approval is now required, some States have increased their requests for HEW participation and HEW has intensified its contract review for compliance with Federal regulation.

In general, we think GAO, by identifying program deficiencies, has produced a document which should be useful to the Department and State agencies in improving Medicaid contracts and contracting procedures. The GAO findings and conclusions provide facts and information to the HCFA organization on policies and procedures pertinent to State Medicaid contracting practices.

GAO Recommendations - Page 37

Recommend that the Secretary of HEW direct the Administrator of HCFA to:

- - issue to its regional offices guidance concerning their role in assisting States in (1) contracting for Medicaid insurance-type contracts and (2) the procedures and methods to be used in evaluating whether States have complied with Federal regulations for contracting under grants and obtaining Medicaid insurance contracts;

- - notify the States of the types of assistance that are available from HEW during procurement of Medicaid contracts and to encourage States to utilize HEW's assistance.

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Department Comment

Concur.

Subsequent to the initiation of the GAO review the Department issued regulations and draft guides regarding Federal requirements for State Medicaid contracts. The Department is currently in the process of modifying the existing regulations 45 CFR 249.82 which became effective August 9, 1975, based on the two years of operational experience and the recommended actions made in the GAO report. The problems associated with State Medicaid contracts have been brought to the attention of the Administrator of the newly created Health Care Financing Administration (HCFA) and plans are being made to allocate more staff to contract concerns in both the central and regional offices. The Regional staff resources presently utilized by State contract concerns are to be increased, under HCFA's Medicaid Bureau plans, to the level of at least one full time person in each region. The State Contract Advisory Staff, a recently established central office unit, is to be increased to 3-5 persons and is expected to assist and coordinate Regional office monitoring and technical assistance efforts. While the GAO report commented exclusively on health insuring arrangements the Department has already determined that States likewise need more guidance, technical assistance and requirements in alternative administrative arrangements such as fiscal agent contracts, HMOs and data processing related procurement. Current plans will increase the Department's attention and activities in all these areas. HCFA has been holding meetings with Regional Medicaid Directors discussing State contract problems and solutions. In addition an Information Memorandum to Regions and States is near completion which informs the States of federally recommended contract features. The Medicaid Bureau will hold training sessions with Regional Medicaid staff focusing on Medicaid contracts. This is to be followed by similar training sessions for State Medicaid personnel arranged through the Bureau's Institute of Medicaid Management.

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Page 3 - Comments

GAO Recommendations - Page 58

Recommend that the Secretary, HEW, instruct the Administrator, HCFA, to require States that desire to administer their Medicaid programs under insurance-type contracts to document their rationale for determining that this method is a proper and efficient method of program administration.

Our recommendation on page 37 to provide guidance to the HEW regional offices for procedures and methods for evaluating whether States comply with Federal regulations when processing Medicaid insuring agreements should also help assure that States follow adequate procurement policies.

Department Comment

Concur.

Contract guide material nearing completion contains the Medicaid Bureau's recommendation that States should submit to the Bureau notices of intent to contract including their rationale for pursuing this administrative approach. Such contracts cover the services of fiscal agents, health insurers (fee for service), HMOs and systems development firms. Some States have provided Medicaid services through insurance contracts from the inception of the program.

GAO Recommendations - Page 77

Recommend that before approving Federal participation in a contract intended as an insuring agreement, the Secretary, HEW:

- - ascertain whether the contract fully complies with Federal regulations for insuring agreements,

- - ascertain that the contract does not permit the contractor to terminate or to change the insuring arrangement for the purpose of reducing or eliminating the underwriting risk assumed by the contractor.

Page 4 - Comments

GAO Recommendations - Page 77 (cont.)

Recommend that HEW require prior approval of changes to an insurance-type contract and that HEW officials not approve changes which would have the effect of eliminating or reducing the underwriting risk assumed by the contractor under the terms of the initial contract approved by HEW.

Department Comment

Concur.

The GAO recommendations cited above are incorporated in the regulation 45 CFR 249.82, as amended August 9, 1975. In our judgment the regulations adequately address the GAO concerns expressed above.

GAO Recommendation - Page 83

Recommend that the Secretary of HEW direct the Administrator of HCFA to develop procedures which delineate the role and responsibilities of HEW Regional offices in monitoring Medicaid insuring agreements so that the Federal interest is protected.

Department Comment

Concur.

The recently established Health Care Financing Administration (HCFA) is organizing and allocating staff to deal with contracting concerns. Increased contracting activities along with increased complexities in the contracts themselves present us with challenging problems. The more recent trend to incorporate extensive system development and operational aspects requires that at all review points the staff must be technically competent in systems procurement, in addition to having knowledge in health care administration. Training sessions have begun in which the respective roles of Regional and Central office staffs are addressed.

GAO Recommendations - Page 109

Recommend that as a condition of contract approval for Federal financial participation the Secretary of HEW require States to:

- - develop and submit to the appropriate HEW contract approval authority an acceptable plan for monitoring Medicaid insurance contracts and for evaluating contractors' financial performance under the contracts,

APPENDIX IV

Page 5 - Comments

GAO Recommendations - Page 109 (cont.)

- - include language in Medicaid insurance contracts which would make the contractor and all subcontractors subject to the Federal procurement standards (45 CFR 74.150 et. seq.) and the Federal cost principles (45 CFR 74.170 et. seq.).

Recommend that the Secretary should also issue regulations:

- - prohibiting the use of percentage of revenue agreements between Medicaid contractors and their subcontractors;

- - requiring that all subcontracts assigning substantial portions of the contractor's responsibilities to a subcontractor be submitted along with the contract at the time of request for contract approval;

- - revise the Medicaid regulations to require (1) State insuring agreements to address interest earned or equivalent benefits to be accrued by contractors on premium payments and accumulated reserves and (2) the consideration of such interest and benefits in establishing premium rates, and profit sharing arrangements.

Department Comment

Concur.

Specific reference to State systems to monitor contractors and subcontractors is being included in revisions of 45 CFR 249.82. Some States are developing standard contracts and monitor the subcontracting practices and performance of subcontractor.

All States having health insurance arrangements already monitor contractors and subcontractors. Regulation 45 CFR 249.82, by reference, requires State Medicaid contracts to adhere to Federal procurement standards (45 CFR 74.150) and the Federal cost principles (45 CFR 74.170).

We concur with the need to discourage the use of percentage of revenue agreements between Medicaid contractors and their subcontractors. This practice has never been widespread in Medicaid programs but we do discourage the practice and are considering the advisability of establishing regulations prohibiting its practice.

Present regulations are currently being interpreted to necessitate the submission of all subcontracts for prior approval in cases where the prime contract exceeds $100,000.

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Page 6 - Comments

Department Comment (cont.)

Although there has been some increase in expenditures under such insurance arrangements, Medicaid expenditures attributable to such insurance contracts are decreasing as a proportion of the total Medicaid expenditure. Only one State, Texas, uses insurance to cover a number of major services.

The Department has under consideration the advisability of requiring States to address the question of lower interest or equivalent benefits accrued by a contractor as well as relating such interest to future premium rates.

GAO note: Page references refer to pages of draft report and not this report.

APPENDIX V

PRINCIPAL HEW OFFICIALS RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph A. Califano	Jan. 1977	Present
F. David Mathews	Aug. 1975	Jan. 1977
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Don I. Wortman (acting)	Jan. 1977	Mar. 1977
Robert Fulton	June 1976	Jan. 1977
Don I. Wortman (acting)	Jan. 1976	June 1976
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION (note a):		
Dr. Robert A. Derzon	Mar. 1977	Present
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Dr. Keith Weikel	July 1974	Present
Howard N. Newman	Feb. 1970	July 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Aug. 1969

a/Replaced the Social and Rehabilitation Service in March 1977 as the Federal agency responsible for administering Medicaid.

(106066)