United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

August 1988

MEDICARE

Experience Shows Ways to Improve Oversight of Health Maintenance Organizations

GAO/HRD-88-73

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-217802

August 17, 1988

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

This report, ~~in response to your request~~, discusses problems with the Health Care Financing Administration's (HCFA) ability to deal decisively with health maintenance organizations (HMOs) with compliance problems that they are either unwilling or unable to resolve in a timely manner.

The report contains a matter for the Subcommittee's consideration regarding increasing HCFA's discretion in applying its authority to suspend Medicare enrollments in HMOs that fail to take timely actions to resolve, or show substantial progress toward resolving, Medicare compliance or financial problems.

The report recommends that the Administrator of HCFA be directed to (1) issue regulations specifying the purpose, circumstances, and procedures for authorizing retroactive disenrollments and (2) establish a formal tracking system to follow requests for corrective actions and the subsequent actions taken by the HMOs.

As arranged with your office, we are sending copies of this report to the Secretary of Health and Human Services, the Administrator of HCFA, other congressional committees, and interested parties.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

The number of health maintenance organizations (HMOs) contracting with Medicare on a risk basis to provide comprehensive services to beneficiaries has grown rapidly, from about 32 in April 1985 to over 130 in January 1988. Likewise, the number of Medicare enrollees in HMOs increased from about 300,000 to nearly 1 million. HMOs offer the potential to reduce Medicare costs, but federal oversight is required to assure that excessive cost cutting does not reduce the quality of care. One contractor, International Medical Centers, Inc. (IMC), which had the largest Medicare enrollment of any HMO, experienced a series of problems with financial solvency and quality of care before ultimately becoming insolvent and being placed in receivership in May 1987.

This report is the result of congressional concerns about the rapid growth of Medicare HMOs, their compliance with federal standards, and the adequacy of federal oversight. The Chairman of the Subcommittee on Health, House Committee on Ways and Means, asked GAO to review (1) the adequacy of data available to determine if HMOs provide quality care at reasonable cost; (2) the adequacy of staffing levels for monitoring HMOs; and (3) the willingness of the Health Care Financing Administration (HCFA), which administers Medicare for the Department of Health and Human Services (HHS), to take action when HMOs are not meeting federal requirements.

Background

HMOs, which contract with Medicare on a risk basis, agree to provide covered services for a predetermined fixed amount per person (or capitation rate) and are thus at risk of financial loss if costs exceed the Medicare payments. Capitation creates strong incentives for HMOs to contain costs, but without adequate safeguards, excessive cost cutting could lead to lowered quality of care. Existing legislation provides federal safeguards against excessive cost cutting and requires that before approving a Medicare contract, HCFA review and find acceptable such factors as the HMO's financial soundness, its quality assurance systems, and the availability and accessibility of services. To help assure continued compliance, HCFA's central and regional offices monitor HMOs.

Results in Brief

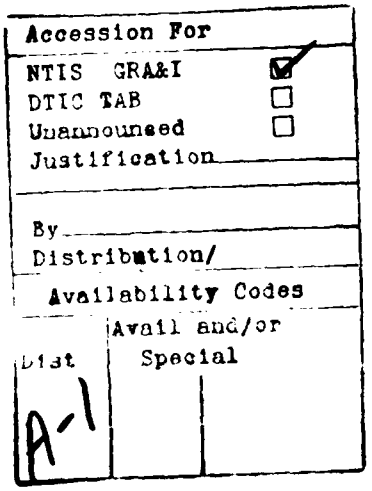
HCFA has relatively limited data with which to monitor HMOs' quality of care and the reasonableness of HMO capitation rates. But available data could be used more effectively. More data will become available as a result of HCFA's initiation in mid-1987 of HMO external peer review and of a system to compile and analyze information from complaints.

HCFA's staffing for compliance monitoring, though increased, has not kept pace with HMO growth, a problem HCFA officials acknowledge. To increase staff productivity, in mid-1987 HCFA initiated a more systematic compliance monitoring approach and is developing better data systems to track complaints against HMOs. Also, HCFA contracted with independent review organizations to conduct peer reviews of HMOs' quality of care. It is too soon, however, to assess the effect of these efforts.

Through monitoring of the HMOs, HCFA has identified numerous problems. Most were resolved quickly after the HMO was notified, but a few HMOs were unresponsive to HCFA's requests for corrective actions. While HCFA tried to resolve these problems, the practical effect often was little more than to document the problems. In each such instance that GAO reviewed, HCFA could have acted more quickly and forcefully. Additional sanction authority could prompt HCFA to do so.

GAO's Analysis

Data Limited for HCFA Oversight



Because the contractor HMOs (instead of Medicare) pay providers, HCFA has no data on individual HMO members' use of physician or outpatient services and only limited (and incomplete) data on inpatient services. The absence of such data means that HCFA cannot screen its files to identify providers having aberrant utilization or charge patterns, a procedure it employs in the regular Medicare program.

The data HCFA does receive are those needed to monitor HMOs' compliance with financial solvency requirements (such as balance sheet and income data) and to calculate HMO payments (primarily enrollment data). These data are not intended to be used for monitoring HMO quality of care. GAO identified several ways HCFA could enhance HMO monitoring, however, by better use of available data. For example, computing HMO disenrollment rates could give HCFA an early indicator of potential problems with HMO marketing and/or quality as high rates have occurred in HMOs having such problems.

HCFA's recent initiation of HMO peer reviews should increase its ability to monitor HMO quality, as should its initiation of a system for tracking complaints. Before these efforts, HCFA did not systematically review the care being provided to HMO members or effectively use complaints as a source for identifying potential problems.

Staffing Lags HMO Growth

The number of risk HMOs and Medicare enrollees increased substantially since 1985, but HCFA's staff for monitoring them has not kept pace. Also, HCFA has spent most of its monitoring resources on resolving the problems of a few HMOs, such as IMC, instead of routinely monitoring all HMOs to help forestall problems. During the program's first 27 months, over half of HCFA's central office site visits were to IMC.

To remedy the situation, HCFA began implementing new monitoring procedures in July 1987 that require each HMO to be reviewed at least every 2 years. HCFA expects this will help it identify and resolve problems early, but believes that additional staff will be needed. Whether additional staff are needed will depend on the extent and nature of problems disclosed by the new monitoring system and the two additional data-gathering and review efforts. (See p. 34.)

Compliance Process Limited—Broader Authorities Needed

When HMOs are willing and able to correct compliance problems, resolution is generally timely. In a few instances, however, HCFA was unable to ascertain from its records whether identified compliance problems were resolved. This occurred because HCFA does not have a system for tracking all compliance problems until they are resolved. Also, a few HMOs have had recurring compliance problems or were either unresponsive or untimely in responding to HCFA's requests for corrective action. GAO selected three such HMOs as case studies on the compliance process and its limitations. These cases provide examples of compliance problems involving financial solvency, marketing practices, and in the IMC case, a broad range of issues related to financing, quality of care, and general management.

The cases show that an HMO's compliance problems can develop gradually over a number of years, during which time the HMO is often free to continue enrolling beneficiaries. Ironically, an increasing Medicare enrollment in an HMO can itself become a reason for HCFA not to terminate a contract where problems persist. For example, in the face of continuous compliance problems but fearing adverse effects of termination on Medicare beneficiaries, HCFA permitted IMC to grow from about 5,000 Medicare enrollees in 1981 to about 135,000 before capping Medicare enrollment in 1986. (See p. 44.)

In each of the three cases studied, instead of termination, HCFA chose to continue working with the HMO. This is the preferred course of action when there is prompt and significant progress toward compliance—but not when such progress is absent.

During the early phases of the HMO program, HCFA could do little with a noncompliant HMO short of terminating its contract. Legislation in 1986 and in December 1987 gave HCFA the authority to prevent the enrollment of additional Medicare beneficiaries in an HMO experiencing certain specific compliance problems, such as submitting inaccurate data to HCFA. But these sanctions cannot be applied to all the problems identified in GAO's three case studies. Among the problems for which HCFA cannot suspend enrollment are those involving fiscal soundness and certain marketing and enrollment practices.

Regulations Needed

Another problem GAO identified in the case studies is the lack of regulations stipulating the circumstances under which HCFA will authorize "retroactive disenrollments." These occur when HCFA changes its records to nullify an enrollment, usually because the Medicare enrollee either did not know he or she was enrolled or did not understand the HMO member's obligations. Typically, such a beneficiary uses non-HMO providers without the HMO's approval and becomes liable for the cost of the services. Retroactive disenrollment switches the beneficiary back to the regular Medicare program, relieving the beneficiary of financial liability. Use of retroactive disenrollment by HCFA for one HMO nearing bankruptcy resulted in about $2 million in Medicare outlays that may not have been warranted.

Matter for Consideration by the Subcommittee

The Subcommittee should consider developing legislation to give HCFA broader discretion to suspend Medicare enrollments in HMOs that—for whatever reason—fail to make substantial progress toward meeting Medicare requirements.

Recommendations to the Secretary of HHS

GAO recommends that the Secretary direct the Administrator of HCFA to (1) issue regulations on retroactive disenrollments and (2) establish a tracking system for all HMO compliance actions.

Agency Comments

HHS, in commenting on a draft of this report, agreed with GAO's recommendations to the Secretary. HHS also provided technical comments, which have been considered in finalizing the report.

Contents

Tables

Abbreviations

ACR	Adjusted Community Rate
BITS	Beneficiary Inquiry Tracking System
BSHC	Bay State Health Care
CMP	competitive medical plan
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IG	Inspector General
IMC	International Medical Centers, Inc.
NDRR	National Data Reporting Requirements
OPHC	Office of Prepaid Health Care
PHS	Public Health Service
PRO	peer review organization
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
UHP	United Health Plan

Chapter 1

Introduction

The Medicare program, which began operation July 1, 1966, was authorized by the Social Security Amendments of 1965, which added title XVIII of the Social Security Act. Medicare pays much of the health care costs for eligible persons age 65 or older. In 1972, the program was extended to provide protection to certain disabled persons and to individuals suffering from kidney (renal) failure. Medicare is administered by the Health Care Financing Administration (HCFA), a component of the Department of Health and Human Services (HHS).

Medicare provides two forms of protection:

- Part A—Hospital Insurance for the Aged and Disabled—covers services furnished by institutional providers, primarily hospitals, home health agencies, and, after a hospital stay, skilled nursing facilities. Inpatient care is subject to various deductible and coinsurance amounts. Part A is principally financed by taxes on earnings paid by employers, employees, and self-employed persons. During calendar year 1987, about 31 million people were eligible for part A benefits, and benefit payments were about $50 billion.
- Part B—Supplementary Medical Insurance for the Aged and Disabled—covers (1) physicians' services, (2) outpatient hospital care, and (3) other medical and health services, such as X-ray and laboratory services. This insurance generally covers 80 percent of the reasonable charges for these services, subject to an annual $75 deductible. Enrollment is voluntary. Part B is financed by beneficiaries' monthly payments and by appropriations from general revenues. During calendar year 1987, an average of 30.9 million people were enrolled, and part B benefit payments were nearly $30 billion, of which about 25 percent was financed by enrollees' premiums and about 75 percent by appropriations.

HCFA administers Medicare through a network of contractors, such as Blue Cross and Blue Shield, which process Medicare claims and make payments on behalf of the government. The contractors that pay institutional providers, such as hospitals and nursing homes, are referred to as part A intermediaries; the contractors that pay for the services of noninstitutional providers, such as doctors, laboratories, and suppliers, are called part B carriers.

HMOs and Medicare

In February 1985, as part of an effort to contain the growth of Medicare costs and following a 3-year demonstration period, HHS initiated a nationwide program to expand the use of risk-based health maintenance

organizations (HMOs) and competitive medical plans[1] (CMPs) by Medicare beneficiaries. At that time, HHS published regulations implementing the risk-contracting provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97-248). This legislation made a number of amendments to the Social Security Act regarding risk contracts that enhanced their attractiveness to HMOs.

The first TEFRA risk contracts for other than demonstration purposes were executed in April 1985. These HMOs operate at risk because they contract to provide Medicare enrollees covered health care for a predetermined monthly payment, or capitation rate, for each enrollee. As a result of the TEFRA incentives, the number of HMOs with risk contracts and of Medicare beneficiaries enrolled in them have increased rapidly.

Medicare enrollment in risk-based HMOs grew during 1985 by about 54 percent, from about 304,400 to 467,400 beneficiaries; in 1986, by 79 percent, to 836,700; and in 1987, by 17 percent, to 981,150. Also, the number of risk-based HMOs grew by 228 percent during 1985 and by 38 percent in 1986. In 1987 there was an 11-percent decrease because several HMOs dropped out of the program at the end of the year. According to HCFA data, Medicare payments to risk-based HMOs more than tripled, from about $495 million in 1985 to $1.6 billion in 1986.

Because the capitation rates that Medicare pays HMOs are based on 95 percent of Medicare's average costs in the areas served by the HMOs, the program is designed to reduce overall Medicare outlays. The program also has the potential to reduce Medicare beneficiaries' overall medical costs. Under TEFRA an HMO may not retain excess profits from its Medicare capitation payments, but is required instead to use the money to give its Medicare enrollees additional services (above those required under Medicare) or reduce their premiums, or alternatively, accept lower Medicare payments.

But incentives that capitation payment provides HMOs to reduce the costs of care also create the need for program safeguards to help guard against potentially excessive cost cutting that could reduce Medicare

[1]CMPs are providers that operate like HMOs in that they provide services and are reimbursed on the basis of a predetermined fixed capitation rate. They are subject to essentially the same Medicare regulatory requirements except they are permitted greater flexibility than HMOs in how they set their commercial premium rates and the services they offer commercial members. For the remainder of this report, except where there is a distinction between HMOs and CMPs, when we use the term HMOs, it also refers to CMPs.

beneficiaries' access to and quality of care. Both the Public Health Service (PHS) Act and TEFRA provide such safeguards to help assure that the HMOs have the administrative systems, financial capacity, and minimum enrollment necessary to assume the associated risks and provide quality care.

To enter into a TEFRA risk-based contract with Medicare, HCFA requires that HMOs first receive federal qualification by demonstrating to HCFA their compliance with PHS Act requirements. To receive qualification, HCFA reviews and must find acceptable such factors as the HMO's management, market area, compliance with state requirements, quality assurance mechanisms, and the availability, accessibility, and continuity of services. The HMO must also meet certain financial solvency requirements to protect enrollees against the risks of the HMO becoming bankrupt. For instance, the regulations that implement the PHS Act require the HMO to have (1) assets greater than liabilities, (2) sufficient cash flow and adequate liquidity to meet its obligations as they become due, and (3) a net operating surplus.

The PHS Act requires federally qualified HMOs to adhere to financial solvency requirements, and the Social Security Act contains membership enrollment standards to safeguard against both insolvency and reductions in quality of care. The Social Security Act also requires that each federally qualified HMO/CMP participating in the Medicare program

- have a fiscally sound operation and a plan for handling insolvency to protect members against the risks of the HMO becoming bankrupt;
- have enrolled at least 5,000 members (rural HMOs must have 1,500 members);[2] and
- limit the number of Medicare and Medicaid enrollees to 50 percent of the total membership to help assure quality of care (on the premise that an HMO's ability to attract substantial commercial membership is itself an indication that the quality of care meets community standards).

HCFA, through its central and regional offices, monitors HMOs to assure that they meet these requirements and maintain the management and quality assurance systems necessary to participate in the Medicare program.

[2]If an HMO is a subsidiary of a larger organization that meets the 5,000 membership rule, the subsidiary HMO must still have 1,000 members before signing a contract. Rural HMOs that are subsidiaries must have 500 members.

Objectives, Scope, and Methodology

As requested by the Chairman of the Subcommittee on Health, House Committee on Ways and Means, we addressed the following questions related to HCFA's oversight of the HMO program:

1. Is HCFA collecting the type and amount of utilization, cost, and quality data necessary to determine whether the HMOs are providing quality services at a reasonable cost?

2. Does HCFA have adequate staff in its central and regional offices to closely monitor HMO operations, particularly with respect to beneficiary enrollment and disenrollment, access to services, and quality assurance?

3. From available evidence, does HCFA appear willing to take appropriate action when monitoring uncovers problems with specific contractors?

The questions arose out of congressional concerns resulting from problems Medicare experienced with International Medical Centers, Inc. (IMC), a south Florida HMO that had a long series of compliance problems before ultimately becoming insolvent and being placed in receivership by the state in May 1987.

To assess HCFA's ability to oversee the program, we reviewed HMO monitoring policies, procedures, and practices at HCFA's Office of Prepaid Health Care (OPHC), which has overall responsibility for the HMO program and at 5 of HCFA's 10 regional offices (Atlanta, Boston, Chicago, San Francisco, and Seattle). As of February 1, 1988, about 87 percent of the Medicare beneficiaries enrolled in risk-based HMOs were enrolled in HMOs located in these five regions.

At HCFA central and regional offices, we reviewed records and interviewed agency officials to determine what information they received about HMOs' activities, the staff involved in monitoring HMOs, and what actions HCFA had taken to resolve problems with specific HMOs. We focused our work on the HMO problems that HCFA had identified through its compliance monitoring process. Our work did not include an independent on-site assessment of HMO activities. We also determined the extent to which the HHS Inspector General (IG), at the central and regional levels, had reviewed HMO activities.

Additionally, we obtained the Group Health Plan Master Record File—HCFA's record of all enrollments and disenrollments for each risk-based HMO—for the period July 1985-June 1987. High disenrollment rates from an HMO can signal beneficiary dissatisfaction with its services and

potential problems with its marketing practices. Thus, we used enrollment/disenrollment data of 95 HMOs with TEFRA risk contracts to determine the percentage of enrollees that disenrolled within 1 year after they enrolled.

As part of our ongoing review of Medicare payments for services provided by HMOs, we reviewed a total of 47 Adjusted Community Rate proposals (ACRs)[2] submitted to HCFA for 19 risk-based contract HMOs and approved by HCFA for contract years 1985-87. Fifteen of the HMOs were randomly selected and four were judgmentally selected. These four were used for our detailed review of HMO records to assess the accuracy of their ACR proposals. The objectives of this effort were to determine the extent to which these HMOs were using their own data to prepare and support their ACR proposals and to determine if the proposals were prepared in accordance with HCFA guidelines and instructions. This work was done at agency headquarters in Baltimore and three HCFA regional offices—Chicago, Philadelphia, and Seattle.

As HCFA had contracted with Mathematica Policy Research, Inc., to analyze and assess the Medicare risk-based HMO program, we discussed these reviews with a Mathematica official and obtained and reviewed copies of the reports issued under its contract with HCFA. HCFA had also contracted with a peer review organization (PRO)[3] in Florida to assess the quality of care provided by IMC. We discussed this review with the PRO executive director and reviewed the PRO's findings and a copy of the report that it issued to IMC.

We did our work between June 1987 and March 1988 in accordance with generally accepted government auditing standards.

[2]The ACR, discussed more fully on p. 19, is an HMO's estimate of what it would charge beneficiaries for the basic Medicare benefit package if its commercial rates applied (adjusted for the utilization characteristics of the plan's Medicare enrollees).

[3]PROs are independent organizations under contract with the Medicare program to review beneficiary records and help assure that services were medically necessary, were delivered in the appropriate setting, and met professionally recognized standards of health care.

Chapter 2

HCFA's Collection of Data to Ensure That HMOs Provide Quality Services at Reasonable Cost

Under the regular Medicare fee-for-service program, HCFA collects data on beneficiaries and providers to make correct and timely payments to providers and to assess the reasonableness of costs and utilization of services. In the HMO program, however, most of the data generated on beneficiaries and providers are not readily available to HCFA. Because providers are paid directly by the HMOs rather than by the Medicare intermediaries and carriers, HCFA does not have direct access to provider and beneficiary health service data.

HCFA requires Medicare HMOs to report data it needs to monitor their compliance with federal financial solvency requirements and calculate HMO reimbursement amounts. The information from these sources

- does not and was not intended to deal directly with quality of care or access to services provided by HMOs, though some of the data (such as disenrollment statistics) could be analyzed and used by HCFA to identify potential quality and access problems, and
- does include data to help determine the reasonableness of Medicare reimbursement rates, though HCFA believes the collection of such data is administratively burdensome and has requested that the Congress rescind data collection requirements.

While the data HCFA obtains from HMOs are too limited to do the types of provider analysis possible with its fee-for-service claims payment databases, it could make better use of the data for program monitoring. Computing HMO disenrollment rates, for example, could give HCFA an early indicator of potential problems with HMO marketing and/or quality and access to care. Similarly, compiling and comparing the utilization and cost data HMOs submit to support their payment rates could increase the data's utility. This could help HCFA monitor the reasonableness of payment rates (the principal purpose of such data) and identify abnormally low use of services and thus potential quality problems. HCFA, however, has not routinely analyzed the reported data to establish HMO trends and norms, identify aberrant conditions, or identify potential problems.

Two HCFA data collection efforts begun in mid-1987 should increase available data for assessing quality of care. First, HCFA began contracting with PROs in June 1987 to routinely assess the quality of services provided to Medicare HMO members. However, both HCFA and some of the PROs have expressed concern about the availability of data the PROs will use to select HMO cases for quality-of-care reviews. Second, in July 1987 HCFA began implementing a computer system to systematically

analyze and track inquiries and complaints to HCFA about HMOs, something it had not done before. This can be an effective source of data for identifying trends and possible problems with quality of or access to care

Data Collected by HCFA About Medicare HMOs

HCFA collects enrollment data from contract HMOs, but little information on enrollees' use of specific Medicare services or the quality of care provided. From the standpoint of efficiency and administrative burden, an advantage of a capitated payment system is a substantial reduction in the amount of utilization and billing information submitted to and processed by intermediaries and carriers. The HMOs pay for all services and provide no information to HCFA on the use or cost of outpatient services or the cost of inpatient services. HMOs are supposed to report the use of inpatient services to the intermediaries, which in turn provide the information to HCFA. But HCFA has found that HMOs often did not report such data and have little incentive to do so because the data are not used for reimbursement purposes. This absence of any outpatient data and reliable inpatient utilization and billing information limits HCFA's and the PROs' ability to monitor the activities of the HMOs through centralized databases.

Some plan-specific information reaches HCFA through the reporting systems set up to monitor compliance with federal financial solvency requirements, calculate HMOs' Medicare reimbursements, and help assure that HMOs are not earning greater profits on their Medicare lines of business than on their non-Medicare lines. Specifically, HCFA receives three types of information from HMOs:

1. Cost and utilization statistics for federally qualified HMOs (to document compliance with financial solvency requirements). Under the PHS Act, all federally qualified HMOs must submit certain financial and utilization information, which is referred to as the National Data Reporting Requirements (NDRR) system. HMOs report the data either quarterly or annually depending on their financial position. The reports contain primarily financial information (such as the HMO's assets, liabilities, income, and net worth); data on enrollments and disenrollments; and utilization data (such as physician visits and inpatient hospital days). From these reports, HCFA summarizes, for each HMO, financial data and enrollment and utilization data by Medicare, Medicaid, and total members. According to HCFA officials, these summary tables are the only analysis done of the reported enrollment and utilization statistics.

2. Monthly enrollment and disenrollment statistics for each HMO with a Medicare risk contract (to calculate payment amounts). HCFA requires HMOs to submit monthly enrollment/disenrollment data, which are entered into a database, the Group Health Plan Master Record System. This system is used primarily to (1) calculate and reconcile monthly payments to the HMO, (2) inform beneficiaries of the effective dates of their HMO enrollments, and (3) determine in conjunction with other membership data whether the HMO is complying with the requirement that no more than 50 percent of its membership be Medicare and Medicaid beneficiaries.

3. HMOs' annual ACR submissions (to help assure that HMOs with Medicare risk contracts are not profiting excessively from Medicare payments). A risk-based HMO must submit its ACR to HCFA before the start of each annual contract period. The ACR is the HMO's estimate of what it would charge beneficiaries for the basic Medicare benefit package if its commercial rates applied (adjusted for the utilization characteristics of the plan's Medicare enrollees). To calculate its ACR, an HMO projects utilization and cost statistics for the services covered under its benefit packages. HCFA reviews the submission to be sure the HMO does not earn a greater profit or surplus on its Medicare programs than on its non-Medicare programs. In effect, the ACR mechanism helps assure that any excess Medicare payments result in increased Medicare enrollee benefits or reductions in Medicare cost, not excessive profits (that is, profits exceeding those made on an HMO's commercial business).

Opportunities to Increase Data Use in Monitoring HMO Programs

While the data HCFA obtains from HMOs are too limited to do the types of provider analysis possible with its fee-for-service claims payment databases, HCFA could make better use of the data for program monitoring. Two areas having potential for an enhanced monitoring effort are disenrollment data and data available through the ACR process.

High disenrollment rates raise questions about beneficiary satisfaction (and thus possible quality-of-care and access problems), as well as issues related to marketing practices. ACR data, particularly compared among HMOs, could help HCFA detect excessive capitation payments. Additionally, because the ACR process could give HCFA its most comprehensive data on utilization of HMO services, the process could be useful to HCFA in identifying aberrantly low use of specific services by enrollees.

HCFA does not routinely use disenrollment data in its monitoring efforts, though it has used the data to conduct special studies. Nor has HCFA used

ACR data to compile a database of HMO utilization statistics, which could be useful in both assessing the reasonableness of the capitation payments and identifying unusually low use of services.

Analysis of Disenrollment Data

High disenrollment rates can indicate potential problems in several areas, such as misleading advertising and beneficiaries' lack of understanding of the lock-in provision,[1] problems in gaining access to care, or dissatisfaction with care. The extent of disenrollment can also be important in assessing whether selection bias occurs in HMOs—that is, whether healthier or less healthy than average Medicare beneficiaries enroll and remain in HMOs. Where bias selection occurs, it results in inequitable HMO payments. For example, HCFA would overcompensate an HMO if its enrollees were healthier than average and undercompensate it if they were less healthy. Therefore, analysis and use of HMOs' disenrollment data could assist HCFA in its monitoring of HMOs' quality of care, the reasonableness of payments, and compliance with a variety of other Medicare requirements.

HCFA does not produce disenrollment statistics for monitoring HMOs, though such statistics can be produced from HCFA's HMO enrollment databases. At one time, HCFA's central office provided regional offices with aggregate disenrollment data for each HMO in their regions. The reports were discontinued, however, because the data were found to be of limited use in program monitoring, regional officials told us. For monitoring purposes, however, instead of reporting aggregate data, a report relating disenrollment rates being experienced by recent enrollees, such as those enrolled in the past 12 months, might be more useful for identifying potential problems.

Using HCFA HMO enrollment data, we found that about one out of six people enrolling in 95 risk-based HMOs across the country (16 percent) terminate their enrollment within 1 year.[2] The variation in disenrollment rates was substantial, ranging from about 3.5 percent for the 10 HMOs

[1]The lock-in provision requires that except for emergency or urgently needed services, enrollees must use the HMO's providers for all services unless they receive HMO approval to go "out of plan" (that is, use non-HMO providers).

[2]We conducted this analysis for all persons who enrolled in these HMOs between July 1, 1985, and June 30, 1986. We did not include HMOs whose contracts were canceled during the period July 1, 1985, through June 1, 1987, because these HMOs had high disenrollment rates due in part to the cancellation of their contracts. In other words, the disenrollment rates were not entirely based on members' decisions not to belong to the HMO.

having the lowest rates to about 36 percent for the 10 HMOs having the highest rates.

About 42 percent of the disenrollments occurred within the first 3 months of enrollment. In view of the waiting period involved in disenrolling from an HMO (up to 30 days),[3] this indicates that many of those who left the HMOs decided to do so in a relatively short time. Because disenrollments are one indicator of beneficiary dissatisfaction, it is important to know why so many beneficiaries elect to disenroll so quickly. HCFA contracted with Mathematica Policy Research, Inc., to conduct an analysis of enrollment and disenrollment in the Medicare HMO demonstration projects that preceded implementation of Medicare's risk-based HMO program.

In its September 1986 report to HCFA, Mathematica found disenrollment rates similar to those we identified.[4] For example, Mathematica's analysis of data from 17 demonstration HMOs showed that 23 percent of the enrollees terminated their enrollment within the first year. Furthermore, about 45 percent of those disenrolling during the first year did so within the first 3 months. Of particular interest is that Mathematica's study showed that the two HMOs with the highest disenrollment rates were IMC and United Health Plan. These two HMOs have experienced many problems extending over several years and consuming a disproportionate share of HCFA's limited monitoring resources. (See pp. 47 and 51 for case studies of these HMOs.)

To determine why Medicare beneficiaries disenrolled and to obtain some measure of their health status at the time they disenrolled, Mathematica analyzed survey responses of 140 people who were originally enrolled in 17 demonstration HMOs,[5] but who had disenrolled at the time of the survey. The survey provides some insight on the reasons for disenrollment. It can also provide some useful guidance to HCFA in monitoring HMO compliance with enrollment/disenrollment and marketing practices.

About 31 percent of the 140 beneficiaries disenrolled because of some misunderstanding, Mathematica found, especially over the requirement

[3]The effective date of a disenrollment is the first day of the month following the request for disenrollment. The waiting period, therefore, could range from 1 to 30 days.

[4]Mathematica Policy Research, Inc., Enrollment and Disenrollment in Medicare Competition Demonstration Plans: A Descriptive Analysis, September 15, 1986.

[5]These disenrollees were originally enrolled in HMOs between November 1, 1984, and January 1, 1985, and later disenrolled within 0-9 months.

that they switch from their own doctor. Most frequently cited reasons for disenrollment were misunderstanding of the lock-in provision (19 percent), not realizing that they had enrolled (7 percent), and lack of availability of a particular service or specialty (6 percent). Roughly, 9 percent disenrolled because they moved out of the area, either permanently or for long periods.

As a result of its findings, Mathematica raised three issues:

"1. A relatively high proportion of Medicare beneficiaries disenroll almost immediately. This pattern suggests that HMOs are failing to adequately inform potential enrollees of the 'lock in' feature of the plan and other aspects of HMO practice style that may be unappealing to some beneficiaries.

"2. Beneficiaries who are more likely to be high users of services are more likely to disenroll and this pattern appears to be consistent across plans and markets. [And] . . . this finding suggests that disenrollments may increase the extent of favorable selection enjoyed by HMOs and, therefore, result in excessively high payments on behalf of continuing enrollees by the Medicare program.

"3. Disenrollment rates differ greatly across plans and market areas."

In addition to contracting for the Mathematica study, HHS issued an interim report to the Congress on HMO disenrollments in August 1987.[6] The report fulfilled a legislative requirement for an interim report (the final is due in Feb. 1990). It summarizes the results of a number of reports, including Mathematica's and a prior GAO report.[7] HHS's report concludes:

". . . These study results suggest that the extent of disenrollments from Medicare HMOs is minimal when measured over a 1-year period.

"The reasons reported for disenrollment tend to be similar and can usually be categorized as a misunderstanding of the HMO concept, a change of location or move from an area, some type of dissatisfaction with the HMO, or a desire for one's own physician."

[6]HCFA, Disenrollment Study of Health Maintenance Organizations and Competitive Medical Plans: Interim Report to the United States Congress, HHS, August 11, 1987.

[7]Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Although HHS concluded that ". . . disenrollments from Medicare HMOs [are] minimal," studies on which it based its conclusion showed disenrollment rates of about 20 percent, thus indicating that the rates were more than minimal.

According to the interim report, HCFA was designing a system to produce disenrollment statistics. It reported that detailed disenrollment information of all risk-based HMOs would be included in HHS's 1990 final report.

HCFA is also planning a nationwide survey of about 17,000 Medicare beneficiaries to determine whether they disenrolled from the HMO for reasons related to health care needs or their inability to get health care from the HMO. The survey results will be used to assess the scope of potential HMO program-wide problems and help target HCFA's future strategy for ongoing monitoring of HMO disenrollments, according to HCFA officials. Although the survey results will be projectable to each HCFA region, they cannot be used to identify potential problems at a specific HMO, according to the officials. The survey had not begun as of July 11, 1988, and HCFA officials expected that it would require several months to complete once it is started.

Analysis of ACR Data

The ACR is HCFA's mechanism for assessing the reasonableness of an individual HMO's payment rates. In approving an HMO's ACR submission, HCFA is in effect acknowledging that the HMO demonstrated, through the historic cost and utilization statistics submitted, that it is providing a fairly priced package of Medicare services or that Medicare is paying a fair price for the services provided. Also, these statistics give HCFA its most detailed data on the services being provided by HMOs to Medicare enrollees. For example, HMOs' supporting data for their ACR submissions would typically include cost and utilization data on inpatient hospital, skilled nursing, home health, ambulance, physician, and similar covered services. The utility of these data are limited, however, because

- not all HMOs use their own utilization and cost data in preparing the ACRs, and
- HCFA has not compiled a database of ACR statistics to allow it to develop norms against which to measure the reasonableness of reported utilization data.

The ACR includes whatever profit margin the HMO makes on its commercial business. If an HMO's Medicare payment rate exceeds what the HMO would charge commercially, it must use the difference (called "savings")

to provide additional services or lower premiums to its Medicare enrollees and/or reduce Medicare's payment rates.

According to federal regulations, the HMO is supposed to use its own statistics to develop its ACR, except during an HMO's initial contract period. If after the initial contract period an HMO lacks adequate statistics to develop an ACR based on its own experiences, the HMO may use cost and utilization statistics from various published studies approved by HCFA for that purpose.

Our review of 1985, 1986, and 1987 ACR submissions for 19 HMOs showed that about 42 percent of the HMOs used at least some data from various sources other than their own experiences. Each HMO was a Medicare risk contractor for at least a year before submitting the ACRs. In addition 12 (or 63 percent) did not provide adequate documentation to support their ACRs. HCFA's lax enforcement of its ACR data and documentation requirements limits the effectiveness of the ACR as a tool for helping assess the reasonableness of the Medicare payments. In effect, allowing the use of other than HMO-specific data could result in HMOs selecting data sources that produce higher ACRs—and thus higher Medicare costs and/or fewer supplementary services or higher premiums to Medicare beneficiaries—than would be justified if the HMOs used their own data to calculate the ACRs.

The utility of the supporting ACR data is further limited because HCFA has not yet compiled individual HMO data in a way that allows comparisons of HMO service utilization rates. By doing so, HCFA could develop norms against which to measure the reasonableness of reported data. For example, if an HMO's projected rates of Medicare inpatient hospital utilization were much higher than other HMOs (thus justifying a higher ACR), HCFA might need to look at the HMO's underlying support to verify the accuracy of the data. In addition, such a database could be useful in identifying HMOs with lower than average use of services, such as skilled nursing or home health care, suggesting potential problems with access to or quality of care. Because the data are not collected for these purposes, HCFA has no plans, we were told, to use ACR data for monitoring HMOs' utilization rates.

HCFA considers the ACR process administratively burdensome—both for HMOs and for itself—and of little utility. Competitive market forces will act as a safeguard against HMOs profiting excessively from the Medicare

business, HCFA believes. Under this reasoning, if an HMO profits excessively from its Medicare business, other HMOs will be encouraged to compete in the same market by offering more services or lower premiums, thereby forcing other HMOs to do the same. Consequently, in a legislative proposal submitted to the Congress in July 1987 (referred to as the "Medicare Expanded Choice Act"), HCFA requested elimination of the ACR requirement. If HCFA's proposal were enacted and no new data requirements were placed on HMOs, HCFA would no longer receive detailed cost and utilization information from the risk-based HMOs, except for much more highly aggregated NDRR data. Nor would it have a means to assess the reasonableness of Medicare capitation payments to individual HMOs. We currently are reviewing the effectiveness of the ACR process in accomplishing its objectives and HCFA's oversight of ACR submissions.

HCFA's New Data Collection Efforts

In mid-1987, HCFA initiated two new efforts that will increase its ability to monitor HMOs' quality of care. The first involves contracting with external peer review organizations to review HMO Medicare beneficiaries' medical records to determine if the care provided by HMOs meets specified standards. Under contracts with HCFA, the PROs will review samples of both inpatient and ambulatory care records and report the results to HCFA. The second effort is a computerized Beneficiary Inquiry Tracking System (BITS) that will track complaints and inquiries sent to HCFA from the date of receipt through resolution.[8] Part of the system involves categorizing the complaints that will allow HCFA to determine how many relate to quality of care and to which HMOs they pertain. This information can then be used to determine which HMOs may have quality problems and if additional action is needed.

Peer Review Organizations

Originally, HCFA had planned to implement PRO review of HMOs' inpatient services during 1985 but, reportedly because of budgetary considerations, delayed its plans. The 1985 Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272), enacted April 7, 1986, specifically authorized HMO peer reviews of both inpatient and outpatient services to begin in January 1987. As of January 1988, HCFA had amended 34 of its 54 PRO contracts to include peer review of HMO inpatient and outpatient services provided on or after April 1, 1987. This external peer review effort will, for the first time, give HCFA the potential to collect systematic

[8]HMO beneficiaries may either complain or simply make an inquiry about some aspect of the HMO's operation. HCFA plans to enter complaints and inquiries into BITS for tracking through resolution. In this report we refer to BITS as a beneficiary complaint tracking system from this point forward.

quality-of-care data with which to assess HMOs' compliance with Medicare and PHS Act requirements.

The peer review process HCFA adopted for HMOs uses a multiple review approach. HMOs that request a limited review plan have their internal quality review plan and a sample of cases reviewed under the internal review plan examined by the PRO. Using criteria included in the contract, the PRO must determine if the HMO's internal quality assurance plan demonstrates the capacity to identify and correct quality problems. If the PRO determines that the plan meets this standard, it reviews individual cases using what HCFA calls the "limited review plan." Under limited review, the PRO looks at a sample of cases reviewed by the HMO under its quality assurance plan, plus a varying percentage of cases in each of six review categories.[9] If the HMO's quality assurance plan does not meet the specified requirements to allow a "limited" review, the PRO uses the "basic review plan." Under a basic review, the PRO looks at a higher percentage of cases in the six review categories. If the number of problem cases found at an HMO under limited or basic review exceeds certain thresholds, the PRO contract requires the PRO to use an intensified review plan for at least 6 months.

As of January 29, 1988, 108 of the 133 Medicare risk HMOs had been placed under either the basic or limited review. Assignment to a review plan was still pending for the remaining 25, according to HCFA officials. Initial analysis of quality assurance plans had been completed for 48 HMOs that had requested an analysis of their plans. Based on the analysis, 29 of the 48 were placed under the basic review plan, and 19 were placed under the limited review plan. In addition, 60 HMOs were placed under the basic review plan because they either requested basic review or failed to respond to HCFA's inquiry for information about their quality assurance plan.

The contract requires the PROs to use fiscal intermediaries' data to identify inpatient hospital cases for review. However, a significant problem has developed regarding these data. Under their risk contracts with HCFA, HMOs pay hospital bills for their Medicare members, and hospitals accordingly bill the plan rather than the Medicare program. HCFA

[9]The contract requires the reviewing organization to draw six samples of cases for review. These samples are taken from the following categories of cases: (1) all inpatient hospital patients, (2) inpatient hospital patients for some of 13 specified medical conditions, (3) deaths in any setting (except for trauma deaths), (4) ambulatory patients, (5) patients transferred from a hospital with which the HMO does not have an agreement to one with which it does, and (6) patients readmitted to an acute care hospital within 30 days of discharge from such a hospital.

requires the HMOs to submit a copy of such "no-payment" bills to Medicare for record-keeping and statistical purposes. As these bills are not used for reimbursement purposes, however, HMOs have little incentive to submit them. HCFA and the PROs have considerable evidence that the HMOs are not submitting all the bills. As a result, the universe of cases from which the PROs are required to select their samples of HMO inpatient hospital cases for review is incomplete. HCFA officials told us that similar problems may exist with regard to the review of ambulatory services, as many PROs will depend on the HMOs for data to determine the universe of cases from which to draw their samples.

Failure by HMOs to submit no-payment bills, or of intermediaries to process the bills, may be a problem for PRO review of HMOs, according to the director, OPHC. A study group composed of representatives of various HCFA operating components was formed to determine how best to assure that PROs obtain the data necessary to identify HMO inpatient hospital cases. The group has recently concluded its study, and HCFA has now decided to request hospitals (rather than the HMOs) to submit no-payment bills for HMO members in the same way they are submitted for other Medicare beneficiaries. As we have reported in the past,[10] hospitals also have been guilty of failing to submit no-payment bills. Consequently, it remains to be seen whether this proposed solution will be effective at assuring all such bills are submitted.

Assessing HMO Activities From Beneficiary Complaints

Before July 1987, HCFA lacked a formal system for tracking complaints about HMOs from the date of receipt through resolution. Nor did HCFA have a system for analyzing those complaints to determine if specific HMOs had problems or if there was a problem program-wide. In July 1987, HCFA began implementing a complaint tracking system that also can be used to analyze complaints to determine if there are quality-of-care problems at one or more HMOs. As of March 1988, HCFA officials told us that they were still "debugging" the system and developing the reports to be used in the monitoring process expected to begin in August 1988. Thus, it is too early to determine if this system will provide useful information for assessing quality of care.

All Medicare beneficiaries (fee-for-service and HMO) can submit complaints about the services they receive or fail to receive under Medicare. Under the fee-for-service program, such complaints are usually sent to the intermediaries and carriers, which have standard procedures for

[10]Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987).

either investigating and resolving them or forwarding them to HCFA for resolution. However, complaints about HMOs usually are sent either to the HMO that provided the service and against which the complaint is made or directly to HCFA's central office or one of its regional offices.

According to a HCFA official, the central office becomes involved in processing HMO beneficiaries' complaints submitted by a member of the Congress. HCFA's central office forwards congressional complaints to its respective regional offices for processing and tracks them until they are resolved, at which time a response is given to the congressional requester, according to the official. He added that beneficiary complaints sent directly to HCFA's central office are also forwarded to the regional offices for processing and resolution, though the central office does not track them through resolution.

Each of the five regional offices visited had a strategy for handling beneficiaries' complaints. Generally, before TEFRA risk-based HMOs and Medicare enrollment in these HMOs began to rapidly increase as a result of HHS's early 1985 initiatives to expand the program, the regions made no distinction between complaints received under the HMO program and those received under the regular Medicare fee-for-service program, according to regional officials. That is, HMO complaints were not separated from other complaints received by the regions. Therefore, HMO complaints were not analyzed to identify patterns of inadequate care, deceptive marketing practices, or problem HMOs. Officials at three of the regions we visited told us that they began developing distinct HMO complaint processing systems after the volume of HMO complaints began increasing. However, none of the systems provided adequate data as to the number or type (like quality of care or marketing) of complaints received, resolved, or referred to another office or agency for resolution.

One region (Atlanta) implemented a system in December 1986 to categorize complaints received by source, type, HMO, etc., and to track them through resolution, according to a HCFA regional official. When the system was begun, the region entered 768 HMO complaints from an unknown universe of complaints that it had received between November 1985 and October 1986. As of June 30, 1987, 3,248 HMO complaints had been entered into the system, 141 of which dealt with quality of care. We reviewed 40 of the quality-of-care complaints to determine their status. The result showed that 13 had been resolved (3 by the IG), with resolution requiring an average of about 10 months, and that 23 were unresolved (5 were with the IG) and had been open for an average of

about 23 months as of September 1987. Documentation was not available for our review of four complaints. The tracking system developed by this region was later modified and adopted by HCFA as its formal standardized complaint processing system.

The complaints received by another region (San Francisco) were located in the respective HMOs' file, and our review of the files yielded data on 74 complaints received before July 1987. (Region officials said that the HMO files had been purged of many complaints received before January 1987.) Fourteen of the complaints dealt with quality-of-care issues, and our review of the status of these complaints disclosed that 5 had been resolved by HCFA, 6 were referred to other organizations for resolution, and we could not determine the status of 3 because HCFA could not locate any documentation. Also, of the 6 complaints referred, documentation was not available for us to determine the status of 5, and resolution of the other was still pending. In total, 40 of the 74 complaints had been resolved, and 34 either were unresolved or their status could not be determined as of July 1987.

From our analysis of the various types of data collected, we concluded that the five HCFA regions received on average about 167 complaints a month. These five regions could expect to receive about 2,000 HMO complaints a year based on an estimated HMO Medicare enrollment of about 783,000 beneficiaries.

Effective in July 1987, HCFA began implementing a computerized system to track and monitor HMO beneficiary complaints. Called BITS, this system was developed to standardize information flow to HCFA's central office from the regions and give the regional offices an automated tool for tracking and monitoring the status of complaints concerning services to HMO Medicare beneficiaries. The BITS data will be analyzed to identify potential problems or conflicts that exist within the Medicare HMO program. As of March 1988, however, BITS was still being implemented, and August 1988 had been established as the target for producing national reports, according to HCFA officials.

Conclusions

HCFA had relatively little data available in its data systems with which to assess quality of care. Data that were available were highly aggregated (for example, total physician encounters), with none on individual beneficiaries' use of ambulatory services and only incomplete data on

the use of inpatient hospital services. Furthermore, the data were collected for purposes other than monitoring quality of care, and they were not used for this purpose.

HCFA's initiation in mid-1987 of external HMO peer review and collection and analysis of information on complaints should increase the information it has available to monitor HMOs' quality of care. Initial implementation of the HMO peer review effort, however, probably will be hampered by incomplete centralized data on Medicare enrollees' use of inpatient hospital services and the absence of centralized data on ambulatory services. HCFA recognizes these problems and is addressing them.

While centralized data have limitations in assessing HMOs' quality of care, a potential exists for HCFA to better use its existing data to monitor HMOs. Two areas with such potential are:

- Routine analysis of HMO disenrollment rates. High rates at an HMO suggest a number of potential problems, which can involve quality of care, marketing, and reimbursement.
- Compilation of data from ACR submissions. ACRs provide utilization data on the full range of HMO services and are currently the most detailed source of information available centrally to HCFA that could be useful in identifying, for more detailed review by the PROs, potential underprovision of services.

HCFA has plans to routinely develop and use disenrollment rate statistics. However, HCFA has sought legislative authority to eliminate the ACR. If this is done and no new data requirements are placed on HMOs, HCFA will no longer receive detailed cost and utilization information from the risk-based HMOs, nor will it have a means for assessing the reasonableness of Medicare capitation payments to individual HMOs. Currently, we have underway a review of the effectiveness of the ACR process in accomplishing its objectives to help assure reasonable HMO payments, and of HCFA's oversight of HMO ACR submissions.

Adequacy of HCFA Staff to Monitor HMO Operations

Since the TEFRA risk program began in early 1985, the number of federally qualified HMOs, as well as the number of TEFRA risk HMOs, has increased substantially. But the number of HCFA central office staff responsible for monitoring the activities of HMOs has not kept pace, although the number of regional staff monitoring compliance with the provisions of the TEFRA risk contracts has increased.

HCFA's monitoring of risk-based HMOs includes various central and regional office activities directed at assuring compliance with statutory and contractual requirements. Some of HCFA's monitoring activities are designed to identify potential problems. In the past, however, HCFA has directed substantial resources to obtaining corrective action after significant problems have developed. For example, over one-half of HCFA's Office of Compliance site visits to TEFRA risk HMOs during a 27-month period from April 1985 through June 1987 were made to one HMO (IMC) that was experiencing financial, management, marketing, and health delivery problems.

Too much of its monitoring of HMO activities has been devoted to reacting to problems, HCFA believes. Thus, the agency is implementing a proactive monitoring protocol, which provides for a routine, systematic approach to on-site monitoring of a broad range of activities at all TEFRA risk-based HMOs. In addition (as discussed in ch. 2), HCFA is testing and implementing two new systems, peer reviews and a complaints tracking system, which should provide better and more timely methods and data to identify potential problems and prevent them from developing.

HCFA officials responsible for the HMO program believe that they will need more monitoring staff as a result of the increase in the number of TEFRA risk HMOs and implementation of the new on-site monitoring protocol and new systems for identifying and forestalling potential problems. We have no basis to disagree with this. It should be noted, however, that HMO program officials have not been successful in their efforts to obtain additional staffing.

Monitoring Shared by Central and Regional Offices

TEFRA risk HMOs must comply with applicable provisions of the PHS and Social Security Acts. Responsibility for monitoring HMOs' compliance with the applicable provisions of these two acts is divided between HCFA's central and regional offices. Within HCFA's central office, OPHC has overall responsibility for administering the TEFRA risk program. OPHC has divided the HMO administrative functions among three organizational units.

OPHC's Office of Qualification reviews HMOs' applications for federal qualification and Medicare risk contracts. That office ensures that the HMO meets the applicable statutory and regulatory requirements. For example, to receive federal qualification an HMO must meet certain financial solvency requirements designed to protect enrollees against the risks of the HMO's becoming bankrupt.

All HMOs that receive federal qualification must continue to comply with applicable provisions of the PHS Act, and those with a TEFRA contract must continue to comply with applicable provisions of the Social Security Act. Within OPHC, the Office of Compliance has primary responsibility for monitoring HMOs, including those having a TEFRA risk contract, to ensure that they continue to meet the requirements for federal qualification and the conditions of their contract. This monitoring focuses on several aspects of the HMO, including the

- availability, accessibility, and continuity of health services it provides;
- adequacy of its management information system, including the experience and qualification of key staff; and
- adequacy of its financing, reasonableness of its financial projections, and its net worth position.

The third office within OPHC, the Office of Financial Management, reviews and approves HMO ACR proposals and calculates HMOs' monthly payments.

HCFA's regional offices monitor HMOs' compliance with the provisions of their TEFRA risk contracts. This involves evaluating the five areas covered by the Medicare risk contracts: marketing, membership enrollment, claims processing, grievances and appeals, and contract administration and management. Regions also use information received through HCFA's complaint processing system to help them monitor these areas. Also, HMOs must submit to the region for prior approval any marketing materials they plan to use.

OPHC's Office of Compliance and certain regional staff are responsible for insuring that HMOs continue to comply with the applicable provisions of the PHS and Social Security Acts and with the provisions of their TEFRA risk contracts. Because of this we focused our review of HCFA's monitoring activities and HCFA staff available to perform these activities on the Office of Compliance and on the HMO monitoring activities at the five regional offices included in our review.

Monitoring Had Focused on Existing HMO Problems

To help ensure that HMOs continue to meet the requirements for federal qualification and comply with the provisions of their TEFRA risk contracts, HCFA performs desk reviews of the data it receives under the Medicare HMO program. But the data HCFA has been receiving may be insufficient to properly evaluate the adequacy of an HMO's performance relative to federal qualification factors. Among these factors are the skills and experience of key management personnel and the accessibility, availability, and continuity of health services. Further, most of the data received by HCFA give only a historical picture of the HMO's performance. This, in essence, causes HCFA to focus on solving existing problems rather than on identifying potential problems before they develop.

Monitoring by Office of Compliance

The Office of Compliance monitors HMOs' compliance with the applicable provisions of the PHS and Social Security Acts. It does so by collecting and analyzing information, maintaining written and oral communications with the HMOs, conducting evaluations, and requiring corrective actions when an HMO is found in noncompliance. The compliance specialists assigned to perform these functions do so mainly by desk reviewing the NDRR and enrollment data routinely submitted by federally qualified HMOs with TEFRA contracts.

From the desk reviews it is possible to (1) determine an HMO's financial condition and assess its financial solvency from the NDRR data; (2) compute HMO capitation payments and assess compliance with certain Medicare enrollment provisions from the enrollment data; and (3) assess an HMO's anticipated profit or loss and determine the reasonableness of its operating costs from the enrollment and ACR data.

But the data HCFA has been receiving may be insufficient to properly evaluate an HMO relative to certain federal qualification and contract performance factors. Desk reviews of financial and limited utilization data from the NDRR and ACR submissions and enrollment data, for example, are inadequate to determine the competency or skills of the HMO's key management personnel. Nor is it sufficient to assess the accessibility, availability, and continuity of health services for which the HMO is responsible or the marketing skill or techniques of individuals responsible for enlisting new enrollees. Only through a detailed evaluation at the HMO can HCFA effectively assess these and other key qualification and contract performance factors.

On-site detailed evaluations generally were performed only at HMOs that had already developed and were experiencing serious problems. When a

desk review identifies a possible problem, the compliance specialist initiates an "evaluation" to resolve it. Depending on the nature of the problem, the evaluation may be handled by (1) telephone conversations with HMO officials, (2) informal correspondence with the HMO, (3) a visit to the HMO by compliance staff members, or (4) a formal written notice to the HMO informing it of the evaluation and defining the problem.

If a formal notice of evaluation is sent, the compliance officer may make a site visit to meet with HMO officials and obtain and verify current information about the HMO's activities to determine if it is in compliance. In some instances, the compliance officer may be accompanied during the site visit by a technical expert from the health care industry and regional HMO monitoring personnel.

After the evaluation is completed, the Office of Compliance issues the HMO a notice of compliance or noncompliance. If the HMO is in noncompliance, HCFA directs it to submit within 30 days a corrective action plan describing the steps it is planning to take to correct the problem. If the HMO has not initiated or carried out corrective action within the time HCFA specified, HCFA can revoke the HMO's federal qualification or terminate its TEFRA risk contract or, in some cases, suspend enrollment or impose a monetary penalty (see p. 37).

HCFA maintains a monthly status report that lists each HMO under evaluation or in noncompliance. During the period April 1985 through July 1987, 10 TEFRA HMOs were under evaluation and 5 were cited for noncompliance. Also, during the period April 1985 through June 1987, the Office of Compliance staff made 48 site visits to HMOs that had risk contracts, but 30 of these visits were made to one HMO (IMC). In fact, 23 of 30 site visits made by Office of Compliance staff during the first 6 months of calendar year 1987 were made to IMC in reaction to crises. Eventually these crises led to the state of Florida placing IMC in receivership and ultimately selling the HMO (see p. 51).

HCFA Regional Offices Also Monitor

The regional offices monitor HMOs' compliance with the provisions of their Medicare contracts with HCFA primarily by responding to complaints and inquiries, maintaining oral and written communications with the HMOs, and desk reviewing the HMOs' marketing materials. Regional staff also conduct site visits, usually from 1 to 5 days, to assess HMO compliance.

From April 1985 through June 1987, regional staff made 104 visits to 65 of the 96 HMOs (as of July 1987) in the five regions included in our review. Most of the visits (63) were for routine evaluation of the five contract areas. The routine evaluations generally dealt with procedural matters and resulted in written recommendations to the HMO. The other 41 visits were made in response to beneficiaries' complaints and inquiries, to provide technical assistance, and, in one case, to conduct a study.

We analyzed 115 recommendations made by one of the five regions that we visited (see table 3.1). These recommendations were based on site visits by regional staff during the period February 1986 through July 1987 and covered 29 of 38 TEFRA risk HMOs located in the region.

Table 3.1: Recommendations by HCFA Regional Staff Based on Site Visits to HMOs

	Recommendations	
Compliance area	**No.**	**Description**
Marketing	18	Revise HMOs' printed materials dealing with their rules, procedures, benefits, charges, services, etc., so beneficiaries can make an informed decision about whether to enroll in an HMO
Membership/enrollment	53	Give proper notice to enrollees before disenrollment for nonpayment of premium; assure that signed and dated requests are obtained for all voluntary disenrollments; assure timely disenrollment of members leaving the service area; revise disenrollment notices to reflect enrollees' right to appeal involuntary disenrollment; assure proper effective dates for voluntary disenrollment; instruct disenrollees to continue to receive services through the plan until the effective date of disenrollment; ensure that all enrollees are notified of their right to appeal involuntary disenrollment; establish procedures to identify/verify institutional status.
Claims processing	24	Ensure that all "no-pay" bills are sent to the fiscal intermediary; revise notice of denial forms to inform enrollee of the right to appeal when the plan denies services
Grievances & appeals procedures	20	Establish an appeals procedure; assure that enrollees are informed of their rights under the appeals process
Total	**115**	

Similarly, report recommendations by other regions that we visited dealt primarily with improvements in marketing, enrollment procedures, claims processing, and beneficiary appeal procedures. In two of the five regions, HCFA officials asked HMOs to either comment on the recommendations or submit plans for corrective action. None of the regions, however, had a system to follow up and document whether HMOs had taken corrective action based on HCFA's recommendations.

HCFA Monitoring Staff Not Increased Proportionate to Number of HMOs

During the period April 1985 (when the first TEFRA risk contracts became effective) through January 1988, the number of federally qualified HMOs increased from 269 to 496 and the number of TEFRA risk HMOs increased from 32 to 133. At the same time, HCFA's HMO-monitoring activities and workload requirements were changing. This was because risk-based HMOs are subject to applicable provisions of both the PHS and Social Security Acts (non-TEFRA, federally qualified HMOs are covered only by the PHS Act). The workload also was affected by the continuing concerns about whether risk-based HMOs provide quality care at reasonable costs. But the number of HCFA central office staff assigned to monitor the activities of federally qualified HMOs has remained relatively unchanged since the TEFRA risk program became operational in April 1985. At the same time, the number of HCFA regional staff assigned to monitor HMOs' compliance with the provisions of their TEFRA contracts with HCFA has increased.

Central Office Monitoring Staff

In estimating its workload and staff requirements in July 1987, OPHC identified 32 full-time employees within its Office of Compliance who performed a variety of HMO-related clerical and analytical functions. But the HMO compliance officers who review and analyze financial data, investigate and help resolve health care delivery problems, and interpret HMO laws and regulations are the only employees within the compliance office who are involved in directly monitoring HMO activities, according to OPHC officials. In April 1985, there were 14 compliance officers performing these functions for 269 federally qualified HMOs. Thus, for HMO monitoring purposes, there was 1 HMO compliance officer for every 19 federally qualified HMOs. By January 1988, the ratio of compliance officers to federally qualified HMOs had increased to 1:33.

The changes from April 1985 to January 1988 in the numbers of federally qualified HMOs, TEFRA risk HMOs, Medicare enrollment in TEFRA risk HMOs, and staff assigned and authorized to monitor HMOs are shown in table 3.2.

Table 3.2: Changes in Federally Qualified and TEFRA HMOs, Medicare Enrollment in TEFRA HMOs, and HMO Monitoring Staff (1985-88)

	April 1985	March 1986	January 1988
HMOs:			
Federally qualified	269	356	496
TEFRA risk	32	114	133
Medicare enrollment:			
TEFRA risk HMOs	304,349	530,658	981,145
HMO Office of Compliance monitoring staff:			
Persons on board	14	13	15
Positions authorized	17	17	17
Ratio of direct monitoring staff to federally qualified HMOs based on:			
Persons on board	1:19	1:27	1:33
Positions authorized	1:16	1:21	1:29

OPHC believes that the current ratio of compliance officers to HMOs is inadequate for monitoring HMO activities, particularly in view of the new monitoring protocol, which includes routine on-site review of all TEFRA risk HMOs. During HCFA's fiscal year 1988 budget process, OPHC officials requested 14 additional compliance officer positions, but were not successful in obtaining them. During the fiscal year 1989 budget process, we were told, they made no requests for additional compliance officers because HCFA was placing higher priority on staffing two other areas (catastrophic health insurance and hearings and appeals). Consequently, authorized staffing levels have remained unchanged since the program began in April 1985.

While authorized staffing levels have not increased, HCFA has contracted with peer review organizations to review the HMOs' quality assurance programs and assess the quality of care that they provide Medicare enrollees. Contracting for these services gives HCFA access to additional HMO monitoring resources. For example, the executive director of the Florida PRO advised us that five nurses were assigned full time to review Medicare HMO activities in that state. However, as HCFA and its contractors intensify their review of HMO activities, the potential for identifying additional problems that must be handled increases.

Monitoring by HCFA Regional Offices

In the five regions we visited, employees responsible for monitoring HMOs' continued compliance with these areas were assigned to the Division of Program Operations. Two of the regions (Atlanta and Chicago)

had established distinct HMO organizational units responsible for monitoring HMO activities. The other three regions had assigned HMO monitoring activities to specific individuals, most of whom also were responsible for various non-HMO activities. In two of the five regions, officials told us that their current HMO staffing was adequate; officials in the other regions said they needed more staff.

The number of TEFRA risk HMOs, Medicare HMO enrollees, and regional full-time-equivalent employees assigned HMO monitoring activities between April 1985 and July 1987 are shown in table 3.3.

Table 3.3: Number of TEFRA Risk HMOs, Medicare HMO Enrollment, and HCFA HMO Regional Monitoring Staff
(5 Regions)

	April 1985	July 1987
Medicare TEFRA risk HMOs	28	95
Medicare TEFRA risk HMO enrollment	297,916	806,732
HMO monitoring staff in regional offices	11	28

New Monitoring Protocol Being Implemented by HCFA

In implementing a new on-site monitoring protocol, HCFA aims to strengthen its monitoring of the TEFRA risk HMOs by becoming more proactive and less reactive. For example, in a July 30, 1987, internal HCFA memorandum, an Office of Compliance official stated that "Historically the focus of monitoring was on For Cause Situations not on routine proactive on-site compliance with all regulatory and contractual requirements . . ." By systematically focusing on all HMOs, HCFA believes the new procedures will allow for earlier detection of potential problems and a better allocation of its monitoring resources. HCFA believes this systematic approach to monitoring will also help it determine whether the problems identified are applicable to an individual HMO, more than one HMO, or program-wide.

In 1987, central office and regional office officials developed a draft document covering HMO on-site monitoring. Under the document, the responsibility for the new monitoring procedures was to be divided between the central and regional offices. The central office will monitor fiscal soundness, insolvency protection, incentive arrangements, ACR proposals, organizational status, health services delivery, quality assurance, and the 50/50 enrollment requirement. The regions will monitor marketing; enrollment, disenrollment, and membership; claims processing; grievances and appeals; and contract administration.

The new monitoring guidelines require HCFA on-site reviews of HMOs at least every 2 years. They also specify that HMOs with new contracts be visited and reviewed by HCFA between the sixth and ninth month after the effective date of the contract. Thus, by following the newly established schedule for visits to HMOs outlined in the monitoring protocol, HCFA will visit all HMOs on a regular basis. This practice should permit HCFA to identify and resolve HMO problems earlier and in a more systematic manner than previously.

Additionally, the new protocol also provides for annual contract performance summaries to be prepared by the regional and central offices on each HMO by September 1 of each year. Together with information received through the beneficiary complaints and inquiry and peer review systems and disenrollment surveys, the summaries will be used to determine whether to continue or terminate the HMO's TEFRA risk contract. As of June 1988, the new monitoring protocol was still in draft form and was being tested by HCFA's regional and central offices staffs, according to HCFA officials.

Conclusions

In the past, HCFA has monitored HMOs' continued compliance with the requirements for federal qualification and performance under their TEFRA risk contracts by desk reviewing HMO-submitted data. The agency has spent most of its monitoring resources on the problem HMOs it identified, and this, together with the substantial increase in the number of TEFRA risk HMOs since the program began in 1985, has put a strain on HCFA's monitoring staff.

That too much of its monitoring effort has been directed at problem HMOs after the problems have already developed, HCFA recognizes. Thus, the agency is instituting a formalized on-site review program. This program, in addition to two new data systems that HCFA is implementing, should improve HCFA's ability to systematically monitor all TEFRA risk HMOs and to more successfully identify and correct problems.

HCFA believes its new approach to HMO monitoring will require additional staff. We have no basis to disagree with this position and believe that additional compliance staff could be useful. OPHC officials, however, were not successful in obtaining the additional staffing requested during HCFA's 1988 budget process and did not request additional staff during the 1989 budget process.

Determining the number of additional staff needed, however, is complicated by the recent initiation by HCFA of its new monitoring protocol and the involvement of PROs in monitoring HMO quality. While it may take additional staff to implement the new systems, the need for staff to be involved in reactive monitoring could be reduced. It can be expected, however, that the PRO reviews, more systematic analysis of complaint data, and more frequent on-site monitoring will uncover additional compliance problems that previously would not have been identified. In that compliance problems can take substantial time and resources to resolve, it is unclear as to the levels of staffing that HCFA will need in its central and regional offices.

Chapter 4

Response to HMO Compliance Problems: Three Case Studies

HCFA has identified numerous problems concerning HMOs' compliance with federal laws and regulations. In most cases notifying the HMO of the problem and requesting resolution resulted in timely corrective action. In a few instances, however, HCFA was unable to ascertain from its records whether identified compliance problems were resolved. This occurred because HCFA does not have a system for tracking all compliance problems from the point an HMO is notified through resolution.

Also, a few HMOs have had recurring compliance problems or were either unresponsive or untimely in responding to HCFA's requests for corrective action. As case studies, we selected three HMOs with a history of compliance problems that were either still unresolved or took a long time (and substantial HCFA resources) to resolve. We believe HCFA could have been quicker and more forceful in seeking resolution of these situations. The HMOs either were nonresponsive to HCFA's requests for corrective action or responded in an untimely manner or with a corrective action or plan that was not successfully implemented or was later found to be deficient. HCFA's response to these continuing problems was to intensify its review activity at the errant HMOs and write additional letters requesting corrective actions. Broader sanction authority might have helped HCFA resolve these problems more quickly.

HCFA's authority has been expanded to provide sanctions, such as suspending new Medicare enrollments in some situations where HMOs violate Medicare requirements. But for many types of violations, the only action authorized is to cancel the HMO's Medicare contract or remove its federal qualification. HCFA is reluctant to take such steps because of their severity. Consideration should be given to broadening HCFA's discretion in using its new sanction authority because some compliance problems cannot be addressed by any of the expanded sanctions. Among these are problems with financial soundness and certain marketing and enrollment practices.

HCFA Compliance Process and Authority

As discussed in chapter 3, HCFA generally follows a four-step process when it identifies and begins working with HMOs to resolve compliance problems. This process consists of (1) having informal written or oral communications with the HMO about a potential problem and the actions the HMO needs to take to correct it, (2) initiating an evaluation to collect information and seek resolution, (3) issuing a written notice of noncompliance requiring the HMO to submit a specific corrective action plan as a condition for continuing its Medicare contract (or retaining its federal

qualification), and (4) issuing a sanction. The process can take considerable time, particularly since, as we discuss later in the case studies, HMOs operating under notices of noncompliance are not always willing or able to meet the specified conditions.

When an HMO fails to resolve compliance problems but the problems are not viewed as severe enough to warrant terminating the Medicare contract, HCFA's sanction authority is limited. Before the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) was enacted, the only actions HCFA could take against an HMO were to

- place it in noncompliance (that is, request a corrective action plan, monitor its implementation, and continue to write letters requesting compliance),
- rescind its federal qualification, or
- cancel or not renew its Medicare contract.

The second step would also result in canceling the contract, because only federally qualified HMOs can have Medicare contracts.

To provide a broader array of sanctions, under the 1986 Reconciliation Act the Congress gave HCFA authority to deal with three specific problems. These sanctions allow HCFA to

- suspend enrollment and payments for new enrollees if an HMO does not comply with the 50/50 enrollment requirements or, if it has a waiver to the requirement, does not make reasonable efforts to comply with it;
- make direct payments to providers (and deduct the amount paid from the HMO's capitation payment) that an HMO has not paid in a timely manner as required in its contract; or
- subject an HMO to a civil monetary penalty of not more than $10,000 for each case in which the HMO fails substantially to provide medically necessary items or services that are required to be provided.

In December 1987 the Congress broadened HCFA's sanction authorities still further. These new sanction authorities, stipulated in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), allow HCFA to assess a civil monetary penalty of not more than $25,000 (or $100,000 under certain circumstances), to suspend Medicare enrollments, or to suspend an HMO's payments for new enrollees (those enrolled after HCFA makes its sanction determination) if the HMO

- fails to provide covered medically necessary items and services if the failure has or is likely to adversely affect the individual;
- imposes premiums on individuals enrolled in excess of the premiums permitted;
- inappropriately expels or refuses to reenroll an individual;
- engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services; or
- misrepresents or falsifies information that it may be required to furnish to the Secretary of HHS, an individual, or any other entity under the Social Security Act.

Also, in the 1987 Reconciliation Act, the Congress required HMOs to provide Medicare enrollees up to 6 months of protection against the loss of supplemental coverage of benefits related to preexisting conditions, should the HMO's Medicare contract terminate. Before this, when an HMO terminated its Medicare contract, beneficiaries were at risk of not being able to immediately obtain supplemental insurance coverage for preexisting conditions because many companies offering supplemental or "medigap" policies exclude coverage for such conditions for up to 6 months. This provision will lessen the potential impact on the beneficiary if, due to compliance problems, HCFA terminates an HMO's contract.

HCFA's System for Tracking HMOs' Corrective Action for Compliance Problems Is Inadequate

By monitoring the TEFRA HMOs, HCFA identifies many compliance problems, but few of them result in sanctions. In most cases that we reviewed, HCFA notified the HMO of the existence of or potential for a compliance problem and requested corrective action, and the HMO responded in a reasonably timely manner. However, HCFA did not have an adequate tracking and follow-up system to ensure that HMOs ultimately respond to its requests for correction action. We identified a few HMOs that were not responsive to potentially significant requests to correct compliance problems related to quality of care and financial solvency.

HCFA initiates compliance actions when it believes or determines that an HMO is near or in noncompliance with one or more of the applicable PHS or Medicare legislative or regulatory requirements or needs additional information to make such a determination. These HCFA-initiated actions range from requesting that the HMO submit additional or clarifying data relative to a problem or potential problem, to placing the HMO under

evaluation (the first stage of the compliance process) or in noncompliance with specific requirements.

When HCFA places an HMO under evaluation or formally cites it for noncompliance with PHS or Medicare legislative or regulatory requirements, the status of the particular evaluation or compliance action, including the HMO's progress toward correcting the problem, is recorded in a monthly report (maintained by the Office of Compliance) until the problem(s) prompting the evaluation or compliance action is corrected by the HMO or otherwise resolved. HCFA, however, does not maintain a comparable system to track the progress of an HMO's corrective action for the problems that have not reached the evaluation or formal compliance phase.

Most HMOs Are Responsive to HCFA Compliance Actions

From our review of HCFA's compliance files for 95 TEFRA HMOs located in five HCFA regions, we identified 167 HMO compliance actions initiated by HCFA's central office during the period April 1985-July 1987. Of these 167 actions, 16 percent (26) resulted in the HMO being placed under evaluation or cited for noncompliance. In the other 84 percent (141 actions), HCFA did not place the HMO under evaluation or cite it for noncompliance, but rather requested additional data, reminded the HMO that required reports were not received on time, advised the HMO that a potential problem might exist, or warned the HMO that it was nearing noncompliance. When the HMO provided the requested data, late report, or evidence that the problem had been or would be corrected, the case was closed.

The 141 corrective action compliance notices initiated by HCFA that we reviewed, categorized by compliance area, and the average HMO response time for those cases for which we were able to identify an HMO response in the HMO's compliance file are presented in table 4.1.

Table 4.1: HCFA Corrective Action Compliance Notices by Compliance Area and HMO Average Response Time
(April 1985-July 1987)

Compliance area	HCFA notices to HMOs	HMO average response time (months)[a]
Fiscal soundness	65	2.0
Insolvency protection	3	5
Quality assurance	7	1.0
Incentive arrangements	1	1.0
ACR proposals	1	b
Organizational status	29	1.7
Services delivery	28	1.7
50/50 enrollment requirement	7	2.0
Totals	**141**	

[a]Average response time is the time between the date that HCFA notified the HMO of a compliance problem and the date that the HMO responded to HCFA's notice as documented in the compliance file.

[b]No response required.

Of the problems we reviewed, the most common dealt with the HMOs' failure to submit complete and timely financial data. For example, 39 of the 65 notices HCFA initiated for compliance problems concerning fiscal soundness were requests and follow-up requests for HMOs to submit delinquent financial reports.

HCFA also notified HMOs of problems and requested corrective actions in other areas, such as health services delivery, 50/50 enrollment requirement, and quality assurance programs. For example, of the HMOs that lacked a waiver to the 50/50 enrollment requirement as of August 1987, the Medicare/Medicaid enrollment at

- 4 HMOs exceeded 50 percent,
- 4 HMOs was 50 percent, and
- 3 HMOs was nearing 50 percent.

HCFA (as of January 1988) planned to send warning letters to the three HMOs with enrollment rates nearing 50 percent. Medicare enrollments had already been frozen at five HMOs, and HCFA recommended curtailing enrollments at three.

Some HMOs Were Nonresponsive and HCFA Did Not Follow Up

Although HCFA officials advised us that the HMOs' responses to its notices for corrective action were in the respective compliance file of each HMO, we could not locate HMOs' responses for 52 of the 141 corrective action notices summarized in table 4.1. Even the responses that we did identify were difficult to locate because they were not attached or cross-

referenced to HCFA's corresponding corrective action notices. Nor did HCFA maintain any correspondence log or report to record the receipt of HMO responses to its corrective action notices.

We judgmentally selected 10 of the 52 cases for which we could not locate the applicable responses, and asked the Compliance Branch chief, Office of Compliance, to locate them for us. The branch chief gave us the HMOs' responses for six notices and advised us that the responses for the other four could not be located. Specifically, one of the HMOs had not responded; one sent its response to the regional office; and two, we were told, may have responded orally, though no written record of the response was prepared.

The one case in which the HMO had not responded involved a quality-of-care problem. Specifically, HCFA in January 1986 received a congressional inquiry concerning an allegation by the spouse of a deceased enrollee that one of the HMO's physicians failed to provide adequate care. An investigation by the HMO's medical director revealed that an internist at one of the HMO's affiliated clinics failed to follow all the appropriate medical procedures given the patient's symptoms and family history. In March 1986 the medical director advised HCFA that he had recommended that the clinics where this internist worked institute certain practices and training to minimize the possibility of such an incident recurring. In April 1986, HCFA advised the HMO that these corrective measures should be implemented at all its clinics, and asked the HMO to submit documentation, including a timetable for implementing the recommendations. The requested documentation was not submitted (or could not be located), and HCFA officials did not follow up to assure that corrective action was taken. The branch chief informed us that this case will be investigated further.

The case for which the HMO's response reportedly was on file at the regional office, but not in the compliance file at HCFA's central office, dealt with several deficiencies, including two related to quality of care. Specifically, during a March 1987 joint HCFA central/regional office monitoring visit, HCFA found that the HMO's quality assurance program was inactive and the accessibility of its services for Medicare enrollees was not equal to that of non-Medicare enrollees. The regional office sent the review team's findings to the HMO on June 15, 1987, and requested a response by July 15. Office of Compliance officials advised us that they did not know the status of the HMO's response. Since December 1986 this same HMO had been under evaluation by HCFA because of suspected noncompliance with HMO financial solvency requirements. (These matters

are discussed in a case study of the HMO on p. 44.) Furthermore, our follow-up with regional officials revealed that the HMO's written response to the on-site review findings did not address either of the quality-of-care problems cited in HCFA's report.

Both cases that we were told may have been resolved orally involved financial solvency issues. In both, the HMOs were asked to submit or clarify discrepancies in required NDRR financial reports, but there was no written record of the HMO's responses in HCFA's central files. Also in both cases, the HMOs ultimately were found (when subsequent NDRR reports were submitted) to have financial problems.

In one case, HCFA notified the HMO in March 1986 that it had not received the HMO's NDRR required financial report for the quarter ended December 31, 1985. Although the compliance file did not contain any supporting documentation and the compliance office staff person who handled the case left HCFA in June 1986, we were told by his supervisor that the staff person probably orally waived the requirement for the quarterly report. The supervisor felt this oral waiver of the reporting requirement may have been given because HCFA had just qualified the HMO in November 1985 and consequently had relatively current financial results. Our review of the compliance file revealed, however, that when the HMO submitted its March 31, 1986, quarterly financial report, HCFA discovered that the HMO was experiencing financial difficulty and later placed it under evaluation.

In the other case, HCFA asked the HMO in January 1986 to clarify apparent discrepancies in revenue amounts shown on the HMO's September 30, 1985, NDRR financial reports (received by HCFA about 90 days past the due date). This action was handled by the same compliance staff person handling the case discussed above. The supervisor of this person again concluded that this issue was probably handled orally and that the compliance staff person did not document the response in the compliance file. As in the case above, this HMO was later placed under evaluation (in October 1987), after its June 1987 quarterly NDRR financial report showed that it may be failing to meet requirements for maintaining a fiscally sound operation.

We believe that the volume of compliance notices, along with the prospect of failing to follow up on cases where the HMO does not respond to

the problems cited by HCFA, illustrate the importance of an adequate system for tracking all compliance problems through final resolution. Additionally, such a system would also allow HCFA to quickly identify HMOs that are experiencing recurring compliance problems.

Case Studies: Three HMOs With Long-Standing Compliance Problems

To demonstrate how the compliance process works and its limitations in dealing with HMOs that cannot or will not take necessary actions to comply with Medicare requirements, we selected three HMOs as case studies. They are Bay State Health Care (BSHC), Cambridge, Massachusetts; United Health Plan (UHP), Los Angeles, California; and IMC, Miami, Florida.

These 3 HMOs were among 10 placed under evaluation by HCFA that we identified in reviewing HCFA's evaluation and compliance records from April 1985 through July 1987 for 95 HMOs in five regions. Five of the 10 HMOs, including the 3 that we studied, ultimately were cited for noncompliance. It took from 3 months to over 4 years either for the evaluations to be completed or, if a notice of noncompliance was issued, for compliance to be restored. After citing an HMO for being out of compliance, HCFA continued to work with it to bring it back into compliance.

We believe that HCFA could have been more forceful in its efforts to correct the problems of these three HMOs. A timely solution often depends not only on HCFA actions, however, but also on the willingness and ability of the HMO to take the necessary corrective actions.

Bay State Health Care

To become and remain federally qualified, an HMO must meet the financial solvency requirements established under the PHS Act and implementing regulations. These are designed to protect enrollees against the risks of the HMO's becoming bankrupt. Among these requirements are that the HMO have (1) assets greater than its liabilities, (2) sufficient cash flow and adequate liquidity to meet its obligations as they become due, and (3) a net operating surplus. BSHC exemplifies an HMO with suspected financial solvency problems.

Surplus Quickly Turns to Deficit

BSHC became a federally qualified HMO in April 1985 and signed a TEFRA risk contract on August 23, 1985, effective October 1, 1985. HCFA learned in late 1985 that the HMO had potentially serious financial problems, according to information in HCFA's compliance files. In February 1988, more than 2 years after the problem was identified and more than a

year after the HMO was cited for noncompliance, this case had not been resolved. In the interim, the number of Medicare enrollees in BSHC's plan grew from 0 in December 1985 (when HCFA initially identified the problem) to nearly 4,400 in June 1988.

The 3-year financial plan that BSHC submitted to HCFA as part of the federal qualification process showed a projected operating surplus for the 6-month period ending September 30, 1985. HCFA accepted the plan and certified BSHC as a federally qualified HMO effective April 1, 1985. Upon receipt and review of BSHC's quarterly financial reports, however, HCFA learned in December 1985 that for the 6 months, BSHC had incurred a deficit of about $2.65 million rather than realizing a $2 million surplus as projected by the plan.

HCFA immediately initiated an evaluation of BSHC's operation to determine its compliance with federal financial solvency requirements. During the next 12 months, this agency made a site visit and requested financial reports and related financial data (which the HMO was not submitting on time as required by the NDRR system or in response to HCFA's requests).

By December 1986, HCFA cited the HMO for noncompliance with federal financial solvency requirements. In the notice of noncompliance, HCFA concluded that BSHC's financial plan on file with HCFA

"... fails to accurately project the financial performance of the Plan. Further based on this document and reported results to date, [HCFA] is unable to ascertain that the Plan will actually achieve cumulative breakeven with available financing. We therefore require from BSHC a new financial plan and evidence that firmly committed financing is in place to cover ongoing and future deficits of the HMO."

BSHC Denies Negative Net Worth

By letter dated January 16, 1987, BSHC claimed that it had been incorrectly classifying "unassigned surplus" under current liabilities and consequently did not have a negative net worth (for the quarters ended June 30 and Sept. 30, 1986). Answering on February 18, 1987, HCFA requested that BSHC obtain a letter from its independent auditor stating the auditor's opinion on the acceptability of the reclassifications proposed.

Receiving no acceptable response to either its December 1986 notice of noncompliance or the follow-up February 1987 letter, HCFA wrote BSHC again on June 25, 1987. The agency reiterated its concerns over the

plan's financial solvency and failure to submit required financial documents, and raised an additional issue about BSHC management. Specifically, HCFA noted that key managers—including the chief executive officer—had quit the firm or were on extended leave, raising ". . . questions about the plan's organizational stability." In this letter, HCFA asked BSHC to submit within 15 days:

1. Audited financial statements for 1986.

2. Audited financial statements for 1986 for BSHC's management company, Bay State HMO Management, and its holding company, Bay State Health Management.

3. A financial plan through 1 year beyond projected breakeven, supported by documented evidence of secured or firmly committed financing to support BSHC's present and continuing deficits.

4. Evidence of the infusion of capital to remedy BSHC's balance sheet deficiencies (estimated at between $1 million and $2 million).

5. A discussion of the arrangements for the delivery of health services consistent with an economically viable HMO, including measures to organize, plan, and control utilization and the cost of basic and supplemental health services to achieve utilization goals.

6. A discussion of actions taken as well as planned in the top management of BSHC.

Failure to furnish one or more of the required items or not to submit reports as required by the NDRR could be grounds for revocation of BSHC's federal qualification, HCFA advised the plan.

As of February 8, 1988, BSHC remained in noncompliance. A HCFA representative told us that the monthly reports HCFA is now requiring the HMO to submit are showing surpluses. However, according to HCFA officials, BSHC had not satisfactorily answered several questions. Therefore, a HCFA decision regarding reestablishing compliance will not be made until after HCFA reviews the results of the annual independent financial audit of BSHC. The results were due by the end of April 1988, but had not been received by HCFA as of June 15, 1988, HCFA officials told us.

United Health Plan

Faulty marketing practices, including failure to adequately explain to prospective enrollees the services to which they are entitled and the lock-in provisions of Medicare HMOs, can create problems for an HMO and its enrollees. The case of UHP presents an example of such problems.

UHP entered into a Medicare risk contract with HCFA as a demonstration project in May 1984. Because of UHP's predominantly Medicaid enrollment (about 85 percent, or 47,680 of 56,331 enrollees, as of December 1984), HCFA waived the requirement that no more than 50 percent of its enrollees be Medicare or Medicaid beneficiaries. In April 1985, UHP converted from a demonstration project by signing a TEFRA risk contract with HCFA. To approve the contract, HCFA continued UHP's waiver of the 50-percent requirement. Although the waiver specified that UHP meet the requirement by April 1988, HCFA did not require the plan to reduce its percentage of Medicare and Medicaid enrollees. Between December 1984 and July 1987 the HMO's total enrollment grew from 56,331 to 61,654, with Medicare and Medicaid enrollment remaining at about 83 percent.

HCFA identified early and recurring problems with UHP's marketing practices that centered on such areas as UHP not adequately informing enrollees of the services they were entitled to and the lock-in provisions of Medicare HMOs. The lock-in provision proved difficult to resolve. Failure to understand it can result in enrollees unknowingly going out of plan, creating potential losses for the enrollee, the provider, the plan, and/or Medicare. HCFA worked with UHP officials for more than 3 years, trying to ensure that UHP adequately explained the lock-in provision. Yet during this time a large number of UHP enrollees obtained out-of-plan services, indicating their lack of understanding of the provision. UHP filed for reorganization under chapter 11 of the Bankruptcy Act in 1987, and HCFA cited it for noncompliance with the financial solvency provisions of the PHS Act and applicable regulations.

Lock-In Not Adequately Explained to Enrollees

In February 1984, during an on-site visit, HCFA regional officials learned that some individuals responsible for explaining UHP's plan to potential enrollees did not themselves fully understand the lock-in provision. Because of this, in February 1984, HCFA wrote the plan emphasizing that the ". . . importance of a thorough explanation of [the] lock-in at the enrollment interview cannot be overemphasized."

Also, HCFA became concerned about UHP's practices of placing enrollment application forms in newspaper advertisements and accepting mailed-in

applications with no face-to-face contact with the beneficiary. This type of mass marketing allowed UHP to achieve "dramatic" increases in enrollments early in its contract. Yet disenrollments were running 150-200 per month in mid-1985, and the usual reason given was that the member did not understand the program. In addition, most complaints UHP received were the result of members not understanding what they had enrolled in.

HCFA wrote UHP officials at least four letters and made two additional visits between February 1984 and April 1986 concerning these matters, according to regional and central office files. In doing so, HCFA stressed the importance of explaining the lock-in provision and raised concerns about mailed-in enrollments.

For instance, after a 5-day site visit in March-April 1986, HCFA officials wrote to UHP's president and chief executive officer reiterating HCFA concerns about UHP's mass marketing activities. Specifically, HCFA officials had interviewed 20 Medicare beneficiaries who enrolled in UHP using the forms included in the newspapers and found the new enrollees ". . . did not seem to be fully aware that they were locked in to UHP for . . . services." The letter also pointed out that the advertisement did not conform to the version reviewed and approved by HCFA. The material HCFA had approved required the applicant, as a condition of enrollment, to attend an orientation meeting. Its deletion was a material change of which HCFA was not informed, the letter said.

A beneficiary's failing to understand the lock-in requirement can result in a number of adverse consequences if he or she obtains out-of-plan services without the HMO's approval. Whichever of the involved parties absorbs the costs of the service loses: the beneficiary, if he or she elects to pay the bill; the provider, if neither the beneficiary nor the HMO pays the bill; the HMO, if it pays the provider for services it did not authorize and that either were not needed or were more costly to provide than if

the HMO delivered the services; or the Medicare program, if the beneficiary is "retroactively disenrolled,"[1] Medicare pays the bill and the bill exceeds the capitation payments for the covered period.

Results Adverse When Enrollees Get Out-of-Plan Services

While HCFA has not attempted to identify beneficiaries or providers who have become liable or incurred costs as a result of out-of-plan services, we found evidence that beneficiaries may have incurred or became liable for substantial costs. For example, a letter to HCFA from an official with a Medicare Advocacy Project in Los Angeles states that ". . . two of [the project's] clients have out-of-plan claims in excess of $30,000 for which UHP is liable," and that these persons were already faced with collection actions. In these situations, we do not know whether the beneficiary paid any part of the bills or the providers were unpaid.

UHP also incurred some losses as a result of paying providers for some out-of-plan services. According to HCFA officials, this at least contributed to the plan's financial problems. Based on a February 20, 1987, meeting with UHP's president, HCFA's associate regional administrator for operations informed HCFA's central office that UHP's financial problems could be reduced by retroactively disenrolling individuals who were eligible for such disenrollments because they did not understand that they were locked in to the plan and obtained out-of-plan services for which the HMO made some reimbursement. Unless UHP could recoup some of what it paid for out-of-plan services—which it estimated at about $4 million—the regional administrator concluded that UHP could become financially insolvent and lose its license to operate in California.

Retroactive Disenrollments Seen as Solution

Subsequently, UHP requested retroactive disenrollment for enrollees who did not understand the lock-in provision and for whom UHP had paid for significant out-of-plan services. For cases that HCFA elected to retroactively disenroll, (1) HCFA would recoup the capitation payments from the HMO, (2) the HMO would recoup the payments it made to the providers for

[1]HCFA will retroactively disenroll members—meaning that it will adjust Medicare records so as to make it appear that the beneficiary was never enrolled or was enrolled for a shorter period of time than the record previously indicated. HCFA views retroactive disenrollment as an administrative process for correcting its records when an erroneous enrollment (for various reasons) occurred. The agency will retroactively disenroll a beneficiary if it is requested to do so and it can be shown that the beneficiary either did not know he or she was enrolled in an HMO or did not understand the implications of being enrolled. By eliminating or shortening the record of enrollment in an HMO, retroactive disenrollment entitles the beneficiary or provider to claim reimbursement under the regular Medicare program. HCFA's decision to allow retroactive disenrollments has no explicit statutory or regulatory basis though it is permitted under HCFA's general authorities to protect its beneficiaries' interests, according to HCFA officials.

out-of-plan services, and (3) HCFA would pay the providers under the regular fee-for-service program. HCFA deviated from its normal procedures for dealing with retroactive disenrollments by waiving the requirement that there be a signed beneficiary statement that they did not understand the lock-in provision for persons who received out-of-plan services before July 1985.[2]

HCFA made this deviation because it believed too much time had elapsed since the July 1985 cutoff date to retrace what had actually happened. Additionally, from the outset the point of the process was to infuse additional Medicare money into the HMO. For example, the HMO was advised by a HCFA official, according to HCFA correspondence, to make a cost-benefit analysis of the loss of capitation payments versus what they would recoup from Medicare paying for the out-of-plan services.

On March 6, 1987, UHP submitted to HCFA 155 cases for which it requested retroactive disenrollments. According to HCFA these cases represented about $2 million in out-of-plan services paid for by UHP and for which UHP had previously received about $215,517 in capitation payments. By June 1988 HCFA had approved for retroactive disenrollment 92 of these cases, partially approved 21, disapproved 23, and had not decided 19. One criterion HCFA used to establish an enrollee's eligibility for retroactive disenrollment was whether the enrollee used any HMO services. Essentially, if UHP had no record of providing services before the date when the enrollee went out of plan, the enrollee was assumed by HCFA to have not understood the lock-in provision.

UHP's Financial Viability Questioned

Although monies recouped from retroactive disenrollments would have helped UHP financially, they would not have been in time and apparently would not have been sufficient to prevent UHP from filing for chapter 11 bankruptcy. On March 11, 1987, the California Department of Corporations wrote UHP expressing serious concerns about UHP's ability to adequately maintain a financially viable operation and requiring it to submit a plan within 30 days to include financial projections for at least 1 year or until the breakeven point was reached. The department became concerned after reviewing the 1986 unaudited quarterly financial statements UHP submitted as required by California laws and regulations. The state's review of the statements showed that UHP had suffered

[2]The July 1985 date was chosen because at that time UHP sent a letter to all of its members explaining the lock-in provision and the provision's importance. Also, at that time HCFA emphasized to UHP the need to inform members about the lock-in provision.

excessive losses and a substantial drop in working capital and that its liabilities were 16 times its tangible net equity.

Shortly thereafter (March 16, 1987), HCFA sent a letter to UHP notifying the plan that it was initiating a compliance evaluation. After examining the plan's December 31, 1986, unaudited financial statements, HCFA concluded that the plan might lack a fiscally sound operation and the administrative and managerial arrangements required under the PHS Act and applicable regulations. HCFA asked UHP to submit monthly financial statements until further notice.

UHP filed for chapter 11 bankruptcy on March 19, 1987. Five days later, staff from HCFA's Office of Compliance made a site visit to ascertain whether the plan, after filing for bankruptcy, would be able to stay in business and adequately serve beneficiaries. During the visit, HCFA found that there were no audited financial records with which to ascertain the plan's financial position. (Although the audited financial statements were not due to HCFA until April 30, 1987, a HCFA official noted in his April 1, 1987, trip report that the 1986 audit probably would not be completed in time to meet the deadline.) At the same time, CDC issued a cease-and-desist order barring UHP from enrolling new members.

HCFA wrote UHP on April 22 advising the plan that by failing to maintain a fiscally sound operation, it was not in compliance with Medicare requirements. HCFA required UHP to submit a financial plan and other items within 120 days of the date UHP filed for chapter 11 bankruptcy. Within less than 2 months, however, CDC partially vacated the March 24, 1987, order and allowed UHP again to enroll Medicaid beneficiaries. Two months after that, HCFA's central office asked UHP to submit a plan for complying with the 50/50 enrollment requirement. The agency rejected the plan UHP submitted in July 1987. However, the Ominbus Budget Reconciliation Act of 1987 specifically granted UHP a waiver from the 50/50 requirement until January 1, 1990.

International Medical Centers, Inc.

Medicare providers are expected to deliver services that "meet professionally recognized standards of care . . ." according to the Social Security Act and that meet specific PHS Act standards. IMC exemplifies a situation in which we believe HCFA could have and should have been more aggressive in enforcing an HMO's compliance with quality-of-care requirements.

IMC participated in HCFA's HMO risk-contract demonstration program from August 1982 through April 1985, when it converted to a TEFRA risk contract. During the demonstration, HCFA gave IMC a waiver to the 50/50 enrollment requirement. When the HMO converted under TEFRA, its members were predominately Medicare beneficiaries. This necessitated that HCFA waive the 50/50 requirement in order to approve IMC's TEFRA contract. At that time, HCFA granted IMC a 3-year exception to the requirement. The exception allowed IMC to continue growing rapidly, unrestrained by the need to attract commercial members and thus establish itself in the commercial marketplace.

Coupled with early and continuing difficulties with fiscal soundness and administrative and managerial systems, this early growth contributed to IMC's compliance problems, which over time became increasingly severe. Many of the problems have been documented in other reports by GAO,[3] in congressional testimony, and in the news media. The denouement came in mid-1987, when HCFA notified IMC of its intention to terminate its contract, and the Florida State Insurance Commission, determining that IMC had become insolvent, placed the HMO in receivership, assumed its operational control, and ultimately arranged for its sale (in June 1987).

Compliance Problems First Found in Early 1980's

Even when HCFA approved (in Aug. 1982) IMC's participation in the risk-contract demonstration program, the HMO was under evaluation by HCFA[4] because of suspected problems with its fiscal soundness and administrative and managerial arrangements. (This evaluation, begun in November 1981 when IMC operated under a Medicare cost contract, was the first of a series of 11 evaluations—6 of which resulted in notices of noncompliance—before the state took operational control of IMC in May 1987). During this time, IMC's enrollment of Medicare beneficiaries increased from about 5,000 in late 1981 to about 135,000 in 1986.

In April 1984, HCFA began an evaluation after it identified problems with IMC's quality assurance system. This evaluation of IMC's fiscal soundness and solvency provisions was completed by April 8, 1985, when HCFA determined that IMC had taken the necessary measures to comply with

[3]Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986); Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, Mar. 8, 1985).

[4]Before March 14, 1986, compliance with PHS Act requirements, such as those dealing with financial solvency, were the responsibility of the Office of Health Maintenance Organizations, within PHS. After this date, the office's responsibilities were transferred to HCFA. For ease of reference, after this point, we attribute all compliance activities to HCFA.

PHS Act requirements and signed a TEFRA risk contract with IMC. Within 5 to 12 months after HCFA signed the contract with IMC, the same issues were again being evaluated by HCFA.

- Insolvency provisions. On August 7, 1985, HCFA placed IMC under evaluation for having unacceptable insolvency arrangements. Although the problem giving rise to this evaluation was resolved in October 1985, it arose for the third time and HCFA began another evaluation on May 20, 1986. This evaluation remained open until the IMC contract was terminated.
- Fiscal soundness. HCFA placed IMC under evaluation for problems related to fiscal soundness on April 4, 1986. The evaluation stemmed from concerns about IMC's financial condition and member and provider complaints about nonpayment of claims. IMC's unaudited balance sheet of September 30, 1985, indicated that the plan had a negative working capital (current liabilities exceeded current assets) of $7,484,080. This meant it lacked sufficient cash flow and liquidity to meet its obligations as they became due. Also, HCFA had concerns about whether the full value of the short- and long-term assets "due from affiliates and related parties" could be collected. HCFA required IMC to submit quarterly financial statements, which it continued monitoring until the state placed the HMO in receivership on May 14, 1987.
- Administrative and managerial arrangements and quality assurance program. These areas were the issue on April 18, 1986, when HCFA again placed IMC under evaluation because of member and provider complaints relating to availability, accessibility, and acceptability of health services. In May 1986, HCFA placed IMC in noncompliance for its failure to maintain satisfactory administrative and managerial arrangements related to health services and general management and for not having an acceptable quality assurance program.

  Among the management and financial deficiencies cited in May 1986 were IMC's lack of accurate information on affiliated providers' referral arrangements, information given affiliated providers and physicians, and continuity of care; inaccuracy in reports produced; late processing of provider claims; and ineffective complaint and grievance procedures. Quality assurance deficiencies included lack of satisfactory organizational arrangements, basic weakness in internal peer review, and weakness in review of patients' charts and procedures to follow up on negative outcomes.

  HCFA required IMC to submit a corrective action plan within 30 days addressing the cited violations or risk loss of federal qualification. IMC

submitted the action plan on time, but HCFA requested additional information before ultimately accepting IMC's submission in August 1986. HCFA continued its monitoring of the corrective actions until the state placed IMC in receivership and assumed its operations in May 1987.

Medicare Enrollment Too High, HCFA Rules

Also, in February 1986, HCFA notified IMC that it planned to monitor the HMO's compliance with the 50/50 enrollment requirement. In March, HCFA's Region IV office asked IMC to submit a plan describing its strategies for increasing non-Medicare enrollment. IMC submitted a plan in April 1986. In May 1986 the region requested IMC to submit additional information, including monthly reports on actual Medicare and non-Medicare enrollment. IMC provided the additional information in June 1986 and began submitting the monthly reports in July 1986.

Because the percentage of IMC's Medicare enrollments continued to increase (from about 71 percent in June 1986 to about 78 percent in April 1987), HCFA suspended Medicare enrollment at IMC in April 1987 and warned IMC it would terminate the contract unless the plan began making progress toward meeting the 50/50 requirement. At the same time, the HHS IG recommended that HCFA terminate IMC's contract because IMC had violated several contract requirements, including the 50/50 enrollment requirement.

On May 1, 1987, HCFA announced that it had notified IMC that it planned to terminate IMC's contract effective July 31, 1987, and was requesting the Florida Insurance Commissioner to review IMC's financial condition and take whatever action it deemed necessary. On May 14, the Florida Insurance Commissioner placed IMC in receivership and declared it insolvent. The state of Florida began operating IMC and on June 1, 1987, IMC was sold to Humana Medical Plan, Inc.

Quality of Care an Issue

Concerns about the quality of IMC's care were long-standing. Since shortly after IMC became involved with Medicare as a contractor, complaints and issues were raised by providers, enrollees, and federal/state oversight personnel. These concerned either quality of care directly or matters with potential quality effects, such as the accessibility and continuity of care and the adequacy of IMC's quality assurance systems. For example:

1. Allegations of poor care and the possibility of involving the Florida PRO (then referred to as the Professional Standards Review Organization) were raised in 1982 internal HCFA discussions on whether to grant IMC a demonstration contract for the pre-TEFRA risk-based program.

2. Also in 1982, an evaluation was begun that was to run for over 2-1/2 years because of recurring concerns over the accessibility and availability of basic and supplemental health services from IMC.

3. In a February 1984 report on an investigation of IMC which was sent to the HCFA director of health plan operations, the HHS IG's Atlanta office asserted that "The large number of patients who expressed dissatisfaction with the care received, particularly those who had serious ailments, should be cause for concern." The office also said that it appeared that the government was failing in its obligation to Medicare beneficiaries "to see that the services they receive in federally funded HMO's meet . . . professionally recognized standards." It was recommended that existing HMOs have a sample of their medical records periodically reviewed by PROs or other such independent Medicare contractors that did individual case reviews to assure the public that their services met professionally recognized standards.

4. In April 1984, under a HCFA contract, the National Committee for Quality Assurance, a private organization affiliated with group health providers such as the HMO industry, issued a report describing its review of IMC's compliance with federal requirements for a quality assurance system. The committee found, based on a 2-day site visit that focused on IMC's quality assurance process (not individual cases), that IMC's quality assurance system did not meet either committee or federal regulatory requirements. Essentially, IMC did not have in place the organizational arrangements necessary for an ongoing quality assurance program. Shortly after receiving the committee's report, HCFA placed IMC under evaluation. Compliance was confirmed and the evaluation closed in April 1985. HCFA began a new evaluation in April 1986 and on May 30, 1986, found the plan in noncompliance with the PHS Act requirements for a quality assurance system. In September 1986 HCFA asked the HHS IG to investigate quality of care complaints at IMC.

While such concerns about IMC were long-standing, HCFA did not systematically look at IMC's patients' medical records to assess the HMO's quality of care. In May 1987, however, in response to continuing quality-related complaints from IMC Medicare enrollees, the HCFA Administrator requested the IG to again investigate IMC. As part of the investigation,

the IG asked the Florida PRO to review a sample of medical records at each of 142 IMC clinics.

In June 1987 the PRO issued a report to IMC (with a copy to HCFA) outlining its findings. At 2 [illegible]C centers, the PRO reported, practitioners had violated their obligations under the Social Security Act to provide care that met professionally recognized standards, according to records the PRO reviewed. At these sites, the PRO found such problems as failure to

- follow up on a patient with breast mass,
- follow up on a cancerous pathology report, and
- evaluate a lung mass identified on chest X-ray.

On an IMC-wide basis, the PRO also found the availability and accessibility of consultants and specialists to be a problem. Shortly after the PRO issued its report, IMC was sold. According to the PRO executive director, the new owner has taken steps to correct some of the problems, including firing some physicians and instituting a new internal quality assurance system, and the PRO will make follow-up reviews.

Broader Sanction Authority Could Encourage More Timely Action

In each case study discussed above, the compliance problems HCFA was evaluating sometimes continued for several years, during which the HMOs continued to enroll Medicare beneficiaries. While HCFA could have sought to terminate the HMO's Medicare contract in each case, the agency instead chose to continue working to bring the HMO into compliance. This is the preferred solution when the HMO demonstrates prompt and significant progress toward achieving compliance. But such progress does not always occur, raising the question of what HCFA should do while remedies (ultimately, the HMO's compliance or HCFA's termination of the contract) are being worked out.

With the enactment of the Omnibus Budget Reconciliation Acts of 1986 and 1987, HCFA's ability to take actions against noncompliant HMOs was broadened. This legislation gave HCFA sanctions to deal more forcefully with HMOs that (1) violate the 50/50 requirement, (2) do not pay their provider bills in a timely fashion, (3) do not meet quality-of-care standards, (4) overcharge on premiums, (5) improperly enroll or disenroll individuals, (6) engage in any practice to deny or discourage enrollment by individuals with a need for substantial medical services, or (7) misrepresent or falsify information.

During much of the period covered by our case studies, HCFA did not have these authorities, which could have been useful and might have led to earlier HCFA action.

From analysis of HCFA data, however, and the case studies discussed above, these additional sanction authorities would not cover situations involving HMOs that

- do not comply with NDRR or other Medicare reporting requirements specified for monitoring the HMOs' compliance with PHS Act requirements or for demonstrating compliance with corrective action plans,
- have ineffectual marketing practices as evidenced by high disenrollment rates and/or higher-than-expected use by enrollees of out-of-plan services, or
- have a history of compliance problems—either different problems or a continuation of the same problem.

HMOs that experience financial losses and consequently fail to meet the PHS Act financial solvency requirements pose a difficult problem for HCFA. Such a problem often can be expected to take some time to resolve despite the HMO's clear interest in improving its financial position. But should the HMO be allowed to continue enrolling Medicare beneficiaries when its continued financial viability is uncertain? Having (and using) the authority to suspend an HMO's enrollment of Medicare members when the HMO is out of compliance with financial solvency requirements and not clearly improving could help HCFA limit the potential adverse effects on Medicare beneficiaries of a bankruptcy or protracted financial difficulties.

Conclusions

Most HMOs having compliance problems identified by HCFA are responsive and reasonably timely in addressing HCFA's requests for corrective actions. This is not the case for a few HMOs, however, which tended to have recurring compliance problems or were unresponsive or untimely in taking HCFA-requested corrective actions. HCFA actively tries to resolve these HMOs' compliance problems, but the practical effect is often little more than to document the history of the problems. The agency has been unwilling to terminate its contract with the HMO until problems have reached a critical state.

Broader Sanction Authority Would Help Ensure Compliance

As the cases we presented demonstrate, it can take a number of years for an HMO's compliance problems to become resolved, and over this period a noncompliant HMO can continue enroiling Medicare beneficiaries. Ironically, if the compliance problems are not ultimately resolved, the number of Medicare beneficiaries enrolled can itself be a key reason for not terminating a contract. This was the case with IMC, when HCFA officials were reluctant to terminate its contract because of the potential adverse effects on beneficiaries, both financially and in terms of continuity of services. This problem became serious, however, because HCFA permitted IMC to grow, despite its recurring compliance problems, from about 5,000 Medicare enrollees in 1981 to over 135,000 before taking actions in 1986 to cap the HMO at this level.

Such rapid growth in Medicare membership as IMC's is not likely to recur because of (1) congressional actions restricting HCFA from granting waivers of the 50/50 requirement and (2) HCFA's stronger enforcement of the requirement since IMC's problems became a major concern. Nonetheless, HCFA cannot suspend Medicare enrollment by an HMO that is neither complying with Medicare requirements nor making substantial progress toward compliance, unless the HMO approaches or exceeds the 50-percent Medicare/Medicaid limitation or falls out of compliance with one of the other specified conditions contained in the 1986 and 1987 Omnibus Budget Reconciliation Acts.

We believe that HCFA should have broader sanction authority for dealing with HMOs that do not respond promptly with lasting corrective action for noncompliance with any Medicare requirement that, if left uncorrected, can be expected to have a potentially adverse effect on beneficiaries.

Issue of Retroactive Disenrollments Needs Clarification

Furthermore, HCFA's use of retroactive disenrollments in the UHP case raises issues that should be clarified to better assure that the practice is (1) used only when justified and (2) consistently applied. In granting retroactive disenrollments for UHP, HCFA deviated from its internal policies by neither investigating the circumstances surrounding the out-of-plan services nor documenting the reasonableness of the disenrollment action by discussing the circumstances with the beneficiaries. Currently there is no explicit statutory authority for retroactive disenrollments, though we believe HCFA's general authorities to protect beneficiaries authorize the procedure. Regulations, however, are needed to specify the circumstances under which use of the procedure is warranted. In our

opinion, such disenrollments are warranted only when it can be shown that

- there is convincing evidence that the beneficiary did not understand his or her obligation to use HMO providers (for example, if the beneficiary says so and is new to the program) and
- the HMO is clearly not liable for such payments (that is, it has taken reasonable measures to inform new members of the lock-in provisions, it did not authorize the service or inappropriately deny a similar service, and the service was not an emergency or urgently needed).

Procedures Needed to Track Corrective Actions

HCFA has not developed a system for tracking and following up on its corrective action requests to ensure that all HMOs respond timely and that their responses appropriately address HCFA's concerns. The absence of such a system has resulted in a few instances in which HCFA was not aware that an HMO did not respond to its request for corrective action or that the HMO's response did not adequately address HCFA's concerns. A system to track the timeliness and adequacy of HMOs' responses to HCFA's requests for corrective action could enhance HCFA's ability to gain timely resolution of compliance problems.

Matter for Consideration by the Subcommittee

While HCFA's authority to sanction noncompliant HMOs has been increased in the past 2 years, the Subcommittee should consider increasing HCFA discretion in applying its authority to suspend Medicare enrollments. Specifically, the Subcommittee should consider developing legislation to give HCFA discretion to suspend Medicare enrollments in HMOs that—for whatever reason—fail to respond to notices of noncompliance in a timely manner, have recurring compliance problems, or are encountering financial difficulties or failing to meet financial solvency requirements and not showing substantial progress in improving from one reporting period to the next.

Recommendations to the Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to (1) issue regulations specifying the purpose for retroactive disenrollments and the circumstances, criteria, and procedures that must be met in authorizing such actions and (2) establish a formal system for tracking through final resolution HCFA's requests for corrective actions and the HMOs' corrective actions.

Agency Comments

In commenting on a draft of this report, HHS agreed with our recommendations. Regarding our recommendation to issue regulations on retroactive disenrollments, HHS said that this item is already in HCFA's regulation agenda. HCFA officials told us that they expect to publish draft regulations in November or December 1988. HHS also concurred with our recommendation to establish a formal system for tracking compliance actions, and it anticipates that the system will be operational in early fiscal year 1989.

While agreeing with our recommendations, HHS commented that the draft report did not clearly acknowledge that, before the spring of 1986, federal oversight of HMOs was not centralized in HHS. At that time, to improve HHS oversight of HMOs, the agency integrated its units with oversight responsibilities into one HCFA unit—OPHC. Since that time, OPHC has been working to improve the efficiency of the entire program, HHS commented.

We do not disagree that HHS and OPHC have been working to improve their oversight of the HMO program. Our report, however, addresses HCFA's current oversight functions and focuses on HCFA's ability to manage the program using its current oversight systems, data, staffing, and organizational structure. We believe we have accurately represented HCFA's oversight functions, as well as the initiatives HCFA had underway at the conclusion of our review to further improve its operations.

HHS also commented that we did not explain the relationship between various legislative requirements governing HMOs and CMPs. Consequently, HHS commented that we made inappropriate references to PHS Act requirements as though they applied to both HMOs and CMPs. HHS pointed out that CMPs are covered not under PHS Act requirements, but under requirements of title XVIII of the Social Security Act.

We are aware of the distinction in legislative requirements between CMPs and HMOs, and for simplicity, we attempted in the draft to deal with this through a footnote. We revised the draft in a number of places to clarify the statutory basis of the requirements discussed.

HHS's comments are included in appendix I.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington D.C. 20201

JUN 2 ? 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report, "Health Maintenance Organizations: Medicare Experience Provides Lessons For Improved Oversight." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

for Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Health Maintenance Organizations: Medicare Experience Provides Lessons For Improved Oversight

Overview

GAO's draft report discusses the adequacy of Federal oversight of Medicare risk-contract health maintenance organizations (HMOs). The report was prepared at the request of the Chairman of the Subcommittee on Health, House Committee on Ways and Means. The Chairman asked GAO to review: the adequacy of data available to determine if HMOs provide quality of care at reasonable cost; the adequacy of staffing levels for monitoring HMOs; and the willingness of the Health Care Financing Administration (HCFA) to take action when HMOs are not meeting Federal requirements.

According to GAO, HCFA has relatively limited data with which to monitor HMOs' quality of care and the reasonableness of HMO capitation rates. In addition, GAO believes that HCFA's staffing for compliance monitoring, though increased, has not kept pace with HMO growth. Finally, GAO reports that through monitoring of the HMOs, HCFA has identified numerous problems of which most were resolved. However, GAO believes that HCFA could have acted more quickly and forcefully and additional sanction authority may have prompted HCFA to do so.

We would like to note that the report does not clearly acknowledge that, prior to the spring of 1986, Federal oversight of HMOs was not centralized in the Department. Rather, two different agencies, HCFA and the Public Health Service (PHS), with historically different roles, administered Federal HMO activities, including monitoring. The Department's recognition of the potential for improved Federal oversight (as well as integration) resulted in the creation of the Office of Prepaid Health Care (OPHC) in HCFA. Since that time, OPHC has been working to improve the efficiency of the entire program. Specific accomplishments include 1) a complete redesign of the plan payment and enrollment/ disenrollment systems, 2) establishing central review of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) risk-contracts, and 3) a complete redesign of the monitoring strategy. OPHC has accomplished a great deal in these areas and others which is not reflected in the GAO report.

The draft report does not explain the relationship of Title XIII of the Public Health Service Act to requirements applicable to Medicare contracts with HMOs/Competitive Medical Plans (CMPs), and often inappropriately references PHS requirements as though they apply universally to all HMO/CMP contracts. The report should clarify that organizations that qualify as HMOs under Title XIII are eligible to contract with HCFA, as are certain other prepaid health care organizations that meet specified requirements of Title XVIII (i.e., CMPs).

GAO Recommendation

That the Secretary of HHS direct the HCFA Administrator to issue regulations specifying the purpose for retroactive disenrollments and the circumstances, criteria, and procedures that must be met in authorizing such actions.

Department Comment

We concur with this recommendation. This item is currently in HCFA's regulations agenda (the "Omnibus HMO Regulations Package") and is scheduled for publication in November or December of this year.

GAO Recommendation

That the Secretary of HHS direct the HCFA Administrator to establish a formal system for tracking through final resolution HCFA's requests for corrective actions and the HMOs' corrective actions.

Department Comment

We concur with this recommendation. HCFA's Office of Compliance has a management information strategy which includes development of such a system. We anticipate this system will be operational in early FY 1989.

U.S. G.P.O. 1988-201-749:87230