

July 2007

**MEDICARE
ADVANTAGE**

**Required Audits of
Limited Value**





Highlights of [GAO-07-945](#), a report to congressional committees

MEDICARE ADVANTAGE

Required Audits of Limited Value

Why GAO Did This Study

In fiscal year 2006, the Centers for Medicare & Medicaid Services (CMS) spent over \$51 billion on the Medicare Advantage program, which serves as an alternative to the traditional fee-for-service program. Under the Medicare Advantage program, companies wishing to participate must annually submit bids (effective with contract year 2006) that identify the health services the company will provide to Medicare members and the estimated cost and revenue requirements for providing those services. For 2001 through 2005, the submissions were called Adjusted Community Rate (ACR) Proposals. The Balanced Budget Act (BBA) of 1997 requires CMS to annually audit the financial records supporting the submissions of at least one-third of participating organizations. BBA also requires that GAO monitor the audits. In this report, GAO examined (1) whether CMS met the one-third requirement for 2001 through 2006, (2) what information the ACR audits provided and how CMS used it, and (3) what information the bid audits provided and how CMS used it.

What GAO Recommends

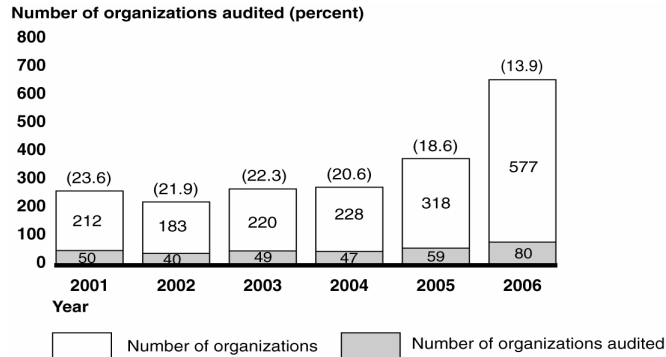
GAO makes five recommendations to CMS for meeting the one-third audit requirement, enhancing its audit follow-up, and improving the bid audit process. CMS concurred with our recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-07-945.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Jeffrey Steinhoff at 202-512-2600 or steinhoffj@gao.gov.

What GAO Found

CMS did not document its process to determine whether it met the requirement for auditing ACRs for one-third of the participating Medicare Advantage organizations for contract years 2001-2005. CMS is planning to conduct other financial reviews of organizations to meet the audit requirement for contract year 2006, but by the end of our fieldwork in June 2007, CMS had not finalized its plans. Further, CMS does not plan to complete the financial reviews until almost 3 years after the bid submission date each contract year. This will affect its ability to address deficiencies in a timely manner.



Source: GAO analysis of CMS data.

CMS did not consistently ensure that the audit process for contract years 2001-2005 provided information to assess the impact on beneficiaries. After contract year 2003 audits were completed, CMS took steps to determine such impact and identified about \$34 million from those audits that beneficiaries could have received in additional benefits. However, in late May 2007, CMS officials told us they were planning to close out the audits without pursuing financial recoveries because the agency does not have the legal authority to do so. According to our assessment of the statutes, CMS had the authority to pursue financial recoveries, but its rights under contracts for 2001-2005 are limited because its implementing regulations did not require that each contract include provisions to inform organizations about the audits and about the steps that CMS would take to address identified deficiencies, including pursuit of financial recoveries.

CMS audited contract year 2006 bids for 80 organizations, and 18 had a material finding that affected amounts in approved bids. CMS officials said that they will use the audit results to help improve bids in subsequent years but took limited action to follow-up on contract year 2006 findings. CMS will not pursue financial recoveries based on audit results because it maintains that it does not have the legal authority to do so. However, according to our assessment of the statutes, CMS has the authority to include terms in bid contracts that would allow it to pursue financial recoveries. CMS also has the authority to sanction organizations but has not identified instances where sanctions are warranted. We also noted that CMS did not document steps taken to mitigate conflicts of interest for the firms performing audits.

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Abbreviations

ACR	adjusted community rate
ACRP	adjusted community rate proposal
ASOP	Actuarial Standards of Practice
BBA	Balanced Budget Act of 1997
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000
CBC	Center for Beneficiary Choices
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HHS	Department of Health and Human Services
HMO	health maintenance organization
HPMS	Health Plan Management System
MA	Medicare Advantage
MCHP	managed-care health plan
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
OACT	Office of the Actuary
OFM	Office of Financial Management
OIG	Office of Inspector General
PPO	preferred provider organization
PSO	provider-sponsored organization
RPPO	regional preferred provider organization

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United States Government Accountability Office
Washington, DC 20548

July 30, 2007

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman
The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Charles B. Rangel
Chairman
The Honorable Jim McCrery
Ranking Member
Committee on Ways and Means
House of Representatives

In fiscal year 2006, the Centers for Medicare & Medicaid Services (CMS) estimated it spent over \$51 billion on the Medicare Advantage program, which serves as an alternative to Medicare's traditional fee-for-service (FFS) program.¹ Under the Medicare Advantage program, CMS approves private companies to offer health plan options to Medicare enrollees that include all Medicare-covered services. In addition, many plans under the program provide supplemental benefits, such as a reduction in required cost sharing (e.g., beneficiaries' Part B premiums)² or coverage for items and services not included under the traditional FFS program, like dental care. According to CMS, in fiscal year 2006, over 16 percent, or about 7 million of the approximately 43 million Medicare members, were enrolled in a Medicare Advantage plan.

¹Total Medicare outlays in fiscal year 2006 were \$381.9 billion.

²Medicare Part B provides coverage for certain physician, outpatient hospital, laboratory, and other services to beneficiaries who pay monthly premiums.

Before 2006, companies choosing to participate in the Medicare Advantage program were required to annually submit an Adjusted Community Rate Proposal (ACRP) to CMS for review and approval for each plan it intended to offer.³ The ACRP consisted of two parts—a plan benefit package and the Adjusted Community Rate (ACR). The plan benefit package contained a detailed description of the benefits offered by the plan, and the ACR contained a detailed description of the costs that the plan estimated it would incur in providing a package of benefits to an enrolled Medicare beneficiary. These costs were to be calculated based on how much a plan would charge a commercial customer to provide the same benefit package if its members had the same expected use of services as Medicare beneficiaries. For each plan offered, the ACR was to provide an estimate of expected per person payments from Medicare, based on published Medicare+Choice payment rates and the characteristics of the plan’s expected enrollees. If the estimated ACR costs were greater than the estimated payment rate, and if the organization still chose to participate, it agreed to accept the CMS payment rate in accordance with its ACRP. However, if the estimated ACR costs were less than the estimated payment rate, the organization had to (1) provide additional services, (2) reduce beneficiary premiums or copayments, (3) distribute the excess to a benefit stabilization fund, or (4) use a combination of these methods. CMS made payments to the companies monthly in advance of rendering services.

In 2003, Congress enacted the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).⁴ Among other things, MMA established a bid submission process to replace the ACRP submission process and authorized a new prescription drug benefit, both effective for 2006. Under the bid process, private companies—called Medicare Advantage (MA) organizations—choosing to participate in the program are required to annually submit bids for review and approval for each plan they intend to offer. The bid submission includes a bid form that provides each MA organization’s estimate of the cost of delivering services to an enrolled Medicare beneficiary and a plan benefit package that provides a detailed description of the benefits offered in each plan. Additionally, each MA organization and prescription drug plan that offers prescription drug

³Participating companies can offer multiple plans. The term “plan” refers to a specific package of benefits offered.

⁴Pub. L. No. 108-173, 117 Stat. 2066 (Dec. 8, 2003).

benefits under Part D⁵ is required to submit a separate prescription drug bid form, a formulary,⁶ and a plan benefit package to CMS for its review and approval. Within the bid forms, MA organizations include an estimate of the per person cost of providing Medicare-covered services. Unlike the cost estimates under the ACRP process, organizations develop CMS bid cost estimates by relying on reasonable projection methods that may include reliance on incurred costs for a base year, adjustments for estimated utilization, and other factors to project costs to the bid contract period. CMS compares the bid amounts to geographic-specific benchmarks to determine the total payment to the MA organization.⁷ If a bid amount is above the benchmark, the MA organization must require enrollees to pay the difference in the form of a premium. If the bid amount is below its benchmark, 75 percent of the difference (or savings), termed a rebate, must be provided to enrollees as extra benefits in the form of cost sharing reductions, premium reductions, or additional covered services.⁸ The remaining 25 percent of the savings is retained by the Federal Treasury.⁹ After bids are approved and payments are established, CMS makes payments to the companies monthly in advance of rendering services.

Until the passage of the Balanced Budget Act of 1997 (BBA), which required CMS to annually audit the supporting financial records (including data relating to Medicare utilization, costs, and computation of the ACR)

⁵Part D is the optional outpatient prescription drug benefit for Medicare established by MMA.

⁶The formulary is a listing of prescription medications that are approved for use or coverage by the plan and that will be dispensed through participating pharmacies to covered enrollees.

⁷Benchmarks are the maximum amount Medicare will pay a MA organization for delivering benefits in a specific geographic area. They are determined by the Secretary of Health and Human Services each year under a methodology provided in the Medicare law.

⁸For prescription drug plans, CMS aggregates the bids for each plan to generate a single weighted national average monthly bid amount for Part D. If the standardized prescription bid exceeds the amount of the national average monthly bid, the plan can increase the base beneficiary premium by the difference. If the standardized prescription bid is below the amount of the national average monthly bid, the plan must decrease the base beneficiary premium by the difference.

⁹For regional preferred provider organizations, 12.5 percent of the difference is retained by the Federal Treasury, and the remaining 12.5 percent is directed to the MA Regional Plan Stabilization Fund.

of at least one-third of the participating organizations,¹⁰ there was limited oversight by CMS of the ACR process. BBA also required that GAO monitor the audit activities mandated by the act. In fulfilling our responsibility, we first reviewed CMS's process for auditing ACRs approved for contract year 2000.¹¹ This was CMS's first effort to meet the audit requirement. We reported that the audits were of limited usefulness because CMS did not follow up on the audit results. In continuing to fulfill our audit monitoring responsibility, this report addresses the following questions:

1. Has CMS met the requirement for auditing the financial records of at least one-third of the participating MA organizations for contract years 2001-2005 as required by the Balanced Budget Act of 1997 and bid submissions for contract year 2006?
2. Did the ACRP audit process provide CMS sufficient information to assess potential impacts on beneficiaries and identify actions to address those impacts?
3. How did CMS conduct audits of bids for 2006, what information did the bid audit process provide CMS, and how did CMS use that information?

To determine whether CMS met requirements for auditing the financial records of at least one-third of the MA organizations for contract years 2001-2005 and the bid submissions for contract year 2006, we obtained from CMS a listing of the organizations that had their ACRPs or bids audited each year and compared it with the total number of approved ACRP and bid submissions for each year obtained from CMS's ACRP and bid management database, the Health Plan Management System (HPMS). We also interviewed CMS staff and officials.

To determine whether information provided by the ACRP audit process was sufficient for CMS to assess potential impacts on beneficiaries and address those impacts, we obtained and reviewed audit reports for contract years 2001-2004 and reports prepared by a contractor that reviewed and analyzed the audits for contract year 2003. We interviewed

¹⁰Pub. L. No. 105-33, tit. IV, § 4001, 111 Stat. 251, 320 (Aug. 5, 1997) (codified at 42 U.S.C. § 1395w-27(d)(1)).

¹¹GAO, *Medicare+Choice Audits: Lack of Follow-up Limits Usefulness*, [GAO-02-33](#) (Washington, D.C.: Oct. 9, 2001).

CMS staff and officials about what they did with the audit results, and we discussed CMS's review of an analysis of contract year 2003 ACR audits performed by the contractor.

To determine how CMS conducted bid audits for contract year 2006, what information the bid audit process provided CMS, and how CMS used that information, we obtained and reviewed CMS's instructions and guidance for bid auditors, bid audit reports for contract year 2006, planned audit procedures, and bid certifications records. We interviewed the bid audit firms and CMS staff and officials about the bid audit process and discussed with CMS how it used the results of the contract year 2006 audits and its plans for future use.

See appendix I for details about our scope and methodology. We requested written comments on a draft of this report from the Secretary of Health and Human Services (HHS) or his designee. We conducted our review from November 2006 to June 2007 in accordance with generally accepted government auditing standards.

Results in Brief

CMS did not document its process to determine whether it met the one-third audit requirement. However, on the basis of our analysis of available CMS data, CMS has not met the statutory requirement to audit the financial records of at least one-third of the participating MA organizations for contract years 2001-2005, nor has it done so yet for the contract year 2006 bid submissions. With respect to contract year 2006, CMS officials acknowledged the one-third requirement, but stated that they did not intend for the audits of contract year 2006 bid submissions to meet the one-third audit requirement. Instead they said they plan to conduct other reviews of the financial records of participating MA organizations and prescription drug plans that will contribute to satisfying the requirement. However, CMS has not clearly laid out how any of these reviews will be conducted to meet the one-third requirement. Further, CMS will not complete these other financial reviews until almost 3 years after the bid submission date for each contract year, in part because it must first reconcile payment data that prescription drug plans are not required to submit to CMS until 6 months after the contract year is over. Such an extended cycle for conducting audits and reviews to meet the one-third requirement will likely affect CMS's ability to recommend and implement any actions needed to address any identified deficiencies in MA organizations' and prescription drug plans' bid processes in a timely manner.

CMS contracted with accounting firms for audits of the ACRs for a selected number of MA organizations for contract years 2001-2005, but did not consistently ensure that the audit process provided information to assess the potential impact on beneficiaries' benefits or payments to the MA organizations. In 2001, we reported that CMS planned to require auditors, where applicable, to quantify in their audit reports the overall impact of errors. CMS did not implement steps to determine such impact until after the audits for contract year 2003 were completed, when CMS contracted with a firm to review all of the 2003 ACR audits and determine if there were any errors identified by the auditors that would affect beneficiaries.¹² On the basis of that review, the contractor reported to CMS that it identified errors in ACRs that would have resulted in approximately \$59 million that beneficiaries could have received in additional benefits, lower copayments, or lower premiums. Staff from CMS's Office of Financial Management (OFM) reviewed the auditors' and contractor's work to evaluate the amount reported by the contractor that would impact beneficiaries. OFM staff revised the amount to \$34 million and concluded that they would make recommendations to CMS's Center for Beneficiary Choices (CBC) on whether corrective action plans or sanctions against MA organizations were warranted. However, in late May 2007, CMS officials told us they were planning to close out the audits without pursuing financial recoveries because legal counsel had determined that the agency does not have the legal authority to recover funds from MA organizations based on ACR audit results. Subsequently, HHS legal counsel explained to us the department's position that CMS lacks the legal authority or the contractual right to pursue financial recoveries when audits determine that approved ACRs reflect errors, incorrect or unreasonable assumptions, or other misstatements. On the basis of our assessment of the statutes, CMS had the authority to pursue financial recoveries, but its rights under contracts with the organizations submitting ACRPs are limited because its implementing regulations did not require that each contract include provisions to inform organizations about the audits and about the steps that CMS would take to address identified deficiencies, including pursuit of financial recoveries. CMS officials acknowledged that they can impose sanctions in cases where an organization misrepresents information that is furnished under the program. However, CMS has never sanctioned an MA organization based on ACR audit results and did not say why it has not.

¹²CMS also contracted with a firm to review the 2004 ACR audits, but the work is not to be completed until August 31, 2007.

CMS contracted with six firms to audit a selected number of contract year 2006 bids and plans to do so for subsequent years. In reviewing the 2006 bid audit reports, we determined that 18 (about 23 percent) of the 80 organizations audited had material findings that have an impact on beneficiaries or plan payments approved in bids. CMS defined material findings¹³ as those that would result in changes in the total bid amount of 1 percent or more or in the estimate for the costs per member per month of 10 percent or more for any bid element. Officials from CMS's Office of the Actuary (OACT) responsible for the bid audit process explained that they will use the audit results to help organizations improve their methods in preparing bids in subsequent years, but their audit follow-up process does not involve pursuing financial recoveries from organizations because CMS maintains that, as with ACRPs, it does not have the legal authority to do so. However, on the basis of our assessment of the statute, CMS has the authority to include terms in its contracts with MA organizations and prescription drug plan sponsors that would allow it to pursue financial recoveries based on the bid audit results. CMS also has the authority to sanction organizations. However, CMS has not sanctioned an MA organization based on contract year 2006 bid audit results. In the absence of changes to its procedures, CMS will continue to invest resources in audits that will likely provide limited value or return on investment. Another weakness that we noted in CMS's bid audit process was the lack of documentation to support steps taken to mitigate conflict of interest situations for the actuarial firms conducting the bid audits. Using available information, we were able to confirm that the actuarial firms did not audit the same bids for which the firms had acted as a consultant in preparing. However, we were not able to confirm the steps taken by CMS to avoid assigning actuarial firms to audit the same bids that the firms had reviewed because information was not available by the end of our fieldwork in June 2007.

This report makes five recommendations to CMS to address ACRP audit results, enhance its approach for meeting the one-third audit requirement, improve its implementing regulations for the Medicare Advantage and Prescription Drug Programs, expand its procedures for following up on bid audit and financial review results, and reinforce the steps it takes to address conflicts of interest with firms that perform bid audits. In written

¹³Findings also include any serious failure to follow applicable Actuarial Standards of Practice. Materiality for identifying observations included all other errors or deviations from the instructions or best actuarial practices that did not meet the criteria for being classified as findings.

comments on a draft of this report, CMS concurred with our recommendations and stated that it is in the process of implementing some of the recommendations including modifying its procedures for selecting MA organizations and prescription drug plans to meet the one-third audit requirement. CMS's comments are discussed in the Agency Comments and Our Evaluation section and reprinted in appendix V. CMS and HHS's Office of the Inspector General (OIG) also provided technical comments, which we incorporated as appropriate.

Background

The Medicare program has a long-standing history of offering its beneficiaries managed care coverage through private plans as an alternative to the traditional FFS program. In 1997, Congress passed the Balanced Budget Act of 1997,¹⁴ which replaced an existing managed care program with the Medicare+Choice program in an effort to expand beneficiaries' managed care options. For oversight of the program, the act also required that CMS annually audit the financial records of at least one-third of the organizations participating in the Medicare+Choice program, including the organizations' data relating to Medicare utilization, costs, and computation of the ACR.¹⁵

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003¹⁶ to expand the role of private entities in providing benefits to Medicare beneficiaries. Among its changes, the law renamed the Medicare+Choice program the Medicare Advantage program. Medicare+Choice organizations were renamed MA organizations.¹⁷ MMA also authorized new prescription drug benefits to Medicare beneficiaries beginning in 2006 and created new types of private health plans such as "regional" MA plans,¹⁸ special needs plans, and prescription drug plans that could be offered in addition to the plan types already being offered such as

¹⁴Pub. L. No. 105-33, 111 Stat. 251 (Aug. 5, 1997).

¹⁵See 42 U.S.C. § 1395w-27(d)(1).

¹⁶Pub. L. No. 108-173, 117 Stat. 2066 (Dec. 8, 2003).

¹⁷Throughout this report, we refer to organizations participating in the Medicare+Choice and MA programs as MA organizations.

¹⁸A regional PPO is defined as an "MA regional plan" and MMA requires that each MA regional plan (1) have a network of providers that have agreed to a contractually specified reimbursement for covered benefits, (2) provide reimbursement for all covered services regardless of whether the benefits are provided by participating providers, and (3) cover the service area of at least one entire MA region.

health maintenance organizations (HMO), preferred provider organizations (PPO), provider-sponsored organizations (PSO), medical savings accounts, and private FFS plans.¹⁹

MMA established a bid submission process to replace the ACRP submission process used under the Medicare+Choice program to annually approve the benefit packages and costs that organizations estimated they would incur in providing benefits to enrolled Medicare beneficiaries. MMA specified that organizations wishing to offer health benefits as part of the MA program and drug benefits must annually submit bids. The bid submission includes a MA bid form indicating each MA organization's estimate of the cost of delivering services to Medicare beneficiaries and a plan benefit package for each plan.²⁰ Additionally, each organization that offers prescription drug benefits under Part D is required to submit a separate prescription drug bid form, a formulary, and a plan benefit package to CMS for its review and approval.

MMA made changes to the methodology that MA organizations use in estimating the costs of benefits. Under the ACRP process, MA organizations were required to include an estimate of their per person cost of providing benefits based on how much they would charge a commercial customer to provide the same benefit package if their members had the same expected use of services as Medicare beneficiaries. The chief executive officer, chief financial officer, and the head marketing official of the MA organization were required to certify that the ACRP contained accurate information.

¹⁹HMOs are a type of managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money every month. PPOs have comprehensive provider networks, but beneficiaries enrolled in PPOs may use out-of-network providers if they pay higher cost sharing. Private FFS plans pay qualified providers for each covered service delivered to its enrollees, and beneficiaries enrolled in FFS plans may go to any doctor or hospital they choose without a referral if the provider accepts the plan's payment terms. PSOs have a group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of managed care plan is run by the doctors and providers themselves, and not by an insurance company.

²⁰The bid form is a series of worksheets that contain actuarial estimates of plan cost and cost sharing for the contract year as well as computation of the benchmark, rebate, and basic member premium that is risk-adjusted based on the characteristics of individual plan enrollees. See appendix III for a further description of these worksheets.

Under the bid process, cost estimates are not based on commercial experience. Under CMS's bid submission instructions, organizations are required to include an estimate of the per person cost of providing Medicare-covered services by relying on reasonable projection methods that may include reliance on incurred costs for a base year, adjustments for estimated utilization, and other factors to project costs to the bid contract period. The allowed costs and additional cost sharing information are to be used to determine net medical costs. To this, nonmedical expenses, such as indirect administration and gain/loss margins, are to be added to establish the required revenue for the contract year for each plan offered. The assumptions, data, and models used in developing cost estimates are prepared by the organizations' actuaries. CMS requires that the actuary who prepared the bid must submit a certification stating that the bid complies with laws, regulations, and the bid instructions and that the actuary has followed the appropriate actuarial standards in completing the bid.

To determine the payments under the bid process, CMS compares the bid amounts to geographic-specific benchmarks.²¹ If a bid is above the benchmark, the enrollee must pay the difference in the form of a premium, referred to as the basic beneficiary premium. If a bid is below its benchmark, 75 percent of the difference (or savings), termed the rebate, must be provided to enrollees as extra benefits in the form of cost sharing reductions, premium reductions for Part B or Part D, or additional covered services. The remaining 25 percent of the savings is retained by the Federal Treasury.

By law, organizations are required to submit bids for each contract year by the first Monday in June before the contract year begins. For contract year 2006, organizations had to submit bids to CMS by June 6, 2005. The bids are submitted through HPMS. CMS subjects the bid forms to a desk review prior to approval. In contract year 2006, CMS contracted with six actuarial consulting firms to assist in reviewing the bid forms. The objective of the bid review was to determine whether the bid was reasonable and fair to the organization, the beneficiary, and CMS. In contract year 2006, the review of the bid forms consisted of a series of structured subreviews that examined the individual cost elements that collectively comprised each

²¹For regional plans, organizations estimate regional plan benchmarks in their June bids until CMS determines the amount for the final regional benchmark and makes it available to the organizations in August. Then the organizations revise the benchmark amounts in their bids accordingly.

bid. CMS's OACT developed metrics for each bid and identified statistical outliers based on "acceptable thresholds" it defined. The contract reviewers investigated the outliers, requesting additional documentation from the organization as necessary, to assess the assumptions and methods supporting the bid elements and their reasonableness to support the overall bid. From early June 2005 through mid-September 2005, CMS contractors reviewed the bids, and CMS approved them.²² CMS awarded contracts for approved bids by mid-September 2005.

After approval of the bids, CMS selects bids for audit.²³ For audits of the contract year 2006 bid forms, OACT contracted with six firms in September 2005. CMS specified audit guidance for the auditors. This included procedures for reviewing the accuracy of organizations' financial data supporting the bid submissions and the reasonableness of assumptions used in the contract year financial projections. Auditors were also instructed to consider whether the bids were developed consistent with the Actuarial Standards of Practice (ASOP) designated by CMS and CMS's bid preparation instructions. (See appendix II for a description of the ASOPs.) Auditors generally reported preliminary findings by April 2006 and issued final reports by August 2006.²⁴

In contract year 2006, OACT required MA organizations to report incurred revenue and expense information for contract year 2004. CMS calls this a 2-year look back. As of June 2007, OACT had made limited use of this 2-year look back information, but intends to use such information to assess the credibility of projected revenue and expenses reported by MA organizations. This would include a review of data to identify possible biases or inaccuracies in a MA organization's bid estimations.

²²CMS does not have authority to review and negotiate medical savings accounts and private fee-for-service plans. 42 U.S.C. § 1395w-24(a)(5) and (a)(6)(B).

²³OACT is responsible for reviewing the bid forms. The audits that we discuss only relate to the bid forms. CBC's Division of Finance and Benefits is responsible for reviewing the MA plan benefit packages, and CBC's Division of Finance and Operations is responsible for reviewing the Part D formularies and prescription drug plan benefit packages.

²⁴The bid auditors held exit conferences or issued preliminary drafts for 45 of the 52 audit reports they issued by April 2006 and issued 34 final reports by August 2006.

GAO Analysis Shows CMS Has Not Met the Audit Requirement for Contract Years 2001-2005 and Has Not Yet Met It for Contract Year 2006

CMS did not document its process to determine whether it met the one-third audit requirement. However, according to our analysis of available CMS data, CMS has not met the statutory requirement to audit the financial records of at least one-third of the participating MA organizations for contract years 2001-2005, nor has it done so yet for the contract year 2006 bid submissions. We performed an analysis to determine if CMS had met the requirement because CMS could not provide documentation to support the method it used to select the ACRs and bids for audit and to demonstrate that it had met the audit requirement for those years. With respect to contract year 2006, CMS officials acknowledged the one-third requirement, but they stated that they did not intend for the audits of contract year 2006 bid submissions to meet the one-third audit requirement. They explained that they plan to conduct other reviews of the financial records of MA organizations and prescription drug plans to meet the requirement for contract year 2006. However, CMS has not clearly laid out how these reviews will be conducted to meet the one-third requirement. Further, CMS is not likely to complete these other financial reviews until almost 3 years after the bid submission date for each contract year, in part because it must first reconcile payment data that prescription drug plans are not required to submit to CMS until 6 months after the contract year is over. Such an extended cycle for conducting these reviews to meet the one-third requirement limits their usefulness to CMS and hinders CMS's ability to timely identify any identified deficiencies in MA organizations' and prescription drug plans' bid processes that require corrective action.

CMS Has Not Met Audit Requirement

The Secretary of Health and Human Services is required to provide for the annual auditing of the financial records (including data relating to Medicare utilization and costs) of at least one-third of the MA organizations.²⁵ In defining what constituted an organization for the purpose of selecting one-third for audit, CMS officials explained that they determined the number of participating organizations based on the number of contracts that they awarded.²⁶ Under each contract an

²⁵42 U.S.C. § 1395w-27(d)(1). Prior to contract year 2006, this audit was required to include the "computation of the adjusted community rate." Pub. L. No. 105-33, tit. IV, § 4001, 111 Stat. 251, 320 (Aug. 5, 1997).

²⁶An MA organization is a public or private entity organized and licensed by a state that is certified by CMS as meeting the MA contract requirements.

organization can offer multiple plans.²⁷ When CMS selects an organization for audit, some, but not all, of the plans offered under the organization's contract are audited.

CMS did not document its approach for selecting ACRs for audit or how its approach was to meet the one-third annual audit requirement. Consequently, we performed an analysis comparing the organizations and plans audited as a percentage of organizations and plans that CMS approved under the Medicare+Choice, Medicare Advantage, and Part D programs from contract year 2001 through contract year 2006. We obtained data on the total number of organizations and plans from CMS's HPMS and data on the audited organizations from the audit reports.²⁸ We determined that between 18.6 and 23.6 percent, or fewer than one-third, of the MA organizations offering plans for contract years 2001-2005 were audited. Similarly, we determined that only 13.9 percent of the MA organizations and prescription drug plans with approved bids for contract year 2006 were audited.²⁹ Table 1 summarizes our results.

Table 1: Summary of Organizations Audited as a Percentage of Total Organizations and Audit Costs

Contract year	Type of audit	Number of organizations audited	Number of organizations	Percentage of organizations audited	Audit costs (dollars in millions)
2001	ACRP	50	212	23.6	\$2.8
2002	ACRP	40	183	21.9	\$2.6
2003	ACRP	49	220	22.3	\$3.8
2004	ACRP	47	228	20.6	\$3.4
2005	ACRP	59	318	18.6	\$2.6
2006	Bid	80	577	13.9	\$3.3

Source: GAO analysis of CMS data and ACRP and bid audit reports.

Note: Audit costs do not include CMS staff costs.

²⁷MA organizations and the contracts that establish them are identified by four-digit contract numbers. The contract number and plan identifier jointly provide a unique identifier for each plan and identify each ACRP or bid submitted. Several plans may be offered by a MA organization in the same geographic area. For example, a high-option plan including a drug benefit and a low-option plan without a drug benefit may be offered by the same MA organization.

²⁸The audit reports for contract year 2005 were not available for our review, so we used a list of audits provided by CMS.

²⁹The 80 organizations audited for contract year 2006 included 60 MA organizations with prescription drug plans and 20 prescription drug plans.

Although CMS selects organizations to meet the one-third audit requirement based on the number of organizations and not the total number of plans offered by organizations, we also analyzed the percentage of plans audited of the total number of plans offered by each audited organization. Our analysis shows that with the exception of contract year 2002, the level of audit coverage achieved by CMS audits has progressively decreased in terms of the percentage of plans audited for those organizations that were audited. Audit coverage has also decreased in terms of the percentage of plans audited of all plans offered by participating organizations each contract year. In contract year 2006, a large increase in the number of bid submissions meant that the 159 plans audited reflected only about 3 percent of all the plans offered. Table 2 summarizes our analysis.

Table 2: Summary of Audited Plans as a Percentage of Those Offered by Audited Organizations and All Participating Organizations

Contract year	Type of audit	Number of plans audited for audited organizations	Number of plans offered by audited organizations	Percentage of plans audited of all plans offered by audited organizations	Number of plans offered by all participating organizations	Percentage of plans audited of all plans offered by participating organizations
2001	ACRP	165	216	76.4	743	22.2
2002	ACRP	84	93	90.3	554	15.2
2003	ACRP	137	254	53.9	770	17.8
2004	ACRP	124	257	48.2	967	12.8
2005	ACRP	100	476	21.0	1,865	5.3
2006	Bid	159	1,194	13.3	4,920	3.2

Source: GAO analysis of CMS data and ACRP and bid audit reports.

Regarding how CMS selected the organizations that were audited for contract years 2001-2004, CMS officials told us they did not know how the MA organizations were selected, and the documentation supporting the selections was either not created or not retained. For contract year 2005 audits, CMS officials told us that the selection criteria included several factors other than simply selecting one-third of the participating MA organizations that were awarded contracts. They said that the criteria considered whether the MA organization had a negative balance in the benefit stabilization fund and the MA organization had been audited previously and had significant issues. Late in June, CMS's OFM staff provided us a summary of the criteria used to select the 59 organizations participating in the MA program that it selected for contract year 2005 ACR audits. However, the number of organizations used by the OFM staff

in selecting the 59 organizations did not agree with the number CMS provided us from the HPMS that we used in our analysis. For this reason, we did not rely on the new information.

For the audits of the contract year 2006 bids, CMS officials explained that they did not intend for the audits of contract year 2006 bid submissions to meet the one-third audit requirement and that they plan to conduct other reviews of the financial records of organizations to meet the requirement for contract year 2006. However, CMS has not clearly laid out how these reviews will be conducted to meet the one-third requirement. OACT officials explained that in selecting the bids for audit they (1) considered whether the organization had been audited within the last 12 months and excluded those because CMS did not want to burden the organization with another audit, (2) selected 25 percent of the organizations based on information collected through the initial bid review process, and (3) randomly selected organizations from the remaining 75 percent.

CMS Has Not Yet Met the Audit Requirement for Contract Year 2006 and Has Not Determined How It Will Do So

As we just discussed, CMS has not yet met the one-third audit requirement for the contract year 2006 bid submissions. Further, CMS has not finalized its approach for how it will meet the requirement for contract year 2006 and beyond. During the course of our review, CMS officials provided differing information about CMS's plans for meeting the one-third audit requirement. Officials from CBC, OACT, and OFM initially told us in January and February 2007 that their plans for meeting the one-third requirement will likely include the bid audits currently directed by OACT and other reviews by OFM of financial records of organizations. In June 2007, however, OFM officials said the requirement will be met solely through their efforts. OFM is currently working with a contractor to develop the agency's overall approach to conducting reviews to meet the one-third audit requirement. But as of June 2007, CMS had not specified how these reviews will meet the one-third audit requirement. Draft audit procedures prepared by the contractor indicate that OFM plans to review solvency, risk scores, related parties, direct medical and administrative costs, and, where relevant, regional PPO cost reconciliation reports for MA bids. For Part D bids, OFM also plans to review other areas, including beneficiaries' true out-of-pocket costs.³⁰ Appendix IV summarizes the

³⁰True out-of-pocket costs are amounts paid by the enrollee or on behalf of the enrollee for covered Part D drugs that count toward the out-of-pocket limit that must be reached before the catastrophic benefit becomes available.

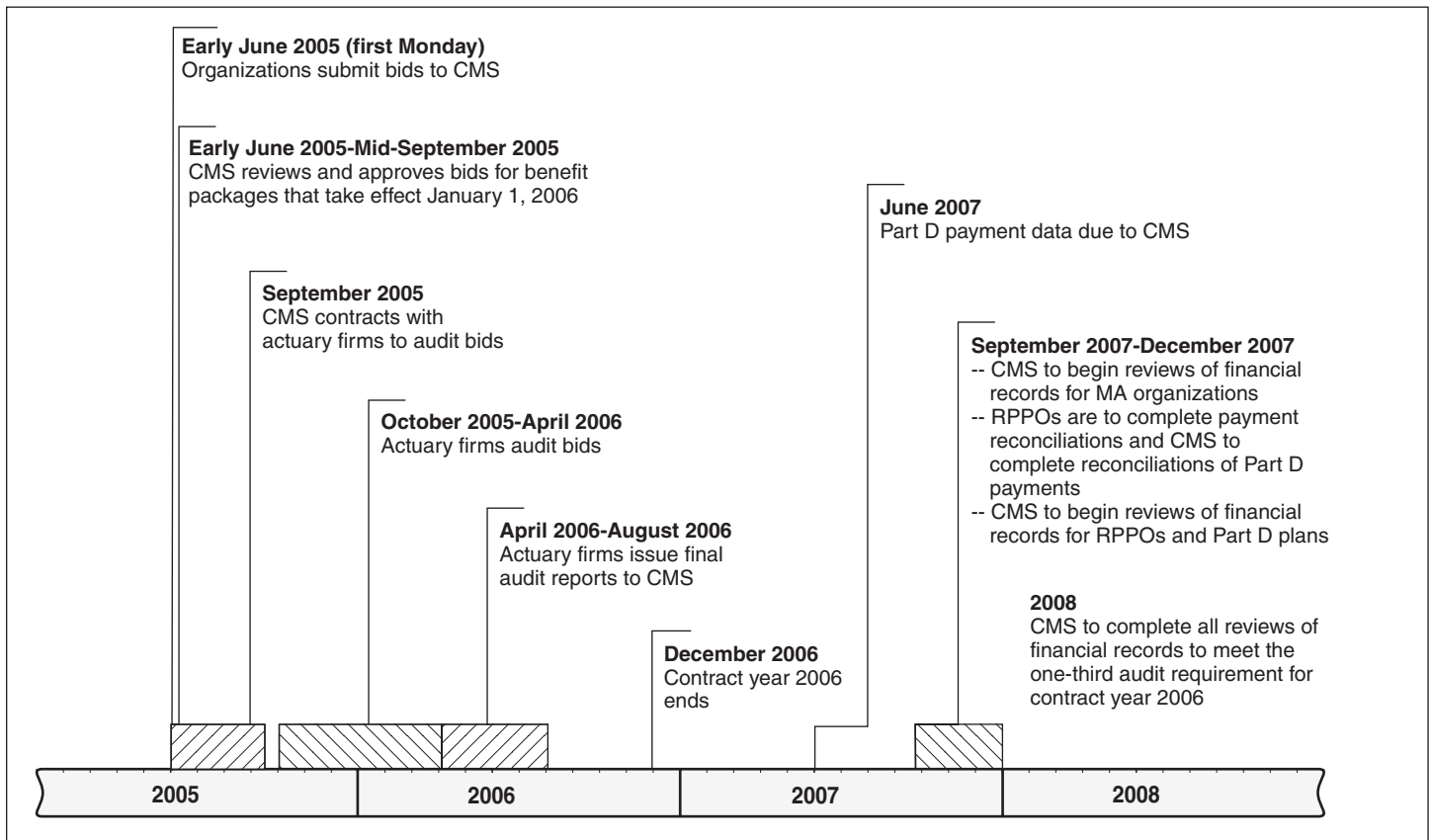
reviews that CMS is currently planning to do for contract year 2006 and beyond, along with the objectives of those reviews.

CMS will not complete the proposed financial reviews until almost 3 years after the bids are submitted for each contract year, as shown in figure 1, in part because it must first reconcile Part D payment data that prescription drug plans are not required to submit to CMS until 6 months after the contract year is over.³¹ Contract year 2006 bids were submitted in June 2005. OFM officials said that they planned to start some of the reviews for MA organizations in August 2007 to test their audit approach. However, review of RPPOs and prescription drug plans will not start until later because RPPO risk-sharing cost reconciliations that OFM says it will review are not due to CMS until December 2007.³² OFM also plans to use Part D payment reconciliations that CBC will not be able to complete until June or July of 2007 because prescription drug plans are not required to submit payment data to CMS until June 2007. This means that reviews of financial records intended to meet the one-third audit requirement for contract year 2006 will not start until the fall of 2007 and will not be completed until sometime in 2008. Results of these reviews might be available to CMS before reviewing and approving bids for contract year 2009 that organizations must submit in June 2008. CMS has not yet developed its approach for following up on the results of these reviews. Such an extended cycle for conducting reviews of financial records to meet the one-third requirement will affect CMS's ability to recommend and implement actions needed to address any identified deficiencies in MA organizations' and prescription drug plans' bid processes in a timely manner.

³¹CMS will reconcile Part D prospective payments made to the organizations based on the approved bids to actual costs incurred by the organizations to provide year-end adjustments to the organizations resulting in payments or recoveries for each contract. The reconciliations are for low-income cost sharing, reinsurance payments to cover drug costs above the catastrophic threshold, and risk corridor payments for cost sharing between Medicare and the MA organizations within specified thresholds or corridors surrounding a drug-spending target.

³²CMS has developed a Risk-sharing Reconciliation Cost report that regional PPOs are to submit annually. CMS plans to use the report to collect allowable cost data and compare these data to target amounts. If the comparison demonstrates that the regional PPO incurred either savings or losses in the contract year, the regulations provide specific risk corridors for CMS to use in determining the risk-sharing reconciliation amount due to either the MA organization or CMS. For MA regional plans for 2006 and 2007, MMA expressly authorizes payment adjustments to reflect higher or lower allowable costs than estimated. See 42 U.S.C. § 1395w-27(a).

Figure 1: Time Elapsed from Contract Year 2006 Bid Submissions to Reviews to Meet Audit Requirement



Source: GAO.

CMS's ACR Audit Process Was Ineffective

CMS contracted with accounting firms to audit the contract year 2001-2005 ACRs for a selected number of MA organizations, but did not consistently ensure that the audit process provided information to assess the potential impact on beneficiaries' benefits or the payments CMS makes to MA organizations. The auditors reported findings ranging from lack of supporting documentation to overstating or understating certain costs, but did not identify how the errors affected beneficiary benefits, copayments, or premiums. In 2001, we reported that CMS planned to require auditors, where applicable, to quantify in their audit reports the overall impact of errors.³³ Further, during our prior work, CMS officials stated that they

³³GAO-02-33, p. 20.

were in the process of determining the impact on beneficiaries and crafting a strategy for audit follow-up and resolving the audit results. CMS did not initiate any actions to attempt to determine such impact until after the audits for contract year 2003 were completed, when CMS contracted with a firm to review all of the 2003 ACR audits to identify any errors from the audits that would affect beneficiaries. The contractor reported to CMS that it had identified errors in ACRs that would have resulted in approximately \$59 million that beneficiaries could have received in additional benefits, lower copayments, or lower premiums. CMS also contracted with a firm to review the 2004 ACR audits, but the work is not to be completed until August 31, 2007. The OFM staff reviewed the 2003 audit reports and the contractor's analysis of the audit reports. OFM revised the amount identified by the contractor's analysis from \$59 million to \$35 million and concluded that it would make recommendations to CBC on whether corrective action plans or sanctions against MA organizations were warranted. However, in late May 2007, CMS informed us that its legal counsel had determined that the agency does not have the legal authority to recover funds from MA organizations based on the findings from the ACR audits. On the basis of our assessment of the statutes, CMS had the authority to pursue financial recoveries, but its rights under the contracts for 2001–2005 are limited because its implementing regulations did not require that each contract include provisions to inform organizations about the audits and about the steps that CMS would take to address identified deficiencies, including pursuit of financial recoveries.³⁴

The ACR Audit Process Did Not Consistently Quantify Impacts on Beneficiaries

CMS contracted with audit firms at a cost of \$15.2 million to audit ACRs for contract years 2001–2005, but did not ensure that the audit process consistently provided information to assess the potential impact on beneficiaries. The instructions and guidance that CMS provided to the auditors of the ACRs generally were not clear that the auditors should quantify and report on how errors identified in the ACRs would affect beneficiary benefits, copayments, or premiums. In our October 2001 report, we reported that for contract year 2001, CMS had planned to require auditors, where applicable, to do so.³⁵ We recommended that CMS fully implement its plans to calculate the net effect of ACR audit findings and adjustments. Computing the net effect of the errors identified by the

³⁴42 U.S.C. § 1395w-27(e)(1) provides authority for CMS to include additional terms and conditions in MA contracts. See 42 C.F.R. § 422.504(j).

³⁵[GAO-02-33](#).

ACR audits is key to assessing the magnitude of the impact on beneficiaries and could aid in developing an appropriate follow-up protocol. In September 2001, CMS stated that it was already addressing this recommendation.

Although CMS indicated it was planning to obtain a calculation of the net effect (i.e., impact on beneficiaries) of errors identified by auditors, the audit guidance and instructions provided by CMS for contract years 2001 and 2002 did not specify that the auditors should quantify the impact of the errors on beneficiary benefits, copayments, or premiums. Consequently, the audit reports did not quantify the impact on the beneficiaries.

The audit guidance and instructions for contract years 2003 and 2004 also did not contain a directive to quantify the impact on beneficiaries of the auditors' findings, and the audit reports did not contain this information. CMS contracted with a firm to review all of the 2003 ACR audit reports to identify any errors from the audits that would affect beneficiaries. The auditors categorized their results as findings and observations, with findings being more significant, depending on their materiality to the average payment rate reported in the ACR. The distinction between findings and observations, however, was based on judgment, and therefore varied among the different auditors. CMS asked the contractor to analyze the audit reports, including both findings and observations, and supporting documentation. After reviewing the ACR reports for the 49 organizations audited and related documentation, the contractor reported in December 2005 that it had identified errors for 41 of the 49 organizations that would have resulted in approximately \$59 million that beneficiaries could have received in additional benefits, lower copayments, or lower premiums.

OFM staff reviewed the contract year 2003 audit reports along with the contractor's analysis of the 2003 ACR audits to evaluate the amount reported by the contractor that would affect beneficiaries. After reviewing all 49 audit reports and the contractor's analysis, OFM staff determined that there were errors for 32 of the 49 organizations audited that would have resulted in approximately \$35 million that beneficiaries could have received in additional benefits, lower copayments, or lower premiums. OFM staff told us they had identified what they considered errors in some of the contractor's work, such as misapplication of the instructions, and revised the amount of the beneficiary impact that the contractor had identified. OFM staff concluded that they would make recommendations to CBC on whether corrective action plans or sanctions against MA organizations were warranted. In September 2006, CMS also contracted with a firm to quantify the overall net effect resulting from the contract

year 2004 ACR audits. CMS officials told us that OFM staff were still working with the contractor on this project, which is not to be completed until August 31, 2007.

For the contract year 2005 ACR audits, CMS's instructions to the auditors required them to clearly identify the net effect or impact of their findings. However, as of June 2007, we had not yet received the contract year 2005 audit reports, and therefore we cannot confirm whether these reports included information on the impact on beneficiaries of identified errors. According to CMS, the audits were delayed because management decided instead to allocate funds intended for this purpose to OACT for the audits of the contract year 2006 bids.

CMS Did Not Act to Recover Funds from or Sanction MA Organizations Based on ACR Audit Results and Has Not Determined How to Close Out the Audits

In our 2001 report, we noted that CMS did not have a formal process in place to resolve the specific problems identified in the audits, and therefore the usefulness of the audit process was undermined. We recommended that CMS develop and implement a follow-up mechanism to address the audit findings in a timely manner and that CMS communicate to each MA organization specific corrective actions. In September 2001, CMS responded that such a process was under development. CMS told us it provided copies of the final audit reports to the MA organizations and instructed them to institute remedial actions in their subsequent ACR submissions and that CMS's intent was to follow up on the audit findings during subsequent audits. For this report, we reviewed audit reports for contract years 2001-2004 and discussed CMS's audit follow-up process with CMS officials and staff.³⁶ The audit reports did not refer to past audit findings, so it is unclear whether the auditors had followed up on the past findings. The only action that CMS has taken was to provide copies of the audit reports to the MA organizations and instruct the organizations to take action in subsequent ACR filings.

In late May 2007, CBC officials explained that they were responsible for resolving the issues resulting from the ACR audit reports and stated that they were working with OFM to develop an approach to address the results from the audit reports for contract years 2003 through 2005,³⁷ but had not yet decided on a plan of action. They also informed us that their

³⁶As discussed earlier, the audit reports for contract year 2005 were not available for our review.

³⁷The CBC officials told us no further action was necessary for the 2001 and 2002 audits.

legal counsel had determined that the agency does not have the legal authority to recover funds from MA organizations based on results of ACR audits. Subsequently, HHS legal counsel explained to us the department's position that CMS lacks the legal authority or the contractual right to pursue financial recoveries when audits determine that approved ACRs reflect errors, incorrect or unreasonable assumptions, or other misstatements. We were told that, based on a determination of the Secretary, general federal contract laws do not apply to the payments made under MA contracts.³⁸ Instead, according to HHS, the contractual rights of CMS and the contracting MA organizations are limited to those set out in statute and the CMS implementing regulations. Those statutes and regulations do not expressly provide for corrective action based on CMS's ACR audits, such as returning funds to CMS or beneficiaries based on errors found during ACR audits when the audits indicate that each beneficiary in a plan should have received a certain amount of additional benefits. On the basis of our assessment of the statutes, CMS had the authority to include terms in its contracts with MA organizations that would allow it to pursue financial recoveries based on the ACR audit results.³⁹ However, CMS's rights under the contracts for contract years 2001–2005 are limited because its implementing regulations for the Medicare+Choice Program did not require that each contract include provisions to inform organizations and plans about the audits and about the steps that CMS would take to address identified deficiencies, including pursuit of financial recoveries.

CMS officials acknowledged that they can impose sanctions in cases where an organization misrepresents information that is furnished under the program and for other reasons.⁴⁰ Intermediate sanction provisions allow for suspension of enrollment of individuals in MA plans, suspension of payments to MA organizations, and civil penalties in the amount of up to \$100,000 for misrepresenting or falsifying information to CMS.⁴¹ However, CMS has never sanctioned an MA organization based on findings

³⁸ 42 U.S.C. § 1395w-27(c)(5) provides authority for this determination. HHS legal counsel also told us that the common law of contracts does not apply to MA contracts.

³⁹ 42 U.S.C. § 1395w-27(e)(1) provides authority for CMS to include additional terms and conditions in MA contracts. See 42 C.F.R. § 422.504(j).

⁴⁰ Authority to impose intermediate sanctions is provided under 42 U.S.C. § 1395w-27(g).

⁴¹ 42 U.S.C. § 1395w-27(g)(2). Other intermediate sanctions vary depending upon the actual basis determined by CMS.

from the ACR audits and did not say why it has not. CMS officials told us that they plan to close out the audits without pursuing financial recoveries. They said that they are considering options, such as determining whether findings are applicable to the current bid process, that could be a basis for current action. CMS officials also stated that they are compiling a list of MA organizations whose contract year 2003 ACR audits resulted in significant findings and will refer the MA organizations to the HHS Office of Inspector General (OIG) for appropriate action, including assessing civil monetary penalties. However, CMS officials acknowledged that the opportunity to take corrective action may have passed, given the amount of time since the audits were completed.

In the past, the OIG has audited ACRs and recommended in some cases that MA organizations return unsupported or unallowable payments to CMS. For example, the OIG conducted 53 of the 80 ACR audits for contract year 2000, the first year of such audits that we reported on in our previous report.⁴² The OIG reported findings that quantified the impact of ACR errors on beneficiaries in 7 of the 53 reports. However, CMS did not take action on the findings. CMS also did not take action on findings from other audits of ACRs that the OIG did under its authority. For example, the OIG audited the modifications to the contract year 2001 ACRPs for six MA organizations to determine whether additional funding provided by the Benefits Improvement Protection Act (BIPA) of 2000 was used in a manner consistent with BIPA requirements and whether the modifications were adequately supported.⁴³ The OIG also audited modifications to the contract year 2004 ACRPs for six MA organizations to determine whether the use of payment increases provided under MMA were adequately supported and allowable under MMA. In five of the BIPA audits and one of the MMA audits, the OIG found that the MA organizations did not support how they used the additional funds, or they determined that MA

⁴²[GAO-02-33](#).

⁴³Past legislation has provided for increased payments to MA organizations. The Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) (Pub. L. No. 106-554, app. F, 114 Stat. 2763, 2763A-463 (Dec. 21, 2000)) provided for increased payments to MA organizations effective March 1, 2001, and required MA organizations with plans that received increased payments to submit revised ACRPs to show how they would use the increase during contract year 2001. Similarly, MMA provided for increased payments effective March 1, 2004, to MA organizations and required them to submit revised ACRPs showing how they would use the increased payments in contract year 2004. Both BIPA and MMA required MA organizations to use the increased payments to reduce beneficiary premiums and cost sharing, enhance benefits, contribute to a benefit stabilization fund, or stabilize or enhance beneficiary access to providers.

organizations did not use the funds in a manner consistent with the applicable law. In its reports dated June 2004 through January 2006, the OIG recommended that the six MA organizations return to CMS a total of almost \$29 million or deposit the funds in a benefit stabilization fund for use in future years.

In CMS's December 2006 management response to the OIG's recommendations, CMS's CBC stated that CMS did not concur with the OIG's recommendations to collect the funds and make them available for benefits because (1) the benefit stabilization fund was abolished with implementation of MMA, (2) a significant time has elapsed since the benefit year in question (2001),⁴⁴ (3) the Medicare+Choice program no longer exists, and (4) the basis for payment has changed from reviews of ACRPs to bids.

Bid Audits Report Findings That Would Affect Premiums and Payments for Contract Year 2006, But CMS Does Not Address the Findings

CMS contracted with six firms to audit a selected number of contract year 2006 bids and plans to do so for subsequent years. In reviewing the 2006 bid audit reports, we determined that 18 (about 23 percent) of the 80 organizations audited had material findings that have an impact on beneficiaries or plan payments approved in bids. CMS defined material findings as those that would result in changes in the total bid amount of 1 percent or more or in the estimate for the costs per member per month of 10 percent or more for any bid element.⁴⁵ OACT officials responsible for the bid audit process explained that they will use the audit results to help organizations improve their methods in preparing bids in subsequent years, but their audit follow-up process does not involve taking action to recover funds from organizations based on audit results because they maintain that CMS does not have the legal authority to do so. However, according to our assessment of the statute, CMS has the authority to include terms in contracts with MA organizations and prescription drug plan sponsors that would allow it to pursue financial recoveries based on the bid audit results. Another weakness that we noted in CMS's bid audit process was the lack of documentation to support steps taken to mitigate conflict of interest situations for the actuarial firms conducting the bid

⁴⁴Five of the six OIG audits that contained recommendations related to 2001 ACRPs. The other OIG report related to a 2004 ACRP.

⁴⁵Findings also include any serious failure to follow applicable ASOPs. Materiality for identifying observations included all other errors or deviations from the instructions or best actuarial practices that did not meet the criteria for being classified as findings.

audits. Using available information, we were able to confirm that the actuarial firms did not audit the same bids that the firms had acted as a consultant in preparing. However, we were not able to confirm the steps taken by CMS to avoid assigning actuarial firms to audit the same bids that the firms had reviewed because information was not available by the end of our fieldwork in June 2007.

Contract Year 2006 Bid Audit Results Identified Significant Impacts on Member Premiums and Medicare Payments

According to requirements in the audit contracts, the auditors were required to categorize the severity of the issues identified in the audits as either significant/material findings or nonsignificant observations.⁴⁶ CMS defined material findings as those that would result in changes in the total bid amount of 1 percent or more or in the estimate for the costs per member per month of 10 percent or more for any bid element, which, if corrected, would be expected to result in (1) reduced payments from CMS to the organization, (2) additional benefits to enrollees, and (3) reduced enrollee premiums or copayments.⁴⁷ CMS defined nonsignificant observations as deficiencies that are not considered material.

The contract year 2006 bid audits covered 80 organizations. For 18 of these organizations (about 23 percent), auditors identified at least one material finding that affected the total bid amount or a particular bid element in an approved bid. Errors in the total bid amount or a bid element can affect the accuracy of Medicare payments. Errors can also affect members' premiums, copayments, and the level of services they are provided. The material findings arose from deficiencies identified by the auditors in how bid estimates were developed, including projected costs, risk scores, trend assumptions, cost sharing, manual rates, and utilization estimates among others.

⁴⁶CMS uses actuaries to review all the bid forms received and assess the assumptions and methods supporting the bid elements and their reasonableness to support the overall bid prior to awarding contracts to the bid sponsors. After the bid contracts are awarded, CMS does a more detailed audit of a selection of bids to determine if the bid was developed according to CMS's bid preparation instructions and designated actuarial standards of practice.

⁴⁷CMS officials also stated that material findings include changes that, if corrected, could increase payments and result in additional or lesser benefits and reduced or increased enrollee premiums or copayments. As such, material audit findings may either increase or decrease bid amounts.

For the other 62 audited organizations, the auditors reported observations primarily relating to departures from CMS's detailed bid preparation instructions, including use of questionable data, assumptions, and methods, and inadequate documentation. CMS provides detailed instructions for organizations to prepare each of the seven spreadsheets that are part of the MA bid form. The instructions are a line-by-line description of the bid spreadsheets that identifies where user inputs are required. They also contain a glossary and identify the required supporting documentation, including a requirement for a completed certification executed by a qualified actuary. Similarly, CMS provides detailed line-by-line instructions for organizations to prepare each of the six spreadsheets that are part of the prescription drug plan bid form.

CMS's Follow-up on Bid Audits Is Similar to Follow-up on the ACR Audits

OACT officials responsible for the bid audit process explained that they will use the audit results to help organizations improve their methods in preparing bids in subsequent years and to help OACT improve the overall bid process. Specifically, they told us they could improve the bid forms, bid instructions, training, and bid review process. OACT's audit follow-up process does not involve pursuing financial recoveries from organizations based on audit results because CMS maintains that, as with ACRPs, it does not have the legal authority to do so. As stated earlier, CMS officials believe that CMS lacks the statutory or contractual right to pursue financial recoveries based on audit findings. However, according to our assessment of the statute, CMS has the authority to include terms in its contracts with MA organizations and prescription drug plan sponsors that would allow it to pursue financial recoveries based on the bid audit results.⁴⁸ However, CMS's contractual rights are limited because its implementing regulations do not require that each contract include provisions to inform organizations and plans about the audits and about the steps that CMS will take to address identified deficiencies, including pursuit of financial recoveries. Such changes would be needed for CMS to be able to adjust the bid amounts after bid approval and pursue financial recoveries.

CMS has authority to sanction organizations but did not identify any findings from the contract year 2006 bid audits where a sanction would be warranted. OACT officials believe the bid audits provide a "sentinel or

⁴⁸42 U.S.C. § 1395w-27(e)(1); 42 C.F.R. § 422.504(j). This provision also applies to prescription drug plans under Part D. 42 U.S.C. § 1395w-112(b)(3)(D).

deterrent effect” for organizations to properly prepare their bids since they do not know when the bids may be selected for a detailed audit. However, the officials acknowledged that the bid process relies heavily on certifying actuaries and that there is a low probability of the bid audits identifying intentional misrepresentations.

Given the current audit coverage, CMS is unlikely to achieve significant deterrent effect, as only 14 percent of participating organizations for contract 2006 have been audited. Further, for those organizations that were audited, CMS’s follow-up on the audit findings may not deter those organizations from making similar errors in future bids. For example, preliminary findings for most of the 2006 audits came out by April 2006, and according to OACT, organizations started preparing their bids for contract year 2007 by April 2006, which would have allowed them time to take corrective actions to address the audit findings. OACT officials noted that they updated the contract year 2007 instructions for bid preparation as a result of audit results and other factors. However, they could not identify any specific revision arising out of the contract year 2006 audit results. Without a more targeted follow-up process to ensure that every finding and observation from the audits is addressed before approving the next year’s bid, the value of the audits is limited. OACT officials said that their process for following up on the audit results will become more focused as each year’s audits are conducted. Officials stated that CMS’s 2007 notification letter to organizations requires the contract year 2008 bid submissions to document how the findings of the prior year audits were addressed in the subsequent bid submission. They also said the 2008 bid review process includes a process for reviewing the prior year’s audit findings for all bids that were audited in the prior year.

CMS is currently developing an approach intended to ensure that one-third of the MA organizations and prescription drug plans are audited each year. As mentioned earlier, CMS plans to review financial issues including plan solvency, risk scores, related parties, direct medical and administrative costs, and beneficiaries’ true out-of-pocket costs for prescription drug plans. However, CMS’s approach does not clearly identify how it will follow up with organizations to ensure that issues identified in the financial reviews are addressed. Also, it is not clear if these financial reviews are being designed to identify misrepresentations and falsifications in the information furnished by organizations in order to impose sanctions, and CMS has not defined what it might consider to be a misrepresentation or falsification. As currently planned, CMS will not complete these financial reviews for contract year 2006 until sometime in 2008. Results might be available before CMS approves bids for contract

year 2009 that must be submitted in June 2008. As we mentioned earlier, such an extended cycle for conducting reviews to meet the one-third requirement will affect CMS's ability to recommend and implement actions needed to address any identified deficiencies in bid processes in a timely manner.

CMS Did Not Document Steps Taken to Mitigate Conflicts of Interest for Contractors That Audited Bids

As part of its contracting process for the audits of contract year 2006 bids, CMS OACT officials said they took several steps to mitigate actual and potential conflicts of interests for the actuarial firms that completed the bid audits. For example, OACT officials considered whether the actuarial firms had acted as consultants in preparing bids or had other relationships with the organizations that they would be auditing. Information about organizations that the firms had prepared bids for, had other relationships with, or had reviewed their bids came from several sources, including the bid certifications, which identify the actuary that certified each bid submission. OACT officials also said that they asked the firms to self-report conflicts of interest at two phases in their process: (1) as part of the request for proposal, when firms were bidding for the audit contracts, and (2) after contracts were awarded, when firms were asked to respond to a list of organizations that they were assigned to audit. CMS required that as part of the request for proposal, the firms include a listing of organizations for which the firms had a conflict of interest, including organizations for which the firm had prepared bids or had another non-Medicare relationship within the prior 12 months. After contracts were awarded to the six actuarial firms, OACT officials said that they obtained information from the firms regarding conflicts that they used to make audit reassignments. OACT maintains information to identify the actuary that performed the bid reviews in the HPMS database.

OACT officials did not have documentation to support the statement that they took steps to avoid assigning actuarial firms to audit the same bids that the firms had prepared. However, we used the bid certifications and audit reports to confirm whether the actuarial firms had audited bids that the firms had also acted as a consultant in preparing. We compared the names of the actuaries on the bid certifications and their organizational affiliations and the names of the actuaries that provided audit opinions and their organizational affiliations as identified in the audit reports for the 80 organizations that were audited in contract year 2006. We found no instances where the bid preparer and the bid auditor were the same individuals or companies.

To confirm whether the actuarial firms audited bids for organizations with which the firms reported having a relationship, we obtained and reviewed the self-reported conflict of interest information submitted in response to the request for proposal by five of the six actuarial firms. OACT did not have the information for the other firm. We also requested the conflict of interest information that OACT said it obtained from the firms to make audit reassignments. However, OACT could not provide this information because it said it collected this information through an informal process and did not have documentation supporting the information it obtained. Using the available conflict of interest information, we found no instances where the five actuarial firms audited a bid when it reported having a relationship.

Finally, OACT officials did not have documentation to support the steps they took to avoid assigning actuarial firms to audit the same bids that the firms had reviewed. Four of the six actuarial firms that performed the contract year 2006 bid audits also reviewed bids as part of CMS's bid review process. We were not able to confirm the steps OACT officials said they took because the information was not available by the end of our field work in June 2007.

Conclusions

When CMS falls short in meeting the statutory audit requirement and in a timely manner resolving the findings arising from those audits, the intended oversight is not achieved and opportunities to determine if organizations have reasonably estimated the costs to provide benefits to Medicare enrollees are lost. Inaction or untimely audit resolution also undermines the presumed deterrent effect of audit efforts.

CMS will continue to invest resources in its current bid audits and its planned reviews of the financial records of MA organizations and prescription drug plans that will likely have limited value in improving the programs if it does not implement a structured process for following up with organizations to make sure that they address deficiencies identified from the audits before approving subsequent year bids. The current bid audits provide CMS with information in a timely manner to address identified deficiencies. These bid audits identify how beneficiaries are adversely affected by errors, incorrect or unreasonable assumptions, or other misstatements in the information furnished to CMS and indicate how funds due to the Treasury are affected.

While the statutory audit requirement does not expressly state the objective of the audits or how CMS should address the results of the

audits, the statute does not preclude CMS from including terms in its contracts that allow it to pursue financial recoveries based on audit results. If CMS maintains the view that statute does not allow it to take certain actions, the utility of CMS's efforts is questionable. Further, if CMS cannot provide assurance that the firms performing the audits are free from potential or actual conflicts of interest, the integrity of the audit process is also threatened.

Recommendations for Executive Action

To help fulfill CMS's responsibilities, we recommend that the Administrator of CMS take the following five actions:

- Finalize a decision and establish implementing procedures on how the prior ACRP audit results will be addressed and closed.
- Finalize an approach for meeting the one-third audit requirement for contract year 2006 and subsequent years. This approach should clearly address:
 - the procedures for annually identifying the organizations whose bid submissions and supporting financial records will be audited as part of the current OACT bid audits and those that will be reviewed as part of the planned financial reviews,
 - the supporting documentation that must be retained to show that the audit requirement was met, and
 - the procedures for conducting planned financial reviews that clearly identify how the reviews will provide results in a timely manner and how the reviews will be designed to identify misrepresentations and falsifications in the information furnished under the program.
- Amend the implementing regulations for the Medicare Advantage Program and Prescription Drug Program to provide that all contracts CMS enters into with Medicare Advantage organizations and prescription drug plan sponsors include terms that inform these organizations of the audits and give CMS authority to address identified deficiencies, including pursuit of financial recoveries. If CMS does not believe it has the authority to amend its implementing regulations for these purposes, it should ask Congress for express authority to do so.
- Develop, as part of its approach for meeting the one-third audit requirement, additional procedures for following up on results of the OACT bid audits and results of the financial reviews. These procedures should clearly address:
 - how CMS will annually ensure that findings and observations from the bid audits are addressed before the next year's bids are approved,
 - how CMS will annually ensure that findings from the financial reviews are addressed before the subsequent year's bids are approved,

-
- the supporting documentation that must be retained to show that the findings and observations from bid audits and findings from the financial reviews were addressed, and
 - how CMS reviews audit findings to determine if intermediate sanctions are warranted.
 - Develop procedures to formalize the reviews and supporting documentation that must be retained to show that conflicts of interest arising from individuals or firms preparing, reviewing, or auditing the same bid have been addressed.

Agency Comments and Our Evaluation

We received written comments on a draft of this report from CMS, which are reprinted in appendix V. CMS concurred with our recommendations and stated that it is in the process of implementing some of them. Specifically, CMS concurred with our recommendation to finalize an approach for meeting the one-third audit requirement that includes procedures for identifying and documenting the organizations that will be audited annually. CMS also commented it has modified and documented its procedures for selecting the MA organizations and Medicare prescription drug plans for audit and begun documenting standard operating procedures for the financial audit process (including procedures for contracting with audit firms, selecting the MA organizations and prescription drug plans for audit, and addressing audit findings.)

CMS provided additional comments on several issues we reported on, including financial recoveries based on the bid audit and the timeliness of its planned audit process. Specifically, CMS noted that the ability to obtain financial recoveries based on the bid audits is extremely complicated and can result in future payments by CMS rather than reimbursements by the plans. We believe that these are issues CMS should address as it takes steps to amend its contractual rights with MA organizations and prescription drug plans. CMS also noted that we did not explain why the audit process can take up to 3 years to be completed. CMS stated that the normal cycle for a contract year is over 2 years, followed by an additional 6 months for plans to submit data for reconciliation. We revised our report to acknowledge that CMS's financial reviews depend on data that is not required to be submitted until 6 months after the end of the contract year. However, the point remains that CMS's decision to develop an audit approach based solely on testing financial records that are not available until 6 months after the contract year and must be reconciled before testing can begin, will result in a 3-year cycle to complete reviews that will affect its ability to recommend and implement any actions needed to address identified audit deficiencies in a timely manner.

We are sending copies of this report to interested congressional committees, the Secretary of Health and Human Services, the Acting Administrator of CMS, the Inspector General of HHS, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>. Should you or your staff have any questions about this report, please contact Jeffrey Steinhoff at (202) 512-2600 or by e-mail at steinhoffj@gao.gov, or Kimberly Brooks, Assistant Director, at (202) 512-9038 or by e-mail at brooksk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.



Jeffrey C. Steinhoff
Managing Director
Financial Management and Assurance

Appendix I: Scope and Methodology

To determine whether the Centers for Medicare & Medicaid Services (CMS) met the requirement for auditing Adjusted Community Rates (ACRs) for one-third of the Medicare Advantage (MA) organizations for contract years 2001 through 2005 and one-third of the bid submissions for contract year 2006, we first requested the criteria and analysis from CMS to show how it met the requirement. However, because CMS did not prepare or retain this information, we instead obtained from CMS a compilation of organizations that were audited for contract years 2001 through 2006. We also obtained from CMS's Health Plan Management System (HPMS) a population of organizations and plans for which CMS had approved contracts to participate in the Medicare Advantage and Part D programs for contract years 2001-2006.

To obtain reasonable assurance with respect to the completeness of CMS's compilation of audited organizations, we compared the organizations listed in CMS's compilation to lists of organizations assigned to each auditor that were contained in the contract files at CMS for contract years 2002 through 2005, where available. Because all of the contract files were not provided to us, we also compared the compilation to the audit reports we obtained from CMS.¹

CMS provided us with a data extract from HPMS in an Excel spreadsheet. We took several steps to assess the reliability of the HPMS data provided by CMS, although we were not able to independently verify the completeness of the population files. To assess the reliability of the HPMS data provided by CMS, we tested specific data elements for reasonableness (e.g., contract year, contract identifier, and plan identifier). Our tests resulted in no exceptions. We also made inquiries with CMS officials to confirm the source of the data. We compared the contract numbers of organizations that were audited with contract numbers in the population files to determine if the audited organizations were included in the population. We found several audited organizations that were not included in the population files CMS originally sent us of organizations participating in the Medicare Advantage program for contract years 2001 through 2005. We communicated these differences to CMS and it responded by sending us new population files that included the MA organizations we identified plus additional MA organizations. CMS did

¹CMS could not locate the contract files for our review for (1) the four firms awarded contracts to audit MA organizations for 2001, (2) three firms awarded contracts for 2002, and (3) two of the nine firms awarded contracts for 2004. The CY 2006 contract files did not contain a list of organizations assigned to each auditor.

not explain the increase in the number of MA organizations in the revised population files. On the basis of the revised population number, we performed an analysis comparing the number of organizations and plans audited as a percentage of organizations and plans that CMS approved to determine if CMS had met the requirement to audit one-third of participating organizations. On the basis of the collective information and interviews with CMS officials, we determined these data were adequate for assessing whether CMS had met the one-third auditing requirement.

To determine whether information provided by the ACR audit process was sufficient for CMS to assess potential impacts on beneficiaries and address those impacts, we obtained and reviewed the following documents:

- audit reports for contract years 2001 through 2004,
- reports prepared by the contractor that reviewed and analyzed the 2003 audit results,
- CMS's analysis of the work performed by the contractor that reviewed and analyzed the 2003 audit results,
- Statements of work from the contracts awarded to the firms to audit the ACRs, and
- CMS's instructions to the auditors (called Uniform Examination Program).

To assess the reliability of the audit reports, we used guidance in GAO's *Financial Audit Manual* Section 650, *Using the Work of Others*, which focused on assessing the auditors' independence, objectivity, and qualifications. We reviewed contract files at CMS for the firms awarded contracts to audit ACRs. Specifically, in the contract files, we reviewed representations as to the firms' independence and objectivity that the firms submitted in response to CMS's requests for proposal and evaluations of the firms by technical evaluation panels.

We also interviewed CMS staff and officials about (1) the audit process, (2) CMS's review of the reviewing contractor's analysis of 2003 audit results, and (3) actions planned by CMS to address the audit findings.

To determine how CMS conducted bid audits, what information the bid audit process provided CMS, and how CMS used that information, we obtained and reviewed related documentation including:

- CMS's instructions and guidance for preparing bids for 2006 and 2007,
- CMS's instructions and guidance for bid reviewers for 2006 and 2007,
- CMS's instructions and guidance for bid auditors for 2006,
- bid audit reports for contract year 2006,

- certifications by actuaries that helped MA organizations prepare their bids, and
- draft agreed-upon procedures for the financial audit of MA organizations and prescription drug plans.

We discussed with Office of Actuary (OACT) officials and five of the six bid auditors (for the 2006 bids) their roles and views of the bid audit process. To identify the information the bid audit process provided CMS, we reviewed the bid audit reports and summarized the nature and number of findings and observations identified by the bid auditors.

We performed some limited testing to identify whether potential conflicts of interest existed among actuaries who helped organizations and plan sponsors prepare bids and those actuaries who audited the bids. Using (1) the bid certifications, which identified the actuaries and organizations that helped organizations prepare their bids; (2) self-reported conflicts of interest, which were transmitted to CMS with the responses to the request for proposal offers; and (3) bid audit reports, which identified the lead actuary performing the bid audit, we identified which particular actuaries (firms and individuals) helped prepare and audit bids. We compared the information on bid preparers to information on bid auditors to determine whether the actuarial consultants who assisted organizations in preparing their bids had also audited the same bids, which would create a conflict of interest. Our tests resulted in no exceptions.

We interviewed CMS staff and officials from CMS's Center for Beneficiary Choices (CBC), Office of the Actuary (OACT), and Office of Financial Management (OFM) about the bid review and audit processes and discussed actions planned to address the bid audit findings. We also discussed actions CMS planned to take to fulfill the requirement for auditing bid submissions for contract year 2006 and beyond. In particular, we discussed OFM's plans for testing solvency, direct medical and administrative costs, risk scores, related party transactions, and other related testing for MA organizations and prescription drug plans.

To assess the reliability of the bid audit reports, we used guidance in GAO's *Financial Audit Manual* Section 650, Using the Work of Others, which focused on assessing the auditors' independence, objectivity, and qualifications. We reviewed contract files at CMS for the firms awarded contracts to review bids and audit bids. Specifically, in the contract files, we reviewed representations as to the firms' independence and objectivity that the firms submitted in response to CMS's requests for proposal and evaluations of the firms by technical evaluation panels.

We briefed officials from CMS on our findings and their implications. We requested written comments on a draft of this report from the Secretary of Health and Human Services or his designee on July 9, 2007. We received comments from CMS on July 19, 2007. We conducted our review from November 2006 to June 2007 in accordance with generally accepted government auditing standards.

Appendix II: Actuarial Standards Applicable to Bid Preparers

The Centers for Medicare & Medicaid Services requires an actuarial certification to accompany each bid. In preparing the actuarial certification, the actuary must consider whether the actuarial work supporting the bid conforms to Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. While other ASOPs apply, CMS's instructions for the contract year 2006 bids placed particular emphasis on the following ASOPs.

ASOP No. 5, Incurred Health and Disability Claims

- ASOP No. 5 provides guidance to actuaries preparing or reviewing financial reports, claims studies, rates, or other actuarial communications involving incurred claims within a valuation period under a health benefit plan.

ASOP No. 8, Regulatory Filings for Rates and Financial Projections for Health Plans

(Particular focus is placed on the sections dealing with the Recognition of Benefit Plan Provisions, Consistency of Business Plan and Assumptions, Reasonableness of Assumptions, and Use of Past Experience to Project Future Results.)

- This standard sets forth recommended practices for actuaries involved in the preparation or the review of actuarial memorandums or similar documents in connection with the filing of rates and financial projections for health plans. This standard applies to filings submitted to state insurance departments and other regulatory bodies for benefits provided by individual and group health plans and contracts and to filings made in conjunction with applications for licensure and rates for health maintenance organizations, hospitals, and medical service organizations.

ASOP No. 16, Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans

- ASOP No. 16 sets forth recommended practices for actuaries dealing with health maintenance organizations (HMO) and other managed-care health plans (MCHP). This standard was intended to provide guidance on several important areas requiring special consideration for HMOs and other MCHPs. According to the Actuarial Standards Board, this standard was repealed for work performed on or after April 26, 2007, because much of the information in the standard was dated, and in general, it is believed

that the guidance provided in the standard is covered, either explicitly or implicitly, in other ASOPs.

ASOP No. 23, Data Quality

(Particular focus is placed on the sections dealing with Analysis of Issues and Recommended Practices and Communications and Disclosures.)

- This ASOP gives guidance to the actuary in the areas of (1) selecting data that underlie the actuarial work product, (2) relying on data supplied by others, (3) reviewing data, (4) using data, and (5) making appropriate disclosures with regard to data quality.

ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage

- The purpose of this ASOP is to provide guidance to actuaries in the selection of a credibility procedure and the assignment of credibility values to sets of data including subject experience and related experience. Credibility procedures are an integral part of rate making and prospective experience rating, and may be used for other purposes. This standard of practice is applicable to accident and health, group term life, property/casualty coverage, and other forms of nonlife coverage.

ASOP No. 31, Documentation in Health Benefit Plan Rate Making

- The purpose of this standard is to define the documentation responsibilities of an actuary in health benefit plan rate making. This standard does not apply to the establishment or documentation of prices, i.e., the amounts charged to the purchaser. Rather, it is limited to documentation related to the development of rates, i.e., the estimates of the expected value of future costs. This standard does not address other considerations that may affect price, such as marketing goals, competition, and legal restrictions.

Appendix III: Description of Bid Worksheets

Table 3: Description of the Medicare Advantage Bid Form Worksheets for MA Plans for Contract Year 2006

Worksheet	Description
1	This worksheet summarizes the base period data and the key assumptions used to calculate the projected allowed costs for the MA plan. It also includes general plan information, base period background information, a summary of the base period data, and an illustration of the factors used to project the base period data to the contract period.
2	This worksheet calculates the projected allowed costs for the contract year. For plans without fully credible experience, CMS requires plans to provide manual rate information.
3A/3B	These worksheets summarize the expected MA cost sharing for the contract year. Worksheet 3A summarizes the plan's in-network cost sharing, such as copayments and coinsurance, whereas worksheet 3B summarizes the plan's out-of-network cost sharing. Further, the plans must provide plan-level deductible information, if applicable. The value of all cost sharing items must be reflected in the total per member per month amount.
4	This worksheet uses the information from other worksheets to determine net medical costs. Nonmedical expenses and gain/loss margins are added to establish the required revenue for the contract year. Values are also allocated between Medicare-covered benefits and A/B Mandatory Supplemental Benefits.
5	This worksheet calculates the A/B benchmark and evaluates whether the plan realizes a savings or needs to charge a basic member premium. Specifically, this worksheet outlines the development of the benchmarks and bids, outlines the development of the savings or basic member premium, blend of risk and demographic payment methodologies, and provides a summary of Statutory Component of Regional Benchmark and projected (plan-specific) information for counties within the service area.
6	This worksheet contains the results of calculations from the bid forms.
7	This worksheet contains the actuarial pricing elements for any optional supplemental benefit packages to be offered during the contract year. While supplemental benefits (either prescription drug or A/B) offered by the plan may be viewed as a single package of supplemental benefits, the two types of supplemental benefits are considered separately for bidding purposes.

Source: CMS.

Table 4: Description of the Medicare Prescription Drug Plan Bid Form Worksheets for Medicare Advantage Plans for Contract Year 2006

Worksheet	Description
1	<p>Prescription Base-Period Experience—This worksheet should be completed for plans that have appropriate base-period experience for modeling the Part D benefit. The determination of the appropriateness of a plan’s experience should include the evaluation of whether the group included in the experience is consistent with the group that the plan expects to cover. In addition, the experience should be representative of the benefits that will be offered in the contract period. Plans without appropriate base-period experience need to develop manual rates to be used in the pricing tool. Development of these manual rates should include the use of available data adjusted to reflect the expected population and the benefit design that will be offered.</p>
2	<p>PDP Projection of Allowed/Non-Pharmacy—This worksheet identifies the components of trend in the allowed prescription cost for covered Part D drugs and for nonpharmacy expenses between the base period and the contract period, and blends in manual rate information for plans that do not have fully credible base-period experience data.</p>
3	<p>Contract Period Projection for Defined Standard Coverage—This worksheet is used to develop the Defined Standard Bid Amount. All plans are required to fill out this worksheet.</p>
4	<p>Standard Coverage with Actuarially Equivalent Cost Sharing—This worksheet is used only if the benefit plan being bid is for standard coverage with actuarially equivalent cost sharing. The two tests that must be met to demonstrate actuarial equivalence are:</p> <ul style="list-style-type: none"> <li data-bbox="727 1220 1511 1297">• The average coinsurance percentage for amounts between the deductible and the initial coverage limit must be actuarially equivalent to 25 percent. <li data-bbox="727 1314 1511 1392">• The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for defined standard coverage. <p>The amount of the bid must be determined since the bid is based upon the cost of the proposed plan rather than the defined standard plan.</p>
5	<p>Alternative Coverage—This worksheet is used if the plan is offering alternative coverage. Basic alternative coverage would result in no supplemental premiums. The worksheet also calculates the supplemental premium for enhanced alternative coverage.</p>
6	<p>Script Projections for Defined Standard, Actuarially Equivalent or Alternative Coverage—This worksheet illustrates the underlying assumptions that are being used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5. The submitted data support an actuarial comparison of the proposed benefit to the defined standard benefit; it is not expected to be a detailed model of the cost sharing of the proposed plan design. All plans are required to develop projected utilization and costs for their proposed Defined Standard Benefit. In addition, plans submitting a bid for an actuarially equivalent or alternative benefit are required to report projected utilization and costs.</p>

Source: CMS.

Appendix IV: Other Reviews of Financial Records CMS Plans to Do to Meet Audit Requirement

Table 5: CMS’s Planned Reviews of Medicare Advantage and Medicare Part D to Meet Audit Requirement

Review objectives	Medicare Advantage	Part D
Solvency—consider organization’s ability to bear the risk of potential financial losses	Y	Y
Risk Scores Review—assess self-reported diagnosis data	Y	Y
Related Party Transactions—identify significant business transactions to identify related party transactions and to determine if the transactions were reported appropriately	Y	Y
Direct Medical and Administrative Costs—evaluate organization’s allocation of (1) expenses to Medicare and non-Medicare memberships and (2) administrative costs	Y	Y
Part D Costs and Payments—review reconciliation methods of the four payment mechanisms for Part D: direct subsidy, low- income subsidy, reinsurance subsidy, and risk sharing		Y
Direct/Indirect Remuneration—determine if amounts were reported appropriately and if allocation method is reasonable		Y
True Out-of-Pocket Cost—verify that prescription drug plans are calculating true out-of-pocket costs accurately		Y
Regional Preferred Provider Organizations (RPPO)—assess risk-sharing computations, whether expenses and revenues are properly classified, and RPPO’s compliance with its CMS contract	Y	

Source: CMS.

Appendix V: Comments from the Department of Health and Human Services



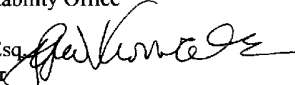
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: JUL 19 2007

TO: Jeffrey Steinhoff
Managing Director, Financial Management & Assurance
Government Accountability Office

FROM: Leslie V. Norwalk, Esq. 
Acting Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Government Accountability Office (GAO) Draft Report: MEDICARE
ADVANTAGE: Required Audits of Limited Value (GAO-07-945)

Thank you for the opportunity to review and comment on the above GAO Draft Report. The GAO's study focused on the annual audits of the Medicare Advantage organizations (MAOs) and provided the Centers for Medicare & Medicaid Services (CMS) with recommendations to improve the auditing process. CMS appreciates the time and resources the GAO has invested in the study and is committed to improving the oversight of the MAOs.

The CMS welcomes constructive suggestions for improving the audit process, and we are in the process of implementing some of the recommendations included in your report. For example, we have modified and documented our procedures for selecting the MAOs and Medicare prescription drug plans (PDPs) for financial audit. Also, we have begun documenting standard operating procedures that clearly describe the financial audit process. This document includes procedures for contracting with auditing firms, selecting the MAOs and PDPs for audit, and addressing audit findings.

We believe you recognize there are key differences between the former adjusted community rate (ACR) audits and the planned financial audits beginning in plan year 2006. You noted that unlike the ACR audits, the financial audits include an analysis of actual costs and that identified findings may have a direct impact on payments to MAOs and PDPs. As a result, CMS can offset payments to the MAOs and PDPs based on the financial review findings.

While the above listed remedies may be exercised for financial audit findings, the bid audit findings present a different scenario. The ability to obtain financial recoveries based on the bid audit is extremely complicated and can result in future payments by CMS rather than reimbursements by the plans. Additionally, changes to the bids based on the bid audit can have an adverse affect on the beneficiaries. (An example of this situation is when a beneficiary becomes caught-up in a plan that must reduce its benefits based on the bid audit findings.)

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Furthermore, it should be noted that the tools, instructions, and training programs for the 2007 bid audits were based on information collected from several sources, including the 2006 bid reviews, 2006 bid audits, an industry survey, and updates to CMS guidance.

Moreover, CMS believes GAO did not explain why the audit process can take up to 3 years to be completed. The normal cycle for a contract year is over 2 years. This is based on the initial bid period which occurs 6 months prior to the actual contract year beginning. This is followed by the actual contract year and an additional 6 months for the plan to submit its data for reconciliation. Final audits of those plans selected for audit is scheduled to begin within months of the final reconciliation. Therefore, CMS is confident that the 3-year period it has established to accept the bid, conduct the contract year, reconcile the data, and audit the reconciliation is consistent with this type of program.

We address each of the report's "Recommendations for Executive Action" in the attached document. Also, we have included technical comments for your consideration.

Centers for Medicare & Medicaid Services' (CMS) Comments to the Government Accountability Office's (GAO) Draft Report: MEDICARE ADVANTAGE: Required Audits of Limited Value (GAO-07-945)

GAO Recommendation 1: Finalize a decision and establish implementing procedures on how the prior ACRP audit results will be addressed and closed.

CMS Response: We concur with this recommendation.

GAO Recommendation 2: Finalize an approach for meeting the one-third audit requirement for contract year 2006 and subsequent years. This approach should clearly address:

- the procedures for annually identifying the organizations whose bid submissions and supporting financial records will be audited as part of the current OACT bid audits and those that will be reviewed as part of the planned financial reviews,
- the supporting documentation that must be retained to show that the audit requirement was met; and
- the procedures for conducting planned financial reviews that clearly identify how the reviews will provide results in a timely manner and how the reviews will be designed to identify misrepresentations and falsifications in the information furnished under the program.

CMS Response: We concur with these recommendations. Our draft audit program was designed to meet the requirements of the one-third audits. We have begun testing the audit program and will make any necessary changes.

GAO Recommendation 3: Amend the implementing regulations for the Medicare Advantage Program and Prescription Drug Program to provide that all contracts CMS enters into with Medicare Advantage organizations and Prescription Drug Plan sponsors include terms that inform these organizations of the audits and give CMS authority to address identified deficiencies, including pursuit of financial recoveries. If CMS does not believe it has the authority to amend its implementing regulations for these purposes, it should ask Congress for express authority to do so.

CMS Response: We concur with this recommendation and will seek legislative authority, if necessary and it preserves the competitive nature of the bidding process.

GAO Recommendation 4: Develop, as part of its approach for meeting the one-third audit requirement, additional procedures for following-up on results of the OACT bid audits and results of the financial reviews. These procedures should clearly address:

- how CMS will annually ensure that findings and observations from the bid audits are addressed before the next year's bids are approved;
- how CMS will annually ensure that findings from the financial reviews are addressed before subsequent year's bids are approved;
- the supporting documentation that must be retained to show that the findings and observations from bid audits and findings from the financial reviews were addressed; and

- how CMS reviews audit findings to determine if intermediate sanctions are warranted.

CMS Response: We agree with this recommendation. The 2007 bid audit results notification letters to the MAOs and PDPs state that the 2008 contract year submissions must document how the findings of the audits were addressed in the subsequent bid submission. The 2008 bid review process includes a process for reviewing the prior year's audit findings for all bids that were audited in the prior year. We will maintain supporting documentation to show that the findings and observations were addressed. This will include proof of payments received from or paid to the MAOs and PDPs as a result of audit findings, etc. Also, CMS will develop a process for determining if intermediate sanctions are warranted.

GAO Recommendation 5: Develop procedures to formalize the reviews and supporting documentation that must be retained to show that conflicts of interest arising from individuals or firms preparing, reviewing, or auditing the same bid have been addressed.

CMS Response: We concur with this recommendation. Since the 2006 contract year, the first year of bid audit. We have improved our documentation efforts since the 2006 contract year, the first year of bid audits, for clearing the conflict of interest concern, but maintaining a process that avoids any real or perceived conflicts of interest remains a top priority.

Appendix VI: GAO Contacts and Staff Acknowledgments

GAO Contacts

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Kimberly Brooks, (202) 512-9038 or brooksk@gao.gov

Acknowledgments

Staff members who made key contributions to this report include Robert Martin (Director), Kimberly Brooks (Assistant Director), Paul Caban (Assistant Director), Abe Dymond, Jason Kirwan, Tarunkant N. Mithani, and Diane Morris.

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Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicare Program; Establishment of the Medicare Advantage Program. [GAO-05-315R](#). Washington, D.C.: February 9, 2005.

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