AUG 18 2000

Memorandum

Date

From for June Gibbs Brown
Inspector General

Subject Results of the Audit of Investment Income Earned by Managed Care Organizations with Risk-Based Contracts (A-02-98-01005)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

The attached final report provides the results of our audit of investment income earned by managed care organizations (MCO) with Medicare risk-based contracts.

The audit objective was to estimate the financial impact on the Medicare program of holding risk-based MCOs accountable for investment income earned on Medicare funds.

The results of our review showed that Medicare risk-based MCOs may have earned in excess of $100 million a year on current year Medicare funding during 1996 and 1997 and continued to earn significant amounts of investment income in 1998. On average, plans earned an estimated 5 percent return from short-term investments of Medicare's prepayment funding. This occurs during the period that falls between the time the MCO receives the funds from the Health Care Financing Administration (HCFA) and the time when these funds are disbursed to providers. The net result is that MCOs were effectively funded at a greater amount (approximately 0.4 percent more) than the 95 percent of Medicare fee-for-service (FFS) costs used as a basis for calculating the MCO payment rates. This estimate is based on a combination of three types of analyses as outlined in the methodologies section of the report. We, therefore, encourage HCFA to study the audit results, consider the significance of the investment income earned on current Medicare funds, and review our recommendations which suggest means to improve the cash management of the risk-based MCO program.

Our audit found that there is no present requirement for MCOs with risk contracts to account for investment income. For example, HCFA does not currently:

- ✔ consider investment income earned by Medicare risk-based MCOs in setting the MCO rates;
- ✔ require an MCO to:
  - factor investment income into its annual presentation of estimated revenue requirements (the adjusted community rate (ACR) proposal);

- use investment income to reduce Medicare expenses, or
- refund investment income to the Federal Government.

We also learned that:

- ✔ although the predetermined payment rates for risk-based MCOs were based on 95 percent of the average costs incurred in providing services under the Medicare FFS program, the FFS funding mechanisms prevent contractors (fiscal intermediaries and carriers) from earning investment income from Medicare provider payments;
- ✔ unlike an FFS contractor, an MCO may invest the predetermined payments from Medicare in interest bearing instruments until the funds are needed for program purposes such as paying the MCO's health care providers or employees for services furnished to Medicare enrollees;
- ✔ the median investment period for short-term investments was 40 days based on the 1996 cash flow information provided by the MCOs and that plans earned about 5 percent on these short-term investments[1]; and
- ✔ the net result of the short-term income from an investment is that MCOs, ***during the float period***, were effectively funded at amounts in excess of the 95 percent of Medicare FFS costs used as a basis for calculating the MCO payment rates.

We also found that the risk-based MCOs' opportunity to earn investment income without any requirement for accountability to the Federal Government was quite different from the way other entities funded by the Department of Health and Human Services and other federally-funded MCO programs must operate. For example,

- Medicare cost-based MCOs are held accountable for investment income;
- grantees funded by the Public Health Service may only retain up to $100 in investment income per fiscal year;
- MCOs participating in the Federal Employees Health Benefits program are funded in such a way that they have little or no opportunity to earn investment income; and

[1]The average 5 percent earnings during the short-term 40 day float investment period equals an annualized rate of return of 0.4 percent of the total Medicare funds paid annually to MCOs.

- MCOs participating in the Department of Defense TRICARE program are reimbursed in the month following the coverage month.

We recommended that HCFA pursue legislation to:

- adjust the timing of Medicare's prepayments to MCOs to maximize the Health Insurance Trust Fund's earnings while minimizing the opportunity MCOs have to earn investment income on Medicare funds, or

- adjust the MCO payment rates to recognize the impact of investment income on the total funding available to MCOs for servicing their Medicare enrollees.

Until such legislation is enacted, we recommend that HCFA develop policies on tracking, estimating, and reporting investment income through measures which could:

- adjust the ACR budgeting process to recognize and account for the investment income earned on Medicare funds,

- improve the cash management of the risk-based MCO program by working with the MCOs to develop policies to hold MCOs accountable for investment income, and

- assure that investment income funds are used for program purposes and to benefit Medicare enrollees.

The HCFA agreed that their policies should hold MCOs accountable for investment income earned on current Medicare funds and should assure that this investment income is used to benefit Medicare enrollees. However, the HCFA noted that some of our recommendations would require legislative changes which they do not intend to pursue at this time.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-02-98-01005 in all correspondence related to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RESULTS OF THE AUDIT OF INVESTMENT INCOME EARNED BY MANAGED CARE ORGANIZATIONS WITH RISK-BASED CONTRACTS

JUNE GIBBS BROWN
Inspector General

AUGUST 2000
A-02-98-01005

EXECUTIVE SUMMARY

Background

There is no present requirement for managed care organizations (MCO) with risk contracts to account for investment income. For example, the Health Care Financing Administration (HCFA) does not currently consider investment income earned by Medicare risk-based MCOs in setting the MCO rates. In addition, HCFA does not require an MCO to factor investment income into its annual presentation of its estimated revenue requirements (the adjusted community rate (ACR) proposal). There is also no requirement that the MCOs use investment income to reduce Medicare expenses or refund investment income to the Federal government.

The HCFA pays an MCO a predetermined amount for each Medicare enrollee by the first of every month. The MCO may then, at its discretion, invest the Medicare funds in interest bearing instruments until the funds are needed for purposes such as paying the MCO's health care providers or employees for services furnished to Medicare enrollees. However, an MCO is under no obligation to report, and is not held accountable to HCFA for, any income generated by its investment of Medicare funds. By comparison, the contractors in the Medicare fee-for-service (FFS) program (fiscal intermediaries and carriers) are not permitted to earn or retain investment income on Medicare funds they receive for provider payments for services rendered to Medicare beneficiaries.

The predetermined payment rates for risk-based MCOs are based on 95 percent of the average costs incurred in providing services under the Medicare FFS program. However, the FFS funding mechanisms prevent contractors from earning investment income but permit risk-based MCOs to earn significant amounts of investment income.

Objective

The audit objective was to estimate the financial impact on the Medicare program of holding risk-based MCOs accountable for investment income earned on Medicare funds.

Summary of Findings

From our analysis of MCO financial management information, we found that:

- Investment income earned by MCOs between the time they receive Medicare funds and the time when the MCOs need these funds for program purposes is estimated at more than $100 million for 1996 and at more than $129 million for 1997. It appeared that at least some MCOs also continued to earn significant amounts of investment income in 1998.

- The median investment period for short-term investments was 40 days based on the 1996 cash flow information provided by the MCOs and that plans earned about 5 percent on these short-term investments[1].

- The net result of the short-term income from an investment is that MCOs, ***during the float period***, were effectively funded at amounts in excess of the 95 percent of Medicare FFS costs used as a basis for calculating the MCO payment rates.

We also found that the risk-based MCOs' opportunity to earn investment income without any requirement for accountability to the Federal government was quite different from the way other entities funded by the Department of Health and Human Services and other Federally-funded MCO programs must operate. For example, Medicare cost-based MCOs are held accountable for investment income. Similarly, grantees funded by the Public Health Service (PHS) may only retain up to $100 in investment income per fiscal year. Finally, MCOs participating in the Federal Employees Health Benefits program and the TRICARE program are funded in such a way that they have little or no opportunity to earn investment income.

Conclusion

The audit results showed that MCOs earned in excess of $100 million a year on current year Medicare funding during 1996 and 1997. We, therefore, encourage HCFA to study the audit results, consider the significance of the investment income earned on current Medicare funds, and review the recommendations below which suggest means to improve the cash management of the risk-based MCO program.

Recommendations

We recommended that HCFA pursue legislation to:

- adjust the timing of Medicare's prepayments to MCOs to maximize the Health Insurance Trust Fund's earnings while minimizing the opportunity MCOs have to earn investment income on Medicare funds, or

- adjust the MCO payment rates and the ACR process to recognize the impact of investment income on the total funding available to MCOs for servicing their Medicare enrollees.

Until such legislation is enacted, we would recommend that HCFA develop policies on tracking, estimating, and reporting investment income through measures which could:

- adjust the ACR budgeting process to recognize and account for the investment income earned on Medicare funds,

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[1]The average 5 percent earnings during the short-term 40 day float investment period equals an annualized rate of return of 0.4 percent of the total Medicare funds paid annually to MCOs.

- improve the cash management of the risk-based MCO program by working with the MCOs to develop policies to hold MCOs accountable for investment income, and

- assure that investment income funds are used for program purposes and to benefit Medicare enrollees.

The HCFA agreed that their policies should hold MCOs accountable for investment income earned on current Medicare funds and should assure that this investment income is used to benefit Medicare enrollees. However, the HCFA noted that some of our recommendations would require legislative changes which they do not intend to pursue at this time.

TABLE OF CONTENTS

INTRODUCTION

This final report presents the results of our review of investment income earned by MCOs with Medicare risk contracts. The audit objective was to estimate the financial impact on the Medicare program of holding risk-based MCOs accountable for investment income earned on Medicare funds.

Background

Medicare beneficiaries may receive their care through the traditional FFS program or through a variety of other arrangements. Medicare MCOs such as health maintenance organizations and competitive medical plans offer beneficiaries one such means of obtaining comprehensive health services. Effective January 1999, MCOs are included in the coordinated care plan options offered under the Medicare+Choice program established by the Balanced Budget Act (BBA) of 1997.

The Medicare MCO program originated as a program of the PHS. At that time, the MCOs were cost-based with PHS funding MCO shortfalls when expenses exceeded projected revenues.

While Medicare continues to sponsor MCOs with cost contracts, section 1876 of the Social Security Act, as amended by section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), made a full risk contracting option available. Today, most MCOs contract with HCFA on a risk basis.

The risk-based program is unique in that an MCO must absorb losses, or may retain profits, derived from its Medicare business. The program is also unique in that Medicare pays predetermined per capita payments to an MCO by the first of every month. In exchange for these capitation payments, a risk-based plan is required to provide all Medicare-covered services to its members.

The predetermined payment rates for MCOs with risk contracts are generally established on a county by county basis and are based on 95 percent of the average benefit and administrative costs incurred in providing services under the Medicare FFS program. Beginning in 1998, the BBA of 1997 changed the formula Medicare used to set payments to MCOs. The new payment rates are set at the highest of three possible amounts: a minimum or 'floor' rate, a minimum percentage increase, or a 'blended' county-wide rate that reflects a combination of local and national average FFS spending. Nevertheless, the 1997 rates, which were based on local FFS spending levels, serve as the base for the new methodology.

There are three general types of MCO models in the Medicare risk program:

- ✔ Individual Practice Associations (IPA) are entities which arrange to deliver health care services through written agreements that specify how they will compensate health care professionals.

- ✔ Group models are groups of health professionals who pool their income and distribute it among the group members according to a prearranged salary, drawing, or other arrangement which is unrelated to the provision of specific health services.

- ✔ Staff models are MCOs that employ health professionals to provide services at facilities maintained by the managed care organization. Staff model MCOs compensate health care professionals through an arrangement other than FFS reimbursement.

As shown at Appendix A, over 4.1 million Medicare beneficiaries were enrolled in one of 230 MCOs with risk contracts by the end of 1996. By the end of 1997 and 1998, enrollment had increased to over 5.2 million and 6.1 million, respectively, among 307 and 346 MCOs with risk contracts.

Objectives, Scope, and Methodology

The objective of the audit was to estimate the financial impact on the Medicare program of holding risk-based MCOs accountable for investment income earned on current Medicare funds.

The MCOs included in this review were those listed in HCFA's "Monthly Report - Medicare Managed Care Plans" for January 1997. From this report, we selected all MCOs with TEFRA risk contracts as of January 1997, but eliminated those MCOs that had no Medicare enrollment as of December 1996.

To accomplish the audit objective, we:

- ▣ reviewed applicable laws and regulations, legislative history, the HMO Manual, and other HCFA instructions,

- ▣ reviewed the laws, regulations, and guidelines applicable to investment income earned by other entities funded by the Department of Health and Human Services and other MCO programs run by the Federal government,

- ▣ held discussions with State regulatory agencies and HCFA regional offices,

- ▣ reviewed published articles about the cash flows of specific MCOs, and

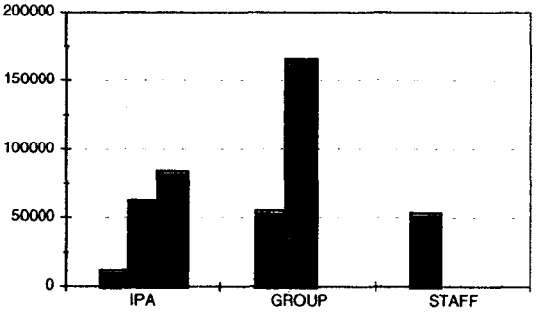
- ▣ reviewed and analyzed financial data from 230 Medicare risk MCOs to estimate the investment income earned by specific MCOs during 1996. As part of this process, we:

  - ▸ conducted a series of on-site audits at 6 locations to review the investment income earned by 11 Medicare risk MCOs,

- inquired about the cash flows of 114 additional MCOs, and
- estimated the investment income of the remaining 105 MCOs.

The on-site audits were planned so that we could gather information about MCOs in different geographic areas because enrollment in Medicare MCOs with risk contracts is heavily concentrated in certain parts of the country (see Appendix B).

To gain a broader perspective, the audits included IPA, group, and staff MCOs. The bar chart shows the Medicare enrollment of the MCOs covered by our reviews at the six audit sites. As of December 1996, the average risk-based MCO enrollment was 17,900. The on-site audits included for-profit MCOs and not-for-profit MCOs.



In addition, these six locations were selected for on-site audits based upon our analysis of the enrollment and premium information reflected on the National Data Reporting Requirements (NDRR) the MCOs filed with HCFA, as required by Title XIII of the Public Health Service Act. Finally, on-site audits were limited to a single location for any MCO chain.

Most MCOs commingle their Medicare funds with funds from other sources and do not separately track the investment income earned solely from their Medicare business. Therefore, it was necessary to develop methods to estimate the investment income attributable only to the Medicare activities of the risk-based MCOs. Our estimation methodology was designed to recognize that the risk feature allows an MCO to earn and retain profits. Thus, we used a variety of techniques to capture investment income earned on current funds and to exclude investment income earned on accumulated earnings.[2]

For example, to identify the investment income earned on current Medicare funds during the on-site audits, we:

- ✓ reviewed payment terms stipulated in the contracts between the MCOs and their health care providers,
- ✓ analyzed "lag reports" to determine the length of time elapsing between dates of medical services and MCO payment of FFS claims,
- ✓ analyzed bank statements for the receipt and disbursement of HCFA funds,
- ✓ traced the movement of funds among bank and investment accounts,

[2]We defined "current funds" as funds available for the average time elapsing between an MCO's receipt of HCFA funds and the MCO's use of those funds to pay for expenses related to providing services to its Medicare enrollees. We defined "accumulated earnings" to include items such as prior year profits, reserves, and pension fund investments.

- ✓ reviewed filings with State regulatory agencies and certified financial statements to identify other sources of investment income,

- ✓ analyzed trial balances of the audited MCO and certain related organizations,

- ✓ held discussions with MCO officials about cash flows, transactions with related parties, and cost allocations, and

- ✓ reviewed and allocated the income earned on investment pools which commingled the funds of the entities' MCO and non-MCO businesses.

To supplement the results of the on-site audits, we:

- ▶ inquired about the cash flows of 114 additional MCOs by contacting representatives of all MCOs reporting total investment income of at least $10 million and of selected nationwide, regional, and individual MCOs. Using this information in conjunction with the revenue and net worth data included in HCFA's data bases and the MCOs' filings with State regulatory agencies, we estimated the investment income earned on current Medicare funds in 1996, and

- ▶ analyzed these results, together with the results of the on-site audits and analysis of generally available industry data, to estimate the investment income of the remaining 105 MCOs.

All of the MCO officials with whom we discussed our methods of estimating investment income for 1996 agreed that our approach was reasonable. The 1996 amount was then trended forward, based on a comparison of NDRR financial and enrollment data for 1996 and 1997, to estimate the investment income earned in 1997.

We did not review the internal control structure of either the MCOs or the HCFA data bases because the objectives of this audit did not require an understanding or assessment of the internal control structure. In all other respects, our review was performed in accordance with generally accepted government auditing standards as they apply to financial-related audits. Field work was conducted at the locations noted at Appendix B and at the Office of Audit Services in New York City between April 1998 and March 1999. In addition, follow-up work was performed in June 2000 in response to HCFA comments.

FINDINGS AND RECOMMENDATIONS

There is no present requirement for MCOs with risk contracts to account for investment income. For example, investment income earned by risk-based MCOs is not currently considered in setting the MCO rates, nor is an MCO required to factor investment income into its annual

presentation to HCFA of estimated revenue requirements (the ACR proposal). As a result, an MCO with a risk contract is not required to use investment income to reduce Medicare expenses as MCOs with cost contracts must do, or to refund investment income to the Federal government as contractors in the FFS Medicare program must do.

We estimated investment income earned on the "float" (i.e., earnings on Medicare funds during the time lapse between the receipt of HCFA funds and the use of those funds by MCOs) at slightly over $100 million for 1996 and $129 million in 1997. In addition, four of the six plans audited on-site reported increases in investment income for 1998.

The MCO rates were based on 95 percent of FFS expenditures to recognize the efficiencies of MCOs and still allow the MCOs to offer additional benefits beyond basic Medicare coverage. Financially astute MCOs were able to invest their current funds at 5 to 5-1/2 percent interest[3]. Thus, the current guidelines, which do not hold the MCOs accountable for investment income earned on current funds, effectively allow MCO funding to exceed the levels envisioned by Congress.

The MCOs' investment income for 1996 may have exceeded $100 million.

Although several Federal and State government industry regulators deemed investment income earned by risk-based MCOs too immaterial to merit regulation, we estimate that over $100 million in investment income was earned on the "float" attributable to the time lapse between the receipt of HCFA funds and the use of those funds during 1996.

As previously noted, the review consisted of three types of analysis which are summarized below:

Estimation Basis	Number of MCOs	Estimated Investment Income
Audits (6 locations)	11	$ 11.3 million
MCO Cash Flows	114	$ 62.3 million
Analysis of MCO Data	105	$ 26.6 million
TOTAL	230	$100.2 million

During on-site audit work at 6 locations, we analyzed the investment income earned by 11 MCOs. The audits included analyses of financial information such as the MCOs' total investment income, accumulated earnings, and current year revenues. In addition, we inquired about, and analyzed documentation related to, the MCOs' investment policies and cash flows (e.g., contracts and lag reports documenting when the MCOs pay their health care providers). At the conclusion of each audit, we discussed the estimation methodology with MCO officials. In

[3]The average 5 percent earnings during the short-term 40 day float investment period equals an annualized rate of return of 0.4 percent of the total Medicare funds paid annually to MCOs.

each instance, the MCO officials agreed with the methods used and the resulting estimates of the investment income earned on current Medicare funds.

The audit results at these six locations are summarized below:

RESULTS OF SIX ON-SITE AUDITS

AUDIT SITE	Revenues		Investment Income		
				Estimated Medicare Amount	
	Total	Medicare Portion	Total	Medicare Total	$ per Medicare Member Month
1	$911,852,002	$434,356,046	$19,418,473	$3,059,000	$3.10
2	832,887,350	381,460,963	9,750,549	874,352	$1.36
3	4,312,181,000	1,100,279,000	17,045,539	2,928,037	$1.61
4	396,671,997	267,111,521	3,436,347	1,047,490	$1.56
5	284,027,438	76,736,925	4,571,196	83,991	$0.55
6	1,566,763,743	403,213,056	15,481,880	3,331,448	$5.11
TOTAL	$8,304,383,530	$2,663,157,511	$69,703,984	$11,324,318	$2.30

As noted above, the estimated 1996 investment income on Medicare funds for the six MCO locations audited ranged from $.55 to $5.11 per Medicare member month. These amounts might appear to be immaterial when considered on a per member per month basis. However, the audit results at these six locations, as confirmed by MCO officials, estimated the investment income earned on 1996 Medicare revenues at $11.3 million.

In addition to the 6 on-site audits, we contacted officials at 114 MCOs by phone to obtain information on their cash flows. This cash flow information was then applied to financial measures such as the MCOs' total investment income, accumulated earnings, and current year revenues. Based on this analysis, it is estimated that the 114 MCOs earned investment income of $62.3 million on Medicare funds during 1996.

For the remaining 105 MCOs, the estimate of Medicare investment income was based on the MCOs' financial information maintained on HCFA data bases. To consider the possibility that local competition and market conditions could affect the cash flows of the 105 MCOs, we calculated the investment income through a series of analyses. The cash flow information for the 105 MCOs was estimated from published articles, data obtained from State regulators, and the results of our analyses of the other 125 MCOs. As a result of this analysis, it is estimated that the 105 MCOs earned $26.6 million in investment income on current Medicare funds for 1996.

In total, the estimate of 1996 investment income on current Medicare funds amounted to $100.2 million. In addition, we estimated that the plans earned over $129 million in investment income during 1997 (see Appendix A for details). Finally, the 1998 investment income earned at the six locations where on-site audits were conducted indicates that significant investment income was earned by at least some Medicare risk-based MCOs in 1998, as well.

By comparison to the investment income earned by the MCOs above, grantees receiving Federal funding from PHS can only draw cash sufficient to cover anticipated expenses and can only retain up to $100 in investment income per fiscal year. It is noteworthy, too, that the $100 limit for PHS grantees applies to the total funds advanced from all Federal agencies.

Since risk-based MCOs are not required to report the investment income earned on current Medicare funds, this investment income essentially represents both undisclosed revenues, and in many cases, additional profits which are generally unavailable to other entities funded by the Federal government.

The MCO rates are based on the costs of the Medicare FFS program, but the two programs are funded differently. Medicare funding mechanisms only give MCOs the opportunity to earn investment income.

As a result of an important difference in the funding of the Medicare FFS and MCO programs, the MCOs have an opportunity to earn significant amounts of investment income.

Medicare risk-based MCOs receive a predetermined payment for each of their members by the first day of every month, but contractors (i.e., fiscal intermediaries and carriers) who pay providers in the Medicare FFS program are generally funded only as expenses are paid. Thus, the FFS contractors do not have an opportunity to earn investment income.

The HCFA's cash management instructions for Medicare FFS contractors are based on guidelines issued by the Department of the Treasury which generally prohibit recipients of cash advances from earning investment income on Federal funds. While it is our understanding that these instructions do not apply to the risk-based MCO program, the intent of the regulations at 31 CFR 205 (Treasury Circular 1075), like the HCFA guideline discussed above, is to establish policy regarding advance financing of Federal programs in order to minimize the impact of such payments on the level of the public debt and related financing costs.[4]

Nevertheless, risk-based MCOs, unlike other entities funded by the Department of Health and Human Services or other MCOs funded by the Federal government (including Medicare MCOs paid under a cost reimbursement contract), are under no obligation to account for investment income generated by the funds received from the Medicare program.

An MCO with a risk contract is not required to use investment income to reduce Medicare expenses.

Cost-based providers such as Medicare cost-based MCOs receive periodic payments based on their actual costs and are held accountable for investment income. In reconciling costs to interim payments received, investment income from any source is generally deemed to have been generated from patient care funds. In such instances, the cost-based MCO, like other cost-based providers in the Medicare program, must reduce reported interest expense by investment

[4]For a further discussion of HCFA and Treasury guidelines on the funding of the FFS Medicare contractors, see Appendix C.

income in determining the allowable interest expense.[5] However, an MCO with a risk contract is not required to use investment income to reduce Medicare expenses.

MCOs participating in the Federal Employees' Health Benefits Program are not prepaid.

Insurance companies offering MCO coverage through the Federal Employees Health Benefits (FEHB) Program have little opportunity to earn investment income on premiums. This is because the Office of Personnel Management (OPM) pays most MCOs in the FEHB program about 45 days after the start of each coverage period. The remaining MCOs in the FEHB program draw OPM funds as checks are presented to a bank for payment.

MCOs participating in the TRICARE Program are not prepaid.

Under the TRICARE program, formally known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), health care that is not available or accessible in a military medical treatment facility is purchased in the private sector. For military dependents and retirees, the cost of such care is financed through risk-sharing contracts which offer participants the choice of a triple option benefit: TRICARE Standard which is the fee-for-service option; TRICARE Extra which is the preferred provider option; and TRICARE Prime which is the HMO or managed care option. TRICARE was established for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services. TRICARE contracts are awarded through the competitive process based on total contract cost. TRICARE contractors are paid $1/12^{th}$ of their competitive bid per month. Unlike Medicare, payments to managed care contractors under TRICARE are made in the month following the coverage period.

MCO commercial plans

The Medicare risk-based MCO program was based on the MCOs' commercial lines of business. Managed care organization officials informed us, however, that although commercial accounts are billed on a prepayment basis, they do not generally prepay the MCOs by the first of the month, as Medicare does, but rather at a later date.

The prompt payment provisions do not generally apply to risk-based MCOs.

Another difference between the Medicare FFS and MCO programs relates to the prompt payment provisions. This standard requires that Medicare's FFS contractors must pay a "clean" claim within 30 days of receipt. For non-"clean" claims, an initial determination is to be rendered by the MCO or FFS contractor within 60 calendar days of receiving the request for payment or services.

In the MCO program, however, the 30-day standard only applies to payments to an MCO's out of network providers. For network providers, who provide the bulk of the services for MCO

[5]Health Insurance Manual #15-1, § 202.2

members, the MCO payments are subject only to the terms of the provider contract (which cannot exceed a period of 60 days under HCFA regulations). Thus, an MCO generally has the opportunity to earn investment income on current funds until it is contractually obligated to pay its network providers.

Medicare's risk-based MCOs have a unique opportunity to earn investment income, without any accountability to the Federal government.

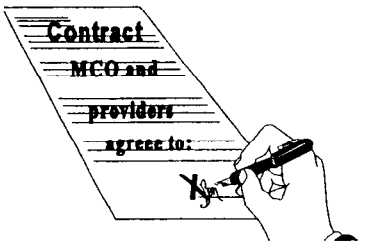
Since Medicare risk-based MCOs receive their capitation payments on a prepayment basis at the start of every month, they may have the opportunity to earn investment income over a substantial time frame.

Our analysis of cash flow information provided by the MCOs indicates that they were able to invest HCFA funds for periods ranging from 9 to 90 days.[6]

For example, investment periods can be quite significant in instances when an MCO reimburses its network providers on an FFS basis. In such instances, the MCO can earn investment income on current funds beginning from:

- the start of a month (when HCFA pays the MCO), through
- dates when services are rendered (which could be any time from the start through the end of any month), through
- dates when providers file claims, and finally
- up to 30 days after the claim is received by the MCO (and until the time the claim is actually paid).

The organizations audited on-site and those furnishing their cash flow information to the Office of Inspector Genreal (OIG) included MCOs which rely heavily on capitated network providers and others which mainly dealt with providers on an FFS basis. The heavily capitated MCOs deal primarily with network providers who are paid according to the terms of a contract between the MCO and the provider. The contracts observed by the OIG generally provided for payments to network providers in periods significantly shorter than the 60 days permitted under the HCFA guidelines and, in some instances, stipulated payments within periods shorter than those required by the prompt payment standard. Nevertheless, our analysis of MCO contracts, financial, and claims processing records indicated that the MCOs had an opportunity to invest current funds and earn significant amounts of investment income during these interim periods.



[6]The median investment period among the MCOs reporting 1996 cash flow information to the OIG was 40 days.

Conclusion

Based on the analyses of investment income for all Medicare risk-based MCOs for 1996 and 1997 and the analysis of the MCOs covered at the six on-site locations for 1998, we concluded that the MCOs earned substantial income by investing Medicare funds until they are needed for services furnished to Medicare beneficiaries.

As previously noted, we estimated the investment income on current Medicare funds for 1996 at about $100 million for the 230 Medicare risk plans included in our review. In addition, we estimated the 1997 amount at over $129 million. Finally, our analysis of the limited 1998 data presently available suggested that the amounts for 1998 are also quite substantial.

We encourage HCFA to study the audit results, consider the significance of the amount of investment income generated by current Medicare funds and review the recommendations below which suggest means to improve the cash management of the risk-based MCO program.

Recommendations

We recommended that HCFA pursue legislation to:

- adjust the timing of Medicare's prepayments to MCOs to maximize the Health Insurance Trust Funds earnings while minimizing the opportunity MCOs have to earn investment income on Medicare funds, or
- adjust the MCO payment rates to recognize the impact of investment income on the total funding available to MCOs for servicing their Medicare enrollees.

Until such legislation is enacted, we would recommend that HCFA develop policies on tracking, estimating, and reporting investment income through measures which could:

- adjust the ACR budgeting process to recognize and account for the investment income earned on Medicare funds,
- improve the cash management of the risk-based MCO program by working with the MCOs to develop policies to hold MCOs accountable for investment income, and
- assure that investment income funds are used for program purposes and to benefit Medicare enrollees.

HCFA Comments

The HCFA agreed that their policies should hold MCOs accountable for investment income earned on current Medicare funds and should assure that this investment income is used to benefit Medicare enrollees.

With respect to the specific recommendations, HCFA:

- stated that they share our concerns about the timing of Medicare's prepayments to MCOs;

- did not specifically address the matter of pursuing legislation to adjust the MCO payment rates;

- did not concur with the recommendation to adjust the ACR budgeting process because they note that the ACR process can account for investment income in instances when an MCO includes investment income in its ACR filing;

- agreed that they need policies which could hold the MCOs accountable for investment income; and

- agreed that they need policies which could assure that investment income funds are used in ways that would benefit Medicare enrollees.

In addition, HCFA stated that they lack the authority to either require an MCO to include investment income in the ACR filings, or to require that investment income be used in a particular way (e.g., to benefit Medicare enrollees). The HCFA also indicates that they do not presently intend to propose any legislation which might be needed to implement the recommendations. Finally, the HCFA notes that our estimate of investment income could be overstated if MCOs have considered investment income in their ACRs.

OIG Response

The HCFA agreed that their policies should hold MCOs accountable for investment income earned and should assure that this investment income is used to benefit Medicare enrollees, but appears to place a great deal of reliance on the ACR budgeting process as a means to accomplish these ends and to improve the cash management of the MCO program.

While we agree that the ACR has the potential to provide an appropriate means of monitoring and accounting for investment income, we note that our experience indicates that this is rarely the case in practice. For example:

- our discussions with State insurance commissioner offices that monitor this industry in the 39 States with risk-based MCOs during the audit period indicate that only two of the 39 States required MCOs to offset a portion of their investment income against the expenses;

- according to the results of our on-site audits at 11 MCOs and our direct inquiry of 114 MCOs, representatives of only 6 of these 125 MCOs asserted that they factor investment income into their ACR calculations. Even among these entities, however, our evidence indicates that several of these MCOs never actually used their investment income for the Medicare MCO program; and

- our discussions with representatives of the actuarial consulting firms that assisted the MCOs in preparing the majority of the year 2000 ACR proposals indicate that neither their clients nor these firms account for investment income on their ACRs.

Therefore, we believe that HCFA should give serious consideration to legislation which would address our mutual concern that investment income should be used to benefit Medicare enrollees. In the meantime, HCFA should, at a minimum:

- encourage the MCOs to include investment income on current Medicare funds in the ACR filings, and

- revise the examination guides used for the ACR audits required under the BBA of 1997 to ensure that these audits determine the extent to which this investment income is included in the ACR filings.

Since the ACR process, as presently implemented, is not an effective mechanism to address our mutual concerns, we also believe that HCFA should pursue legislation which would address the discrepancies between the timing of payments to Medicare risk-based MCOs and the MCOs participating in other Federal programs.

Finally, in its technical comments, the HCFA raised an issue which may indicate a misunderstanding of the audit objective and recommendations. Specifically, HCFA cites regulations which prohibit an MCO from recognizing certain investment losses on the ACR proposal. We take this opportunity to reiterate that the audit objectives and recommendations relate only to investment income earned on the "float" --- i.e., investment income earned on HCFA's prepayments between the time the MCO receives these funds and the time when these funds are disbursed. It is our firm belief that while losses may occur on longer term investments, a prudent MCO's investment of these short-term funds is highly unlikely to produce an investment loss.

We have modified this final report to take into account HCFA's comments to our draft report.


APPENDICES

STATISTICAL SUMMARY

MEDICARE RISK-BASED MANAGED CARE ORGANIZATIONS

Medicare Enrollment in Plans with Risk Contracts as of December 1996

	Medicare Enrollment	# of Plans
Individual Practice Arrangements	2,544,291	161
Group Model Plans	816,861	49
Staff Model Plans	748,385	20
TOTAL	4,109,537	230
For-Profit Plans	2,832,559	161
Non-Profit Plans	1,276,978	69
TOTAL	4,109,537	230

Financial Analysis

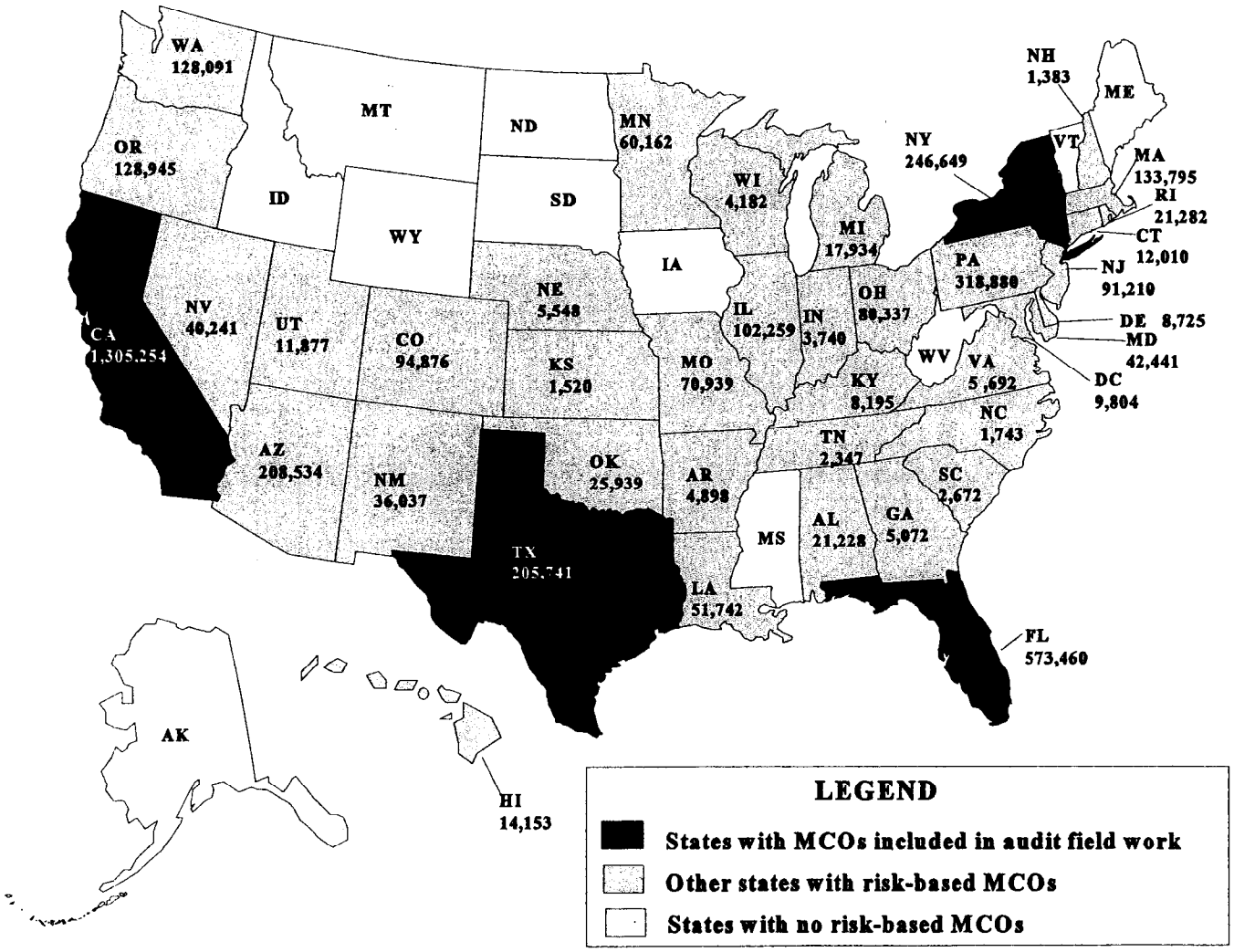
Number of Financial Filings for the 230 MCOs	175
Total Revenues	$80,410,557,108
Medicare Premium Revenues	$20,224,948,500
Total Investment Income	$887,891,565

Estimated Investment Income Earned on 1997 Medicare Revenues

$129,470,054

The 1997 estimate was developed by comparing total investment income per member per month in 1997 and 1996. For both years, this information was obtained from HCFA's data bases. The 1996 estimate of Medicare investment income, $100,275,826, was trended forward to 1997 by applying the ratio of 1997 to 1996 total investment income per member per month to the 1996 estimate of Medicare investment income.

POPULATION OF MEDICARE BENEFICIARIES ENROLLED IN RISK-BASED MCOs AS OF DECEMBER 1996



Audit field work was conducted in four States with significant Medicare enrollments. There were also risk-based MCOs in 35 other States and the District of Columbia. We contacted MCO officials representing plans in 25 of these States (and the District of Columbia) about the cash flows of their MCOs.

HCFA and Department of Treasury Guidelines on Funding of Federal Programs

The HCFA's cash management instructions for contractors in the Medicare FFS programs are based on guidelines issued by the Department of the Treasury. These guidelines, which do not apply to the risk-based MCO program, generally prohibit recipients of cash advances from earning investment income on Federal funds.

HCFA Guidelines - The "letter-of-credit checks paid method" of financing Medicare benefits paid by contractors in the FFS program reduces the Federal debt by postponing cash withdrawals until checks are presented to a contractor's bank for payment. To obtain Federal funds, the contractors' banks forward daily payment vouchers to the Federal Reserve Bank. The daily voucher amount must equal total checks paid, electronic payments, and bank debit memos, less any balance in the accounts resulting from amounts collected (such as refunds of overpayments, interest collected, payments stopped, or voided), or any other credits. The banks are also expected to assure that the daily voucher amount is the minimum amount required to finance current disbursements. In addition, the banks maintain a time account. Use of the time account precludes the excessive use of Federal funds by delaying deposits to the account until contractors' checks clear.[7]

With respect to claims for FFS contractors' administrative costs, funds are drawn in line with periodic expenditures; excess administrative funds drawn are to be adjusted within 30 calendar days of preparing the monthly interim expenditure report. If costs claimed on the annual reconciliation are less than the administrative funds drawn, current cash draws for administrative costs are to be reduced to account for the excess funds drawn for the prior fiscal period.[8]

Treasury Guidelines - The HCFA's cash management instructions for Medicare FFS contractors are based on guidelines issued by the Department of the Treasury which generally prohibit any recipient of cash advances from earning investment income on Federal funds. The intent of the regulation at 31 CFR 205 (Treasury Circular 1075), like the HCFA guidelines, is to establish policy to minimize the impact of advance financing of Federal programs on the level of the public debt and related financing costs. The regulation applies to any "...organization outside the Federal Government (including any State and local government,...and any other public and private organization) receiving cash advances under Federal grant and other programs." The regulation, however, apparently does not apply to the Medicare MCO program.

Implementing instructions at section 2040.10 of the Treasury Financial Manual (TFM) prescribe use of the "Letter-of-Credit Method" when a Federal program agency has a continuing relationship with a recipient organization for at least 1 year involving annual advances aggregating at least $120,000. The instruction also explains that:

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[7]Medicare Intermediary Manual §§ 1400, 1408, 1412.1; Medicare Carriers Manual §§ 4400, 4409, 4412.1

[8]Medicare Intermediary Manual §§ 1300, 1340, 1363; Medicare Carriers Manual §§ 4340, 4363

> The letter-of-credit method enables the recipient organization to withdraw Treasury funds with no time lag between the receipt of Federal funds from Treasury and disbursement by the recipient organization.

For instances when the annual advances are expected to be less than $120,000, the instructions prescribe the "Direct Treasury Check Method" whereby a Federal program agency should schedule advances so the funds are available to an organization only immediately prior to their disbursement by the organization.[9]

Finally, according to the instructions at section 2075.30a of the TFM, any interest income earned by a recipient organization on Federal funds must be promptly refunded to the Federal program agency unless specifically prohibited by law.

[9]Treasury Financial Manual § 2030

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administra

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ExecSec
Date Sent 6/15/

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Results of the Audit of Investment Income Earned by Managed Care Organizations"

Thank you for the opportunity to review the above-mentioned report.

The Health Care Financing Administration (HCFA) shares the OIG's concerns that managed care organizations (MCOs) should be held accountable for the $100 million in investment income that you estimate MCOs earned from Medicare+Choice (M+C) capitation payments. Further, we agree that investment income should be used to benefit Medicare enrollees. That is why the current system already allows for this to take place.

As discussed in the attachment, the law permits the current Adjusted Community Rate (ACR) calculation to reflect an average Medicare rate adjusted for investment income. In fact, if an MCO takes investment income into account in the determination of the premiums it charges for its commercial products, it would follow from the ACR process that this investment would also be taken into account for purposes of their Medicare products. However, Congress would need to change the law in order for HCFA to require that investment income always be taken into account in the Medicare ACR process or to require in all cases that investment income be used in a particular way.

Also, we believe that adjustments to the overall payment process for M+C should only be made after carefully considering all aspects of the program. Given the growing array of so-called "over-payments" and "under-payments" that M+C plans receive compared to fee-for-service equivalence, we are concerned that any proposed changes, such as the OIG's recommendations related to investment income, should only be implemented as part of a comprehensive proposal --not on a piecemeal basis. As always, the affect of any changes in M+C will be evaluated with our primary goal in mind --making sure that beneficiaries receive the care they need and deserve. Also, HCFA will carefully evaluate how any proposed changes affect the stability of M+C.

We thank the OIG for examining this issue and look forward to working with you to find ways to better serve Medicare's beneficiaries.

Attachment

Comments of the Health Care Financing Administration on the OIG Draft Report: "Review of the Audit of Investment Income Earned by Managed Care Organizations with Risk Based Contracts (A-02-98-01005)

OIG Recommendation

OIG recommends that HCFA work with the managed care organization (MCO) community to develop policies (such as tacking, estimating, and reporting investment income) which could hold MCOs accountable to the Medicare program for investment income earned on Medicare funds. In addition, OIG recommends that HCFA work with the MCOs to assure investment income is used to benefit Medicare enrollees.

HCFA Response

We concur with this recommendation. HCFA shares the OIG's concerns that MCOs should be held accountable for the $100 million in investment income that you estimate MCOs earned from Medicare+Choice (M+C) capitation payments. Further, we agree that investment income should be used to benefit Medicare enrollees. That is why the current system already allows for this to take place.

The law permits the current Adjusted Community Rate (ACR) calculation to reflect an average Medicare rate adjusted for investment income. In fact, if an MCO takes investment income into account in the determination of the premiums it charges for its commercial products, it would follow from the ACR process that this investment would be taken into account for purposes of their Medicare products. However, Congress would need to change the law in order for HCFA to require that investment income always be taken into account in the Medicare ACR process or to require in all cases that investment income be used in a particular way. Section 1854 of the Social Security Act is very specific and incorporates the definition of "community rating system" in section 1302(8) of the Public Health Service Act, which grant's MCOs with discretion in establishing the "initial rate" that is then adjusted for the Medicare population to determine the ACR amount.

Also, we believe that adjustments to the overall payment process for M+C should only be made after carefully considering all aspects of the program. Given the growing array of so-called "over-payments" and "under-payments" that M+C plans receive compared to fee-for-service equivalence, we are concerned that any proposed changes, such as the OIG's recommendations related to investment income, should only be implemented as part of a comprehensive proposal --not on a piecemeal basis. For example, the President has proposed a Medicare prescription drug benefit that would subsidize drug costs to M+C organizations and provide them with fiscal relief. Any changes made to the

payment structure for M+C would need to account for this and any other payment proposals. As always, the affect of any changes in M+C will be evaluated with our primary goal in mind --making sure that beneficiaries receive the care they need and deserve. Also, HCFA will carefully evaluate how any proposed changes affect the stability of M+C.

OIG Recommendation

Alternatively, HCFA pursue legislation to:

- adjust timing of Medicare's prepayments to MCOs thereby, minimizing MCO's opportunity to earn investment income from Medicare funds; or,

- adjust MCO payment rates to recognize the impact of investment income on the total funding available to MCOs for servicing their Medicare enrollees.

HCFA Response

As discussed above, we share the OIG's concerns regarding the timing of payments. However, we believe that the issue of investment income should be examined in the context of the larger program and not addressed on a piecemeal basis.

Technical Comments

We have concerns about the methodology used by the OIG in making this recommendation. The OIG assumes that MCOs are not required to account for investment income in setting rates for Medicare enrollees yet the Adjusted Community Rate calculation does reflect investment income in some cases. Therefore, it is important to think of the $100 million estimate as an upper bound.

In its draft audit report, the OIG states:

> "For example, the Health Care Financing Administration (HCFA) does not currently consider investment income earned by Medicare risk-based MCOs in setting MCO rates. In addition, HCFA does not require an MCO to factor investment income into its annual presentation of its estimated revenue requirements (the Adjusted Community Rate (ACR) Proposal)."

Page 3 -- Response on Investment Income Earned by Managed Care Organizations

Although the Social Security Act does not require an MCO to take into account investment income when establishing its non-Medicare charges, MCOs may consider investment income when non-Medicare charges are established. If an MCO considers investment income when establishing its non-Medicare charges, the ACR methodology automatically adjusts the MCO's average Medicare rate.

The first element of the ACR calculation is the Initial Rate (the average rate the M+C organization charges all non-Medicare enrollees for its benefit packages). The Initial Rate is then modified for differences in utilization characteristics between the Medicare and non-Medicare populations thereby producing the ACR. Therefore, to the extent the MCO has taken into account investment income in developing its charges to the non-Medicare population, the ACR will reflect an average Medicare rate adjusted for investment income.

For example, assume the following per member per month costs for an MCO:

The average non-Medicare rate without considering Investment Income	$150.00
Average investment income of non-Medicare enrollees	$ 5.00
The organization's factor representing differences in utilization characteristics (usually between 3.0 and 5.0) for basic benefits	4.0

If the MCO considers investment income in establishing its non-Medicare rates, the Initial Rate for ACR purposes is $145.00 ($150.00 - $5.00). The ACR would then equal $580.00 ($145.00 x 4.0) for Medicare covered and additional benefits instead of $600.00 ($150.00 x 4.0). In those years where the MCO incurs an investment loss or any loss, 42 CFR 422.310(b)(5) prohibits the MCO from including any losses experienced in a previous year in the current Initial Rate. To the extent the MCO expects no investment income, or expects an investment loss in the future, the Initial (non-Medicare) Rate, and consequently the ACR, will be higher than it would have been otherwise.

Thus, the ACR does adjust for investment income when the MCO uses investment income to partially fund its non-Medicare charges for premiums and cost sharing. A review of the actuarial assumptions and accounting methods used by MCOs in their rate-setting process for non-Medicare enrollees might confirm that MCOs use investment income to partially fund their non-Medicare charges for premiums and cost sharing. If this investment income offset is considered, the OIG estimates would be significantly reduced.